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A critical analysis of neo-liberal reforms to the English NHS since the year 2000.

By David Ian Benbow

*Submitted in accordance with the requirements for the degree of Doctor of  
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Keele University

Centre for Law, Ethics and Society

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## Abstract

Solidarity was important in the creation and maintenance of the English NHS, which was the product of class compromise. Its founding principles were that it was to be free (at the point of access), universal, comprehensive and primarily funded from general taxation. In recent decades, successive governments have renewed the neo-liberal project. This has involved new governance mechanisms (quasi-markets and targets) being emplaced in the NHS and private healthcare companies (which have influenced government policy) being afforded increasing opportunities to deliver NHS services. Such privatisation is antagonistic to patient needs. I undertake an ideology critique of the NHS reforms of the New Labour governments and of governments since 2010. I examine the influences on, justifications for, resistance to, and potential reifying effects of, such reforms. Misrepresentations and mystification may legitimate and obscure legal changes. I identify the ideological modes and strategies that governments have employed to justify their reforms. I also analyse several modes of reification (identity thinking, instrumental rationality, depoliticisation and the legitimisation effect of law) to assess whether the reforms produced estrangement, which is the opposite of solidarity.

Many of the justifications for successive reforms were contested. Although such reforms have rendered healthcare more opaque, solidarity endures. Neo-liberal norms compete with residual norms (including the NHS' founding principles) and emergent norms (which developed due to the problems of welfare states, such as their failure to empower recipients and the persistence of health inequalities). As validity has been

given to residual and emergent norms, which have been superficially articulated within government discourse, but which are undermined by neo-liberal policies, a legitimisation crisis may arise as public experience increasingly diverges from them. I advocate amending legislation which has undermined residual norms, democratising the NHS to empower patients and the public and increased intervention in capitalism to address health inequalities.

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## Introduction

“Men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past. The tradition of all dead generations weighs like a nightmare on the brains of the living”.<sup>1</sup>

### Introduction

Karl Marx's above contemplation indicates that altering social relations is not straightforward. In this dissertation, I highlight that although neo-liberalism is currently the dominant ideology, the translation of neo-liberal norms into health and healthcare, through mechanisms, such as law, has not been a seamless process. The National Health Service (NHS) was established in 1948 to provide universal, comprehensive and free at the point of access (with access based on need) health care to UK citizens who registered. It was the product of class compromise.<sup>2</sup> In institutionalising solidarity concerning healthcare,<sup>3</sup> it was symptomatic of what Francois Ewald described as social law, which recognises the interdependence of citizens.<sup>4</sup> The Minister of Health who established the NHS, Aneurin Bevan, stated that it was a first fruit and that more

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<sup>1</sup> Marx, K. (1852) *The Eighteenth Brumaire of Louis Bonaparte* [On-line] Available: <https://www.marxists.org/archive/marx/works/1852/18th-brumaire/> [Accessed: 07 October 2014].

<sup>2</sup> Wright, E. (2015) *Understanding Class*. London: Verso, p231.

<sup>3</sup> Jaeggi, R. (2001) 'Solidarity and Indifference' in ter Meulen, R. et al (eds) *Solidarity and Health Care in Europe*. London: Kluwer, pp287-308 at p292.

<sup>4</sup> Ewald, F. (1988) 'A Concept of Social Law' in Teubner, G. (ed) *Dilemmas of Law in the Welfare State*. New York: Walter de Gruyter, pp40-75 at p43.

goods and services should be delivered in ways other than the market.<sup>5</sup> In the neo-liberal era, numerous policy and legal changes (legislation, regulations and ministerial directions) have reformed the English NHS.<sup>6</sup>

I primarily focus on reforms characteristic of roll-out neo-liberalism,<sup>7</sup> which involves states more directly supporting capital through social policy.<sup>8</sup> Such reforms have altered NHS governance through performance management, marketization (aided by legal forms, such as contract) and privatisation (which may be locked in by supranational legal regimes). In furnishing private companies with more opportunities, the reforms that I examine divert money away from patient needs to bureaucracies (required to administer quasi-markets) and the coffers of private companies and undermine risk pooling and cross subsidy within the NHS, which underpin a service provided in response to need.<sup>9</sup> While the NHS was created on the basis that it was beneficial for society in improving health and moral (as it was argued that income should not affect access to health services),<sup>10</sup> the distributive effects of neo-liberal policies have been accompanied by a moral politics emphasising individual responsibility for health which endeavours to justify excluding some patients. Neo-liberal policies have reduced the comprehensiveness of the NHS. This, coupled with

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<sup>5</sup> Bevan, A. (1950) *Democratic Values*. London: Fabian Society, p14.

<sup>6</sup> The provision of healthcare is a devolved competence for Northern Ireland, Scotland and Wales.

<sup>7</sup> The third neo-liberal transformation, identified by Jamie Peck and Adam Tickell. The first was roll-back neo-liberalism and the second was a transition to more ameliorative forms. See Peck, J. and Tickell, A. (2002) 'Neoliberalizing Space'. *Antipode*, Vol.34(3), pp380-404 at pp388-389.

<sup>8</sup> Veitch, K. (2013) 'Law, Social Policy, and the Constitution of Markets and Profit Making'. *Journal of Law and Society*, Vol. 40(1), pp137-154 at p138.

<sup>9</sup> Doctors for the NHS (2015) 'An NHS Beyond the Market'. [On-line] Available: <http://www.doctorsforthenhs.org.uk/nhs-threats/privatisation/an-nhs-beyond-the-market/> [Accessed: 16 October 2016].

<sup>10</sup> Glyn, A. (2006) *Capitalism Unleashed: Finance, Globalization and Welfare*. Oxford: Oxford University Press, p158.

insufficient funding, has resulted in more people paying for health care. This is inequitable, as where health is treated “as a commodity with a price, it tends to be differentially distributed among members of a society”.<sup>11</sup> Neo-liberals are desirous of citizens attending to their needs through markets,<sup>12</sup> which they idealise as essential in allocating resources and ensuring freedom.<sup>13</sup> I analyse the reforms from a Marxist perspective. Marxists view markets as inefficient (I argue that quasi-markets have rendered the NHS less allocatively efficient) and opaque. Marxists desire to organise society according to the following principle: “from each according to his abilities, to each according to his needs”.<sup>14</sup> Marxists are thus antipathetic to reforms which undermine patient’s needs.

In order to understand how the distributive effects of neo-liberal reforms may be legitimated or obscured, I undertake an ideology critique of the reforms of the New Labour governments (1997-2010) and governments since 2010 and analyse developments up to the 2017 general election. I examine the influences on (including neo-liberalism and private healthcare companies), the justifications for, opposition and resistance to, and the effects of, such reforms. I also consider the broader policies of the respective governments and their impact on health and healthcare. In particular, I note that while NHS investment increased under New Labour, it has decreased under subsequent governments. In this respect, the Select Committee on the Long-Term

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<sup>11</sup> Waitzkin, H. and Waterman, B. (1974) *The Exploitation of Illness in Capitalist Society*. Indianapolis: Bobbs-Merrill, p12.

<sup>12</sup> Offe, C. (1984) ‘Legitimacy versus Efficiency’ in Keane, J. (ed) *Contradictions of the Welfare State*. London: Hutchinson, pp130-146 at p138.

<sup>13</sup> Turner, R. (2008) *Neo-Liberal Ideology: History, Concepts and Policies*. Edinburgh: Edinburgh University Press, p4.

<sup>14</sup> Marx, K. (1875) *Critique of the Gotha Program*. [On-line] Available: <https://www.marxists.org/archive/marx/works/1875/gotha/ch01.htm> [Accessed: 5 September 2017].

Sustainability of the NHS recently determined that a tax funded, free at the point of use NHS remains the most appropriate model and requires increased funding.<sup>15</sup>

I briefly examine New Labour's extension of the private finance initiative (PFI), for the financing of hospital construction, which involved private profit taking precedence over patient need. However, I mainly focus on the increased opportunities afforded to private companies in delivering clinical services within the NHS. In this respect, the '*NHS Plan*', published in 2000, led to a concordat with the Independent Healthcare Association (IHA). This was an informal agreement for the NHS to increasingly use private facilities. It also instigated performance management in the NHS (through the use of targets).<sup>16</sup> New Labour's reforms increasingly marketized the NHS. Such reforms included supply side reforms, such as the creation of independent sector treatment centres (ISTCs) and foundation trusts (FTs), which were conferred with powers to borrow, generate surpluses and establish joint ventures with private companies. It also involved demand side reforms (such as patient choice of provider for some services), transactional reforms (such as the introduction of payment by results (PBR) for some treatments) and system management reforms. New Labour's primary care reforms (ending the GP monopoly of primary care services<sup>17</sup> and the creation of polyclinics) also increased opportunities for private companies.

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<sup>15</sup> Select Committee on the Long-Term Sustainability of the NHS (2017) *The Long-Term Sustainability of the NHS and Adult Social Care Report of Session 2016-17*. London: House of Lords, p3.

<sup>16</sup> Exworthy, M. et al (2010) *Decentralisation and Performance: Autonomy and Incentives in Local Health Economies*. Southampton: National Coordinating Centre for the Service Delivery and Organisation, p69.

<sup>17</sup> National Health Service (NHS) Act (1977), S.16CC(2)(B) as amended by Health and Social Care (Community Health and Standards) (HSC) Act (2003), S.174/National Health Service (NHS) Act (2006), S.83(2)(B).

The Conservative-Liberal Democrat coalition (2010-2015) reformed the NHS via the Health and Social Care (HSC) Act (2012). The HSC Act (2012) undermines the NHS' founding principles as it: permits FTs to derive up to forty-nine percent of their income from fee paying patients<sup>18</sup> (undermining equality of access); introduces eligibility criteria into the NHS<sup>19</sup> (undermining universality); facilitated the reduction of the comprehensiveness of the NHS (for example, by replacing Primary Care Trusts (PCTs), which were required to provide or secure certain services, such as services concerning drug and alcohol misuse,<sup>20</sup> with Clinical Commissioning Groups (CCGs), which are not<sup>21</sup>); and, facilitates the further reduction of the comprehensiveness of the NHS through its amendment to the duty of the Secretary of State for Health (who is now only required to promote, not provide, a comprehensive health service<sup>22</sup>). The coalition sought to depoliticise healthcare by delegating power to ostensibly non-political bodies, such as NHS England (NHSE). Although the coalition claimed that it wanted to decentralise power within the NHS and move away from process targets, the NHS has become increasingly centralised and such targets persist. I contend that the outcomes data that is being produced in the NHS (partly to facilitate patient choice) is superficial.

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<sup>18</sup> NHS Act (2006), S.43(2A) as amended by Health and Social Care (HSC) Act (2012), S.164(1).

<sup>19</sup> HSC Act (2012), S.103(1).

<sup>20</sup> National Health Service (functions of strategic health authorities and primary care trusts and administration arrangements) (England) Regulations, SI 2002/2548.

<sup>21</sup> Pollock, A. et al., 'Health and Social Care Bill 2011: a legal basis for charging and providing fewer services to people in England'. *British Medical Journal* 2012;344:e1729.

<sup>22</sup> NHS Act (2006), S.1(1) as amended by HSC Act (2012), S.1.



The coalition claimed that it wanted to empower GPs (working together in CCGs, which commission secondary care services) to act on behalf of patients. Although the discretion afforded to commissioners regarding the use of competition is contested, many commissioners have acted as though their discretion was curtailed and private providers are increasingly delivering NHS services. This has negative implications for equity, efficiency, accountability and quality and may fragment the NHS. Nonetheless, there are countervailing forces to competition, such as resource constraints and public opposition. Many interpret NHSE's emphasis on integration in '*Five Year Forward View*' ('*FYFV*'), and subsequently, as a move away from competition. However, the integrated care organisations that are being developed, in some parts of England, are attractive to private companies, which are reportedly interested in filling projected gaps in funding for the sustainability and transformation plans (STPs) devised to implement '*FYFV*'.<sup>23</sup>

A consumerist view of public engagement in health services informed the reforms of successive governments, which have weakened mechanisms for patient and public involvement. The reforms encountered opposition and resistance and have been the subject of numerous academic critiques. The method of ideology critique was often unclear and is eschewed by many contemporary critical theorists.<sup>24</sup> Nonetheless, I utilise it (in my own particular way) within this dissertation, to illuminate the contestation between dominant neo-liberal ideas and competing ideas and the imperfect translation of neo-liberal ideas into practice, via mechanisms, including law

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<sup>23</sup> Forster, K., 'Budget 2017: Philip Hammond accused of back-door NHS privatisation by funding 'shady' reform plans', *Independent*, 9 March 2017.

<sup>24</sup> Jaeggi, R. (2009) 'Rethinking Ideology' in de Bruin, R. and Zurn, C. (eds) *New Waves in Political Philosophy*. Basingstoke: Palgrave, pp63-86 at p63.

(which involves attempt, incompleteness and resistance<sup>25</sup>), which is neglected in other critiques of recent NHS reforms. Below, I outline the key claims advanced within my thesis, set out my research questions and present an overview of the chapters.

### Thesis Claims

There are several different, but potentially compatible, ways of conceiving neo-liberalism.<sup>26</sup> The problem with conceiving neo-liberalism as a process, or as a set of policies, is that such conceptions do not identify an agent.<sup>27</sup> Neo-liberalism is conceived in Foucauldian literature as a political rationality, which seeks to impose the logic of the market on an increasing number of spheres through mechanisms of governance. Foucauldian approaches neglect the translation of political rationalities into practice<sup>28</sup> and de-emphasise the power and domination of capital.<sup>29</sup> My ideology critique draws on Marxist conceptions of neo-liberalism, as a hegemonic class project, which identify the ruling bourgeois class as the agent of neo-liberal policies and processes and account for the often imperfect translation of political rationalities into practice. Although neo-liberal methods and norms of governance have been emplaced within the NHS, I aver that neo-liberalism has not been as successful as some scholars

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<sup>25</sup> Hunt, A. and Wickham, G. (1994) *Foucault and Law: Towards a Sociology of law as Governance*. London: Pluto, pp102-104.

<sup>26</sup> It has been conceived as a process, as a set of policies, as a type of governmentality and as a hegemonic ideological project. See Ward, K. and England, K. (2007) 'Introduction: Reading Neoliberalization' in Ward, K. and England, K. (eds) *Neoliberalization: States, Networks, Peoples*. Malden, MA: Blackwell, pp1-22.

<sup>27</sup> Birch, K. (2015) *We Have Never Been Neoliberal: A Manifesto for a Doomed Youth*. Winchester: Zero Books

<sup>28</sup> Clarke, J. (2009) 'Programmatic Statements and Dull Empiricism: Foucault's Neo-liberalism and Social Policy'. *Journal of Cultural Economy*, Vol.2(1-2), pp227-231 at p229.

<sup>29</sup> Brown, W. (2015) *Undoing the Demos: Neoliberalism's Stealth Revolution*. Brooklyn, NY: Zone Books, p13.

suggest. Wendy Brown argues that the space between liberal democratic ideals and lived realities is no longer exploitable as neo-liberalism has expunged liberal conceptions of the good life and its formal promises of freedom and equality.<sup>30</sup> Brown contends that in the neo-liberal era, states derive their legitimacy merely from economic growth.<sup>31</sup> My analysis of NHS reforms repudiates Brown's arguments.

Neo-liberals contend that welfare states undermine competitiveness<sup>32</sup> and that public-sector bureaucrats are self-maximising entrepreneurs (rather than motivated by a public service ethos) incentivised by democracy to raise budgets.<sup>33</sup> New governance methods, such as targets and quasi-markets (as complete marketization has been deemed to be electorally unviable), have been employed within the NHS during the neo-liberal era. Both Brown and David Harvey note that corporations have an increased role in fashioning law and policy.<sup>34</sup> I posit that there is a micro-ideology pertaining to private healthcare companies, proponents of which seek to justify their increased involvement in delivering clinical services, which is in the material interests of such companies.<sup>35</sup> I explicate the influence that the agents of such companies have exerted on the reforms.

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<sup>30</sup> Ibid at p57.

<sup>31</sup> Ibid at p26.

<sup>32</sup> Gough, I. (2000) *Global Capital, human needs and Social Policies*. Basingstoke: Palgrave, p177.

<sup>33</sup> Seymour, R. (2014) *Against Austerity: How we can fix the crisis they made*. London: Pluto, p10.

<sup>34</sup> Brown, W. (2015) *Undoing the Demos*, op cit., n.29 at p43/ Harvey, D. (2007) *A Brief History of Neo-liberalism*. Oxford: Oxford University Press, pp76-77.

<sup>35</sup> Profit rates have been low since the 1970s and, as John McKinley noted, healthcare is attractive for capitalists as demand appears to be insatiable and the state is a guarantor of profit. See McKinley, J. (1984) 'Introduction' in McKinley, J. (ed) *Issues in the Political Economy of Healthcare*. London: Tavistock, pp1-19 at p5.

Although neo-liberalism is dominant, my analysis of NHS reforms indicates that, it competes with, what Raymond Williams described as, residual and emergent cultural forms.<sup>36</sup> I argue that residual norms include the liberal democratic norms of legitimacy, freedom and equality and the NHS' founding principles (which are part of what E.P. Thompson described as a moral economy,<sup>37</sup> as there is a popular consensus concerning them). I argue that emergent forms include a developing consciousness which, Roberto Unger noted, arose in recognition of the problems and limitations of welfare states.<sup>38</sup> My analysis shows that governments continue to validate such residual and emergent norms, which indicates that neo-liberalism has not been as successful, normatively, as some have argued. It also suggests, contrary to Brown's arguments, that welfare states and ideology continue to be important components of legitimation.

Brown asserts that inequality (the medium and relation of competing capitals, which neo-liberalism seeks to turn subjects into) has become normative in "legislation, jurisprudence and the popular imaginary".<sup>39</sup> However, as public support for the founding values of the NHS, such as formal equality of access, endures,<sup>40</sup> successive governments claimed to support such values (which I characterise as residual norms) while implementing reforms which undermine them. In addition, New Labour and subsequent Conservative-led governments adopted the goal of reducing health

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<sup>36</sup> Williams, R. (1977) *Marxism and Literature*. Oxford: Oxford University Press, p122.

<sup>37</sup> Thompson, E. (1971) 'The Moral Economy of the English crowd in the Eighteenth Century'. *Past and Present*, Vol.50(1), pp76-136 at p79.

<sup>38</sup> Unger, R. (1984) *Knowledge and Politics*. New York: Free Press, p20.

<sup>39</sup> Brown, W. (2015) *Undoing the Demos*, op cit., n.29 at p38.

<sup>40</sup> For example, eighty-nine percent of respondents to a recent survey strongly agreed with the government supporting a tax funded, free at the point of use NHS providing comprehensive care for all citizens. See Gershlick, B. et al (2015) *Public Attitudes to the NHS*. London: Health Foundation, p11.

inequalities (which I characterise as an emergent norm), with the Conservative-Liberal Democrat coalition creating statutory duties in this regard (outlined in chapter six). Nonetheless, the coalition's policies (such as austerity) are likely to exacerbate health inequalities.<sup>41</sup> Successive governments have sought to redefine freedom, as freedom of choice, by interpellating patients as consumers. However, patient choice policies have faced recalcitrance<sup>42</sup> and have taken a backseat.<sup>43</sup> The liberal norm of citizenship (collective decision making) has not been extinguished, but reforms have weakened mechanisms for patient and public involvement. Residual and emergent norms are undermined by dominant neo-liberal norms. For example, privatisation, which the neo-liberal norm of competition effectuates, may adversely affect the states competence "to do things which it once managed very well",<sup>44</sup> such as through undermining risk pooling and cross subsidy within the NHS.

The resonance of residual and emergent norms means that efforts to undermine the NHS have been covert<sup>45</sup> as successive governments have deemed overt challenges to such norms to be politically unviable. Successive governments have adopted strategies to misrepresent and mystify healthcare. I examine the ideological modes (legitimation, dissimulation, unification, differentiation and reification) and their strategies, delineated by John B. Thompson,<sup>46</sup> which governments have employed to

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<sup>41</sup> Bambra, C. (2013) 'All in it Together? Health Inequalities, Austerity and the Great Recession' in Wood, C. (ed) *Health in Austerity*. London: Demos, pp49-57 at p51.

<sup>42</sup> Clarke, J. (2007) "It's not like Shopping': Citizens, Consumers and the reform of public services' in Bevir, M. and Trentmann, F. (eds) *Governance, Consumers and Citizens: Agency and Resistance in Contemporary Politics*. Basingstoke: Palgrave, pp97-118 at pp114-115.

<sup>43</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one: NHS Reform*. London: Kings Fund, p18.

<sup>44</sup> Crouch, C. (2004) *Post-Democracy*. Cambridge: Polity Press, p41.

<sup>45</sup> Colin Leys and Stewart Player argue that there has been a covert plot to undermine the NHS. See Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin, p2.

<sup>46</sup> Thompson, J. (2007) *Ideology and Modern Culture*. Cambridge: Polity Press, p60.

justify their reforms. Theodor Adorno stated that “ideologies...become false only by their relationship to the existing reality”.<sup>47</sup> I assess whether such justifications are borne out in reality. Estrangement is the opposite of solidarity and is caused by reification.<sup>48</sup> Law may reify social relations via a “legitimation effect”<sup>49</sup> (whereby law appears to be natural and unmediated by history and class dynamics<sup>50</sup>), via instrumental rationality (whereby the law, or means sanctioned by law, become ends in themselves) and identity thinking (in which the concepts it uses are not identical with the objects that they describe<sup>51</sup>). Additionally, law may reify social relations by facilitating depoliticisation, which can occur on the levels of politics (for example, through governmentalization and constitutional law, such as the new constitutionalism identified by Stephen Gill<sup>52</sup>), policy and polity (for example, through shifting the boundary between the political and the non-political and alterations to the political division of labour<sup>53</sup>) and may be contested. My overarching argument is that although strategies to misrepresent and mystify healthcare have had varying levels of success (concisely summarised in the following paragraphs), the solidarity that was important in the creation and maintenance of the NHS survives. My conclusions are contingent as I recognise that, as social relations develop, further research may justify altered conclusions.

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<sup>47</sup> Adorno, T. (1973) ‘Ideology’ in Frankfurt Institute of Social Research (ed) *Aspects of Sociology*. Vierter, J., Trans. London: Heinemann, pp182-205 at p198.

<sup>48</sup> Torrance, J. (1977) *Estrangement, Alienation and Exploitation: A Sociological Approach to Historical Materialism*. Basingstoke: Macmillan, p315.

<sup>49</sup> Kennedy, D. (1997) *A Critique of Adjudication: fin de siècle*. Cambridge, MA: Harvard University Press, p236.

<sup>50</sup> Hedrick, T. (2014) ‘Reification in and Through Law: Elements of a Theory in Marx, Lukacs and Honneth’. *European Journal of Political Theory*, Vol.13(2), pp178-198 at p192.

<sup>51</sup> Cook, D. (2001) ‘Adorno, Ideology and Ideology Critique’. *Philosophy & Social Criticism*, Vol.27(1) pp1-20 at p2.

<sup>52</sup> Gill, S. (2008) *Power and Resistance in the new world order: 2<sup>nd</sup> edition*. Basingstoke: Palgrave, p79.

<sup>53</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises’ in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at pp96-106.

Successive governments presented their reforms as being in everyone's interests (indicative of the universalization strategy of the ideological mode of legitimation) by claiming, for example, that they would enhance quality and value for money. Such claims were contested, as critics argued that marketization and privatisation negatively affect quality and efficiency. Successive governments also sought to naturalise their reforms (a strategy of the ideological mode of reification) by claiming that there were no alternatives. Such claims were contested, as critics argued that reforms were political choices and not necessities. Successive governments sought to interpellate patients as consumers (indicative of the standardization strategy of the unification mode of ideology, and of identity thinking, as consumerism treats people alike, thereby neglecting differences which may affect choices) but faced recalcitrance.<sup>54</sup> Successive governments sought to differentiate (a strategy of the ideological mode of fragmentation) citizens by emphasising individual responsibility for health and claiming that an ageing population threatens the sustainability of healthcare. However, critics note the impact of social determinants on health and argue that there is “no evidence...that ageing itself will lead to a funding crisis”.<sup>55</sup> Successive governments have superficially articulated residual and emergent norms within their discourse (indicative of the ideological mode of dissimulation), while implementing reforms which undermine them. Although such norms are being undermined, they continue to enable and inform critiques which exploit the space between ideals and lived realities and are

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<sup>54</sup> Clarke, J. (2007) “It’s not like Shopping”, op cit., n.42 at p114-115.

<sup>55</sup> Pollock, A. (2016) ‘The Myth of the ‘Demographic Time Bomb’’. [On-line] Available: <https://www.sochealth.co.uk/2016/11/14/myth-demographic-time-bomb/> [Accessed: 25 June 2017].

a basis for conceiving alternatives. I postulate that the hindered realization of such norms may provoke a legitimization crisis.

I identify evidence that the means adopted in NHS governance (quasi-markets and targets) have become ends in themselves to the detriment of patients. Identity thinking is evident in the extension of the exchange principle through the reduction of the comprehensiveness of the NHS (due to successive government's policies) and through increased private activity outside of the NHS, due to pressures on the NHS caused by inadequate funding. Identity thinking is also evident in the increased use of indicators, which evince a preference for superficial knowledge.<sup>56</sup> The use of targets (based on indicators) is a tactic of the self-responsibilization strategy of depoliticisation. However, where targets are missed, responsibility often attaches to ministers.<sup>57</sup> Another tactic of this strategy is the overemphasis on individual responsibility for health (lifestyle drift) which has characterised the discourse of successive governments. If this colonises common sense, it could legitimise decisions to restrict access to services. However, the attempts of some CCGs to restrict access have faced both public and professional opposition.

The strategy of institutional depoliticisation has been somewhat successful. For example, New Labour's creation of Monitor to regulate FTs was partially successful, as many problems with such hospitals were dealt with without parliamentary or

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<sup>56</sup> Merry, S. (2011) 'Measuring the World: Indicators, Human Rights and Global Governance'. *Current Anthropology*, Vol.52(3), pp83-95 at p86.

<sup>57</sup> Diamond, P. (2015) 'New Labour, Politicisation and Depoliticisation: The Delivery Agenda in public services 1997-2007'. *British Politics*, Vol.10(4), pp429-453 at p446.



ministerial involvement, although ministers have intervened in response to scandals, despite the law. The coalition created NHSE to oversee the day-to-day running of the NHS. The operation of NHSE, so far, indicates that it has the potential both to depoliticise and politicise healthcare. The creation of NHSE enables governments to attempt to shift blame for healthcare problems. Nonetheless, as the government retains important powers over the NHS, such as determining its funding, strategies to shift blame are unlikely to be successful. The reforms have rendered healthcare more opaque by making accountability more arcane and through the increased use of private companies, which are not subject to freedom of information requests, thereby reducing public oversight.

The strategy of attempting to shift the boundary between the political and the economic (for example, through marketization and juridification)<sup>58</sup> has been partially successful as business norms and legal rules increasingly govern the behaviour of NHS actors. In respect of the latter, my analysis of the NHS reforms corroborates Scott Veitch et al's notion of a fifth epoch of juridification, characterised by increased marketization of, and a re-embedding of private law mechanisms in, areas once considered public.<sup>59</sup> However, although privatisation is increasingly determined by legal rules, it remains highly politicised, partly due to the activities of campaign groups, such as Keep Our NHS Public (KONP).<sup>60</sup> As the NHS was increasingly marketized, European Union (EU) public procurement and competition laws became increasingly applicable (although

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<sup>58</sup> Jessop, B. (2015) 'Repoliticising depoliticisation', op cit., n.53 at p101.

<sup>59</sup> Veitch, S. et al (2012) *Jurisprudence: Themes and Concepts 2<sup>nd</sup> edition*. Abingdon: Routledge, p262.

<sup>60</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation? Profit-making in English health services after the 2012 Health and Social Care Act'. *Social Science and Medicine*, Vol.124, pp215-223 at p220.

scope exists for exceptions), which could potentially lock-in neo-liberal reforms, as per Gill's notion of new constitutionalism. The UK's imminent withdrawal from the EU may remove the constraints it potentially imposed on NHS policymaking, but this may be restricted by other external constitutional constraints. I identify a heightened awareness of the potential of external constitutional constraints to restrict NHS policymaking, evident in concern regarding the impact of the prospective free trade deal between the US and the EU, known as the transatlantic trade and investment partnership (TTIP), and potential post-Brexit trade deals, on the NHS. Potential constraints are thus likely to be politically contested in the future. External constitutional constraints have been successfully resisted elsewhere. For example, a successful public relations campaign against Bechtel meant that it settled its claim, for the breach of an international agreement<sup>61</sup> after civil unrest resulted in the termination of its contract to run water services in Cochabamba, Bolivia, for a token amount.<sup>62</sup> As many citizens appear to be incognisant of the reforms,<sup>63</sup> it is difficult to assess the potential legitimisation effect of law. There is a tension between the potential legitimisation effect of law which has undermined residual norms and the aforementioned moral economy whereby deviation from such norms is illegitimate. As mentioned above, I aver that as public experience increasingly diverges from such residual norms, a crisis of legitimacy may arise.

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<sup>61</sup> Agreement on encouragement and reciprocal protection of investments between the Kingdom of the Netherlands and the Republic of Bolivia (signed 10 March 1992; entered into force 1 November 1994).

<sup>62</sup> Sinclair, S. (2015) 'Trade agreements and progressive governance' in Gill, S. (ed) *Critical Perspectives on the Crisis in Global Governance: Reimagining the Future*. Basingstoke: Palgrave, pp110-133 at p120.

<sup>63</sup> Ipsos MORI (2012) *Public Perceptions of the NHS and Social Care*. London: Ipsos MORI, p22.

The opposition to the NHS reforms has sought to prevent and reverse them. I support the NHS (Reinstatement) Bill<sup>64</sup> which would amend legislation that has undermined the NHS' founding principles. However, I argue that it is also necessary to effectuate emerging norms, such as reducing health inequalities, decentralisation and debureaucratisation.<sup>65</sup> Such norms were co-opted by New Labour and subsequent Conservative-led governments, but health inequalities are likely to increase (due to austerity) and the NHS has become more centralised (although the centre is fragmented)<sup>66</sup> and more bureaucratic.<sup>67</sup> Boaventura de Sousa Santos criticised the utopian notion that law could be used to engineer a resolution of the contradictions of society.<sup>68</sup> Although the creation of the NHS emancipated patients from the fear of financial hardship that ill health could augur, by decommodifying health care, its failure to reduce health inequalities is indicative of the limits of the formal equality regarding access to health care that it engendered. I reject the notion that it is wrong to treat health care as a commodity as it is unlike other goods and services. Rather, it is problematic to treat any good or service as a commodity as this mystifies social relations and the inequalities that capitalist production entails. I argue that the state must increasingly intervene in capitalist production to address inequalities (such as health inequalities). However, empowerment requires that areas of social life not only be decommodified but also democratised.

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<sup>64</sup> National Health Service H.C. Bill (2016-17) [51].

<sup>65</sup> Unger, R. (1984) *Knowledge and Politics*, op cit., n.38 at p178.

<sup>66</sup> Jarman, H. and Greer, S. (2015) 'The big bang: Health and Social Care reform under the coalition' in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp50-67 at p50/Greer, S. and Matzke, M. (2015) 'Health Policy in the European Union' in Kuhlmann, E. et al (eds) *The Palgrave International Handbook of Healthcare Policy and Governance*. Basingstoke: Palgrave, pp254-269 at p262.

<sup>67</sup> Lister, J. (2012) 'In Defiance of the evidence: Conservatives threaten to reform away England's National Health Service'. *International Journal of Health Services*, Vol.42(1), pp137-155 at p140.

<sup>68</sup> Santos, B. (1995) *Toward a new common sense: Law, Science and Politics in the Paradigmatic Transition*. London: Routledge, p89.

## Thesis Questions

Santos correctly identified the limitations of modern law, but I reject his oppositional postmodernist solution of unthinking law.<sup>69</sup> Rather, I contend that the task of ideology critique, and the aim of my thesis, is to identify the contradictions, mystifications and limitations of law and to think of alternatives (although there are no emancipatory guarantees in this regard<sup>70</sup>). The key questions guiding this thesis are: What influence have competing ideas (dominant, residual and emergent) and interests had on successive (namely, reforms since the year 2000, which have afforded private companies more opportunities in delivering clinical services) NHS reforms? Are the justifications for the reforms borne out in reality? What attempts, incompleteness and resistance can be identified in respect of the reforms? Have the reforms had, or might they have, mystifying effects? What alternatives are suggested by ideology critique?

## Chapter Overviews

In chapter one, I examine the historical development of healthcare within England. The fear of social unrest and the desire of the bourgeoisie for a fit workforce meant that rudimentary healthcare provision developed prior to the twentieth century.<sup>71</sup> In the

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<sup>69</sup> Ibid at p90.

<sup>70</sup> Marks, S. (2000) *The Riddle of All Constitutions: International Law, Democracy and the Critique of Ideology*. Oxford: Oxford University Press, p27.

<sup>71</sup> Mulholland, C. (2009) *A Socialist History of the NHS*. Saarbrücken: VDM Verlag, p5.

twentieth century, class compromise resulted in the development of the welfare state and the creation of the NHS. Although the NHS was beneficial for the working class, an emerging consciousness arose which recognised its problems and limitations, such as its failure to reduce health inequalities or to empower patients. Following economic crises in the 1970s, neo-liberal ideology became dominant. I outline the alternative ways of conceiving neo-liberalism (mentioned above) and contend that they are potentially compatible. I examine government NHS policies within the first two neo-liberal transformations: roll-back neo-liberalism and a transition to more ameliorative forms.<sup>72</sup>

In chapter two, I elucidate the method of ideology critique employed within this dissertation. Marxist legal theory has grappled with two main problems, namely where the law is situated within the base/superstructure metaphor (which I reject) and how the law is determined. I contend that positive conceptions of ideology are helpful in understanding how law is made, although, as stated above, the translation of ideologies into practice, via mechanisms, such as law, is not straightforward. I aver that negative conceptions of ideology are helpful in examining how legal changes may be based upon misrepresentations and how law may mystify social relations. I examine and repudiate criticisms of the concept of ideology. I also explain the techniques that I employ and identify the policy documents, speeches and legislation that I examine.

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<sup>72</sup> Peck, J. and Tickell, A. (2002) 'Neoliberalizing Space', op cit., n.7 at pp388-389.

I examine New Labour's reforms in chapters three and four. New Labour's philosophy has been described as "socialised neo-liberalism"<sup>73</sup> as, once elected in 1997, it was "committed to working within the constraints of neo-liberalism",<sup>74</sup> but invested substantially in health and education in a manner akin to orthodox social democratic governments.<sup>75</sup> In chapter three, I briefly examine PFI, but concentrate primarily on the '*NHS Plan*', the creation of ISTCs and changes to the mechanisms for patient and public involvement. New Labour's NHS reforms were strongly influenced by neo-liberal ideas and private healthcare companies. The '*NHS Plan*' instigated performance management in the NHS,<sup>76</sup> recommended more co-operative working with the private sector<sup>77</sup> (leading to a concordat with the IHA) and announced the replacement of Community Health Councils (CHCs) by other patient and public involvement mechanisms.<sup>78</sup>

New Labour justified the involvement of the private sector on the basis that it would increase capacity, ensure quality and value for money and lead to innovation. I note, in chapter four, that New Labour subsequently averred that it would be beneficial for patients in stimulating competition and in reducing health inequalities. All of these claims were contested and, I argue, were not borne out. New Labour stated that it wanted to enhance patient voices, but it weakened mechanisms for patient and public

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<sup>73</sup> Wilkinson, R. (2000) 'New Labour and the Global Economy' in Coates, D. and Lawler, P. (eds) *New Labour in Power*. Manchester: Manchester University Press, pp136-148 at p138.

<sup>74</sup> Gamble, A. (2009) *The Spectre at the Feast: Capitalist Crisis and the Politics of Recession*. Basingstoke: Palgrave, p106.

<sup>75</sup> Gamble, A. (2010) 'New Labour and Political Change'. *Parliamentary Affairs*, Vol.63(4), pp639-652 at p649.

<sup>76</sup> Exworthy, M. et al (2010) *Decentralisation and Performance*, op cit., n.16 at p69.

<sup>77</sup> Department of Health (2000) *NHS Plan. A Plan for Investment. A Plan for Reform*. London: HMSO, p96.

<sup>78</sup> *Ibid* at p95.

involvement. Although New Labour had been critical of their Conservative predecessor's policies (while in opposition), and claimed to adhere to traditional NHS values, it emulated the Conservatives and undermined such values: by continuing to transfer services from the NHS to local authorities (undermining the comprehensiveness of the NHS);<sup>79</sup> by focusing on personal responsibility for, rather than the socio-economic determinants of, ill health;<sup>80</sup> and, by developing a quasi-market in secondary care.

In chapter four, I examine New Labour's creation of FTs and a mimic-market in secondary care and its changes to primary care. I repudiate New Labour's claims that FTs would improve NHS performance, facilitate genuine local ownership and enable health inequalities to be more effectively tackled. In addition to supply side reforms (the creation of ISTCs and FTs), New Labour's mimic-market involved demand side reforms (patient choice and commissioning), transactional reforms (PBR) and system management reforms. New Labour's attempt to interpellate patients as consumers (for example, via its patient choice policy) was simplistic and faced recalcitrance.<sup>81</sup> I argue (in chapters three and four) that the means adopted by New Labour to improve the NHS, such as targets and the mimic-market, became ends in themselves to the detriment of patients. I also note, in both chapters, that the examined reforms were opposed, and in some cases tempered, for example, by Labour backbenchers, academics and trade unions. I aver that New Labour was somewhat successful in its

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<sup>79</sup> Mandelstam, M. (2007) *Betraying the NHS: Health Abandoned*. London: Jessica Kingsley, p201.

<sup>80</sup> Popay, J. and Williams, G. (2009) 'Equalizing the people's health: A Sociological Perspective' in Gabe, J. and Calnan, M. (eds) *The New Sociology of the Health Service*. Abingdon: Routledge, pp222-245 at p235.

<sup>81</sup> Clarke, J. (2007) "It's not like Shopping", op cit., n.42 at pp114-115.

attempts to depoliticise healthcare, for example, by delegating power to ostensibly non-political bodies (such as Monitor).

I examine the coalition's NHS reforms in chapters five and six. The coalition used the deficit, which arose following the Great Recession (2008-2009), to argue that there was no alternative to its central policy of austerity, which involved spending cuts and welfare state retrenchment. Austerity has negative implications for public health<sup>82</sup> and was influenced by discredited economic research.<sup>83</sup> The coalition and subsequent Conservative governments have not adequately funded the NHS and cuts elsewhere (such as social care) have increased pressures on the service. The coalition's NHS reforms were influenced by neo-liberal ideas and private healthcare companies and their representatives (for example, via lobbying). I rebut the coalition's claims that there was no alternative to the HSC Act (2012) as the NHS would become unaffordable without reform, that it was necessary to improve productivity and health outcomes and that research had shown that the competition and choice it would engender would benefit patients. Although the legislation provoked opposition (for example, from professional organisations, trade unions and campaign groups), this was not sufficient to prevent it becoming law. Such opposition was undermined by spurious claims that the legislation had been substantially changed and through a legislative pause, after

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<sup>82</sup> Stuckler, D. and Basu, S. (2013) *The Body Economic: Why Austerity Kills*. New York: Basic Books, p140.

<sup>83</sup> Brodie, J. (2015) 'Income Inequality and the Future of Global Governance' in Gill, S. (ed) *Critical Perspectives on the Crisis in Global Governance: Reimagining the Future*. Basingstoke: Palgrave, pp45-68 at p59.



which the concept of integration was emphasised,<sup>84</sup> which the competition that the statute engendered rendered more difficult.<sup>85</sup>

In chapter six, I examine the main provisions of the HSC Act (2012) and its effects. As mentioned above, the statute undermined the NHS' founding principles, for example, by facilitating the reduction of the NHS' comprehensiveness through amending the duty of the Secretary of State for Health, who is now only required to promote, not provide, a comprehensive health service.<sup>86</sup> Allyson Pollock argues that the change to the duty indicates that alternative funding will be pursued.<sup>87</sup> Nonetheless, the law may not furnish reductions in the comprehensiveness of the NHS, or moves to alternative funding, with legitimacy, as such changes conflict with the aforementioned moral economy. The HSC Act (2012) extends the ambit of neo-liberal norms within the NHS, which is evident in the duties that it stipulates and the competition that it effectuates. The current NHS quasi-market has become an end in itself to the detriment of patients. Nonetheless, there are countervailing forces to competition, such as resource constraints and NHSE's renewed emphasis on integration in 'FYFV'.

The HSC Act (2012) also contains emerging norms, such as the reduction of health inequalities and empowering patients. The former has not been implemented

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<sup>84</sup> Glynos, J. et al (2014) 'Logics of Marginalisation in health and social care reform: Integration, Choice and Provider Blind Provision'. *Critical Social Policy*, Vol.35(1), pp45-68 at p46.

<sup>85</sup> Hudson, B. (2013) *Competition and Collaboration in the new NHS*. London: Centre for Health and the Public Interest, p13.

<sup>86</sup> NHS Act (2006), S.1(1) as amended by HSC Act (2012), S.1.

<sup>87</sup> Pollock, A. (2014) 'Submission to Health Committee Enquiry: Public Expenditure on Health and Social Care'. [On-line] Available: [http://www.allysonpollock.com/wp-content/uploads/2014/11/AP\\_2014\\_Pollock\\_HealthCommitteePublicExpenditure.pdf](http://www.allysonpollock.com/wp-content/uploads/2014/11/AP_2014_Pollock_HealthCommitteePublicExpenditure.pdf) [Accessed: 26 May 2016], p8.

effectively<sup>88</sup> and is undermined by austerity, which is likely to exacerbate health inequalities.<sup>89</sup> Patients were to be empowered through patient choice, but this relies on superficial indicators and has taken a backseat.<sup>90</sup> The coalition also established new voice mechanisms, but these are regarded as weak. The coalition sought to depoliticise healthcare by juridifying the NHS (for example, privatisation has become a technical legal matter<sup>91</sup>) and by delegating power to ostensibly non-political bodies, such as NHSE and CCGs. Nonetheless, the activities of campaign groups, such as KONP, suggest that it remains politicised<sup>92</sup>.

In chapter seven, I outline my conclusions. I argue that my analysis of successive NHS reforms evidences the continued relevance of the method of ideology critique in revealing the gap between ideals and lived realities and in assisting researchers in conceiving alternatives. My thesis challenges government discourse and may inform political mobilization opposing neo-liberal reforms. I argue that other researchers may be able to employ the method of ideology critique, in a similar manner to me, to illuminate the ideological terrain, and challenge dominant discourses, relating to other policy areas. In formulating alternatives to neo-liberal policies, I consider how to realise residual and emergent norms. As the founding principles of the NHS have been undermined by recent legislative changes, I support the NHS (Reinstatement) Bill which proposes amending such legislation. The NHS (Reinstatement) Bill

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<sup>88</sup> Wenzl, M. and Mossialos, E. (2016) 'Achieving Equity in health service commissioning' in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp233-254 at p248.

<sup>89</sup> Bambra, C. (2013) 'All in it Together?', op cit., n.41 at p51.

<sup>90</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.43 at p81.

<sup>91</sup> Davies, A. (2013) 'This Time It's for Real: The Health and Social Care Act 2012'. *Modern Law Review*, Vol. 76(3), pp564-588 at p587.

<sup>92</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation?', op cit., n.60 at p220.

recommends re-establishing CHCs.<sup>93</sup> I contend that this is not sufficient to empower patients and that the NHS should be democratised. I argue that, in order to successfully reduce health inequalities, governments must increasingly intervene in capitalist production.

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<sup>93</sup> National Health Service H.C. Bill (2016-17) [51], cl.17.

## Chapter One: Healthcare in England

### Introduction

The development of healthcare within England was influenced, historically, by actual and potential unrest, and, in the capitalist epoch, by the desire of the bourgeoisie for healthy workers. Whereas classical liberals (whose views predominated in the nineteenth century) viewed health as an individual responsibility, Friedrich Engels and Karl Marx perceived that social conditions were a major cause of illness. The state began to intervene to improve public health for pragmatic and instrumental reasons. A social democratic consensus predominated in the immediate post Second World War (WWII) era. Class compromise led to the development of welfare states in Western states (such as the UK), which institutionalised solidarity. Welfare states stabilized capitalism, but also evince principles contrary to its logic. For example, access to the NHS (which was free, universal, comprehensive and primarily funded from general taxation) was based on need.

The NHS was criticised by many from both the left and the right of the political spectrum. An emerging consciousness developed which recognised its problems and limitations, such as its failure to empower patients or to reduce health inequalities. The post-war consensus ended in the 1970s and neo-liberal ideology became dominant. I contend that Marxist views of neo-liberalism are potentially compatible with, and can remedy the deficiencies of, alternate views. In the neo-liberal era, new governance

mechanisms (such as markets and increased auditing) were introduced in public services to resolve their perceived problems. Three neo-liberal transformations have been identified (roll-back neo-liberalism, a transition to more ameliorative forms and roll-out neo-liberalism). I contend that the reforms examined in subsequent chapters are indicative of roll-out neo-liberalism and of a fifth epoch of juridification.

### The Historical Development of Healthcare in England

Although historically health has been viewed merely as the absence of disease, the World Health Organisation (WHO), a United Nations (UN) agency established in 1948, defined it as “a state of complete physical, mental and social wellbeing” and a fundamental human right.<sup>1</sup> The International Covenant on Social, Economic and Cultural Rights (ICESCR) requires signatories (including the UK) to recognise the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.<sup>2</sup> Ciaran Mulholland states that various forms of healthcare for the poor were provided, in England, over the centuries, to prevent disorder and ensure a healthy populace for factories and wars.<sup>3</sup> The fear of social disorder led to the development of the poor law<sup>4</sup> (administered by parishes<sup>5</sup>) which undertook medical and welfare provision, although this was not mentioned within the relevant legislation.<sup>6</sup>

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<sup>1</sup> Constitution of the World Health Organisation (Signed 22 July 1946; entered into force 7 April 1948) 14 U.N.T.S. 185/ Declaration of Alma-Ata. *International Conference on Primary Health Care*. 1978. Alma-Ata, USSR: World Health Organisation, Article 1.

<sup>2</sup> ICSECR (Signed 16 December 1966; entered into force, 3 January 1976) 993 U.N.T.S. 3.

<sup>3</sup> Mulholland, C. (2009) *A Socialist History of the NHS*. Saarbrücken: VDM Verlag, p5.

<sup>4</sup> Fraser, D. (2009) *The Evolution of the British Welfare State: 4<sup>th</sup> Edition*. Basingstoke: Palgrave, p38.

<sup>5</sup> Lane, J. (2001) *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950*. London: Routledge, p44.

<sup>6</sup> *Ibid* at p54.

The fear of unrest also motivated the creation of voluntary hospitals in the eighteenth century.<sup>7</sup> Poor patients received treatment at voluntary hospitals and workhouses<sup>8</sup> (established under the poor law) while patients of middle and high income families paid private fees to receive care at home.<sup>9</sup> The Poor Law Amendment Act (1834) established conditions at workhouses (stripping supplicants of their property as a precondition of minimal relief<sup>10</sup>) that only the destitute would choose.<sup>11</sup> In dividing the destitute from the rest of the poor,<sup>12</sup> it was designed to “create a national labour market”.<sup>13</sup> E.P. Thompson described the statute, and its subsequent administration, as “perhaps the most sustained attempt to impose an ideological dogma, in defiance of the evidence of human need, in English history”.<sup>14</sup> Following scandals of gross neglect at workhouses,<sup>15</sup> the Metropolitan Poor Act (1867) and the Poor Law Amendment Act (1868) empowered “London and Provincial Unions to provide separate infirmaries [known as public hospitals] for their destitute sick”.<sup>16</sup> Such legislation was the “first explicit acknowledgement of the government’s responsibility to provide hospitals for the poor”<sup>17</sup> and “initiated a major period of hospital building”.<sup>18</sup>

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<sup>7</sup> Ibid at p82.

<sup>8</sup> Administered by Boards of Guardians between 1835 and 1930. The Local Government Act (1929), S.1 placed local authorities in charge of workhouse infirmaries, which became known as municipal hospitals.

<sup>9</sup> Walters, V. (1980) *Class Inequality and Health Care*. London: Croom Helm, pp24-25.

<sup>10</sup> Tudor-Hart, J. (2006) *The Political Economy of Healthcare: A Clinical Perspective*. Bristol: Policy Press, p168.

<sup>11</sup> Jones, E. and Pickstone, J. (2008) *The Quest for Public Health in Manchester: The Industrial City, the NHS and the recent history*. Manchester: Manchester NHS Primary Care Trust, p10.

<sup>12</sup> Ibid.

<sup>13</sup> Ferguson, I., et al (2002) *Rethinking Welfare: A Critical Perspective*. London: Sage, p29.

<sup>14</sup> Thompson, E. (1963) *The Making of the English Working Class*. New York: Vintage Books, p267.

<sup>15</sup> Pinker, R. (1971) *Social Theory and Social Policy*. London: Heinemann, p70.

<sup>16</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p31.

<sup>17</sup> Ibid.

<sup>18</sup> Pinker, R. (1971) *Social Theory and Social Policy*, op cit., n.15 at p72.

Derek Fraser contends that while there was no public health problem in pre-industrial England, other than the periodic visitation of the bubonic plague, the industrial revolution created a public health problem.<sup>19</sup> The insanitary housing conditions within urban areas, where the population rose to meet the demand of industry for labour, led to an increase in the national death rate<sup>20</sup> as diseases associated with such conditions (such as rickets and tuberculosis) became more common.<sup>21</sup> Engels noted that epidemics in cities, such as Manchester and Liverpool, were “three times more fatal than in country districts”.<sup>22</sup> Fran Collyer argues that Engels and Marx provided one of the “first truly sociological theories of illness and disease”.<sup>23</sup> They challenged liberal theories that disease resulted from the inherently weak bodies of the poor, medical theories which treated disease as a fixed natural entity and Social Darwinist theories that disease was inevitable and necessary to improve the human species.<sup>24</sup> Rather Engels and Marx perceived that social conditions were a major cause of disease. Lesley Doyal and Imogen Pennell state that various cholera epidemics in the 1830s and 1840s, the fear of working class unrest and the desire of employers for fitter workers led to the Public Health Act (1848).<sup>25</sup> This required towns where the death rate exceeded twenty-three per 1,000 to establish local Boards of Health responsible for cleansing, sewerage and providing adequate water supplies.<sup>26</sup> Further cholera

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<sup>19</sup> Fraser, D. (2009) *The Evolution of the British Welfare State*, op cit., n.4 at p70.

<sup>20</sup> Ibid at p74.

<sup>21</sup> Porter, R. (1993) *Disease, Medicine and Society in England, 1550-1860: 2<sup>nd</sup> edition*. Cambridge: Cambridge University Press, p40.

<sup>22</sup> Engels, F. (1845) *The Condition of the Working Class in England*. [On-line] Available: <https://www.marxists.org/archive/marx/works/1845/condition-working-class/> [Accessed: 07 December 2014].

<sup>23</sup> Collyer, F. (2015) ‘Karl Marx, Friedrich Engels: Capitalism, Health and the Healthcare Industry’ in Collyer, F. (ed) *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*. Basingstoke: Palgrave, pp35-59 at p36.

<sup>24</sup> Ibid at p48.

<sup>25</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*. London: Pluto, pp145-146.

<sup>26</sup> Fulton-Phin, N. (2009) ‘The Historical Development of Public Health’ in Wilson, F. and Mabhala, M. (eds) *Key Concepts in Public Health*. London: Sage, pp5-10 at p6.

outbreaks, and Prince Albert's death from typhus in 1861, led to the Local Government Act (1872), which required all districts to provide public health services, and the Public Health Act (1875), which consolidated existing public health legislation and gave local authorities "far-reaching powers to intervene on behalf of the health of their populations".<sup>27</sup> The consequent developments in clean water, sanitation and sewage reduced deaths.<sup>28</sup> Increases in food supplies in the nineteenth century also enhanced health by improving nutrition.<sup>29</sup> The industrial revolution led to illnesses due to industrial processes, unhealthy working conditions and accidents.<sup>30</sup> In this respect, the Factory Acts, which regulated working conditions, improved workers' "health and well-being".<sup>31</sup> Nonetheless, occupational and environmental hazards persist.<sup>32</sup>

Karl Polanyi contended that "economic liberalism was the organising principle of a society engaged in creating a market system".<sup>33</sup> John Gray states that liberal attitudes (influenced by economists, such as Adam Smith and David Ricardo, and philosophers, such as John Locke, Jeremy Bentham and John Stuart Mill) dominated political practice within England, from the early nineteenth century and into the twentieth century.<sup>34</sup> Classical liberals viewed the state as a necessary evil that "should interfere as little as possible in the sphere of action of individuals".<sup>35</sup> For example, Mill stated that "each [individual] is the proper guardian of his own health, whether bodily, or

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<sup>27</sup> Ibid at pp6-7.

<sup>28</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*, op cit., n.25 at p56.

<sup>29</sup> McKeown, T. (1976) *The Role of Medicine: Dream, Mirage or Nemesis?* London: Nuffield Trust, p69.

<sup>30</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*, op cit., n.25 at pp52-53.

<sup>31</sup> Ibid at p146.

<sup>32</sup> Eyer, J. (1984) 'Capitalism, Health and Illness' in McKinley, J. (ed) *Issues in the Political Economy of Healthcare*. London: Tavistock, pp23-59 at p27.

<sup>33</sup> Polanyi, K. (1968) *The Great Transformation*. Boston: Beacon Press, p135.

<sup>34</sup> Gray, J. (1995) *Liberalism: 2<sup>nd</sup> Edition*. Buckingham: Open University Press, p27.

<sup>35</sup> Bobbio, N. (1990) *Liberalism and Democracy*. Ryle, M. and Soper, K., Trans. London: Verso, p16.



mental and spiritual”.<sup>36</sup> David Roberts argued that laissez faire liberal views stemmed from special interests (attachment to local offices, property and low taxes).<sup>37</sup> However, the widening of the franchise, via successive Reform Acts, politicised “issues such as public health, housing, education and working conditions”.<sup>38</sup> Fraser contends that social policy developments in the nineteenth century were “practical, pragmatic, unplanned, ad hoc [state] response[s]”.<sup>39</sup> Marx’s writings concerning factory legislation indicate that he thought that “workers could begin to establish socialist values and institutions, piecemeal”, but that little progress could be made in a market dominated society.<sup>40</sup> The working class began to organise collectively, in the nineteenth century, to relieve suffering, for example through trade unions, friendly societies<sup>41</sup> and through purchasing doctors and their premises.<sup>42</sup>

Roy Porter states that the place of doctors in society was precarious until they were confident in their power “to conquer disease and tame death”.<sup>43</sup> For example, Porter states that they faced competition from quacks,<sup>44</sup> although he notes the difficulty in demarcating orthodox from heterodox medicine in the eighteenth and early nineteenth centuries.<sup>45</sup> Numerous medical developments occurred in the late nineteenth century,

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<sup>36</sup> Mill, J. (2010) *On Liberty and Other Essays*. Lawrence, KS: Digireads, p12.

<sup>37</sup> Roberts, D. (1960) *Victorian Origins of the British Welfare State*. New Haven, CT: Yale University Press, p23.

<sup>38</sup> Fraser, D. (2009) *The Evolution of the British Welfare State*, op cit., n.4 at p167.

<sup>39</sup> Ibid at p140.

<sup>40</sup> Mishra, R. (1981) *Society and Social Policy: Theories and Practice of Welfare 2<sup>nd</sup> Edition*. Basingstoke: Macmillan, pp69-72.

<sup>41</sup> Mulholland, C. (2009) *A Socialist History of the NHS*, op cit., n.3 at p22.

<sup>42</sup> Ibid at p24.

<sup>43</sup> Porter, R. (1993) *Disease, Medicine and Society in England, 1550-1860*, op cit., n.21 at p63.

<sup>44</sup> Ibid at p40.

<sup>45</sup> Porter, R. (1989) *Health for Sale: Quackery in England, 1660-1850*. Manchester: Manchester University Press, p16.

such as the use of artery clamps, anaesthesia and antisepsis in surgery,<sup>46</sup> vaccinations (for example, for cholera and tetanus) and the discovery of disease causing organisms.<sup>47</sup> In the twentieth century, there were further developments in surgery (such as organ transplants), vaccinations and drugs (such as the discovery of penicillin in 1928). In the future, genomic sequencing may facilitate more precise targeted health interventions<sup>48</sup> and technology (such as smartphones) could democratise medicine.<sup>49</sup> However, there are also threats to modern medicine, such as increased antimicrobial resistance.<sup>50</sup> Medical professions developed over time and are represented by numerous Royal Colleges.<sup>51</sup> The British Medical Association (BMA), which represents all doctors, was established in 1832. Frankfurt School theorists and Michel Foucault critiqued reason “as an instrument of oppression”.<sup>52</sup> Foucault stated that the truth claims of modern medicine are “governed by arbitrary structures”.<sup>53</sup> Herbert Marcuse argued that a new science was required to sever the link between science and domination.<sup>54</sup> Michael Taussig and Howard Waitzkin note the reifying effects of medicine, whereby the signs and symptoms of disease are seen as natural and scientific facts instead of resulting from social relations.<sup>55</sup> Waitzkin also notes that

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<sup>46</sup> Hardy, A. (2001) *Health and Medicine in Britain since 1860*. Basingstoke: Palgrave, p9.

<sup>47</sup> Ibid at p5.

<sup>48</sup> Darzi, A. and Keown, O. (2016) ‘What if every patient were to have their genome mapped?’ [On-line] Available: <https://www.kingsfund.org.uk/reports/thenhsif/what-if-every-patient-were-to-have-their-genome-mapped/> [Accessed: 12 January 2017].

<sup>49</sup> Topol, E. (2015) *The Patient will see you now: The Future of Medicine is in your hands*. New York: Basic Books, p54.

<sup>50</sup> Davies, S. and Sugden, R. (2016) ‘What if antibiotics were to stop working’. [On-line] Available: <https://www.kingsfund.org.uk/reports/thenhsif/> [Accessed: 12 January 2017].

<sup>51</sup> Leathard, A. (1993) *Health Care Provision: Past, Present and Future*. London: Chapman and Hall, p10.

<sup>52</sup> Hawkes, D. (2003) *Ideology: 2<sup>nd</sup> Edition*. London: Routledge, p158.

<sup>53</sup> Dreyfus, H. and Rabinow, P. (1983) *Michel Foucault: Beyond Structuralism and Hermeneutics: 2<sup>nd</sup> Edition*. Chicago, IL: University of Chicago Press, pp12-13/Foucault, M. (2000) *The Birth of the Clinic: An Archaeology of Medical Perception*. Sheridan, A., Trans. London: Routledge.

<sup>54</sup> Marcuse, H. (1991) *One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society*. London: Routledge, p166.

<sup>55</sup> Taussig, M. (1980) ‘Reification and the Consciousness of the Patient’. *Social Science and Medicine*, Vol.14(1), pp3-13 at p3/Waitzkin, H. (1989) ‘A Critical Theory of Medical Discourse: Ideology, Social

many societal problems have been transformed into individual problems through medicalisation.<sup>56</sup> Nonetheless, proponents of social medicine recognise that many social evils manifest in disease, require social and economic reform.<sup>57</sup>

The Liberal government (1905-1915) created an “embryonic welfare state” characterised by limited coverage and a limited scope of state intervention and responsibility.<sup>58</sup> Numerous factors influenced such intervention, including: studies (for example, of Charles Booth and Joseph Rowntree) which undermined the notion that the poor were responsible for their own condition;<sup>59</sup> the increasing influence of a pro-collectivist liberal creed (typified by thinkers such as Thomas Hill Green and Leonard Trelawny Hobhouse);<sup>60</sup> the threat to the Liberals from the Labour party;<sup>61</sup> concerns regarding the fact that forty-eight percent of potential soldiers could not be recruited for the second Boer War (1899-1902) due to poor health;<sup>62</sup> and, unrest elsewhere in Europe (such as the 1905 October revolution in Russia) which convinced many that concessions were needed.<sup>63</sup> In the last respect, Otto von Bismarck (German

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Control and the Processing of Social Context in Medical Encounters’. *Journal of Health and Social Behaviour*, Vol.30, pp220-239 at p224.

<sup>56</sup> Waitzkin, H. (2000) *The Second Sickness: Contradictions of Capitalist Health Care*. Oxford: Rowan and Littlefield, pp34-35.

<sup>57</sup> Ryle, J., ‘Social Medicine: Meaning and Scope’. *British Medical Journal*, 1943:2;633.

<sup>58</sup> Dale, J. (1981) ‘A Marxist Perspective’ in Taylor-Gooby, P. and Dale, J., *Social Theory and Social Welfare*. London: Edward Arnold, pp141-265 at p194.

<sup>59</sup> Leathard, A. (1993) *Health Care Provision*, op cit., n.51 at pp17-18.

<sup>60</sup> Turner, R. (2008) *Neo-Liberal Ideology: History, Concepts and Policies*. Edinburgh: Edinburgh University Press, p1.

<sup>61</sup> Lister, J. (2008) *The NHS After 60: For Patients or Profits?* London: Middlesex University Press, p11.

<sup>62</sup> Navarro, V. (1978) *Class Struggle, the State and Medicine: An Historical and Contemporary Analysis of the Medical Sector in Great Britain*. Oxford: Martin Robertson and Co., p10.

<sup>63</sup> Ibid at p9.

Chancellor between 1871 and 1890) was influential as his introduction of state insurance in Germany had undermined support for socialism.<sup>64</sup>

The Liberal government established the first state pensions and unemployment insurance<sup>65</sup> and the National Insurance Act (1911) created a national health insurance scheme (introduced in 1913) paid for by contributions from employees, employers and the Treasury.<sup>66</sup> Friendly Societies, which had been hostile to government activity, were enabled to administer the scheme.<sup>67</sup> The scheme “provided primary medical care from GPs and sickness benefit [for up to thirteen weeks] for...workers paid £250.00 a year or less”.<sup>68</sup> However, it did not cover most women, all children, the elderly or the self-employed<sup>69</sup> and did not include hospital or specialist care.<sup>70</sup> Although some people not covered by the scheme were members of private schemes and hospital savings associations, Joan Higgins notes that many vulnerable groups were excluded and were unable to insure themselves privately.<sup>71</sup> In 1911, only “a small minority of the medical profession [such as Professor Benjamin Moore] advocated a full public health service”.<sup>72</sup> In 1912, Moore created the State Medical Services Association, a forerunner of the Socialist Medical Association (SMA), which was established in 1930 and campaigned for a national health service.<sup>73</sup>

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<sup>64</sup> Fraser, D. (2009) *The Evolution of the British Welfare State*, op cit., n.4 at p195.

<sup>65</sup> Timmins, N. (1996) *The Five Giants: A Biography of the Welfare State*. London: Fontana, p13.

<sup>66</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p40.

<sup>67</sup> Carrier, J. and Kendall, I. (2016) *Health and the National Health Service: 2<sup>nd</sup> Edition*. Abingdon: Routledge, p27.

<sup>68</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p40.

<sup>69</sup> Hardy, A. (2001) *Health and Medicine in Britain since 1860*, op cit., n.46 at p80.

<sup>70</sup> Leathard, A. (1993) *Health Care Provision*, op cit., n.51 at p4.

<sup>71</sup> Higgins, J. (1988) *The Business of Medicine: Private Health Care in Britain*. Basingstoke: Macmillan, p6.

<sup>72</sup> Abel-Smith, B. (1964) *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*. London: Heinemann, p249.

<sup>73</sup> Mulholland, C. (2009) *A Socialist History of the NHS*, op cit., n.3 at p45.

## The Creation of the NHS

Labour won its first majority in the House of Commons at the 1945 general election and Clement Attlee became Prime Minister. Attlee's government adopted Keynesian economic policies (prioritising full employment<sup>74</sup>), nationalised some industries, such as coal mining and steel (which Anton Pannekoek contended "was a capitalist necessity" and did not empower workers<sup>75</sup>), and expanded the welfare state. The National Health Service (NHS) Act (1946) created the NHS, which became operational on the 5<sup>th</sup> of July 1948. John Lister notes that the NHS was "part of a much wider international awakening of political leaders to the need for some form of collective provision of health care".<sup>76</sup> The NHS Act (1946) centred on the minister's duty to provide rather than patient's rights to receive care.<sup>77</sup> Health, education and social services were justified on the basis that everyone should have access to such services irrespective of their family income and because state provision of such services was perceived to benefit society.<sup>78</sup> The service was organised into three parts, with locally appointed Executive Councils administering general practitioners (GPs), dentists, etc., local authorities having responsibility for a range of personal and environmental health services and hospitals being administered by Boards of Governors (which administered teaching hospitals), Regional Hospital Boards (RHBs), appointed by the

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<sup>74</sup> Beckett, C. and Beckett, F. (2004) *Bevan*. London: Haus, p97.

<sup>75</sup> Pannekoek, A. (2003) *Workers' Councils*. Edinburgh: AK Press, p199.

<sup>76</sup> Lister, J. (2008) *The NHS After 60*, op cit., n.61 at p291.

<sup>77</sup> Mold, A. (2015) 'Complaining in the age of Consumption: Patients, Consumers or Citizens?' in Reinartz, J. and Wynter, R (eds) *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives*. Abingdon: Routledge, pp167-183 at p172.

<sup>78</sup> Glyn, A. (2006) *Capitalism Unleashed: Finance, Globalization and Welfare*. Oxford: Oxford University Press, p158.

Minister, and Hospital Management Committees (HMCs).<sup>79</sup> The National Assistance Act (1948) also enabled local authorities to provide a subsidiary (means tested) system for those needing social care. Herbert Morrison (Deputy Prime Minister between 1945 and 1951) opposed transferring responsibility for hospitals from local authorities to appointed bodies, in cabinet, on democratic grounds.<sup>80</sup> Aneurin Bevan subsequently conceded that “election is a better principle than selection”<sup>81</sup> and hoped that a future reform would democratise the system.<sup>82</sup> Fred Messer (a Labour backbencher) lamented the “loss of faith in the elected principle”.<sup>83</sup> Messer subsequently became President of the Campaign for a Democratic Health Service which proposed direct election to boards or transferring NHS administration to local government.<sup>84</sup>

Bevan argued that there should be a high degree of governmental accountability for the service. He stated that “if a bedpan lands on the floor in the hospital in Tredegar it should be clanging in Whitehall”.<sup>85</sup> Nonetheless, he favoured “a maximum of decentralisation to local bodies [and], a minimum of itemised central approval”.<sup>86</sup> Christopher Newdick states that the NHS was commonly regulated through circulars (often issued in line with the Minister’s power to give directions<sup>87</sup>) and other policy

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<sup>79</sup> Ham, C. (2004) *Health Policy in Britain: 5<sup>th</sup> Edition*. Basingstoke: Palgrave, pp15-16.

<sup>80</sup> Abel-Smith, B. (1964) *The Hospitals 1800-1948*, op cit., n.72 at p476

<sup>81</sup> Bevan, A. (1990) *In Place of Fear*. London: Quartet, p114.

<sup>82</sup> Foot, M. (1982) *Aneurin Bevan 1945-1960*. St Albans: Granada, p133.

<sup>83</sup> H.C. Deb. 30 April 1946, Vol.422, Col.140.

<sup>84</sup> Campaign for a Democratic Health Service (1969) ‘Proposals for Reform of the National Health Service’. [On-line] Available: <https://www.sochealth.co.uk/national-health-service/democracy-involvement-and-accountability-in-health/proposals-for-reform-of-the-national-health-service/> [Accessed: 17 April 2017].

<sup>85</sup> Jenkins, S. (2011) *A Short History of England*. London: Profile Books, p311.

<sup>86</sup> Klein, R. (2008) *The New Politics of the NHS*. Abingdon: Radcliffe, p37.

<sup>87</sup> National Health Service (NHS) Act (1977), S.17.

statements from the Department of Health.<sup>88</sup> However, the centre could not simply dictate as entrepreneurial, judgmental and professional knowledge, which was “too complex to be caught in crude statistics”, lay with the periphery.<sup>89</sup> The Merrison report described “detailed ministerial accountability” as “largely a constitutional fiction”.<sup>90</sup> The NHS was to be primarily funded from general taxation, universal, comprehensive and free at the point of access (decommodifying health care). Such characteristics are generally regarded as the NHS’ founding principles. Martin Powell notes that there was little explicit emphasis on equality or equity in the parliamentary debates and legislation on the NHS beyond the idea of equality of entitlement or eligibility.<sup>91</sup> Powell avers that the NHS has been largely financed from progressive taxation<sup>92</sup> and covered all groups<sup>93</sup> (although a minority decided to go private<sup>94</sup>) but that it has never been entirely comprehensive, as some forms of health care were excluded, services have been rationed and doctors have been able to determine who to treat.<sup>95</sup>

Welfare states were part of a “positive class compromise”<sup>96</sup> which developed due to several forces, including “social democratic reformism, Christian socialism, enlightened conservative political and economic elites and large industrial

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<sup>88</sup> Newdick, C. (2005) *Who Should we Treat?: Rights, Rationing and Resources in the NHS: 2<sup>nd</sup> Edition*. Oxford: Oxford University Press, p75.

<sup>89</sup> Klein, R. (2010) ‘The Eternal Triangle: Sixty Years of the centre-periphery relationship in the National Health Service’. *Social Policy and Administration*, Vol.44(3), pp285-304 at p291.

<sup>90</sup> Merrison, A. (1979) *Report of the Royal Commission on the National Health Service*, Cmnd 7615. London: HMSO, p298.

<sup>91</sup> Powell, M. (1996) ‘Granny’s Footsteps, Fractures and the Principles of the NHS’. *Critical Social Policy*, Vol.47(16), pp27-44 at p31.

<sup>92</sup> *Ibid* at p36.

<sup>93</sup> *Ibid* at p34.

<sup>94</sup> *Ibid* at p37.

<sup>95</sup> *Ibid* at pp34-35.

<sup>96</sup> Wright, E. (2015) *Understanding Class*. London: Verso, p231.

unions...which fought for and conceded more and more...”.<sup>97</sup> In respect of the elites, Kenneth Hoover and Raymond Plant note that the Great Depression (1930-1931) appeared to show the bankruptcy of laissez faire ideas.<sup>98</sup> Eric Hobsbawm stated that the successful revolution in Russia in 1917, and Russia’s immunity to the West’s economic problems in the 1930s, incentivised reform.<sup>99</sup> The chief architects of, what Bob Jessop terms, the Keynesian welfare national state (KWNS),<sup>100</sup> William Beveridge (who proposed reforms, during WWII, to eliminate the giant evils of squalor, want, ignorance, idleness and disease<sup>101</sup>) and John Maynard Keynes (whose economic ideas dominated government policy in the UK in the post-war period until the 1970s) were revisionary liberals who “attempted to steer a middle way between the old capitalist order and new socialist ideals”.<sup>102</sup> Claus Offe described the welfare state as a “peace formula”<sup>103</sup> and contended that there would be “exploding conflict and anarchy” (a legitimisation crisis) if it was undermined.<sup>104</sup> Similarly, Theodor Adorno contended that state interventionism was “the embodiment of self-defence” to “damper and police the antagonisms...lest society...disintegrate”.<sup>105</sup> The KWNS co-existed with capitalism in its Atlantic-Fordist form,<sup>106</sup> characterised by standardized

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<sup>97</sup> Offe, C. (1984) ‘Some Contradictions of the Modern Welfare State’ in Keane, J. (ed) *Contradictions of the Welfare State*. London: Hutchinson, pp147-161 at p148.

<sup>98</sup> Hoover, K. and Plant, R. (1989) *Conservative Capitalism in Britain and the United States: A Critical Appraisal*. London: Routledge, p142.

<sup>99</sup> Hobsbawm, E. (1995) *Age of Extremes: The Short Twentieth Century 1914-1991*. London: Abacus, p84.

<sup>100</sup> Jessop, B. (2002) *The Future of the Capitalist State*. Cambridge: Polity Press, p275.

<sup>101</sup> Beveridge, W. (1942) *Social Insurance and Allied Services*. London: HMSO, p6.

<sup>102</sup> Gray, J. (1995) *Liberalism*, op cit., n.34 at p35.

<sup>103</sup> Offe, C. (1984) ‘Some Contradictions of the Modern Welfare State’, op cit., n.97 at p147.

<sup>104</sup> Ibid at p153.

<sup>105</sup> Adorno, T. (1968) *Late Capitalism or Industrial Society?* [On-line] Available: <https://www.marxists.org/reference/archive/adorno/1968/late-capitalism.htm> [Accessed: 28 December 2014].

<sup>106</sup> Jessop, B. (2002) *The Future of the Capitalist State*, op cit., n.100 at p275.



production and mass consumption,<sup>107</sup> to secure conditions for profitable capital accumulation and social harmony.<sup>108</sup>

Social democrat reformists drew on the notion of solidarity, which Rahel Jaeggi states involves “standing up for each other because one recognises one’s own fate in the fate of the other”.<sup>109</sup> Jaeggi contends that welfare institutions are institutionalised solidarity.<sup>110</sup> In healthcare this encompasses sharing health risks (risk pooling) through support for healthcare institutions.<sup>111</sup> In effectuating solidarity in healthcare nationally, the NHS emulated the solidarity evinced by workers who, as mentioned above, often banded together to acquire mutual medical services. For example, Bevan’s father was a founder of Tredegar Working Men’s Medical Aid Society in 1890.<sup>112</sup> The NHS was symptomatic of social (as opposed to liberal) law which presupposes “relationships of interdependence and solidarity”.<sup>113</sup> The creation of the NHS was also influenced by “a new popular radicalism”, a desire for the machinery of government, which had been effectively organised to fight WWII, to be used to improve social conditions.<sup>114</sup> In addition, the Ministry of Health (created in 1919) and doctors became aware of the need for reform through the emergency medical services (EMS), operative during

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<sup>107</sup> Harvey, D. (1990) *The Condition of Postmodernity: An Enquiry into the Origins of Cultural Change*. Oxford: Blackwell, p126.

<sup>108</sup> O’Connor, J. (2009) *The Fiscal Crisis of the State*. New Brunswick, NJ: Transaction Publishers, p6.

<sup>109</sup> Jaeggi, R. (2001) ‘Solidarity and Indifference’ in ter Meulen, R. et al (eds) *Solidarity and Health Care in Europe*. London: Kluwer, pp287-308 at p291. Although Deborah Prainsack and Alena Buyx note that solidarity has been ascribed numerous meanings, they favour Jaeggi’s definition. See Prainsack, B. and Buyx, A. (2011) *Solidarity: Reflections on an Emerging Concept in Bioethics*. Swindon: Nuffield Council on Bioethics, p47.

<sup>110</sup> Jaeggi, R. (2001) ‘Solidarity and Indifference’, op cit., n.109 at p292.

<sup>111</sup> Ibid at p296.

<sup>112</sup> Mulholland, C. (2009) *A Socialist History of the NHS*, op cit., n.3 at p24.

<sup>113</sup> Ewald, F. (1988) ‘A Concept of Social Law’ in Teubner, G. (ed) *Dilemmas of Law in the Welfare State*. New York: Walter de Gruyter, pp40-75 at p43.

<sup>114</sup> Miliband, R. (1961) *Parliamentary Socialism: A Study in the Politics of Labour*. London: George Allen and Unwin Limited, p272.

WWII.<sup>115</sup> John Torrance argued that estrangement (“a process or condition, by which people become or are strangers or enemies to one another”<sup>116</sup>), a form of alienation distinct from relinquishment, is the opposite of solidarity.<sup>117</sup> Torrance stated that reification causes estrangement.<sup>118</sup> Reification may undermine the solidarity which was important in the creation and maintenance of the NHS. Istvan Meszaros contends that alienation and reification produce the deceptive “appearance of the individual’s independence, self-sufficiency and autonomy”.<sup>119</sup> This is evident in lifestyle drift, the overemphasis on individual responsibility for health.<sup>120</sup>

The BMA had advocated a national health service in the 1930s, but retreated from such support before 1945.<sup>121</sup> The BMA, and the right-wing press, continued to oppose the service after the NHS Act (1946) was passed.<sup>122</sup> The BMA’s principal argument was that “state intervention would erode professional freedom”.<sup>123</sup> In actuality, the NHS has afforded medical professionals a substantial degree of autonomy.<sup>124</sup> The BMA opposed the idea of a salaried service, local authority control<sup>125</sup> and plans to abolish the sale of practices.<sup>126</sup> Vivienne Walters contends that such opposition was

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<sup>115</sup> Abel-Smith, B. (1964) *The Hospitals 1800-1948*, op cit., n.72 at p440.

<sup>116</sup> Torrance, J. (1977) *Estrangement, Alienation and Exploitation: A Sociological Approach to Historical Materialism*. Basingstoke: Macmillan, pxiii.

<sup>117</sup> Ibid at p105.

<sup>118</sup> Ibid at p315.

<sup>119</sup> Meszaros, I. (2005) *Marx’s Theory of Alienation*. London: Merlin Press, p258.

<sup>120</sup> Douglas, M. (2016) ‘Beyond ‘Health’: Why don’t we tackle the cause of health inequalities?’ in Smith, K. et al., *Health Inequalities: Critical Perspectives*. Oxford: Oxford University Press, pp109-123 at p112.

<sup>121</sup> Berridge, V. (1996) ‘Health and Medicine’ in Thompson, F. (ed) *The Cambridge Social History of Britain 1750-1950 Vol. 3 Social Agencies and Institutions*. Cambridge: Cambridge University Press, pp171-242 at p237.

<sup>122</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p95.

<sup>123</sup> Ibid.

<sup>124</sup> Taylor, R. (2013) *God Bless the NHS: The Truth Behind the Current Crisis*. London: Faber and Faber, pp197-198.

<sup>125</sup> Berridge, V. (1996) ‘Health and Medicine’, op cit., n.121 at p237.

<sup>126</sup> Foot, M. (1982) *Aneurin Bevan 1945-1960*, op cit., n.82 at p149.

a bargaining strategy to secure concessions.<sup>127</sup> Virginia Berridge states that the medical profession was divided, as some GPs and medical officers of health already working within the local authority structure supported a universal free service, while hospital consultants and GPs in wealthier areas did not.<sup>128</sup> The BMA's leadership primarily spoke for older and wealthier GPs.<sup>129</sup> Marvin Rintala notes that nurses and midwives were unrepresented in almost all debates, discussions and negotiations regarding the NHS hence their subordinate position in its structure is not surprising.<sup>130</sup> The service was opposed by ninety percent of doctors in a plebiscite in early 1948.<sup>131</sup> However, it was supported by the public,<sup>132</sup> and doctors who did not participate would not be entitled to part of the £66 million agreed in compensation for the abolition of the sale of practices.<sup>133</sup> In a subsequent plebiscite, the opposition of doctors dwindled to sixty-five percent,<sup>134</sup> which the BMA deemed insufficient to continue its resistance.<sup>135</sup> Nonetheless, anti-NHS politics continued to be advanced, for example, by the Fellowship for Freedom in Medicine (FFM), which published pamphlets and articles, lobbied politicians and supported private health insurance.<sup>136</sup> Brain Abel-Smith noted that early attacks on the welfare state as a bureaucratic waste subsequently shifted to arguments about freedom of choice.<sup>137</sup>

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<sup>127</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p100.

<sup>128</sup> Berridge, V. (1996) 'Health and Medicine', op cit., n.121 at p237.

<sup>129</sup> Navarro, V. (1978) *Class Struggle, the State and Medicine*, op cit., n.62 at p41.

<sup>130</sup> Rintala, M. (2005) *Creating the National Health Service: Aneurin Bevan and the Medical Lords*. London: Frank Cass, p105.

<sup>131</sup> Eckstein, H. (1959) *The English Health Service: Its Origin, Structure and Achievements*. London: Oxford University Press, p161.

<sup>132</sup> Foot, M. (1982) *Aneurin Bevan 1945-1960*, op cit., n.82 at p192.

<sup>133</sup> Campbell, J. (1987) *Nye Bevan and the Mirage of British Socialism*. London: Weidenfield and Nicolson, p175.

<sup>134</sup> Eckstein, H. (1959) *The English Health Service*, op cit., n.131 at p161.

<sup>135</sup> Campbell, J. (1987) *Nye Bevan and the Mirage of British Socialism*, op cit., n.133 at p177.

<sup>136</sup> Seaton, A. (2015) 'Against the 'Sacred Cow': NHS Opposition and the Fellowship for Freedom in Medicine, 1948-1972'. *Twentieth Century British History*, Vol.26(3), pp424-449 at p428.

<sup>137</sup> Abel-Smith, B. (1967) *Freedom in the Welfare State*. London: Fabian Society, p3.

Although the SMA pressed Bevan not to make concessions,<sup>138</sup> he did so to persuade doctors to participate in the service. GPs remained independent contractors remunerated via “fixed annual payments...for every patient registered with them” (capitation fees)<sup>139</sup> and were compensated for the abolition of the sale of practices. Private practice was also retained.<sup>140</sup> Although most voluntary hospitals were nationalised, along with the municipal hospitals, 230 were disclaimed from the statute’s provisions and provided “the core of private sector provision for some years after the war”.<sup>141</sup> Many pay beds were provided within NHS institutions as it was feared that some doctors would choose private practice over NHS work if they could not combine them.<sup>142</sup> In the 1970s, Barbara Castle (Secretary of State for Health and Social Services between 1974 and 1976) wanted private practice to “stand on its own feet”<sup>143</sup> and established the Health Services Board<sup>144</sup> to phase out pay beds.<sup>145</sup> BUPA established the Independent Hospital Group to oppose Castle’s plans.<sup>146</sup> This subsequently merged (in 1987) with the Association of Independent Hospitals and kindred organisations (formed in 1949), creating the Independent Healthcare Association.<sup>147</sup> Castle’s policy inadvertently led to the “take off of the private sector” which was evident in increasing insurance coverage and the expansion of private hospitals.<sup>148</sup> The continuing existence of private practice was criticised as it was

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<sup>138</sup> Lee, J. (1981) *My Life with Nye*. Harmondsworth: Penguin, p208.

<sup>139</sup> Eckstein, H. (1959) *The English Health Service*, op cit., n.131 at p197.

<sup>140</sup> Pollock, A. et al (2005) *NHS PLC: The Privatisation of our Healthcare*. London: Verso, pp15-16.

<sup>141</sup> Higgins, J. (1988) *The Business of Medicine*, op cit., n.71 at p27.

<sup>142</sup> Campbell, J. (1987) *Nye Bevan and the Mirage of British Socialism*, op cit., n.133 at p168.

<sup>143</sup> Castle, B. (1976) *NHS Revisited*. London: Fabian Society, p11.

<sup>144</sup> Health Services Act (1976), S.1(1).

<sup>145</sup> Ibid at S.2(1)(B).

<sup>146</sup> Higgins, J. (1988) *The Business of Medicine*, op cit., n.71 at p69.

<sup>147</sup> Ibid at p74.

<sup>148</sup> Timmins, N. (1996) *The Five Giants*, op cit., n.65 at p339.

argued that NHS standards could be reduced “without affecting the health care of the decision makers themselves”.<sup>149</sup> The commercial sector supplies the NHS with drugs and equipment.<sup>150</sup> Pharmaceutical companies have been accused of milking the NHS via excessive charges.<sup>151</sup>

A month after the NHS became operational, ninety-seven percent of the population had registered and only ten percent of doctors remained outside.<sup>152</sup> Doctors have generally benefited from the NHS which has provided them with security of tenure and income.<sup>153</sup> Nicholas Timmins contends that by the 1980s a new generation of doctors emerged and that the BMA became the “biggest defender” of the NHS.<sup>154</sup> The NHS enabled many (including most women) to access medical care for the first time (manifest in an immense backlog of untreated disease),<sup>155</sup> assisted the decline in infant mortality rates,<sup>156</sup> facilitated more concerted efforts to vaccinate against certain diseases<sup>157</sup> and improved the distribution of doctors and diagnostic equipment.<sup>158</sup> However, financial constraints meant that, in its first decade, no new hospitals were built (despite many being “in a poor condition”<sup>159</sup>) and only a few Health Centres were constructed.<sup>160</sup> Many District General Hospitals were established following the

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<sup>149</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*, op cit., n.25 at p191.

<sup>150</sup> Ibid at p188.

<sup>151</sup> Widgery, D. (1979) *Health in Danger: The Crisis in the National Health Service*. Basingstoke: Macmillan, p43.

<sup>152</sup> Beckett, C. and Beckett, F. (2004) *Bevan*, op cit., n.74 at p86.

<sup>153</sup> Mishra, R. (1981) *Society and Social Policy*, op cit., n.40 at p128.

<sup>154</sup> Timmins, N. (1996) *The Five Giants*, op cit., n.65 at p412.

<sup>155</sup> Tudor-Hart, J. (1971) ‘The Inverse Care Law’. *The Lancet*, Vol.297(7696), pp405-412 at p406.

<sup>156</sup> Berridge, V. (1999) *Health and Society in Britain since 1939*. Cambridge: Cambridge University Press, p7.

<sup>157</sup> Webster, C. (2002) *The National Health Service: A Political History 2<sup>nd</sup> edition*. Oxford: Oxford University Press, p48.

<sup>158</sup> Rintala, M. (2005) *Creating the National Health Service*, op cit., n.130 at p142.

<sup>159</sup> Eckstein, H. (1959) *The English Health Service*, op cit., n.131 at p185/Timmins, N. (1996) *The Five Giants*, op cit., n.65 at pp209-210.

<sup>160</sup> Campbell, J. (1987) *Nye Bevan and the Mirage of British Socialism*, op cit., n.133 at p179.

Hospital Plan in 1962.<sup>161</sup> In 1951, Attlee's government introduced charges for dental care and spectacles, to pay for the Korean War (1950-1953). Bevan resigned from the cabinet as he thought that the NHS' principles would be eroded, analogising that "avalanches start with the movement of a very small stone".<sup>162</sup> The Conservative government, elected in October 1951, accommodated itself to the mixed economy and the welfare state.<sup>163</sup> Nonetheless, prescription charges were introduced in 1952<sup>164</sup> and the Guillebaud Committee was established to examine the cost of the NHS. Although, the committee was expected to justify cuts,<sup>165</sup> it found no opportunity for recommending reductions in, or new sources of, revenue.<sup>166</sup> The post-war consensus led to some discontent in the lower echelons of the Conservative party,<sup>167</sup> based partly on a dislike of growing trade union power and the level of taxation required to fund the welfare state.<sup>168</sup> Some Conservatives, such as Enoch Powell and Iain Macleod, favoured introducing charges and expanding the private sector in healthcare.<sup>169</sup>

### Criticisms of the NHS

Anti-collectivists criticised the welfare state, and specifically the NHS, for several reasons. Firstly, anti-collectivists contended that the NHS necessarily increases costs

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<sup>161</sup> Ministry of Health (1962) *A Hospital Plan for England and Wales*. London: Stationery Office.

<sup>162</sup> Foot, M. (1982) *Aneurin Bevan 1945-1960*, op cit., n.82 at p334.

<sup>163</sup> Green, E. (2002) *Ideologies of Conservatism: Conservative Political Ideas in the Twentieth Century*. Oxford: Oxford University Press, p218.

<sup>164</sup> Via the National Health Service (NHS) Act (1946), S.38(3) as amended by NHS Amendment Act (1949), S.16.

<sup>165</sup> Walsh, M., et al (2000) *Social Policy and Welfare*. Cheltenham: Stanley Thornes, p166.

<sup>166</sup> Guillebaud, C. (1956) *Report of the Committee of Enquiry into the cost of the National Health Service*, Cmnd.9663. London: HMSO, p268.

<sup>167</sup> Green, E. (2002) *Ideologies of Conservatism*, op cit., n.163 at p227.

<sup>168</sup> Ibid at p224.

<sup>169</sup> Berridge, V. (1999) *Health and Society in Britain since 1939*, op cit., n.156 at p26.

because at nil price demand is infinite.<sup>170</sup> However, Penelope Mullen argued that the amount of disease is finite, that recipients may incur a cost (for example, time and inconvenience) and that there is no theoretical or practical support for the notion that patients wish to consume infinite amounts of healthcare (as demand ceases when marginal utility falls to zero).<sup>171</sup> Secondly, anti-collectivists averred that welfare states produce alienation and complaint.<sup>172</sup> Powell argued that dissatisfaction was “endemic and inherent” in the NHS.<sup>173</sup> Thirdly, anti-collectivists asserted that there was insouciance about costs and efficiency.<sup>174</sup> The new right argued that the NHS wasted resources in excessive bureaucracy,<sup>175</sup> was inefficient (as it used its resources less intensively than it might),<sup>176</sup> was “slow to innovate in methods of organisation and financing” compared to the United States (US)<sup>177</sup> and that its rationing, via waiting lists, was unpleasant and unfair.<sup>178</sup> Nick Bosanquet rejected such claims as the administrative overheads of insurance schemes exceeded those of the NHS,<sup>179</sup> studies suggesting that it used resources less intensively did not use fair comparisons,<sup>180</sup> innovations in the US sought to emulate the UK NHS<sup>181</sup> and it was not clear that markets would be more pleasant or fair.<sup>182</sup>

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<sup>170</sup> George, V. and Wilding, P. (1996) *Ideology and Social Welfare*. Abingdon: Routledge, p28/Pirie, M. and Butler, E. (1988) *The Health of Nations: Solutions to the Problem of Finance in the Health Sector*. London: Adam Smith Institute, p4.

<sup>171</sup> Mullen, P. (1998) ‘Is it Necessary to Ration Health Care?’ *Public Money and Management*, Vol.18(1), pp53-58 at p53.

<sup>172</sup> George, V. and Wilding, P. (1996) *Ideology and Social Welfare*, op cit., n.170 at p28.

<sup>173</sup> Powell, E. (1976) *Medicine and Politics: 1975 and After*. Tunbridge Wells: Pitman Medical, p73.

<sup>174</sup> George, V. and Wilding, P. (1996) *Ideology and Social Welfare*, op cit., n.170 at p29.

<sup>175</sup> Bosanquet, N. (1983) *After the New Right*. London: Heinemann, p155.

<sup>176</sup> Ibid.

<sup>177</sup> Seldon, A. (1981) *Wither the Welfare State*. London: Institute of Economic Affairs, p20.

<sup>178</sup> Bosanquet, N. (1983) *After the New Right*, op cit., n.175 at p155.

<sup>179</sup> Ibid at p156.

<sup>180</sup> Ibid at p157.

<sup>181</sup> Ibid at p159.

<sup>182</sup> Ibid.

Peter Miller and Nikolas Rose contend that neo-liberal welfare reforms drew support from their consonance with other challenges to social government mechanisms, for example, from libertarians, feminists<sup>183</sup> and socialists.<sup>184</sup> Jurgen Habermas argued that welfare state bureaucracies had reifying effects as they “treated [people] as objects”.<sup>185</sup> Habermas characterised the rise of welfare states as signalling a fourth epoch of juridification.<sup>186</sup> The preceding epochs had led to the bourgeois state (in which the economy and the state were differentiated and legal subjects were constituted), the constitutional state (in which state power became subject to the rule of law) and the democratic constitutional state (in which constitutionalised state power was democratised).<sup>187</sup> I argue that Scott Veitch et al’s notion of a fifth epoch, characterised by an increased “marketisation” of, and a re-embedding of private law mechanisms (particularly contract and property law) in, areas formerly considered public, accounts for the reforms of the neo-liberal era.<sup>188</sup> While Habermas and others view juridification as a legal problem, it is also viewed as a political problem arising from the legal system appropriating (juridifying) political conflicts.<sup>189</sup> For example, the concept was used by Otto Kirchheimer, to describe labour disputes which had been “formalized juridically and thereby neutralized”,<sup>190</sup> and Boaventura de Sousa Santos, to describe the receding of politics as “the protection of more and more social interests

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<sup>183</sup> Who contend that welfare states increase men’s control over women. See Berridge, V. (1999) *Health and Society in Britain since 1939*, op cit., n.156 at p5.

<sup>184</sup> Miller, P. and Rose, N. (2008) *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge: Policy Press, p82.

<sup>185</sup> Habermas, J. (2006) *The Theory of Communicative Action Volume 2: Lifeworld and System: A Critique of Functionalist Reason*. McCarthy, T., Trans. Cambridge: Polity Press, p370.

<sup>186</sup> Ibid at p357.

<sup>187</sup> Ibid at pp357-360.

<sup>188</sup> Veitch, S. et al (2012) *Jurisprudence: Themes and Concepts 2<sup>nd</sup> edition*. Abingdon: Routledge, p262.

<sup>189</sup> Ibid at p260.

<sup>190</sup> Kirchheimer, O. (1969) ‘The Socialist and Bolshevik theory of the state’ in Burin, F. and Shell, K. (eds) *Politics, Law and Social Change: Selected Essays*. New York: Columbia University Press, pp3-21 at p7.



became a function of technically minded legal experts”.<sup>191</sup> Juridification is thus a mode of depoliticisation (which is examined in chapter two).

Roberto Unger identified an emergent consciousness of the welfare corporate state interested “in the decentralization and debureaucratization of institutional life”.<sup>192</sup> According to Miller and Rose “welfarism creates domains in which political decisions are dominated by technical calculations”.<sup>193</sup> For example, they argue that the NHS was established as a medical enclosure due to a profound optimism concerning “the ability of medical science to alleviate illness and promote health”.<sup>194</sup> The professional control over medicine was criticised by Ivan Illich, who described it as an iatrogenic epidemic.<sup>195</sup> John Harrington states that Bevan and Richard Titmuss (an academic champion of the welfare state) characterised the NHS as a utopian enclave,<sup>196</sup> an idealized zone exempted from the morals of the marketplace.<sup>197</sup> It was believed that the NHS would overcome alienation as, for example, doctors would no longer compete for patients and clinical judgment would prevail over economic concerns.<sup>198</sup> However, Harrington notes that commercial imperatives continued to limit professional autonomy.<sup>199</sup> Ian Kennedy’s anti-utopian critique of the NHS described it as

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<sup>191</sup> Santos, B. (2005) ‘Beyond neo-liberal governance: The World Social Forum as Subaltern Cosmopolitan Politics and Legality’ in Santos, B. and Rodriguez-Garavito, C. (eds) *Law and Globalization from below: Towards a Cosmopolitan Legality*. Cambridge: Cambridge University Press, pp29-63 at p37.

<sup>192</sup> Unger, R. (1984) *Knowledge and Politics*. New York: Free Press, p178.

<sup>193</sup> Miller, P. and Rose, N. (2008) *Governing the Present*, op cit., n.184 at p77.

<sup>194</sup> Ibid at p75.

<sup>195</sup> Illich, I. (2010) *Limits to Medicine: Medical Nemesis- The Expropriation of Health*. London: Marion Boyars, p3

<sup>196</sup> Harrington, J. (2017) *Towards a Rhetoric of Medical Law*. Abingdon: Routledge, pp90-91.

<sup>197</sup> Harrington, J. (2009) ‘Visions of Utopia: Markets, Medicine and the National Health Service’. *Legal Studies*, Vol.29(3), pp376-399 at p377.

<sup>198</sup> Harrington, J. (2017) *Towards a Rhetoric of Medical Law*, op cit., n.196 at p103.

<sup>199</sup> Ibid at p99.

reinforcing, rather than overcoming, alienation.<sup>200</sup> Kennedy argued that the principles determining most medical decisions were moral and ethical, rather than technical,<sup>201</sup> and should be the product of general discussion and debate.<sup>202</sup> Numerous patient groups were established in the 1960s as part of a “populist counterculture backlash against scientific and technological arrogance”.<sup>203</sup> For example, the Patients Association was established, in 1962, in response to patients being used in research without their knowledge.<sup>204</sup> Charlotte Williamson contends that patient groups are part of an emancipation movement.<sup>205</sup> Alex Mold states that demands for a greater say for patients were strengthened by several scandals in the 1960s.<sup>206</sup> Mold notes that despite professional resistance, by the 1990s, three rights were enshrined in law:<sup>207</sup> the right to access medical records;<sup>208</sup> the right to consent; and, the right to complain.<sup>209</sup>

Many GPs established patient participation groups in the 1970s.<sup>210</sup> Community Health Councils (CHCs) were created, as part of a re-organisation in the early 1970s, to

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<sup>200</sup> Ibid at p105.

<sup>201</sup> Kennedy, I. (1981) *The Unmasking of Medicine*. London: George Allen and Unwin, p78.

<sup>202</sup> Ibid at p98.

<sup>203</sup> Porter, R. (2004) *Blood and Guts: A Short History of Medicine*. London: Penguin, pp167-168.

<sup>204</sup> Mold, A. (2015) ‘Complaining in the age of Consumption’, op cit., n.77 at p169. This contravened the Nuremberg Code (Permissible Medical Experiments. Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law. No.10 Vol.2, Nuremberg October 1946-April 1949. Washington D.C.: US Government Printing) and the Helsinki Declaration (World Medical Association (1964) Declaration of Helsinki. Adopted by the 18<sup>th</sup> World Medical Assembly, Helsinki, Finland).

<sup>205</sup> Williamson, C. (2010) *Towards the Emancipation of Patients? Patients Experiences and the Patient Movement*. Bristol: Policy Press, p1.

<sup>206</sup> Mold, A. (2015) *Making the Patient Consumer: Patient Organisations and Health Consumerism in Britain*. Manchester: Manchester University Press, p45.

<sup>207</sup> Ibid at p94.

<sup>208</sup> To electronic records via the Data Protection Act (1984) and paper records via the Access to Health Records Act (1990).

<sup>209</sup> Hospitals Complaints Procedure Act (1985).

<sup>210</sup> Coulter, A. (2011) *Engaging Patients in Healthcare*. Maidenhead: Open University Press, p165.

represent patient's interests.<sup>211</sup> A Health Service Ombudsman was also created,<sup>212</sup> but could not consider clinical matters until 1996.<sup>213</sup> The reorganisation sought to unify the structure of the NHS and strengthen accountability to the centre.<sup>214</sup> Most public health functions of local authorities were transferred to the NHS. RHBs and HMCs were replaced with Regional Health Authorities (RHAs), Area Health Authorities (AHAs)<sup>215</sup> and District Management Teams (DMTs). The authorities consisted of professionals, lay members and local representatives. Messer noted, in his criticism of a white paper that influenced the legislation, that the latter were not directly elected but were selected because they "happened to be councillors".<sup>216</sup> The Secretary of State appointed RHA members and AHA chairmen. AHAs were required to appoint Family Practitioner Committees (FPCs),<sup>217</sup> which replaced Executive Councils.<sup>218</sup> Health and local authorities were required to co-operate through joint consultative committees.<sup>219</sup> However, these were undermined by financial pressures.<sup>220</sup> CHCs initially comprised thirty members (consisting of local authority and RHA appointees and members of voluntary organisations). CHCs reviewed services, made recommendations and inspected providers.<sup>221</sup> Christine Hogg contends that CHCs

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<sup>211</sup> National Health Service Reorganisation (NHSR) Act (1973), S.9(3)(A).

<sup>212</sup> NHSR Act (1973), S.31.

<sup>213</sup> Health Service Commissioners (Amendment) Act (1996), S.6.

<sup>214</sup> Day, P. and Klein, R. (1987) *Accountability: Five Public Services*. London: Tavistock, p78.

<sup>215</sup> NHSR Act (1973), S.5(1)(A) and (B). AHAs were abolished in 1982 and District Health Authorities (DHAs) replaced DMTs.

<sup>216</sup> Messer, F. (1971) *The National Health Service: A Miracle of Social Welfare. Can it be saved?* London: Co-op Political Committee, p12.

<sup>217</sup> NHSR Act (1973), S.5(5).

<sup>218</sup> FPCs were renamed Family Health Service Authorities FHSAs in 1990. See National Health Service and Community Care (NHSCC) Act (1990), S.2(1)(A). FHSAs, RHAs and DHAs were abolished in 1996 and replaced by 100 Health Authorities, as per the Health Authorities Act (1995), S.1.

<sup>219</sup> NHSR Act (1973), S.10(2).

<sup>220</sup> Humphries, R. et al (2012) *Health and Well-being boards: System leaders or talking shops?* London: Kings Fund, p8.

<sup>221</sup> National Health Service (Community Health Councils) Regulations, SI 1973/2217, R.19 and R.22.

opened up the NHS to more scrutiny and politicised issues,<sup>222</sup> changed attitudes towards users and pioneered activities, such as advocacy schemes and support for self-help groups.<sup>223</sup> However, CHCs contained low working class representation<sup>224</sup> and had limited ability to effect change at a wider level.<sup>225</sup>

Doyal and Pennell state that there was a “naive assumption” that healthcare costs would be stabilised “through an improvement in the general health of the population”.<sup>226</sup> In actuality, costs have increased and class inequalities in health have persisted,<sup>227</sup> as has been identified by successive reports.<sup>228</sup> Julian Le Grand argued that the latter demonstrated the failure of “promoting equality through public expenditure on the social services”.<sup>229</sup> Health inequalities have been explained by reference to material, cultural, and genetic factors.<sup>230</sup> There is a high correlation between ill health and wealth inequalities.<sup>231</sup> Thomas Piketty notes that material inequalities have increased since the 1970s.<sup>232</sup> Although the WHO initially focused on

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<sup>222</sup> Hogg, C. (2009) *Citizens, Consumers and the NHS: Capturing Voices*. Basingstoke: Palgrave, p45.

<sup>223</sup> Hogg, C. (1999) *Patients, Power and Politics: From Patients to Citizens*. London: Sage, p89.

<sup>224</sup> Navarro, V. (1978) *Class Struggle, the State and Medicine*, op cit., n.62 at p61.

<sup>225</sup> Mold, A. (2015) *Making the Patient Consumer*, op cit., n.206 at p43.

<sup>226</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*, op cit., n.25 at p183.

<sup>227</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p127.

<sup>228</sup> Townsend, P., et al (eds) (1990) *Inequalities in Health: The Black Report and the Health Divide*.

London: Penguin/Acheson, D. (1998) *Independent Inquiry into Inequalities in Health Report*. London:

Stationery Office/Marmot, M. et al (2010) *Fair Society, Healthy Lives: The Marmot Review*. London: University College London.

<sup>229</sup> Le Grand, J. (1982) *The Strategy of Equality: Redistribution and the Social Services*. London: George Allen and Unwin, p132.

<sup>230</sup> Bartley, M. (2004) *Health Inequality: An Introduction to theories, concepts and methods*. Cambridge: Polity, pp9-10.

<sup>231</sup> Nowatzki, N. (2014) ‘Wealth Inequality and health: A Political Economy Perspective’ in Navarro, V. and Muntaner, C. (eds) *The Financial and Economic Crises and their impact on health and social well-being*. Amityville, NY: Baywood, pp432-453 at p441.

<sup>232</sup> Piketty, T. (2014) *Capital in the Twenty-First Century*. Goldhammer, A., Trans. Cambridge, MA: Belknap Press of Harvard University Press, p271.

health determinants, it subsequently adopted a medicalised view of health.<sup>233</sup> A renewed focus on health determinants was evident in its Alma-Ata declaration, in 1978, but it became side-lined as a global leader on health policy and the World Bank (established in 1945 to lend to states in need of foreign investment), which favoured market mechanisms and disciplines, became the dominant voice.<sup>234</sup> The World Bank mandated, and partially funded, managed competition reforms in Colombia, in 1994, which subsequently became a model for reform elsewhere.<sup>235</sup>

As the NHS failed to address class inequalities in health and legitimised medical definitions of health, Walters contended that it “served an ideological function”.<sup>236</sup> She concluded that a “more effective attack on illness may require the state to intervene in the process of capital accumulation”.<sup>237</sup> Fredric Jameson states that there are two lines of descendancy from Thomas More’s *Utopia*:<sup>238</sup> one intent on the realization of the utopian programme, the other where Utopia serves as the bait for ideology, for example, “social democratic and liberal reforms...allegorical of a wholesale transformation of the social totality”.<sup>239</sup> Harrington notes that many early proponents of the NHS invested it with allegorical meaning.<sup>240</sup> The NHS was described by Bevan as a first fruit<sup>241</sup> and by Julian Tudor Hart as the beginning “of an alternative economy,

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<sup>233</sup> Meier, B. (2010) ‘The World Health Organisation, the evolution of human rights and the failure to achieve health for all’ in Harrington, J. and Stuttaford, M. (eds) *Global Health and Human Rights: Legal and Philosophical Perspectives*. Abingdon: Routledge, pp163-189 at p172.

<sup>234</sup> Lister, J. (2013) *Health Policy Reform: Global Health versus Private Profit*. Faringdon: Libri, pp4-5.

<sup>235</sup> Waitzkin, H. and Hellander, I. (2016) ‘The History and future of neo-liberal health reform: Obamacare and its predecessors’. *International Journal of Health Services*, Vol.46(4), pp747-766 at p748.

<sup>236</sup> Walters, V. (1980) *Class Inequality and Health Care*, op cit., n.9 at p161.

<sup>237</sup> Ibid at p160.

<sup>238</sup> More, T. (1965) *Utopia*. Harmondsworth: Penguin.

<sup>239</sup> Jameson, F. (2005) *Archaeologies of the Future: The Desire Called Utopia and other Science Fictions*. London: Verso, pp3-4.

<sup>240</sup> Harrington, J. (2017) *Towards a Rhetoric of Medical Law*, op cit., n.196 at p97.

<sup>241</sup> Bevan, A. (1950) *Democratic Values*. London: Fabian Society, p14.

driven by human needs rather than pursuit of profit”.<sup>242</sup> Santos described the notion that law could engineer a resolution of societal contradictions as utopian.<sup>243</sup> Meszaros states that utopianism offers partial remedies to problems.<sup>244</sup> In this respect, merely legally decommodifying healthcare is insufficient to remedy the problems of capitalism and its effect on health.

The socialist nature of the NHS has been questioned.<sup>245</sup> Calum Paton contended that it met some socialist criteria (as it is publicly financed and provided) but not others (as it has been inadequately funded historically and health inequalities persist).<sup>246</sup> Doyal and Pennell contend that a socialist medical service would demystify medical knowledge and “break down barriers of authority and status both among health workers themselves and between workers and consumers”.<sup>247</sup> Nonetheless, as Mold states, the power imbalance with professionals may be difficult to overcome completely.<sup>248</sup> Some Marxists view the welfare state as “a controlling agency of the ruling capitalist class”.<sup>249</sup> In this respect, the NHS helped “achieve social peace between capital and labour” and discharged “the responsibility of the state to maintain a suitably fit workforce”.<sup>250</sup> The NHS can be viewed as what Erik Olin Wright termed

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<sup>242</sup> Tudor-Hart, J. (2002) *The National Health Service as Precursor for Future Society*. [On-line] Available: <http://www.sochealth.co.uk/the-socialist-health-association/members/distinguished-members/julian-tudor-hart/the-national-health-service-as-precursor-for-future-society/> [Accessed: 15 February 2016].

<sup>243</sup> Santos, B. (1995) *Toward a new common sense: Law, Science and Politics in the Paradigmatic Transition*. London: Routledge, p89.

<sup>244</sup> Meszaros, I. (2005) *Marx's Theory of Alienation*, op cit., n.119 at p297.

<sup>245</sup> See, for example, Saville, J. (1957-1958) ‘The Welfare State: An Historical Approach’. *New Reasoner*, No.3, pp5-25 at p20.

<sup>246</sup> Paton, C. (1997) ‘Necessary Conditions for a Socialist Health Service’. *Health Care Analysis*, Vol.5(3), pp205-216 at p206.

<sup>247</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*, op cit., n.25 at p294.

<sup>248</sup> Mold, A. (2015) *Making the Patient Consumer*, op cit., n.206 at p204.

<sup>249</sup> Pierson, C. (1999) ‘Marxism and the Welfare State’ in Gamble, A., Marsh, D. and Tant, T. (eds) *Marxism and Social Science*. Basingstoke: Macmillan, pp175-194 at p175.

<sup>250</sup> Harrington, J. (2017) *Towards a Rhetoric of Medical Law*, op cit., n.196 at p95.

a symbiotic transformation (institutional forms of social empowerment which solve a problem of the dominant class<sup>251</sup>) in contrast to ruptural transformations (radical disjunctures in institutional structures through direct confrontation and political struggles) and interstitial transformations (new forms of social empowerment in the margins of capitalist society<sup>252</sup>). Wright argues that successful symbiotic strategies have the potential, with interstitial strategies, to cumulatively transform the whole system, but may also strengthen the hegemonic capacity of capitalism.<sup>253</sup> Some Marxists view the welfare state as “a Trojan horse for socialism”,<sup>254</sup> as it evinces a logic contrary to that of capitalism and may inspire alternatives. The welfare state is thus contradictory as it has the potential to stabilise and undermine capitalism.<sup>255</sup> Consequently, Offe stated that “while capitalism cannot coexist with, neither can it exist without the welfare state”.<sup>256</sup>

### Neo-liberalism

In the 1970s, the UK experienced stagflation, which Marxist economists attribute to falling profit rates.<sup>257</sup> In 1976, James Callaghan (Prime Minister between 1976 and 1979) formally announced his government’s break with Keynesian economic policy.<sup>258</sup>

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<sup>251</sup> Wright, E. (2010) *Envisioning Real Utopias*. London: Verso, p212.

<sup>252</sup> Ibid at p211.

<sup>253</sup> Ibid at pp254-255.

<sup>254</sup> Pierson, C. (1999) ‘Marxism and the Welfare State’, op cit., n.249 at p175.

<sup>255</sup> Gough, I. (1979) *The Political Economy of the Welfare State*. Basingstoke: Macmillan, p12/Offe, C. (1984) ‘Some Contradictions of the Modern Welfare State’, op cit., n.97 at p153.

<sup>256</sup> Offe, C. (1984) ‘Some Contradictions of the Modern Welfare State’, op cit., n.97 at p153.

<sup>257</sup> Parker, J. (2012) ‘Unravelling the neoliberal Paradox with Marx’. *Journal of Australian Political Economy*, Vol.70, pp193-213 at p196.

<sup>258</sup> Timmins, N. (1996) *The Five Giants*, op cit., n. 65 at p315.

David Harvey states that there was a move from Fordism to flexible accumulation.<sup>259</sup> The UK moved to a service economy model characterised by a decline in industrial jobs and a “rise in service sector jobs”.<sup>260</sup> Jessop states that the KWNS was replaced by the Schumpeterian workfare state, which subordinates social policy to the demands of “labour market flexibility and structural competitiveness”.<sup>261</sup> Gray notes that “the disintegration of the Keynesian paradigm” led to increased interest in the writings of neo-liberal thinkers,<sup>262</sup> such as Friedrich Hayek, Milton Friedman and Ludwig von Mises. Laurence Cox and Alf Gunvald Nilsen describe neoliberalism as “a social movement from above” which seeks “to restore profitability through market-oriented economic reforms”.<sup>263</sup> The neo-liberal era has involved an “assault on the institutional foundations of class compromise”.<sup>264</sup>

Rachel Turner states that neo-liberals sought to modernise and re-conceptualise liberalism.<sup>265</sup> Although there are numerous schools of neo-liberal thought, including German ordo-liberals, Chicago School theorists and public choice theorists,<sup>266</sup> Turner identifies four generic principles uniting them. The first is the idealisation of the market as a “mechanism for efficiently allocating resources and safeguarding individual freedom”.<sup>267</sup> William Davies notes that ordo-liberals sought to translate liberal

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<sup>259</sup> Harvey, D. (1990) *The Condition of Postmodernity*, op cit., n.107 at p171.

<sup>260</sup> Hardt, M. and Negri, A. (2001) *Empire*. London: Harvard University Press, p286.

<sup>261</sup> Jessop, B. (1993) ‘Towards a Schumpeterian Workfare State-Preliminary Remarks on the Post-Fordist Political Economy’. *Studies in Political Economy*, Vol.40(1), pp7-39 at p10.

<sup>262</sup> Gray, J. (1995) *Liberalism*, op cit., n.34 at p39.

<sup>263</sup> Cox, L. and Nilsen, A. (2014) *We Make our own history: Marxism and Social Movements in the Twilight of Neo-liberalism*. London: Pluto, pvi.

<sup>264</sup> Wright, E. (2015) *Understanding Class*, op cit., n.96 at p236.

<sup>265</sup> Turner, R.(2007) ‘The ‘Rebirth of Liberalism’: The origins of neo-liberal ideology’. *Journal of Political Ideologies*, Vol.12(1), pp67-83 at p68.

<sup>266</sup> Birch, K. (2015) *We Have Never Been Neoliberal: A Manifesto for a Doomed Youth*. Winchester: Zero Books, p27

<sup>267</sup> Turner, R. (2008) *Neo-Liberal Ideology*, op cit., n.60 at p4.



economic concepts into legal language in order to extend economic governance across society.<sup>268</sup> Chicago School economists, such as Ronald Coase and Richard Posner, asserted that economic rationality was applicable to law.<sup>269</sup> In the neo-liberal era, new governance mechanisms (such as markets) have been introduced in public services and choice, rather than voice, has been the preferred means of empowering recipients.<sup>270</sup> While D.S. Lees contended that medical care could be treated like “other goods in the market”,<sup>271</sup> Titmuss noted the problems of uncertainty and unpredictability.<sup>272</sup> I argue that voice is preferable to choice because, as Jameson argued, freedom of choice is exaggerated and “is scarcely the same thing as the freedom of human beings to control their own destinies and to play an active part in shaping their collective life”.<sup>273</sup>

The second principle is a commitment to the rule of law state.<sup>274</sup> Hayek was influenced by Michael Oakeshott’s distinction between a nomocracy and a teleocracy.<sup>275</sup> According to Oakeshott, the rule of law has independent virtue within a nomocracy, where the state does not seek to attain particular ends, but not within a teleocracy, where the state pursues a particular goal.<sup>276</sup> Hayek wanted to subject the coercive

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<sup>268</sup> Davies, W. (2014) *The Limits of Neoliberalism: Authority, Sovereignty and the Logic of Competition*. London: Sage, p81.

<sup>269</sup> Coase, R. (1990) *The Firm, the Market and the Law*. London: University of Chicago Press, p3/  
Posner, R. (1981) *The Economics of Justice*. London: Harvard University Press, p1.

<sup>270</sup> Albert Hirschman outlined the dichotomy between voice and exit (choice). See Hirschman, A. (1970) *Exit, Voice and Loyalty: Responses to Decline in Firms, Organisations and States*. London: Harvard University Press.

<sup>271</sup> Lees, D. (1961) *Health through Choice: An Economic Analysis of the National Health Service*. London: Institute of Economic Affairs, p21.

<sup>272</sup> Titmuss, R. (1976) *Commitment to Welfare: 2<sup>nd</sup> Edition*. London: George Allen and Unwin, p145.

<sup>273</sup> Jameson, F. (2010) *Valences of the Dialectic*. London: Verso, p386.

<sup>274</sup> Turner, R. (2008) *Neo-Liberal Ideology*, op cit., n.60 at p4.

<sup>275</sup> Plant, R. (2010) *The Neo-liberal State*. Oxford: Oxford University Press, p6/Hayek, F. (1976) *Law, Legislation and Liberty Vol.2*. London: Routledge and Kegan Paul, p15.

<sup>276</sup> Oakeshott, M. (2006) *Lectures in the History of Political Thought*. Exeter: Imprint Academic, p484.

powers of democracy to the rule of law.<sup>277</sup> Honor Brabazon states that law has been crucial in conceiving, constructing (for example, contract law has facilitated the extension of market-like relations<sup>278</sup>) and cohering neoliberalism.<sup>279</sup> Turner argues that the constitutional limitations advocated by neo-liberal thinkers “are inherently political” as “they embody different views about desirable forms of social organisation”.<sup>280</sup> Christine Sypnowich argues that capitalism undermines the rule of law, for example, due to unequal access to legal representation, conservative bias in the judiciary and a distorted agenda for law enforcement.<sup>281</sup>

The third principle is minimal state intervention.<sup>282</sup> However, as Andrew Gamble contends, the neo-liberal state is not a laissez faire state.<sup>283</sup> Rather the free economy requires a strong state, to overcome opposition and obstacles, and to legitimate the social order by providing non-market institutions.<sup>284</sup> Nonetheless, neo-liberals characterised welfare states as drains on competitiveness and economic performance<sup>285</sup> to justify retrenchment. Mark Featherstone argues that the contemporary neo-liberal vision of the state is a fusion of ordo-liberal theory concerned with state responsibility for market order and competition and an anarcho-capitalist

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<sup>277</sup> Turner, R. (2008) ‘Neo-liberal Constitutionalism: Ideology, Government and the Rule of Law’. *Journal of Politics and Law*, Vol.1(2), pp47-55 at p51.

<sup>278</sup> Birch, K. (2016) ‘Market vs Contract? The Implications of Contractual Theories of Corporate Governance to the analysis of Neoliberalism’. *Ephemera*, Vol.16(1), pp107-133 at p125.

<sup>279</sup> Brabazon, H. (2017) ‘Introduction: Understanding Neoliberal Legality’ in Brabazon, H. (ed) *Neoliberal Legality: Understanding the role of law in the Neoliberal Project*. Abingdon: Routledge, pp1-21 at p2.

<sup>280</sup> Turner, R. (2008) ‘Neo-liberal Constitutionalism’, op cit., n.277 at p48.

<sup>281</sup> Sypnowich, C. (1990) *The Concept of Socialist Law*. Oxford: Clarendon Press, p158.

<sup>282</sup> Turner, R. (2008) *Neo-Liberal Ideology*, op cit., n.60 at p5.

<sup>283</sup> Gamble, A. (2009) *The Spectre at the Feast: Capitalist Crisis and the Politics of Recession*. Basingstoke: Palgrave, p63.

<sup>284</sup> Ibid at p72.

<sup>285</sup> Hay, C. and Wincott, D. (2012) *The Political Economy of European Welfare Capitalism*. Basingstoke: Palgrave, p67.

fear of big government.<sup>286</sup> Although some early neo-liberal thinkers, such as Henry Simons and the ordo-liberal school, were critical of monopolies, later Chicago School theorists, such as Coase, argued that state regulation was dangerous<sup>287</sup> and that monopolies “could be more efficient [by reducing transaction costs] than markets and therefore justifiable”.<sup>288</sup> Brett Christophers contends that their influence led to the weakening of competition law and rampant monopoly.<sup>289</sup> In contrast, neo-liberals have criticised the NHS for being a monopoly<sup>290</sup> and reforms have increased transaction costs. Although neo-liberals have advocated increasing competition in English healthcare, neo-liberal reforms in other states, such as Colombia and the US, have not always generated it.<sup>291</sup> The fourth principle is private property.<sup>292</sup> Colin Hay states that neo-liberals also desire labour market flexibility, removing welfare benefits which discourage market participation and a global regime of free trade and free capital mobility.<sup>293</sup> Additionally, neo-liberals perceive inequality as a driver for progress.<sup>294</sup>

Hayek recognised the importance of institutions, networks and organisations in disseminating ideas.<sup>295</sup> He wanted liberals to learn from socialists whose “courage to

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<sup>286</sup> Featherstone, M. (2016) ‘The Spectre of Neo-liberalism: Thanatonomics and the possibility of trans-individualism’. *Fast Capitalism*, Vol.13(1).

<sup>287</sup> Birch, K. (2015) *We Have Never Been Neoliberal*, op cit., n.266 at pp37-39.

<sup>288</sup> Ibid at p40.

<sup>289</sup> Christophers, B. (2016) *The Great Leveler: Capitalism and Competition in the Court of Law*. London: Harvard University Press, p25.

<sup>290</sup> See, for example, Green, D. (1986) *Challenge to the NHS: A Study of Competition in American Healthcare and the lessons for Britain*. London: Institute for Economic Affairs, p102.

<sup>291</sup> Waitzkin, H. and Hellander, I. (2016) ‘The History and future of neo-liberal health reform’, op cit., n.235 at p753.

<sup>292</sup> Turner, R. (2008) *Neo-Liberal Ideology*, op cit., n.60 at p5.

<sup>293</sup> Hay, C. (2007) *Why We Hate Politics*. Cambridge: Polity Press, p97.

<sup>294</sup> Mirowski, P. (2013) *Never Let a Serious Crisis go to Waste*. London: Verso, p63.

<sup>295</sup> Plehwe, D. and Walpen, B. (2006) ‘Between Network and Complex Organisation: The Making of Neoliberal Knowledge and Hegemony’ in Plehwe, D., Walpen, B. and Neunhoffer, G. (eds) *Neoliberal Hegemony: A Global Critique*. London: Routledge, pp27-51 at p32.

be utopian” was “daily making possible what only recently seemed utterly remote”.<sup>296</sup> Hayek founded the Mont Pelerin Society (MPS) in 1947<sup>297</sup> to develop and disseminate neoliberal ideas. Subsequently, numerous neo-liberal think tanks were established in the UK, such as the Institute of Economic Affairs (IEA)<sup>298</sup> and the Centre for Policy Studies (CPS), founded by Keith Joseph. Ben Jackson contends that the right-wing press broadly coalesced around neo-liberalism in the early 1970s.<sup>299</sup> Hay states that public choice theory played an important role in normativising and naturalising neo-liberalism.<sup>300</sup> Public choice theorists narrated the crisis in the 1970s as one of political and bureaucratic overload, whereby voters, politicians and bureaucrats inflated state costs by acting self-interestedly.<sup>301</sup> For example, public sector bureaucrats were portrayed as self-maximising entrepreneurs (rather than motivated by a public service ethos) incentivised by democracy to raise budgets.<sup>302</sup> Hay contends that the overload thesis is based on unrealistic assumptions, such as the notion that voters disregard the state of the economy.<sup>303</sup> Le Grand states that policymakers began to see public sector employees more as knaves than knights and deemed that beneficiaries should be treated as queens rather than pawns.<sup>304</sup> Le Grand championed quasi-markets as a means of using scarce resources more efficiently.<sup>305</sup>

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<sup>296</sup> Hayek, F. (1960) ‘The Intellectuals and Socialism’ in de Huszar, G. (ed) *The Intellectuals: A Controversial Portrait*. Glencoe, IL: Free Press, pp371-384 at p384.

<sup>297</sup> Plehwe, D. and Walpen, B. (2006) ‘Between Network and Complex Organisation’, op cit., n.295 at p31.

<sup>298</sup> Ibid at p40.

<sup>299</sup> Jackson, B. (2012) ‘The Think Tank Archipelago’ in Jackson, B. and Saunders, R. (eds) *Making Thatcher’s Britain*. Cambridge: Cambridge University Press, pp43-61 at p56.

<sup>300</sup> Hay, C. (2007) *Why We Hate Politics*, op cit., n.293 at p98.

<sup>301</sup> Ibid at p99.

<sup>302</sup> Seymour, R. (2014) *Against Austerity: How we can fix the crisis they made*. London: Pluto, p10.

<sup>303</sup> Hay, C. (2005) ‘The Normalizing role of rationalist assumptions in the institutional embedding of neo-liberalism’. *Economy and Society*, Vol.33(4), pp500-527 at p512.

<sup>304</sup> Le Grand, J. (2003) *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens*. Oxford: Oxford University Press, px.

<sup>305</sup> Ibid at p4.

Kevin Ward and Kim England identify four main ways of understanding neo-liberalism.<sup>306</sup> Firstly, they aver that Marxists conceive it as an ideological hegemonic project.<sup>307</sup> Gamble contends that ideology is one of four dimensions of hegemony along with electoral, economic and state dimensions.<sup>308</sup> Secondly, Ward and England state that it is conceived as a set of policies and programs.<sup>309</sup> Policies which are generally characterised as neo-liberal are those that liberalise the economy, reduce the state's economic role (privatisation) and contribute to fiscal austerity and macro-economic stabilization.<sup>310</sup> Thirdly, Ward and England note that neo-liberalism is conceived as a state form, resulting from a process of restructuring, for example, by Jamie Peck and Adam Tickell.<sup>311</sup> Jessop notes that neo-liberalism may refer to different processes in different states, such as a system transformation (for example, in Russia following the cold war), a regime shift from a post-war compromise to regulation favouring capital over labour (for example, in the UK and the US), policy adjustments (for example, in Nordic social democracies) and structural adjustment programs (conditions imposed on states in the global south).<sup>312</sup> Fourthly, Ward and England note that neo-liberalism has been conceived as a type of governmentality.<sup>313</sup>

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<sup>306</sup> Ward, K. and England, K. (2007) 'Introduction: Reading Neoliberalization' in Ward, K. and England, K. (eds) *Neoliberalization: States, Networks, Peoples*. Malden, MA: Blackwell, pp1-22 at p11.

<sup>307</sup> Ibid.

<sup>308</sup> Gamble, A. (1994) *The Free Economy and the Strong State: The Politics of Thatcherism*. Basingstoke: Macmillan, p9.

<sup>309</sup> Ward, K. and England, K. (2007) 'Introduction', op cit., n.306 at p12.

<sup>310</sup> Boas, T. and Gans-Morse, J. (2009) 'Neoliberalism: From New Liberal Philosophy to Anti-Liberal Slogan'. *Studies in Comparative International Development*, Vol.44(2), pp137-161 at p143.

<sup>311</sup> Ward, K. and England, K. (2007) 'Introduction', op cit., n.306 at p12/Peck, J. and Tickell, A. (2002) 'Neoliberalizing Space'. *Antipode*, Vol.34(3), pp380-404.

<sup>312</sup> Jessop, B. (2010) 'From Hegemony to Crisis: The Continuing Ecological Dominance of Neoliberalism' in Birch, K. and Mykhnenko, V. (eds) *The Rise and Fall of Neo-Liberalism: The Collapse of an Economic Order?* London: Zed Books, pp171-187 at pp172-174.

<sup>313</sup> Ward, K. and England, K. (2007) 'Introduction', op cit., n.306 at p13.

This perspective is adopted by Foucauldian scholars.<sup>314</sup> Foucault argued that neo-liberals sought to extend the model of *homo economicus* (the man of exchange) “to every social actor in general”.<sup>315</sup> Similarly, Pierre Dardot and Christian Laval state that neo-liberalism generalizes “competition as a behavioural norm and...the enterprise as a model of subjectivization”.<sup>316</sup> In respect of biopolitics (a term Foucault used to describe the politics of biological life), neo-liberal governmentality attempts to decrease state responsibility for health by converting citizens into entrepreneurs of their own health.<sup>317</sup> This has been accompanied by a moral politics designed to police (and potentially exclude) individuals.<sup>318</sup>

Simon Springer notes that “scholars typically amalgamate” such views.<sup>319</sup> The problem with conceiving neo-liberalism as a process or set of policies is that this does not identify an agent.<sup>320</sup> John Clarke argues that Foucauldian scholars have overlooked the translation of political rationalities into practice.<sup>321</sup> Wendy Brown argues that Foucault’s writings about neo-liberalism are limited by his relative indifference to both democracy and capital,<sup>322</sup> the second of which he de-emphasises

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<sup>314</sup> Springer, S. (2012) ‘Neo-liberalism as Discourse: Between Foucauldian Political Economy and Marxian Poststructuralism’. *Critical Discourse Studies*, Vol.9(2), pp133-147 at p137.

<sup>315</sup> Foucault, M. (2008) *The Birth of Biopolitics: Lectures at the College De France 1978-79*. Burchell, G., Trans. Basingstoke: Palgrave, p270.

<sup>316</sup> Dardot, P. and Laval, C. (2013) *The New Way of the World: On Neo-liberal Society*. Elliott, G., Trans. London: Verso, p4.

<sup>317</sup> Vatter, M. (2014) ‘Foucault and Hayek: Republican Law and Liberal Civil Society’ in Lemm, V. and Vatter, M. (eds) *The Government of Life: Foucault, Biopolitics and Neo-Liberalism*. New York: Fordham University Press, pp163-185 at p170.

<sup>318</sup> Featherstone, M. (2016) ‘The Spectre of Neo-liberalism’, op cit., n.286.

<sup>319</sup> Springer, S. (2012) ‘Neo-liberalism as Discourse: Between Foucauldian Political Economy and Marxian Poststructuralism’, op cit., n.314 at p137.

<sup>320</sup> Birch, K. (2015) *We Have Never Been Neoliberal*, op cit., n.266 at p120.

<sup>321</sup> Clarke, J. (2009) ‘Programmatic Statements and Dull Empiricism: Foucault’s Neo-liberalism and Social Policy’. *Journal of Cultural Economy*, Vol.2(1-2), pp227-231 at p229.

<sup>322</sup> Brown, W. (2015) *Undoing the Demos: Neoliberalism’s Stealth Revolution*. Brooklyn, NY: Zone Books, p77.

“as a domain of power and source of domination”.<sup>323</sup> The Marxist conception is potentially compatible with, and can remedy the deficiencies of, the other perspectives. Harvey notes that Foucault’s writings are compatible with Marxism as they continue Marx’s arguments about the rise of disciplinary capitalism.<sup>324</sup> Offe contended, similarly to Foucauldian scholars, that neo-liberals desire citizens attending to all their needs “through participation in market processes”.<sup>325</sup> Marxists identify the ruling bourgeois class as the agent of neo-liberal policies and processes and recognise “the partial, contradictory and unstable character of dominant strategies”.<sup>326</sup> This is also recognised by Alan Hunt and Gary Wickham’s theory of law as governance, which was influenced by Foucault’s later writings.<sup>327</sup> Hunt and Wickham state that all instances of law as governance contain elements of attempt and incompleteness.<sup>328</sup>

Postmodernists, such as Foucault, replaced the concept of ideology with the concept of discourse.<sup>329</sup> I utilise the method of ideology critique, inspired by Marxist scholars, rather than discourse analysis. Foucault’s concept of discourse<sup>330</sup> is not an adequate replacement for the concept of ideology as it is unable to mediate between the ideal and the material (as it is purely material) in a manner akin to the concept of ideology.<sup>331</sup>

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<sup>323</sup> Ibid at p13.

<sup>324</sup> Harvey, D. (2010) *A Companion to Marx’s Capital*. London: Verso, pp147-149.

<sup>325</sup> Offe, C. (1984) ‘Legitimacy versus Efficiency’ in Keane, J. (ed) *Contradictions of the Welfare State*. London: Hutchinson, pp130-146 at p138.

<sup>326</sup> Clarke, J. (2004) *Changing Welfare, Changing States: New Directions in Social Policy*. London: Sage, p70.

<sup>327</sup> Hunt, A. and Wickham, G. (1994) *Foucault and Law: Towards a Sociology of law as Governance*. London: Pluto.

<sup>328</sup> Ibid at p102.

<sup>329</sup> Jameson, F. (2009) *Postmodernism, or the Cultural Logic of Late Capitalism*. London: Verso, p263.

<sup>330</sup> Foucault defined discourse as “the general domain of all statements”, an “individualizable group of statements” or “regulated practices that account for a number of statements”. See: Foucault, M. (1972) *The Archaeology of Knowledge and the Discourse on Language*. Sheridan Smith, A., Trans. New York: Pantheon Books, p80.

<sup>331</sup> Hawkes, D. (2003) *Ideology*, op cit., n.52 at p156.

Although I analyse discourse within this dissertation, this technique alone is imperfect as it can isolate the study of language from the study of practice.<sup>332</sup> I study both language and practice. Brown contends that the neo-liberal state derives its legitimacy merely from economic growth.<sup>333</sup> In contrast, I argue that welfare states and ideology continue to be important components of legitimation. Brown asserts that neo-liberalism has reoriented liberal norms of legitimacy, freedom and equality and that liberal views of the good life have lost their salience, undermining critiques which seek to exploit the gap between ideals and lived realities.<sup>334</sup> However, I contend that neo-liberalism has not successfully reoriented such norms and that the gap between ideals and lived realities continues to be exploitable.

Santos identified a shift in focus “from legitimacy to governability, from governability to governance”.<sup>335</sup> Public sector governance has been characterised by marketization, privatisation and a “proliferation of auditing”<sup>336</sup> (which Marilyn Strathern described as an audit culture<sup>337</sup>) in the neo-liberal era. Dexter Whitfield states that marketization (the imposition of market forces in public services) creates the conditions (economic and ideological) and social relations to develop privatisation.<sup>338</sup> Marketization is often

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<sup>332</sup> Newman, J. (2000) ‘Beyond the New Public Management? Modernizing Public Services’ in Clarke, J. et al (eds) *New Managerialism, New Welfare?* London: Sage, pp45-61 at p45.

<sup>333</sup> Brown, W. (2015) *Undoing the Demos*, op cit., n.322 at p26.

<sup>334</sup> Ibid at p57.

<sup>335</sup> Santos, B. (2005) ‘Beyond neo-liberal governance’, op cit., n.191 at p35.

<sup>336</sup> Leys, C. (2001) *Market Driven Politics*. London: Verso, p70.

<sup>337</sup> Strathern, M. (2000) ‘Accountability...and Ethnography’ in Strathern, M. (ed) *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy*. London: Routledge, pp279-304 at p288.

<sup>338</sup> Whitfield, D. (2006) ‘A Typology of Privatisation and Marketization’. [On-line] Available: <http://www.european-services-strategy.org.uk/publications/essu-research-reports/essu-research-paper-1/essu-research-paper-1-2.pdf> [Accessed: 22 November 2016], p4.



shaped by legal forms<sup>339</sup> and accompanied by the centralization of control.<sup>340</sup> The WHO defined privatisation as “a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services”.<sup>341</sup> Whitfield notes that politicians and senior managers “frequently attempt to redefine privatisation, claiming that it is limited to the sale of assets”.<sup>342</sup> Harvey contends that privatisation is “a particular form of enclosure of the commons” resulting in the appropriation of the assets and rights of the common people.<sup>343</sup> Harvey states that privatisation is an element of accumulation by dispossession, a concept influenced by both Marx’s and Rosa Luxembour’s writings about primitive accumulation.<sup>344</sup> Alex Callinicos and Sam Ashman contend that the boundaries of the concept of accumulation by dispossession are unclear and suggest restricting it to commodification, re-commodification and restructuring.<sup>345</sup> The increase in auditing was partly driven by new public management (NPM).<sup>346</sup> It involves arbitrary mechanisms for evaluating and ranking outcomes<sup>347</sup> to facilitate comparisons between public bodies.<sup>348</sup>

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<sup>339</sup> Brabazon, H. (2017) ‘Dissent in a Juridified Political Sphere’ in Brabazon, H. (ed) *Neoliberal Legality: Understanding the role of law in the Neoliberal Project*. Abingdon: Routledge, pp166-189 at p184.

<sup>340</sup> Apple, M. (2005) ‘Audit Cultures, Commodification and class and race strategies in education’. *Policy Futures in Education*, Vol.3(4), pp379-399 at p382.

<sup>341</sup> Muschell, J. (1995) *Health Economics Technical Briefing Note: Privatization in Health*. Geneva: World Health Organisation, p3.

<sup>342</sup> Whitfield, D. (2006) ‘A Typology of Privatisation and Marketization’, op cit., n.338 at p5.

<sup>343</sup> Harvey, D. (2010) *A Companion to Marx’s Capital*, op cit., n.324 at p309.

<sup>344</sup> Harvey, D. (2003) *The New Imperialism*. Oxford: Oxford University Press, p141.

<sup>345</sup> Callinicos, A. and Ashman, S. (2006) ‘Capital Accumulation and the State System: Assessing David Harvey’s The New Imperialism’. *Historical Materialism*, Vol. 14(4), pp107-131 at p120.

<sup>346</sup> Power, M. (1997) *The Audit Society: Rituals of Verification*. Oxford: Oxford University Press, p66.

<sup>347</sup> Fisher, M. and Gilbert, J. (2014) ‘Reclaim Modernity: Beyond Markets, Beyond Machines’. [On-line] Available: [http://www.compassonline.org.uk/wp-content/uploads/2014/10/Compass-Reclaiming-Modernity-Beyond-markets\\_-2.pdf](http://www.compassonline.org.uk/wp-content/uploads/2014/10/Compass-Reclaiming-Modernity-Beyond-markets_-2.pdf) [Accessed: 22 November 2016], p18.

<sup>348</sup> Apple, M. (2005) ‘Audit Cultures, Commodification and class and race strategies in education’, op cit., n.340 at p381.

## Neo-liberalism in Practice

Peck and Tickell conceive neo-liberalisation “as a process [which is not monolithic or universal in effect], not an end state”.<sup>349</sup> They have identified three neoliberal transformations. The first transformation (roll-back neo-liberalism) was the move from the “abstract intellectualism of Hayek and Friedman to the state authored restructuring projects of [Margaret] Thatcher [UK Prime Minister between 1979 and 1990] and [Ronald] Reagan [US President between 1981 and 1989]”.<sup>350</sup> Hayek’s influence on Thatcher is evidenced by her reportedly slamming a copy of his ‘*The Constitution of Liberty*’<sup>351</sup> onto a table in a cabinet meeting and declaring “this is what we believe”.<sup>352</sup> Naomi Klein avers that Thatcher used the popularity that she accrued from the Falklands war, in 1982, to launch a “corporatist revolution”.<sup>353</sup> Thatcher’s policies included deindustrialisation, deregulation, privatisation (for example, of electricity, water, gas and steel) and weakening trade unions. They resulted in substantial increases in socioeconomic and health inequalities.<sup>354</sup> Thatcher’s government assiduously avoided the term inequality<sup>355</sup> and focused on individual responsibility for,

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<sup>349</sup> Peck, J. and Tickell, A. (2002) ‘Neoliberalizing Space’, op cit., n.311 at pp383-384.

<sup>350</sup> Ibid at p388.

<sup>351</sup> Hayek, F. (2006) *The Constitution of Liberty*. Abingdon: Routledge.

<sup>352</sup> Green, E. (2002) *Ideologies of Conservatism*, op cit., n.163 at p258.

<sup>353</sup> Klein, N. (2008) *The Shock Doctrine: The Rise of Disaster Capitalism*. New York: Metropolitan Books, p138.

<sup>354</sup> Scott-Samuel, A. et al (2014) ‘The Impact of Thatcherism on Health and Well-Being in Britain. *International Journal of Public Health Services*, Vol.44(1), pp53-71 at p54.

<sup>355</sup> Williams, G. (2007) ‘Health inequalities in their place’ in Cropper, S. et al (eds) *Community Health and Well-being: Action Research on Health Inequalities*. Bristol: Policy Press, pp1-22 at p2.

rather than the structural causes of, ill health.<sup>356</sup> However, its attempts to suppress the Black report on health inequalities, published in 1980, generated a political scandal.<sup>357</sup>

Various right-wing think tanks recommended NHS reforms in the 1980s. For example, Oliver Letwin and John Redwood recommended working slowly “from the present system towards a national insurance scheme” in a CPS pamphlet.<sup>358</sup> Thatcher’s government tacitly considered various options for privatising health care in 1982, but public outcry was provoked when this was leaked forcing Thatcher to promise that the NHS was safe with the Conservatives.<sup>359</sup> Harvey states that institutions, such as the NHS, could only be touched “at the margins”.<sup>360</sup> Similarly, Stuart Hall described the NHS as Thatcher’s Maginot line.<sup>361</sup> Nonetheless, Thatcher’s government sought to encourage the growth of private medicine, for example, by introducing tax concessions on employer paid medical insurance premiums.<sup>362</sup> The NHS was subjected to relative austerity during the 1980s,<sup>363</sup> which, Gordon Brown argued, encouraged private sector growth.<sup>364</sup> By 1987, over nine percent of the UK population was covered by private insurance.<sup>365</sup>

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<sup>356</sup> Guy, W. (1996) ‘Health for All?’ in Levitas, R, and Guy, W. (eds) *Interpreting Official Statistics*. London: Routledge, pp87-110 at p87.

<sup>357</sup> Bartley, M. and Blane, D. (2016) ‘Reflections on the legacy of British health inequalities research’ in Smith, K. et al., *Health Inequalities: Critical Perspectives*. Oxford: Oxford University Press, pp22-32 at p24.

<sup>358</sup> Letwin, O. and Redwood, J. (1988) *Britain’s Biggest Enterprise: Ideas for Radical Reform of the NHS*. London: Centre for Policy Studies, p19.

<sup>359</sup> Leys, C. (2001) *Market Driven Politics*, op cit., n.336 at p168.

<sup>360</sup> Harvey, D. (2010) *The Enigma of Capital and the Crises of Capitalism*. London: Profile Books, p224.

<sup>361</sup> Hall, S. (1990) *Thatcherism and the Crisis of the Left: The Hard Road to Renewal*. London: Verso, p81.

<sup>362</sup> Webster, C. (2002) *The National Health Service*, op cit., n.157 at p155.

<sup>363</sup> Jacobs, A. (1998) ‘Market Health Reform in Europe’. *Journal of Health Politics, Policy and Law*, Vol. 23(1) pp1-33 at p21.

<sup>364</sup> Brown, G. (1989) *Where There is Greed: Margaret Thatcher and the Betrayal of Britain’s Future*. Edinburgh: Mainstream, p162.

<sup>365</sup> Leathard, A. (1993) *Health Care Provision*, op cit., n.51 at p143.

Thatcher's government did implement several significant NHS reforms. There was a shift from a "professional and health logic to a management/commercial logic" between 1979 and 1990.<sup>366</sup> Timmins argues that following the publication of Roy Griffiths' report, in 1983, the NHS moved from an administered to a managed system.<sup>367</sup> The government implemented Griffiths' recommendations to introduce general management<sup>368</sup> (which increased administrative spending<sup>369</sup>) and to establish a Supervisory Board (to make strategic decisions) and a Management Board (to plan the implementation of policies<sup>370</sup>). Rudolf Klein contends that the division of responsibility between the two boards, within the Department of Health, was blurred.<sup>371</sup> In 1989, the Supervisory Board was replaced with the Policy Board (which was abolished in 1995) and the Management Board became the NHS Management Executive (renamed the NHS Executive in 1995).<sup>372</sup> The latter was moved to Leeds, but day-to-day decision making remained with ministers in London.<sup>373</sup> Sue Dopson argues that the Griffiths report was indicative of the efficiency drive form of NPM.<sup>374</sup> NPM, which consists of a "cluster of ideas borrowed from the conceptual framework of private sector administrative practice",<sup>375</sup> became the dominant ideology in public

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<sup>366</sup> Filippou, J. et al (2016) 'Liberalizing the English National Health Service: Background and risks to healthcare entitlement'. *Cad. Saude Publica*, Vol.32(8), pp1-14 at p2.

<sup>367</sup> Timmins, N. (2015) 'History and Analysis' in Timmins, N. and Davies, E. (eds) *Glaziers and Window Breakers: The role of the Secretary of State for Health in their own words*. London: Health Foundation, pp1-56 at p18.

<sup>368</sup> Griffiths, R. (1983) *Report on the NHS Management Inquiry*. London: HMSO, p11.

<sup>369</sup> Pollock, A. et al (2005) *NHS PLC*, op cit., n.140 at p39.

<sup>370</sup> Griffiths, R. (1983) *Report on the NHS Management Inquiry*, op cit., n.368 at p3.

<sup>371</sup> Klein, R. (2008) *The New Politics of the NHS*, op cit., n.86 at p118.

<sup>372</sup> Edwards, B. and Fall, M. (2005) *The Executive Years of the NHS: The England Account 1985-2003*. Abingdon: Radcliffe, p49.

<sup>373</sup> *Ibid* at p108.

<sup>374</sup> Dopson, S. (2009) 'Changing Forms of Managerialism in the NHS: Hierarchies, Markets and Networks' in Gabe, J. and Calnan, M. (eds) *The New Sociology of the Health Service*. Abingdon: Routledge, pp37-55 at p38.

<sup>375</sup> Power, M. (1997) *The Audit Society*, op cit., n.346 at p43.

administration textbooks in the 1980s.<sup>376</sup> NPM informed the commodification, marketization and incentivization of the provision of public goods and public sector performance.<sup>377</sup> NPM also influenced outsourcing.<sup>378</sup> In the NHS, “non-clinical tasks, such as cleaning, laundry and catering” were contracted out.<sup>379</sup> NHS coverage was also reduced.<sup>380</sup> For example, long-stay nursing care of the elderly was transferred to local authorities<sup>381</sup> and charges for eye tests and dental check-ups were introduced.<sup>382</sup>

The 1989 white paper ‘*Working for Patients*’, many proposals of which were implemented via the National Health Service and Community Care (NHSCC) Act (1990), announced the expansion of medical audit<sup>383</sup> (the Clinical Services Advisory Group was established to this end<sup>384</sup>), that the Audit Commission would audit the accounts of NHS bodies<sup>385</sup> and that an internal market (which split purchasers and providers) would be introduced, to improve value for money, increase responsiveness to patients and enhance patient choice.<sup>386</sup> The government chose two recommended purchasing models:<sup>387</sup> District Health Authorities (DHAs)<sup>388</sup> and GPs.<sup>389</sup> Providers

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<sup>376</sup> Pollock, A. et al (2005) *NHS PLC*, op cit., n.140 at p38.

<sup>377</sup> Hay, C. (2007) *Why We Hate Politics*, op cit., n.293 at p111.

<sup>378</sup> Pollock, A. et al (2005) *NHS PLC*, op cit., n.140 at p38.

<sup>379</sup> Ibid.

<sup>380</sup> Ibid at p39.

<sup>381</sup> Ranade, W. (1997) *A Future for the NHS: Healthcare for the Millennium 2<sup>nd</sup> edition*. London: Longman, p199.

<sup>382</sup> Leathard, A. (1993) *Health Care Provision*, op cit., n.51 at p106/Health and Medicines Act (1988), S.11 and S.14.

<sup>383</sup> Department of Health (1989) *Working for Patients*. London: Stationery Office, p5.

<sup>384</sup> NHSCC Act (1990), S.62.

<sup>385</sup> Department of Health (1989) *Working for Patients*, op cit., n.383 at p6. This was enacted via NHSCC Act (1990), S.20.

<sup>386</sup> Ibid at pp3-6.

<sup>387</sup> Glennerster, H. and Matsaganis, M. (1993) ‘The UK Health Reforms: The Fundholding Experiment’. *Health Policy*, Vol.23(3), pp179-191 at p180

<sup>388</sup> Enthoven, A. (1985) *Reflections on the Management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, p40.

<sup>389</sup> Maynard, A. (1986) ‘Performance Incentives in General Practice’ in Teeling Smith, G. (ed) *Health, Education and General Practice*. London: Office of Health Economics, pp44-46. The NHSCC Act (1990), S.14 enabled GPs to apply to become fundholders.

were able to apply to become trusts,<sup>390</sup> which are semi-independent non-profit organisations.<sup>391</sup> Simon Jenkins states that introducing trusts meant that management and financial functions became dominant in hospitals.<sup>392</sup> The private sector board model was imported into public services,<sup>393</sup> such as NHS trusts<sup>394</sup> and health authorities.<sup>395</sup> Senior officials became executive directors and members became non-executive directors.<sup>396</sup> The reforms were criticised for increasing the democratic deficit, as even less attention was paid to representativeness.<sup>397</sup>

Accountability is an imprecise and contested concept.<sup>398</sup> Jo Maybin et al conceptualise it as the requirement to report and explain.<sup>399</sup> This may occur through scrutiny, regulation, election, management or contract.<sup>400</sup> The internal market reforms were regarded as replacing a management hierarchy with contracting between purchasers and providers.<sup>401</sup> Three types of contracts were introduced: block contracts, cost per case contracts and cost and volume contracts.<sup>402</sup> Agreements between health service

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<sup>390</sup> NHSCC Act (1990), S.5.

<sup>391</sup> Filippou, J. et al (2016) 'Liberalizing the English National Health Service', op cit., n.366 at p7.

<sup>392</sup> Jenkins, S. (1995) *Accountable to None: The Tory Nationalisation of Britain*. London: Hamish Hamilton, p78.

<sup>393</sup> Ferlie, E. et al (1996) *The New Public Management in action*. Oxford: Oxford University Press, p117.

<sup>394</sup> NHSCC (1990), S.5(5)(A).

<sup>395</sup> Regional and District Health Authorities (Membership and Procedure) Regulations, SI 1990/1331, R.2 and 3.

<sup>396</sup> Ferlie, E. et al (1995) 'Corporate governance and the public sector: Some Issues and Evidence from the NHS'. *Public Administration*, Vol.73(3), pp375-392 at p378.

<sup>397</sup> Davies, A. (2001) *Accountability: A Public Law analysis of government by contract*. Oxford: Oxford University Press, p23.

<sup>398</sup> Maybin, J. et al (2011) *Accountability in the NHS: Implications of the government's reform programme*. London: Kings Fund, p7.

<sup>399</sup> Ibid.

<sup>400</sup> Ibid at pvii.

<sup>401</sup> Goddard, M. et al (1997) *Contracting in the NHS: Purpose, Process and Policy: Discussion Paper 156*. York: Centre for Health Economics, p1.

<sup>402</sup> Bartlett, W. (1991) *Quasi-Markets and Contracts: A Market and Hierarchies Perspective on NHS reform*. Bristol: SAUS Publications, p9.

bodies did not give rise to contractual rights or responsibilities.<sup>403</sup> Pauline Allen states that the contracts were attenuated and that the hierarchical chain of relationships remained largely intact.<sup>404</sup> Allen et al argue that difficulties in specifying and measuring complex human services explains why contractual mechanisms were initially absent from the public sector.<sup>405</sup> Julia Lear et al state that it is a legal puzzle (unassessed by the courts) whether European Union (EU) (which the UK joined in 1973<sup>406</sup>) competition law became applicable once the internal market was introduced.<sup>407</sup>

Paton describes the internal market as “an elite initiative”<sup>408</sup> which “preserved public provision while embracing reform enough to please the Thatcherites”.<sup>409</sup> Paton argues that market reforms have “come in with a bang and gone out with a whimper”.<sup>410</sup> He states that while Virginia Bottomley was Secretary of State for Health (between 1992 and 1995), clinical objectives were prioritised over the market.<sup>411</sup> Despite government rhetoric that the reforms would enhance choice and local autonomy, there is evidence that they reduced choice<sup>412</sup> and that purchasers were strongly influenced by central

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<sup>403</sup> NHSCC (1990), S.4(3). This was repealed by the National Health Service (Consequential Provisions) Act (2006), Schedule 4. However, the National Health Service (NHS) Act (2006), S.9 (5) reaffirms that NHS contracts do not give rise to contractual rights or liabilities.

<sup>404</sup> Allen, P. (2002) ‘A Socio-Legal and economic analysis of contracting in the NHS internal market using a case study of contracting for district nursing’. *Social Science and Medicine*, Vol.54(2), pp255-266 at p259.

<sup>405</sup> Allen, P. et al (2016) ‘Public Contracts as Accountability Mechanisms: Assuring Quality in Public Healthcare in England and Wales’. *Public Management Review*, Vo.18(1), pp20-39 at p36.

<sup>406</sup> European Communities Act (1972).

<sup>407</sup> Lear, J. et al (2010) ‘EU Competition law and health policy’ in Mossialos, E. et al (eds) *Health Systems Governance in Europe: The Role of European Union Law and Policy*. Cambridge: Cambridge University Press, pp337-378 at p345.

<sup>408</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England’s Permanent Revolution*. London: Palgrave, p14.

<sup>409</sup> Ibid at p5.

<sup>410</sup> Ibid at p106.

<sup>411</sup> Ibid at p16.

<sup>412</sup> Fotaki, M. (1999) ‘The Impact of Market-Oriented Reforms on Choice and Information: A Case Study of Cataract Surgery in Outer London and Stockholm’. *Social Science & Medicine*, Vol.48(10), pp1415-1432 at p1430.

guidance.<sup>413</sup> The centralising effect of the management and market reforms led Jenkins to argue that, by 1997, “Bevan’s desire to hear the clatter of every bedpan in the corridors of Westminster had been realized” as the NHS became “micro-managed from the centre to meet the needs of short-term, media-led politics”.<sup>414</sup> The BMA organised an unsuccessful national campaign against the internal market. Ian Greener argues that this revealed that medical influence on government policy-making was “optional”<sup>415</sup> and rendered doctors “more circumspect about again attempting to launch a national campaign against health reform”.<sup>416</sup> Marianna Fotaki’s case study research, in Outer London, indicated that many patients (around half of the participants in her study) were unaware of the reforms.<sup>417</sup>

Thatcherism meant that welfare discourse was penetrated with consumerist words,<sup>418</sup> such as “choice”, “efficiency” and “quality”, which as Clarke and Janet Newman note, may depoliticise social issues and “displace real political and policy choices into a series of managerial imperatives”.<sup>419</sup> The interpellation of citizens as taxpayers and consumers sought to legitimate the pursuit of efficiency and comparability.<sup>420</sup> Arik Mordoh states that “quality is a complex multidimensional concept”.<sup>421</sup> Patient safety,

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<sup>413</sup> Davies, A. (2001) *Accountability*, op cit., n.397 at pp118-121.

<sup>414</sup> Jenkins, S. (2006) *Thatcher and Sons: A Revolution in Three Acts*. London: Penguin, p181.

<sup>415</sup> Greener, I. (2012) ‘The Case Study as History: ‘Ideology, Class and the National Health Service’ by Rudolf Klein’ in Exworthy, M. et al (eds) *Shaping Health Policy: Case Study, Methods and Analysis*. Bristol: Polity Press, pp77-94 at p87.

<sup>416</sup> Ibid at p89.

<sup>417</sup> Fotaki, M. (1999) ‘The Impact of Market-Oriented Reforms on Choice and Information’, op cit., n.412 at p1423.

<sup>418</sup> Phillips, L. (1998) ‘Hegemony and Political Discourse: The Lasting Impact of Thatcherism’. *Sociology*, Vol.32(4), pp847-867 at p864.

<sup>419</sup> Clarke, J. and Newman, J. (1997) *The Managerial State: Power, Politics and Ideology in the Remaking of Social Welfare*. London: Sage, p159.

<sup>420</sup> Clarke, J. (2004) ‘Dissolving the Public Realm? The Logics and Limits of Neo-liberalism’. *Journal of Social Policy*, Vol.33(1), pp27-48 at p40.

<sup>421</sup> Mordoh, A. (2011) *Critical Review of the Quality and Competition Measures and Identification Strategies used in Health Care Studies*, Office of Health Economics Occasional Paper 11/05, p12.



patient experience and effectiveness of care were identified as components of quality by a review in 2008<sup>422</sup> and subsequently incorporated into legislation.<sup>423</sup> Avedis Donabedian identified the following components: efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy (conforming to social preferences) and equity (just and fair distribution of health care and its benefits).<sup>424</sup> Efficiency in healthcare may refer to technical efficiency (obtaining the maximum possible improvement in outcome from a set of resource inputs), productive efficiency (maximising health outcomes at a given cost) or allocative efficiency (allocating resources to maximise welfare).<sup>425</sup> The government did not evaluate the impact of the internal market on efficiency.<sup>426</sup> Le Grand argued that efficiency increased, as activity rose faster than resources between 1991 and 1997.<sup>427</sup> In contrast, as the reforms led hospitals to focus on easily measured activities, Carol Propper et al contend that efficiency may have decreased.<sup>428</sup> The reforms were not allocatively efficient, as an estimated £2 billion was spent on the required organisational changes<sup>429</sup> which increased bureaucracy and overhead costs<sup>430</sup> by ending the advantages of cost-sharing and integrated care.<sup>431</sup> The reforms also detrimentally affected equity (as there is evidence that the patients of fundholders

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<sup>422</sup> Department of Health (DOH) (2008) *High Quality Care for all: NHS Next Stage Review Final Report*. London: DOH, p47.

<sup>423</sup> The NHS Act (2006), S.1A as amended by the Health and Social Care Act (2012), S.2, requires the Secretary of State to secure continuous improvement in outcomes (as per subsection 2), identified (in subsection 3) as the effectiveness and safety of services and the quality of patient experience.

<sup>424</sup> Donabedian, A. (2003) *An Introduction to Quality Assurance in Health Care*. Oxford: Oxford University Press, pp6-24.

<sup>425</sup> Palmer, S. and Torgerson, D., 'Definitions of Efficiency'. *British Medical Journal* 1999; 318:1136.

<sup>426</sup> Lister, J. (2007) *Health Policy Reform: Driving the Wrong Way? A Critical Guide to the Global 'Health Reform' industry*. London: Middlesex University Press, pxi.

<sup>427</sup> Le Grand, J. (2007) *The Other Invisible Hand: Delivering Public Services Through Choice and Competition*. Princeton: Princeton University Press, p103/Le Grand, J. et al (1998) 'The Reforms: Success or failure or neither?' in Le Grand, J. (ed) *Learning from the NHS Internal Market: A Review of the Evidence*. London: Kings Fund, pp117-143 at p120.

<sup>428</sup> Propper, C. et al (2008) 'Competition and Quality: Evidence from the NHS Internal Market 1991-9'. *Economic Journal*, Vol.188 (525), pp138-170 at p165.

<sup>429</sup> Greener, I. et al (2014) *Reforming Healthcare: What's the Evidence?* Bristol: Polity Press, p32.

<sup>430</sup> Lister, J. (2007) *Health Policy Reform*, op cit., n.426 at pxi.

<sup>431</sup> Pollock, A. et al (2005) *NHS PLC*, op cit., n.140 at p47.

were advantaged<sup>432</sup>) and lowered satisfaction for patients of fundholders.<sup>433</sup> An umbrella review of systematic reviews of healthcare reforms in high-income countries, conducted by Katherine Footman et al, found that marketization and privatisation did not improve quality.<sup>434</sup>

The Patient's Charter,<sup>435</sup> adopted in 1991, focused on individual patient rights<sup>436</sup> and was criticised for conflating citizen and consumer rights.<sup>437</sup> In 1994, the government agreed to liberalise hospital services under the rules of the World Trade Organisation (WTO).<sup>438</sup> The General Agreement on Trade in Services (GATS) brought services under the domain of multilateral trade rules for the first time.<sup>439</sup> My searches of Hansard and newspaper archives reveal that the potential constraints that GATS imposed on NHS policymaking did not elicit parliamentary or journalistic comment in the mid-1990s. Services provided in the exercise of governmental authority are exempt from GATS.<sup>440</sup> Such services must be supplied "neither on a commercial basis, nor in competition".<sup>441</sup> Kyriaki-Korina Raptopoulou contends that the exemption

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<sup>432</sup> Coulter, A. (1995) 'Evaluating General Practice Fundholding in the United Kingdom'. *European Journal of Public Health*, Vol.5(4), pp233-239 at p237.

<sup>433</sup> Dusheiko, M., et al (2007) 'The Impact of budgets for gatekeeping physicians on patient satisfaction: Evidence from Fundholding'. *Journal of Health Economics*, Vol.26(4), pp742-762 at p743.

<sup>434</sup> Footman, K. et al (2014) 'Quality Check: Does it Matter for Quality how you organise and pay for health care? A Review of the International Evidence'. *International Journal of Health Services*, Vol.44(3) pp479-505 at p498.

<sup>435</sup> Department of Health (1991) *Patient's Charter*. London: HMSO.

<sup>436</sup> Mold, A. (2015) *Making the Patient Consumer*, op cit., n.206 at p12.

<sup>437</sup> Plamping, D. and Delamothe, T., 'The Citizen's charter and the NHS'. *British Medical Journal* 1991; 303: 203.

<sup>438</sup> Pollock, A. and Price, D., 'Extending Choice in the NHS'. *British Medical Journal* 2002;325:293.

<sup>439</sup> Sinclair, S. (2015) 'Trade agreements and progressive governance' in Gill, S. (ed) *Critical Perspectives on the Crisis in Global Governance: Reimagining the Future*. Basingstoke: Palgrave, pp110-133 at p112.

<sup>440</sup> General Agreement on Trade in Services (GATS) (signed 14 April 1994; entered into force 1 January 1995), 1869 U.N.T.S. 183, Article 1:3(B).

<sup>441</sup> Ibid at Article1:3(C).

has been narrowly construed and would not apply to health care.<sup>442</sup> As the role of non-NHS providers increases, it becomes more likely that parts of the NHS may fall under GATS rules<sup>443</sup> which may entrench privatisation.<sup>444</sup> Stephen Gill argues that the WTO's regulatory policies are indicative of new constitutionalism.<sup>445</sup> Gill defines this as "the political project of attempting to make transnational liberalism, and if possible liberal democratic capitalism, the sole model for future development".<sup>446</sup> Gill states that it involves alterations to the "supreme laws and governing frameworks of nations" and the extension of 'pre-commitment' mechanisms... "designed to 'lock in' commitments to disciplinary neo-liberalism and to 'lock out'...alternatives (e.g. socialism) partly by making many of their means (e.g. nationalisation) illegal".<sup>447</sup> This logic is also evident in the EU, which Bastiaan van Apeldoorn avers subordinates the democratic governance of member states to the dictates of the single market.<sup>448</sup> I examine the impact of EU law on the NHS in subsequent chapters.

Peck and Tickell argue that, in the early 1990s, "the perverse economic consequences and profound social externalities" attributable to roll-back neo-liberalism, facilitated the second neo-liberal shift, a metamorphosis into "more socially interventionist and

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<sup>442</sup> Raptopoulou, K. (2015) 'The Legal Implications for the NHS of Transatlantic Trade and Investment Partnership: Executive Summary'. [On-line] Available: <http://www.unitetheunion.org/uploaded/documents/FINAL%20Legal%20implications%20of%20TTIP%20for%20the%20NHS%2012%20Feb%20201511-21864.pdf> [Accessed: 31 May 2016], p14.

<sup>443</sup> Vincent-Jones, P. (2006) *The New Public Contracting: Regulation, Responsiveness, Rationality*. Oxford: Oxford University Press, p64.

<sup>444</sup> Sexton, S. (2003) 'GATS, Privatisation and Health' in Politics of Health Group, *UK Health Watch 2005: The Experiences of Health in an unequal society*. London: Politics of Health Group, pp95-106 at p100.

<sup>445</sup> Gill, S. (1995) 'Globalisation, Market Civilisation and Disciplinary neo-liberalism'. *Journal of International Studies*, Vol.24(3), pp399-423 at p412.

<sup>446</sup> Ibid.

<sup>447</sup> Gill, S. (2008) *Power and Resistance in the new world order: 2<sup>nd</sup> edition*. Basingstoke: Palgrave, p79.

<sup>448</sup> Van Apeldoorn, B. (2013) 'The European Capitalist Class and the crisis of its hegemonic project'. *Socialist Register*, Vol.50, pp189-206 at p189.

ameliorative forms epitomised by the third way”.<sup>449</sup> Hans Jurgen Bieling states that third way approaches, exemplified by the governments of Bill Clinton (US President between 1993 and 2001) and Tony Blair (UK Prime Minister between 1997 and 2007), did not fundamentally depart from previous neo-liberal methods of capitalist reorganisation but that communitarian ideas supplanted conservative ones.<sup>450</sup> Such ameliorative language has continued in the era of roll-out neo-liberalism (the third neo-liberal transformation).<sup>451</sup> Roll-out neo-liberalism is manifest in states more directly supporting capital through social policy.<sup>452</sup> Colin Crouch notes that “contracts to provide services, demand for which is completely guaranteed for several years by government, give firms a highly attractive sellers-market” and explains the pressure exerted on governments to privatise services.<sup>453</sup> Such policies covertly redistribute wealth to the affluent and powerful<sup>454</sup> by enabling private companies to profit from publicly funded services.<sup>455</sup> NHS reforms since 2000 have afforded private healthcare companies more opportunities to provide clinical services. Although there are numerous critiques of such reforms (which I draw on in subsequent chapters), they have not been subjected to a comprehensive ideology critique. I postulate that this will illuminate the contestation between competing norms, the imperfect translation of norms into practice, the possible reifying effects of the reforms and provide a basis for conceiving alternatives.

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<sup>449</sup> Peck, J. and Tickell, A. (2002) ‘Neoliberalizing Space’, op cit., n.311 at p388.

<sup>450</sup> Bieling, H. (2006) ‘Neoliberalism and Communitarianism: Social Conditions, Discourses and Politics’ in Plehwe, D., Walpen, B. and Neunhoffer, G. (eds) *Neoliberal Hegemony: A Global Critique*. London: Routledge, pp207-221 at p217.

<sup>451</sup> Peck, J. and Tickell, A. (2002) ‘Neoliberalizing Space’, op cit., n.311 at p389.

<sup>452</sup> Veitch, K. (2013) ‘Law, Social Policy, and the Constitution of Markets and Profit Making’. *Journal of Law and Society*, Vol. 40(1), pp137-154 at p138.

<sup>453</sup> Crouch, C. (2011) *The Strange Non-Death of Neo-liberalism*. Cambridge: Polity Press, p86.

<sup>454</sup> Woolhandler, S. and Himmelstein, D., ‘Competition in a Publicly Funded Healthcare System’, *British Medical Journal* 2007; 335:1126.

<sup>455</sup> Navarro, V. (1976) *Medicine under Capitalism*. New York: Prodist, p216.

## Conclusion

In this chapter, I contended that the development of healthcare within England has been influenced historically by actual and potential unrest and, in the capitalist epoch, by the desire of the bourgeoisie for healthy workers. The welfare state (which institutionalised solidarity) was the product of class compromise. Welfare states stabilized capitalism but also instantiate values contrary to its logic. Doctor's interests influenced the organisation of the NHS, although doctors have, generally, become its defenders. The NHS has been beneficial for the working class, but an emerging consciousness recognised its problems and limitations, such as its failure to reduce health inequalities or to empower patients. Neo-liberal ideology became ascendant following the demise of the post-war consensus and new governance mechanisms have been introduced in the NHS. I argued that Marxist views of neo-liberalism are potentially compatible with, and can remedy the deficiencies of, other ways of conceiving neo-liberalism. Three neo-liberal transformations have been identified. The reforms examined in subsequent chapters are indicative of roll-out neo-liberalism and of a fifth epoch of juridification.

## Chapter Two: Ideology Critique: Methodology and Method

### Introduction

I employ the method of ideology critique to analyse recent NHS reforms. Alan Hunt notes that the concept of ideology is mainly used by Marxist legal theorists and that there is no equivalent concept in the mainstream sociology of law.<sup>1</sup> Rahel Jaeggi states that ideology critique was embraced by the various traditions of Western Marxism<sup>2</sup> up until contemporary critical theory.<sup>3</sup> Jaeggi contends that ideology critique is still required, as forms of social domination persist, but laments that the method was often unclear.<sup>4</sup> As neo-liberal NHS reforms provide private companies with more opportunities, they extend the domination of the capitalist class and detrimentally affect patient need by diverting money to bureaucracies (required to administer quasi-markets) and private companies. I clarify my own particular use of the method of ideology critique, within this chapter, which I use to understand efforts to legitimate and obscure such consequences. I concisely summarise Marxism and examine two problems which have confronted Marxist legal theorists, namely where the law is situated within the base/superstructure framework (which I reject) and how the law is determined. Terry Eagleton notes that “no single conception of ideology...has commanded universal assent”.<sup>5</sup> Broadly, ideology can be conceived positively, for

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<sup>1</sup> Hunt, A. (1985) ‘The Ideology of Law: Advances and Problems in recent applications of the concept of ideology to the analysis of law’. *Law & Society Review*, Vol.19(1), pp11-38 at p12.

<sup>2</sup> This refers to Marxist theorists based in Western Europe, such as Gyorgy Lukacs, Antonio Gramsci, Theodor Adorno and Louis Althusser. See Anderson, P. (1976) *Considerations on Western Marxism*. London: New Left Books, pp25-26.

<sup>3</sup> Jaeggi, R. (2009) ‘Rethinking Ideology’ in de Bruin, R. and Zurn, C. (eds) *New Waves in Political Philosophy*. Basingstoke: Palgrave, pp63-86 at p63.

<sup>4</sup> Ibid.

<sup>5</sup> Eagleton, T. (1996) ‘Introduction’ in Eagleton, T. (ed) *Ideology*. Harlow: Longman, pp1-22 at p14.

example, as a political tradition, a type of social cement<sup>6</sup> or the ideas of groups or individuals, and negatively (or critically) as misrepresentation or mystification.<sup>7</sup>

Susan Marks did not employ positive conceptions of ideology, within her ideology critique of democratic norm thesis in international law scholarship, on the basis that they are not critical.<sup>8</sup> However, such conceptions can be critical if a link is established between an ideology and a group or if it is demonstrated that a set of ideas are characterised by inversion and idealisation. Hugh Collins and David Moxon utilised positive conceptions of ideology to explain how laws are determined. I contend that the current hegemonic ideology of neo-liberalism is linked to the ruling capitalist class and is based on the fetishistic illusion of the freedom of the market, which is idealised. I argue that neo-liberalism has influenced the examined reforms, along with a posited micro-ideology of private health companies. Nonetheless, I aver that it competes with residual and emergent forms. Marks utilised ideological modes (and their strategies), identified by John B. Thompson,<sup>9</sup> within her ideology critique. I also utilise such modes in critiquing the justifications for NHS reforms. Marks did not use the conception of ideology as false consciousness. In contrast, I argue that the notion of misrecognition of reality may aid understanding of estrangement and I examine several modes of reification. I also examine and repudiate criticisms of the concept of ideology.

## Marxism

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<sup>6</sup> Marks, S. (2000) *The Riddle of All Constitutions: International Law, Democracy and the Critique of Ideology*. Oxford: Oxford University Press, pp9-10.

<sup>7</sup> Larrain, J. (1983) *Marxism and Ideology*. Basingstoke: Macmillan, p4.

<sup>8</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p11.

<sup>9</sup> Thompson, J. (2007) *Ideology and Modern Culture*. Cambridge: Polity Press, p60.

Karl Marx's theory of historical materialism is an explanatory and normative framework<sup>10</sup> which posits that different epochs, characterised by the dominant mode of production, can be discerned within history. Marx was a dialectical thinker who, as Bertell Ollman notes, "attributed change to the inner contradictions of the system or systems in which it occurs".<sup>11</sup> A fundamental aspect of Marx's writings was the notion of class struggle,<sup>12</sup> which Marx viewed as the motor of history.<sup>13</sup> Erik Olin Wright contends that antagonistic relations between classes are rooted in the exploitation<sup>14</sup> involved in the social relations of production.<sup>15</sup> Marx averred that, in the current capitalist epoch, there are two main classes: the ruling bourgeois class, who own the means of production, and the subordinate proletarian class, who sell their labour power to capitalists for wages.<sup>16</sup> Jon Elster states that Marx charged capitalism with being inhuman (as it leads to alienation), unjust (as it involves exploitation) and "inherently and needlessly irrational and wasteful" (as markets are an inefficient way of co-ordinating economic decisions and frequently lead to crises).<sup>17</sup> Marx predicted that the proletariat would overthrow the bourgeoisie and establish a communist society, which would enable individual self-realization.<sup>18</sup> Although Friedrich Engels

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<sup>10</sup> Hughes, J. (2000) *Ecology and Historical Materialism*. Cambridge: Cambridge University Press, p1.

<sup>11</sup> Ollman, B. (2003) *Dance of the Dialectic: Steps in Marx's Method*. Chicago, IL: University of Illinois Press, p18.

<sup>12</sup> Ste Croix, G. (1981) *The Class Struggle in the Ancient Greek World: From the Archaic Age to the Arab Conquests*. Ithaca, NY: Cornell University Press, p3.

<sup>13</sup> Wright, E. (1998) *Classes*. London: Verso, p33.

<sup>14</sup> Wright defines exploitation as "the acquisition of economic benefits from the labouring activity of those who are dominated". See Wright, E. (2015) *Understanding Class*. London: Verso, p9.

<sup>15</sup> Wright, E. (1998) *Classes*, op cit., n.13 at p34.

<sup>16</sup> Marx, K. (1847) *Wage Labour and Capital*. [On-line] Available:

<https://www.marxists.org/archive/marx/works/1847/wage-labour/> [Accessed: 08 October 2014].

<sup>17</sup> Elster, J. (1985) *Making Sense of Marx*. Cambridge: Cambridge University Press, pp515-517.

<sup>18</sup> Elster, J. (1986) *An Introduction to Karl Marx*. Cambridge: Cambridge University Press, p43.



contended that law would wither away under communism<sup>19</sup>, others argue that law is necessary for socialism.<sup>20</sup>

Subsequent Marxists (such as Western Marxists and Analytical Marxists<sup>21</sup>) have been more pessimistic about the prospects for revolution. The fall of communist regimes in Eastern Europe, in 1989, and the perceived “triumph of capitalism”, led to the claim that “Marxism is dead”.<sup>22</sup> However, although such regimes were inspired by Marxist theory, they developed in “circumstances that Marx never foresaw and resorted to devices that Marx never recommended”.<sup>23</sup> Ralph Miliband therefore described them as “monstrous deformation[s] of socialism”.<sup>24</sup> Contrary to those who have proclaimed its death, I agree with Eagleton that, as Marxism is a “searching, rigorous, comprehensive critique” of capitalism, “as long as capitalism is still in business, Marxism must be as well”.<sup>25</sup> Eric Hobsbawm noted that by the centenary of Marx’s death, in 1983, Marxist theory had become increasingly heterogeneous.<sup>26</sup> I do not profess fidelity to a figmental official Marxism, but utilise the ideas of many Marxist (and other) writers.

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<sup>19</sup> Engels, F. (1975) *Socialism: Utopian and Scientific*. Peking: Foreign Languages Press, p94.

<sup>20</sup> Hunt, A. (1992) ‘A Socialist Interest in Law’. *New Left Review*, Vol.192, pp105-119 at pp113-114/ Sypnowich, C. (1990) *The Concept of Socialist Law*. Oxford: Clarendon Press, p155.

<sup>21</sup> This refers to Marxist thinkers, such as G.A. Cohen, Jon Elster and Erik Olin Wright, who sought to ascertain where Marxist social science worked well. See Roemer, J. (1986) ‘Introduction’ in Roemer, J. (ed) *Analytical Marxism*. Cambridge: Cambridge University Press, p4.

<sup>22</sup> Marsh, D. (1999) ‘Resurrecting Marxism’ in Gamble, A., Marsh, D. and Tant, T. (eds) *Marxism and Social Science*. Basingstoke: Macmillan, pp320-340 at p320.

<sup>23</sup> Roth, B. (2008) ‘Marxian Insights for the Human Rights Project’ in Marks, S. (ed) *International Law on the Left: Re-examining Marxist Legacies*. Cambridge: Cambridge University Press, pp220-251 at p251.

<sup>24</sup> Miliband, R. (2007) *Socialism for a Sceptical Age*. Cambridge: Polity Press, p144.

<sup>25</sup> Eagleton, T. (2011) *Why Marx Was Right*. London: Yale University Press, p2.

<sup>26</sup> Hobsbawm, E. (2011) *How to Change the World: Reflections on Marx and Marxism*. London: Yale University Press, p369.

## Marxist Legal Theory

The subject of law has not been the primary focus of most Marxist thinkers.<sup>27</sup> However, Moxon states that in the 1970s, “many of the wider debates within Marxism were conducted through the prism of the law”.<sup>28</sup> Since then scholars, such as Collins and Moxon, have sought to remedy the theoretical deficiencies in Marxist legal theory. Scholars have also applied Marxist theory to studying international law<sup>29</sup> and human rights.<sup>30</sup> In addition, Marxism has influenced critical legal theorists (such as Duncan Kennedy, Karl Klare and Roberto Unger) and radical feminists (such as Joanne Conaghan and Wendy Brown). The subject of law was largely “peripheral”<sup>31</sup> in Marx’s writings. Marx famously contended that:

“The totality of these relations of production constitutes the economic structure of society, the real foundation, on which arises a legal and political superstructure and to which correspond definite forms of social consciousness. The mode of production of material life conditions the general process of social, political and intellectual life”.<sup>32</sup>

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<sup>27</sup> Collins, H. (1988) *Marxism and Law*. Oxford: Oxford University Press, p9.

<sup>28</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*. [On-line] Available: <http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.489053> [Accessed: 3 February 2013], p3.

<sup>29</sup> For example, Bill Bowring, A. Claire Cutler, Susan Marks and China Mieville.

<sup>30</sup> For example, Brad R. Roth.

<sup>31</sup> Vincent, A. (1993) ‘Marx and Law’. *Journal of Law and Society*, Vol. 20 (4), pp371- 397 at p371.

<sup>32</sup> Marx, K. (1859) ‘Preface’ in *A Contribution to the Critique of Political Economy*. [On-line] Available: <http://www.marxists.org/archive/marx/works/1859/critique-pol-economy/preface-abs.htm> [Accessed: 3 February 2013].

Moxon avers that subsequent Marxists were confronted with two problems when theorising about law.<sup>33</sup> The first problem concerns determination, namely explaining how the law is determined by the economic base of a society “without denying human agency”.<sup>34</sup> The second problem concerns where the law is situated within Marx’s base/superstructure framework.<sup>35</sup> G.A. Cohen asked “if the economic structure is constituted of property (or ownership) relations, how can it be distinct from the legal superstructure which it is supposed to explain?”<sup>36</sup> E.P. Thompson rejected the framework as his research indicated that “law did not keep politely to a level but was at every bloody level”.<sup>37</sup>

Collins notes that two schools of thought, economism (crude materialism) and class instrumentalism, sought to resolve the problems.<sup>38</sup> Proponents of economism, such as Evgeny Pashukanis, contended that the economic base of a society determines the law.<sup>39</sup> Proponents of class instrumentalism, such as Vladimir Lenin, contended that the law reflects the will of the dominant class.<sup>40</sup> Moxon argues that economism is reductionist and “cannot convincingly account for the role of conscious human action in shaping law and legal systems”.<sup>41</sup> Moxon contends that class instrumentalism merely asserts “that the ruling class use law to pursue their own ends” which “does not provide a [clear] solution”.<sup>42</sup> Moxon states that class instrumentalists also failed to

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<sup>33</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p32.

<sup>34</sup> Ibid at p37.

<sup>35</sup> Ibid.

<sup>36</sup> Cohen, G. (1991) *Karl Marx’s Theory of History: A Defence*. Oxford: Clarendon Press, pp217-218.

<sup>37</sup> Thompson, E. (1995) *The Poverty of Theory: or an Orrery of Errors*. London: Merlin Press, p130.

<sup>38</sup> Collins, H. (1988) *Marxism and Law*, op cit., n.27 at p22.

<sup>39</sup> Ibid at p23.

<sup>40</sup> Ibid at p27.

<sup>41</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p73.

<sup>42</sup> Ibid at p93.

solve the base/superstructure problem.<sup>43</sup> However, he agrees with China Mieville that Pashukanis provided a plausible theoretical solution to the problem.<sup>44</sup>

### Base/Superstructure Metaphor

Pashukanis stated that the legal form is part of the base and is actualised “through the necessary particularities of the legal superstructure”, such as court proceedings.<sup>45</sup> However, Moxon notes that Pashukanis failed to explain “why certain classes, in filling the empty form of law with its content, are attracted to certain ideas and have an understanding...of their needs and interests”.<sup>46</sup> Cohen contended that the “relations of production are a momentary power relation which quickly comes under the governance of superstructural rules”.<sup>47</sup> However, Collins notes that Cohen did not explain “why this happens”.<sup>48</sup> Collins argued that ideologies are formed by the relations of production and determine the content of law, which is thus superstructural, but that law has a “metanormative quality” allowing it to operate within the material base.<sup>49</sup> Collins has been criticised by Hunt, for unproblematically assigning “ideology to the superstructure”,<sup>50</sup> and by Moxon, for failing to provide a plausible concept of law.<sup>51</sup> Moxon avers that “law [which originates superstructurally] can be distinguished

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<sup>43</sup> Ibid.

<sup>44</sup> Ibid at p73/Mieville, C. (2006) *Between Equal Rights: A Marxist Theory of International Law*. London: Pluto, p96.

<sup>45</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p73/Mieville, C. (2006) *Between Equal Rights*, op cit., n.44 at p96/Pashukanis, E. (1924) *The General Theory of Law and Marxism*. [On-line] Available: <http://www.marxists.org/archive/pashukanis/1924/law/index.htm> [Accessed: 17 October 2013].

<sup>46</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p76.

<sup>47</sup> Collins, H. (1988) *Marxism and Law*, op cit., n.27 at p84.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid at pp88-89.

<sup>50</sup> Hunt, A. (1983) ‘Marxist Legal Theory and Legal Positivism’. *Modern Law Review*, Vol.46 (2), pp236-243 at p238.

<sup>51</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p149.

from mere norms [which comprise the material base] in terms of its legitimacy”.<sup>52</sup>

Moxon states that:

“law is a formal, rational, abstract system of rules that finds its legitimacy in the fact that it fosters and expresses something of the underlying nature of capitalist rationality, and it is internalised by at least some members of the society”.<sup>53</sup>

However, the notion that law merely derives its legitimacy from fostering and expressing capitalist rationality does not account for the development of welfare states.

I reject the base/superstructure metaphor because, as Bob Jessop stated, the economic base cannot be plausibly designated as “the ‘cause without cause’ which determines other social spheres” as it “is neither exclusively economic in its elements nor absolutely autonomous”.<sup>54</sup> Maureen Cain and Hunt note that the metaphor did not constrain Marx’s or Engels’ writings concerning law.<sup>55</sup> The use of the metaphor may lead to “both forcing and superficiality”,<sup>56</sup> as Raymond Williams noted in his literature studies. It may also lead to a failure to take law seriously<sup>57</sup> which is regrettable because, as, for example, Boaventura de Sousa Santos,<sup>58</sup> Klare<sup>59</sup> and Marks<sup>60</sup> note,

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<sup>52</sup> Ibid at p144.

<sup>53</sup> Ibid at p152.

<sup>54</sup> Jessop, B. (1990) *State Theory: Putting the Capitalist State in its Place*. Cambridge: Polity Press, p101.

<sup>55</sup> Cain, M. and Hunt, A. (1979) *Marx and Engels on Law*. London: Academic Press, p50.

<sup>56</sup> Williams, R. (1960) *Culture and Society 1780-1950*. New York: Anchor Books, p300.

<sup>57</sup> Sugarman, D. (1983) ‘Introduction and Overview’ in Sugarman, D. (ed) *Legality, Ideology and the State*. London: Academic Press, pp1-10 at p1.

<sup>58</sup> Santos, B. (1995) *Toward a new common sense: Law, Science and Politics in the Paradigmatic Transition*. London: Routledge, p111.

<sup>59</sup> Klare, K. (1979) ‘Law Making as Praxis’. *Telos*, Vol.40, pp123-135 at p128.

<sup>60</sup> Marks, S. (2007) ‘International Judicial Activism and the Commodity Form Theory of International Law’. *The European Journal of International Law*, Vol.18(1), pp199-211 at p202.

law has emancipatory potential. For example, the creation of the NHS emancipated people from the fear of financial hardship that ill health could augur. Santos averred that law evolves due to the political mobilization of competing social forces.<sup>61</sup> Similarly, Hunt argues that the law is an arena of struggle in which different class and political positions engage.<sup>62</sup> E.P. Thompson stated that while law “as an institution or as personnel may very easily be assimilated to those of the ruling class” all “that is entailed in law is not subsumed in these institutions”.<sup>63</sup> Thompson noted that law could also be seen as an ideology.<sup>64</sup> Hunt states that the ideological content of law can be identified at three levels: concrete legal norms, legal principles and the form of law.<sup>65</sup> Thompson contended that law can also be seen “as particular rules and sanctions which stand in a definite and active relationship (often a field of conflict) to social norms” and “in terms of its own logic, rules and procedures-that is, simply as law”.<sup>66</sup> In the latter respect, Annelise Riles states that the technicality of law defines and distinguishes it from other kinds of social knowledge.<sup>67</sup>

The concept of relative autonomy was used by Engels (who argued that the economic sphere is the “ultimately determining factor in history”<sup>68</sup>) and Louis Althusser (who stated that the economic sphere was determinative in the last instance<sup>69</sup>) to solve the

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<sup>61</sup> Santos, B. (1995) *Toward a new common sense*, op cit., n.58 at p111.

<sup>62</sup> Hunt, A. (1993) *Explorations in Law and Society: Toward a Constitutive Theory of Law*. London: Routledge, p90.

<sup>63</sup> Thompson, E. (1990) *Whigs and Hunters: The Origin of the Black Act*. London: Penguin, p260.

<sup>64</sup> Ibid.

<sup>65</sup> Hunt, A. (1985) ‘The Ideology of Law’, op cit., n.1 at p22.

<sup>66</sup> Thompson, E. (1990) *Whigs and Hunters*, op cit., n.63 at p260.

<sup>67</sup> Riles, A. (2016) ‘Afterword: A Method more than a subject’ in Cowan, D. and Wincott, D. (eds) *Exploring the ‘legal’ in ‘socio-legal studies’*. London: Palgrave, pp257-264 at p258.

<sup>68</sup> Engels, F. (1890) *Letter to J. Bloch in Königsberg*. [On-line] Available: [https://www.marxists.org/archive/marx/works/1890/letters/90\\_09\\_21.htm](https://www.marxists.org/archive/marx/works/1890/letters/90_09_21.htm) [Accessed: 26 February 2014].

<sup>69</sup> Althusser, L. (1969) *For Marx*. Brewster, B., Trans. London: Penguin, pp231-232.

base/superstructure problem. However, it is unclear what ultimately determining factor means.<sup>70</sup> Jack Lindsay argued that the notion of the last instance was used to defer the problem with the metaphor indefinitely.<sup>71</sup> E.P. Thompson asserted that “the complexity of relations is not ...illuminated by giving to it a reputable new name like relative autonomy”.<sup>72</sup> A preferable alternative to the metaphor has been identified by both Williams, who stated that “social being determines consciousness”,<sup>73</sup> and Thompson, who averred that there is a “dialogue between social being and social consciousness”.<sup>74</sup> Both Thompson and Williams defined “determine” as setting limits.<sup>75</sup>

### Positive Conceptions of Ideology

Marx and Engels used ideology in a negative sense in ‘*The German Ideology*’ (see below). However, Marx’s conception of ideology was broader in subsequent writings.<sup>76</sup> For example, Marx stated that ideological forms are forms “in which men become conscious of this conflict [i.e. class struggle] and fight it out”.<sup>77</sup> Although ‘*The German Ideology*’ was written in 1845, it was not published until 1932. Its absence influenced a shift from a negative to a positive conception.<sup>78</sup> Ideology was conceptualised as

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<sup>70</sup> Gilbert, J. (2014) *Common Ground: Democracy and Collectivity in an Age of Individualism*. London: Pluto, p84.

<sup>71</sup> Lindsay, J. (1981) *The Crisis in Marxism*. Bradford-on-Avon: Moonraker Press, p99.

<sup>72</sup> Thompson, E. (1995) *The Poverty of Theory*, op cit., n.37 at p213.

<sup>73</sup> Williams, R. (1973) ‘Base and Superstructure in Marxist Cultural Theory’. *New Left Review*, 1/82, pp3-16 at p3.

<sup>74</sup> Thompson, E. (1995) *The Poverty of Theory*, op cit., n.62 at p12.

<sup>75</sup> Ibid at p214/Williams, R. (1973) ‘Base and Superstructure in Marxist Cultural Theory’, op cit., n.73 at p4.

<sup>76</sup> Larrain, J. (1983) *Marxism and Ideology*, op cit., n.7 at p47.

<sup>77</sup> Marx, K. (1859) ‘Preface’, op cit., n.32.

<sup>78</sup> Larrain, J. (1983) *Marxism and Ideology*, op cit., n.7 at p54/Rehmann, J. (2013) *Theories of Ideology: The Powers of Alienation and Subjection*. Boston: Brill, p62.

class consciousness by Lenin.<sup>79</sup> Lenin stated that there were two ideologies which represented the interests of the two main classes: bourgeois and socialist ideology.<sup>80</sup> However, ideologies may pertain to social relations other than class, such as between sexes and ethnic groups (for example, patriarchy and nationalism).<sup>81</sup> John B. Thompson therefore stated that studying ideology involves examining the manner “in which meaning (or signification) serves to [establish and] sustain relations of domination”.<sup>82</sup> Nonetheless, the concept of class consciousness usefully describes how members of classes may become aware of an identity of interests “as against those of other classes”.<sup>83</sup>

Ideology has also been used to refer to worldviews (for example, by Karl Mannheim and Lucien Goldmann) and political traditions.<sup>84</sup> Michael Freeden notes that the latter use bridged the Marxist and political science concepts of ideology.<sup>85</sup> Marks did not use such conceptions on the basis that they are neutral rather than critical conceptions.<sup>86</sup> However, such conceptions can be critical if a link between a particular worldview or political tradition and a dominant group is identified. I reject the Post-Marxist<sup>87</sup> notion that there is “no logical connection whatsoever” between class and ideology.<sup>88</sup> Rather,

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<sup>79</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p9.

<sup>80</sup> Lenin, V. (1902) *What is to be done?* [On-line] Available: <https://www.marxists.org/archive/lenin/works/1901/witbd/> [Accessed: 07 October 2014]

<sup>81</sup> Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.9 at p57.

<sup>82</sup> Thompson, J. (1984) *Studies in the Theory of Ideology*. Berkeley: University of California Press, p194.

<sup>83</sup> Thompson, E. (1963) *The Making of the English Working Class*. New York: Vintage Books, p807.

<sup>84</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p9.

<sup>85</sup> Freeden, M. (1996) *Ideologies and Political Theory: A Conceptual Approach*. Oxford: Oxford University Press, p19.

<sup>86</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p11. Marks also rejected the conceptions of ideology as dogma and as culture (see pp8-10), which I do not utilise.

<sup>87</sup> This refers to “writers with an explicitly Marxist background, whose recent work has gone beyond Marxist problematics and who do not publicly claim a continuing Marxist commitment”. See Therborn, G. (2008) *From Marxism to Post-Marxism*. London: Verso, p165.

<sup>88</sup> Laclau, E. and Mouffe, C. (2001) *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics 2<sup>nd</sup> edition*. London: Verso, p84.



as Eagleton states, “the relations between certain social locations, and certain political forms, is a necessary [but not inevitable] one” hence it is not “wholly coincidental that all capitalists are not also revolutionary socialists”.<sup>89</sup> I agree with David Harvey that neo-liberalism is a “class project” to “restore and consolidate capitalist class power”.<sup>90</sup> The use of such conceptions may also be critical if it is demonstrated that the political tradition involves inversion (“certain false beliefs or assumptions about human action”<sup>91</sup>) and idealisation (the tendency to convert ideas into ideals), two characteristics that John Torrance stated Marx ascribed to ideologies.<sup>92</sup> Inversion may involve abstraction or projection.<sup>93</sup> Harvey states that the inversion in neo-liberalism is the “fetishistic illusion” of the freedom of the market.<sup>94</sup> Neo-liberals convert the abstract idea of the market into an ideal. In this respect, Anthony Culyer argued that as markets are imperfect, “the marketeers’ image of the market for health is a completely irrelevant description of an unattainable utopia”.<sup>95</sup> Similarly, Calum Paton averred that the necessary conditions for a successful market in the NHS, such as perfect competition and an unambiguous profit-making culture on the part of providers, have never existed or been properly sought by policymakers, as they are chimerical and hugely expensive.<sup>96</sup> Paton contends that such conditions have been rationalised ex post facto by idealists.<sup>97</sup>

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<sup>89</sup> Eagleton, T. (2007) *Ideology: An Introduction*. London: Verso, p218.

<sup>90</sup> Harvey, D. (2010) *The Enigma of Capital and the Crises of Capitalism*. London: Profile Books Limited, p10.

<sup>91</sup> Torrance, J. (1995) *Karl Marx’s Theory of Ideas*. Cambridge: Cambridge University Press, p209.

<sup>92</sup> Ibid at p201.

<sup>93</sup> Elster, J. (1985) *Making Sense of Marx*, op cit., n.17 at p477.

<sup>94</sup> Harvey, D. (2010) *A Companion to Marx’s Capital*. London: Verso, p42.

<sup>95</sup> Culyer, A. (1982) ‘The NHS and the Market: Images and Realities’ in McLachlan, G. and Maynard, A. (eds) *The Public/Private Mix for Health: The Relevance and effects of change*. London: Nuffield Provincial Hospitals Trust, pp23-55 at p27.

<sup>96</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England’s Permanent Revolution*. London: Palgrave, p110.

<sup>97</sup> Ibid.

Marks also rejected Gramsci's and Althusser's conceptualisations of ideology as a type of social cement.<sup>98</sup> In contrast, I contend that this conception is useful because, as Freeden stated, "ideologies aim at cementing the relationship between words and concepts", attaching "a single meaning to a...term".<sup>99</sup> Thus, as Valentin Voloshinov argued, sign is an important "arena of the class struggle".<sup>100</sup> Gramsci distinguished between organic ideologies ("the necessary superstructure of a particular structure"<sup>101</sup>) and "the polemics of individual ideologues"<sup>102</sup> (the "arbitrary elucubrations of individuals"<sup>103</sup>). He viewed the former "as the cement which holds together the structure".<sup>104</sup> Similarly, Althusser stated that ideology was required to reproduce "the kinds of people who will be able to participate in the process of production".<sup>105</sup> Althusser argued that repressive state apparatuses (RSAs) functioned "predominantly by repression" and that ideological state apparatuses (ISAs), such as churches and schools, functioned "predominantly by ideology".<sup>106</sup> Althusser's concept of ISAs has been criticised for simplifying social institutions, which are not purely ideological structures.<sup>107</sup>

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<sup>98</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p10.

<sup>99</sup> Freeden, M. (1996) *Ideologies and Political Theory*, op cit., n.85 at p76.

<sup>100</sup> Voloshinov, V. (1973) *Marxism and the Philosophy of Language*. Matejka, L. and Titunik, I., Trans. London: Harvard University Press, p23.

<sup>101</sup> Gramsci, A. (1991) *Selections from Prison Notebooks*. Hoare, Q. and Nowell-Smith, G. (ed)., Trans. London: Lawrence and Wishart, p376.

<sup>102</sup> Barrett, M. (1991) *The Politics of Truth: From Marx to Foucault*. Cambridge: Polity Press, p52.

<sup>103</sup> Gramsci, A. (1991) *Selections from Prison Notebooks*. op cit., n.101 at p376.

<sup>104</sup> Hall, S., Lumley, B. and McLennan, G. (1980) 'Politics and Ideology: Gramsci' in Centre for Contemporary Cultural Studies (ed) *On Ideology*. London: Hutchinson, pp45-76 at p53.

<sup>105</sup> Hawkes, D. (2003) *Ideology: 2<sup>nd</sup> Edition*. London: Routledge, p118.

<sup>106</sup> Althusser, L. (1977) 'Ideology and Ideological State Apparatuses' in Althusser, L. *Lenin and Philosophy and Other Essays 2<sup>nd</sup> Edition*. Brewster, B., Trans. London: New Left Books, p138.

<sup>107</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p147.

Michelle Barrett states that the “concept of hegemony is the organising focus of Gramsci’s thought on politics and ideology”.<sup>108</sup> Harvey notes that Gramsci uses hegemony in two ways, firstly political power exercised through leadership and consent as opposed to coercion (which is how Harvey uses the concept) and secondly, coercion and consent.<sup>109</sup> Perry Anderson argued that Gramsci’s use of the terms state and civil society and his analysis of the relationship between them was inconsistent.<sup>110</sup> Many interpret Gramsci as associating hegemony with civil society, “the whole range of institutions intermediate between state and economy” (including the family, schools, medical institutions<sup>111</sup> and the media) which “bind individuals to the ruling power by consent” (as opposed to coercion which is used by the state).<sup>112</sup> I contend that both the state and civil society are involved in constructing hegemony. Gramsci averred that consent was achieved through the dissemination of “a conception of the world which is uncritically absorbed”.<sup>113</sup>

Althusser drew on Jacques Lacan’s notion, that the ego is formed through identification at the mirror stage of a child’s development,<sup>114</sup> to propose that ideology interpellates individuals as subjects, hence “there is no ideology except by the subject and for subjects”.<sup>115</sup> The concept of interpellation usefully describes how subjects come to recognise what exists, what is good and what is possible.<sup>116</sup> Nonetheless, as

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<sup>108</sup> Barrett, M. (1991) *The Politics of Truth: From Marx to Foucault*, op cit., n.102 at p54.

<sup>109</sup> Harvey, D. (2003) *The New Imperialism*. Oxford: Oxford University Press, p36.

<sup>110</sup> Anderson, P. (1976) ‘The Antinomies of Antonio Gramsci’. *New Left Review*, Vol.100, pp5-78 at p12.

<sup>111</sup> Waitzkin, H. (1989) ‘A Critical Theory of Medical Discourse: Ideology, Social Control and the Processing of Social Context in Medical Encounters’. *Journal of Health and Social Behaviour*, Vol.30, pp220-239 at p223.

<sup>112</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p56.

<sup>113</sup> Gramsci, A. (1991) *Selections from Prison Notebooks*. op cit., n.101 at p419.

<sup>114</sup> Lacan, J. (1994) ‘The Mirror-Phase as Formative of the Function of the I’ in Zizek, S. (ed) *Mapping Ideology*. London: Verso, pp93-100 at p94.

<sup>115</sup> Althusser, L. (1977) ‘Ideology and Ideological State Apparatuses’, op cit., n.106 at p159.

<sup>116</sup> Therborn, G. (1999) *The Ideology of Power and the Power of Ideology*. London: Verso, p18.

Eagleton states, Althusser's ideas are "too monistic", as subjects "may be ideologically accosted - partially, wholly or hardly at all - by discourses themselves which form no obvious cohesive unity".<sup>117</sup> Norman Fairclough argues that although subjects are positioned ideologically, they can also act creatively by making their own connections between ideologies and practices.<sup>118</sup>

Gramsci contended that ideology was a relatively autonomous "terrain on which men move, acquire consciousness of their position, struggle".<sup>119</sup> He distinguished between a war of position (the movement of classes to gain vantage points within civil society) and a war of movement (the seizure of state power).<sup>120</sup> Gramsci argued that the task of the philosophy of praxis was to coincide with *buon senso* (good sense),<sup>121</sup> to repel the overwhelming impact of ideologies within the *senso commune* (a composite of historical layers and opposite social perspectives<sup>122</sup>) "on common sense and to strengthen the inherent potentials of realistic experience and capacity to act".<sup>123</sup> Williams stated that "hegemony does not just passively exist as a form of dominance", rather "it has continually to be renewed, recreated, defended and modified".<sup>124</sup> For example, Thatcherism, Blairism and Cameronism are distinct neo-liberal hegemonic projects.<sup>125</sup> Williams contended that dominant forms are "also continually resisted,

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<sup>117</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p145.

<sup>118</sup> Fairclough, N. (1992) *Discourse and Social Change*. Cambridge: Polity, p91.

<sup>119</sup> Gramsci, A. (1991) *Selections from Prison Notebooks*. op cit., n.101 at p377.

<sup>120</sup> Hall, S., Lumley, B. and McLennan, G. (1980) 'Politics and Ideology: Gramsci', op cit., n.104 at p51.

<sup>121</sup> Rehmann, J. (2014) 'Philosophy of Praxis, Ideology-Critique, and the relevance of a 'Luxemburg-Gramsci line'. *Historical Materialism*, Vol.22(2), pp99-116 at p107.

<sup>122</sup> Ibid.

<sup>123</sup> Rehmann, J. (2015) 'Ideology-Critique with the conceptual hinterland of a theory of the ideological'. *Critical Sociology*, Vol.41(3), p433-448 at p442.

<sup>124</sup> Williams, R. (1977) *Marxism and Literature*. Oxford: Oxford University Press, p110.

<sup>125</sup> Kerr, P. et al (2011) 'Theorising Cameronism'. *Political Studies Review*, Vol.9(2), pp193-207 at p198.

limited, altered, challenged”<sup>126</sup> by residual and emergent forms.<sup>127</sup> I argue that the residual forms, which the current dominant form of neo-liberalism competes with, include liberal norms, such as freedom and equality. Brown contends that neo-liberalism has successfully redefined such norms.<sup>128</sup> In contrast, Anita Chari avers that neo-liberalism continues to rely on liberalism’s normative legitimation (although it inverts classical liberal discourses regarding the relationship between economics and politics).<sup>129</sup>

E.P. Thompson identified a “popular consensus as to what were legitimate and what were illegitimate practices in marketing, milling, banking, etc.”, in the eighteenth century, based on a “traditional view of social norms and obligations” which, he stated, constituted a “moral economy of the poor”.<sup>130</sup> Colin Barker used the moral economy concept to describe local opposition to the closure of Booth Hall Hospital in North Manchester in the early 1990s.<sup>131</sup> Barker stated that a moral economy is characterised by a perceived problem or threat to people’s needs, a counter ethic (a vision of the common good entailing non-monetary values) and aspects of tradition or custom (something already known, practiced and valued) and is a kind of battle cry.<sup>132</sup> Barker notes that part of a moral economy’s practical power comes from the partial validity

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<sup>126</sup> Williams, R. (1977) *Marxism and Literature*, op cit., n.124 at p110.

<sup>127</sup> Ibid at p122.

<sup>128</sup> Brown, W. (2005) *Edgework: Critical Essays on Knowledge and Politics*. Oxford: Princeton University Press, p57.

<sup>129</sup> Chari, A. (2015) *A Political Economy of the Senses: Neo-liberalism, Reification, Critique*. Chichester, NH: Columbia University Press, p34.

<sup>130</sup> Thompson, E. (1971) ‘The Moral Economy of the English crowd in the Eighteenth Century’. *Past and Present*, Vol.50(1), pp76-136 at p79.

<sup>131</sup> Barker, C., ‘A Modern Moral Economy? Edward Thompson and Valentin Voloshinov meet in North Manchester’. Paper presented to the conference on Making Social Movements: The British Marxist Historians and the study of social movements, Edge Hill College of Higher Education, June 26-28, 2002.

<sup>132</sup> Ibid.

the powerful have previously granted it.<sup>133</sup> There is overwhelming public support (a popular consensus) for the NHS' founding principles (which I categorise as residual norms).<sup>134</sup> The organisation of the NHS, on the basis of need, has been known, practiced and valued and the powerful have given validity to it. NHS reforms which threaten people's needs contravene this popular consensus. Wolfgang Streeck highlights the tension between social justice (vested in a society's moral economy) and market justice.<sup>135</sup> Streeck argues that the existence of a non-capitalist politics capable of defining and enforcing general interests is necessary to prevent capitalism's self-destruction.<sup>136</sup> The erosion of socially organised mitigation has led to some scholars questioning whether capitalism can survive.<sup>137</sup> Streeck argues that neo-liberal capitalism is dysfunctional (evident in declining growth and rising inequality) and that a post-capitalist interregnum is dawning,<sup>138</sup> which, in Gramsci's words, means that the "old [order] is dying but the new cannot yet be born".<sup>139</sup> In respect of emerging norms, as mentioned in chapter one, Unger identified an emerging consciousness of the welfare corporate state<sup>140</sup> which developed norms in recognition of the problems and limitations of welfare states.

Collins drew on Gramsci's and Althusser's ideas to explain how the law is determined.

Collins contended that "the ruling class share common perceptions of interest as a

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<sup>133</sup> Ibid.

<sup>134</sup> As is evidenced by Gershlick, B. et al (2015) *Public Attitudes to the NHS*. London: Health Foundation, p11.

<sup>135</sup> Streeck, W. (2016) *How Will Capitalism End? Essays on a Failing System*. London: Verso, p213.

<sup>136</sup> Ibid at p224.

<sup>137</sup> See for example: Calhoun, C. (2013) 'What Threatens Capitalism Now' in Wallerstein, I. et al (eds) *Does Capitalism have a future?* Oxford: Oxford University Press, pp131-161 at p148/Gamble, A.

(2016) *Can the Welfare State Survive?* Cambridge: Policy Press, p104.

<sup>138</sup> Streeck, W. (2016) 'The post-capitalist interregnum'. *Juncture*, Vol.23(2), pp68-77.

<sup>139</sup> Gramsci, A. (1991) *Selections from Prison Notebooks*, op cit., n.101 at p276.

<sup>140</sup> Unger, R. (1984) *Knowledge and Politics*. New York: Free Press, p20.

result of similar processes of socialisation and experiences of productive activities” which establishes “a consensus of values”.<sup>141</sup> Collins states that the ruling class therefore enact “laws pursuant to that ideology”.<sup>142</sup> Olufemi Taiwo asserted that recourse to ideology “merely puts class instrumentalism under a thicker layer of verbiage”.<sup>143</sup> However, I contend that ideology has more explanatory value than Taiwo credits. Moxon states that Taiwo’s Marxist theory of natural law (that certain laws “are necessary to or constitutive of the mode of production”<sup>144</sup>) is “potentially compatible with Collins’ notion of ideology”.<sup>145</sup> Nonetheless, Moxon states that Collins’ idea of an overarching dominant ideology is problematic as: it would need to be “implausibly extended” to explain all laws (such as “prohibitions of victimless crimes”<sup>146</sup>); it is not “rigorous enough to be of much use theoretically” or empirically;<sup>147</sup> and, it “is increasingly implausible in a late modern landscape”<sup>148</sup> due to the increasing fragmentation of society<sup>149</sup> and the fact that states are increasingly ceding powers to other actors (for example, through privatisation).<sup>150</sup> Moxon proposes substituting such an overarching dominant ideology with micro-ideologies, formed in the same way as Collins suggested, to remedy such problems.<sup>151</sup> Moxon stated that empirical analysis of ideologies at the micro-level could pertain to both individuals and groups.<sup>152</sup> Some of the changes that Moxon states characterise late modernity, such as privatisation, are attributable to neo-liberal ideology. I therefore contend that both dominant and

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<sup>141</sup> Collins, H. (1988) *Marxism and Law*, op cit., n.27 at p40.

<sup>142</sup> Ibid at p43.

<sup>143</sup> Taiwo, O. (1996) *Legal Naturalism: A Marxist Theory of Law*. Ithaca, NY: Cornell University Press, p90.

<sup>144</sup> Ibid at p59.

<sup>145</sup> Moxon, D. (2008) *Marxist Legal Theory in Late Modernity*, op cit., n.28 at p150.

<sup>146</sup> Ibid at p139.

<sup>147</sup> Ibid at p140.

<sup>148</sup> Ibid at p184.

<sup>149</sup> Ibid at p216.

<sup>150</sup> Ibid at p218.

<sup>151</sup> Ibid at p219.

<sup>152</sup> Ibid at p254.

micro-ideologies may aid understanding of how laws are determined. Both Brown and Harvey note that corporations are increasingly fashioning law and policy in the neo-liberal era.<sup>153</sup> I examine the influence of neo-liberalism and a posited micro-ideology of private healthcare companies on successive NHS reforms.

### Negative Conceptions of Ideology

Although there are numerous interpretations of Marx's and Engels' writings concerning ideology,<sup>154</sup> I agree with Bhikhu Parekh that the concept is used in two interrelated senses within '*The German Ideology*': "first, idealism and second, an apologetic body of thought".<sup>155</sup> In respect of the latter, Marx and Engels averred that the "the ideas of the ruling class are in every epoch the ruling ideas" as the ruling class controls the means of mental production.<sup>156</sup> Such ideas are described as being "hypocritical", as bourgeois ideology "voices their particular interests as universal interests".<sup>157</sup> Eagleton states that this is so that the sectoral nature of the ideology does not "loom too embarrassingly large" as this would "impede its general acceptance".<sup>158</sup> Similarly, E.P. Thompson argued that law needed to be presented as being in everyone's interests as if it were "evidently partial or unjust it will mask nothing, legitimise nothing".<sup>159</sup> Apologia may be intended or otherwise.<sup>160</sup> Brown notes that Marx argued

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<sup>153</sup> Brown, W. (2015) *Undoing the Demos: Neoliberalism's Stealth Revolution*. Brooklyn, NY: Zone Books, p43/Harvey, D. (2007) *A Brief History of Neo-liberalism*. Oxford: Oxford University Press, pp76-77.

<sup>154</sup> Barrett, M. (1991) *The Politics of Truth: From Marx to Foucault*, op cit., n.102 at p3.

<sup>155</sup> Parekh, B. (1982) *Marx's Theory of Ideology*. London: Croom Helm, p1.

<sup>156</sup> Marx, K. and Engels, F. (1998) *The German Ideology*. New York: Prometheus Books, p67.

<sup>157</sup> Ibid at p194.

<sup>158</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p56.

<sup>159</sup> Thompson, E. (1990) *Whigs and Hunters*, op cit., n.63 at p263.

<sup>160</sup> Parekh, B. (1982) *Marx's Theory of Ideology*, op cit., n.155 at p12.



(in 'On the Jewish Question'<sup>161</sup>) that liberal constitutionalism grants rights to abstract as opposed to concrete subjects.<sup>162</sup> It thereby constructs an “illusory politics of equality, liberty and community in the domain of the state” disguising “the unequal, un-free and individualistic domain of civil society”.<sup>163</sup> This may aid groups in representing sectional interests as universal interests. With regards to Marxist state theory, Colin Hay notes that it has been characterised by a battle between instrumentalists (such as Miliband) and structuralists (such as Nicos Poulantzas).<sup>164</sup> I favour Jessop's strategic-relational approach which locates the state “within a complex dialectic of structures and strategies”.<sup>165</sup>

John B. Thompson identified five general modes of ideology (legitimation, dissimulation, unification, fragmentation and reification) and their common strategies.<sup>166</sup> Thompson contends that universalization is a common strategy of the legitimation mode of ideology, along with rationalization (the construction of a chain of reasoning justifying social relations or institutions) and narrativization (in which claims are embedded in stories about the present).<sup>167</sup> Thompson avers that dissimulation operates by concealing, denying or obscuring relations of domination, for example, through displacement and euphemization.<sup>168</sup> Thompson states that unification involves “embracing individuals in a collective identity”, while, inversely, fragmentation

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<sup>161</sup> Marx, K. (1844) *On the Jewish Question*. [On-line] Available: <http://www.marxists.org/archive/marx/works/1844/jewish-question/> [Accessed: 13 May 2014].

<sup>162</sup> Brown, W. (1995) *States of Injury: Power and Freedom in Late Modernity*. Chichester, NH: Princeton University Press, p106.

<sup>163</sup> Ibid at p114.

<sup>164</sup> Hay, C. (1999) 'Marxism and the State' in Gamble, A., Marsh, D. and Tant, T. (eds) *Marxism and Social Science*. Basingstoke: Macmillan, pp152-174 at p173.

<sup>165</sup> Jessop, B. (1990) *State Theory*, op cit., n.54 at p129.

<sup>166</sup> Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.9 at p60.

<sup>167</sup> Ibid at p61.

<sup>168</sup> Ibid at pp61-62.

involves dividing groups which could challenge dominant groups.<sup>169</sup> According to Thompson, reification involves the naturalization and eternalization of states of affairs, or the deletion of actors and agency via nominalization and passivization.<sup>170</sup> Marks utilised Thompson's ideas as the basis of her ideology critique.<sup>171</sup> I also utilise the modes and strategies identified by Thompson to critique the justifications for NHS reforms. Theodor Adorno stated that "ideology is justification" and that the critique of ideology "is only possible insofar as the ideology contains a rational element with which the critique can deal".<sup>172</sup> Thus "ideologies...become false only by their relationship to the existing reality".<sup>173</sup> Both Max Horkheimer<sup>174</sup> and Unger<sup>175</sup> described the conflict between the existent and ideology as a spur to historical change.

Adorno stated that liberal ideology could not simply be rejected as false consciousness of existing conditions because it also provides a foundation for critiquing such conditions.<sup>176</sup> He argued that as the "emphatic concepts of liberal ideology are not identical with the experiences they subsume" they tacitly denounce existing conditions.<sup>177</sup> However, in contrast to Horkheimer, Adorno thought that the alternative possibilities to ideology had "no emancipatory guarantees attached".<sup>178</sup> Adorno believed that liberal ideology was losing, or may have already lost, the critical moment

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<sup>169</sup> Ibid at p64.

<sup>170</sup> Ibid at pp65-66.

<sup>171</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p10.

<sup>172</sup> Adorno, T. (1973) 'Ideology' in Frankfurt Institute of Social Research (ed) *Aspects of Sociology*. Viertel, J., Trans. London: Heinemann, pp182-205 at p190.

<sup>173</sup> Ibid at p198.

<sup>174</sup> Horkheimer, M. (2013) *Eclipse of Reason*. London: Bloomsbury, p126.

<sup>175</sup> Unger, R. (1977) *Law in Modern Society: Toward a Criticism of Social Theory*. New York: Free Press, p153.

<sup>176</sup> Cook, D. (2001) 'Adorno, Ideology and Ideology Critique'. *Philosophy & Social Criticism*, Vol.27(1) pp1-20 at p10.

<sup>177</sup> Ibid.

<sup>178</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p27.

that it possessed.<sup>179</sup> He was critical of what he described as positivist ideology which “hardly says more than that things are the way they are”.<sup>180</sup> He theorised that there was a convergence between reality and ideology<sup>181</sup> which rendered ideology critique more difficult as there is not “a crevice in the cliff of the established order into which an ironist might hook a fingernail”.<sup>182</sup> However, Deborah Cook opines that Adorno erred in some passages of his work by denying “the important motivational role that [liberal] ideas like freedom and equality continue to play in contemporary consciousness”.<sup>183</sup> Cook views Adorno’s negative dialectics<sup>184</sup> as “an attempt to find a finger-hold in the cliff of the established order”.<sup>185</sup>

Idealism is the “belief that human consciousness is autonomous, self-sufficient and capable of being studied and explained in its own terms”.<sup>186</sup> In opposition to the idealism of Georg Hegel (whose dialectical method they inverted), Marx and Engels argued that “the production of ideas, of conceptions, of consciousness, is at first directly interwoven with the material activities and the material intercourse of men—the language of real life”.<sup>187</sup> David Hawkes states that ‘*The German Ideology*’ misled some Marxists into explaining ideology simply by reference to economic developments.<sup>188</sup> Hawkes notes that Marx stated that “the tradition of all the dead

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<sup>179</sup> Cook, D. (2001) ‘Adorno, Ideology and Ideology Critique’, op cit., n.176 at p16.

<sup>180</sup> Adorno, T. (1973) ‘Ideology’, op cit., n.172 at p202

<sup>181</sup> Ibid.

<sup>182</sup> Adorno, T. (1951) *Minima Moralia*. [On-line] Available: <http://www.marxists.org/reference/archive/adorno/1951/mm/> [Accessed: 07 October 2014].

<sup>183</sup> Cook, D. (1996) *The Culture Industry Revisited: Theodor W. Adorno on Mass Culture*. London: Rowan and Littlefield, p89.

<sup>184</sup> Which Adorno defined as a dialectics of non-identity. Adorno, T. (2008) *Lectures on Negative Dialectics: Fragments of a Lecture Course 1965-1966*. Livingstone, R., Trans. Cambridge, Polity, p6.

<sup>185</sup> Cook, D. (2001) ‘Adorno, Ideology and Ideology Critique’, op cit., n.176 at p14.

<sup>186</sup> Parekh, B. (1982) *Marx’s Theory of Ideology*, op cit., n.155 at p7.

<sup>187</sup> Marx, K. and Engels, F. (1998) *The German Ideology*, op cit., n.156 at p42.

<sup>188</sup> Hawkes, D. (2003) *Ideology*, op cit., n.105 at p89.

generations weighs like a nightmare on the brain of the living”.<sup>189</sup> Consequently, Hawkes contends that Marx believed that “ideas and matter form a totality, which cannot be broken up into discrete elements without producing serious errors”.<sup>190</sup> Marks rejected the notion of ideology as false consciousness.<sup>191</sup> In contrast, I agree with Torrance that the phrase can be legitimately read back into Marx as the notion of “misrecognition of reality due to social causes”.<sup>192</sup> Although Marx did not use the term reification, he distinguished between a collectively planned society, which would be understood by its members, as its essence would be their own stated intention and would coincide with its appearance,<sup>193</sup> and an unplanned opaque society.<sup>194</sup> Elster contends that Marx had a utopian conception of communism as “social causality will always to some extent remain opaque”.<sup>195</sup>

Marx argued that “ideology arises from the opacity of reality,...the fact that the forms in which reality ‘presents itself’ to man, or the forms of its appearance, conceal those real relations which themselves produce the appearances”.<sup>196</sup> Thus, as John Mepham stated, ideology involves persons “thinking in terms of categories which necessarily generate falsehood and illusion”.<sup>197</sup> For example, “to see something as a commodity is to view it as something which it is not”.<sup>198</sup> This is known as commodity fetishism, in

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<sup>189</sup> Ibid at p92/Marx, K. (1852) *The Eighteenth Brumaire of Louis Bonaparte*. [On-line] Available: <https://www.marxists.org/archive/marx/works/1852/18th-brumaire/> [Accessed: 07 October 2014].

<sup>190</sup> Hawkes, D. (2003) *Ideology*, op cit., n.105 at p91.

<sup>191</sup> Marks, S. (2000) *The Riddle of All Constitutions*, op cit., n.6 at p9.

<sup>192</sup> Torrance, J. (1995) *Karl Marx’s Theory of Ideas*, op cit., n.91 at p5.

<sup>193</sup> Ibid at p57.

<sup>194</sup> Ibid at p60.

<sup>195</sup> Elster, J. (1986) *An Introduction to Karl Marx*, op cit., n.18 at p166.

<sup>196</sup> Mepham, J. (1996) ‘The Theory of Ideology in Capital’ in Eagleton, T. (ed) *Ideology*. Harlow: Longman, pp211-237 at p217.

<sup>197</sup> Ibid at p233.

<sup>198</sup> Hawkes, D. (2003) *Ideology*, op cit., n.105 at p101.

which commodities “appear as autonomous figures endowed with a life of their own”.<sup>199</sup> Slavoj Zizek notes that ideological illusion operates in social reality itself, hence individuals are fetishists in practice if not in theory.<sup>200</sup> For example, they know that there is no magic behind money but nevertheless “treat it as an embodiment of wealth”.<sup>201</sup>

Commodity fetishism is part of Marx’s broader theory of alienation.<sup>202</sup> Chari states that alienation refers to a form of depoliticisation specific to capitalism that produces two kinds of effects: rigidification of the political form (sedimented in the distinction between state and civil society) and obfuscation of the relationship between the political and economic spheres.<sup>203</sup> In respect of the former, Chari contends that Marx’s critique of alienation, in both ‘*The Economic and Philosophical Manuscripts*’<sup>204</sup> and ‘*On the Jewish Question*’, is “a critique of the hypostatization of abstraction, which results in the depoliticisation of [economic and political] institutions”.<sup>205</sup> In respect of the latter, Chari contends that Marx’s analysis of commodity fetishism (which was deepened by Gyorgy Lukacs’ theory of reification) is that it is “depoliticising in the way it obscures the relationship between actions and their social effects” resulting in the bracketing of certain areas of social life from political deliberation and subjective

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<sup>199</sup> Marx, K. (1990) *Capital: Volume 1*. London: Penguin, p165.

<sup>200</sup> Zizek, S. (1989) *The Sublime Object of Ideology*. London: Verso, pp30-31.

<sup>201</sup> Ibid at p31.

<sup>202</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p70.

<sup>203</sup> Chari, A. (2015) *A Political Economy of the Senses*, op cit., n.129 at p95.

<sup>204</sup> Marx, K. (1844) *The Economic and Philosophical Manuscripts*. [On-line] Available: <https://www.marxists.org/archive/marx/works/1844/manuscripts/preface.htm> [Accessed: 5 January 2015].

<sup>205</sup> Chari, A. (2015) *A Political Economy of the Senses*, op cit., n.129 at p97.

experience.<sup>206</sup> Reification produces estrangement which is the opposite of solidarity<sup>207</sup> (which was important in the creation and maintenance of the NHS). Hunt states that the relationship between social relations and law should not be prejudged.<sup>208</sup> I identify various ways in which social relations may be reified (through the legitimation effect of law, identity thinking, instrumental rationality and depoliticisation) in the following paragraphs. I assess the effectiveness of such mystifying modes in subsequent chapters. I do not utilise Jurgen Habermas' or Axel Honneth's conceptualisations of reification, as the colonization of lifeworlds by systems and as a forgetfulness of recognition,<sup>209</sup> respectively, as the former is fragmentary<sup>210</sup> and undermined by contemporary neo-liberal policies<sup>211</sup> and the latter is, as Chari argues, ahistorical (as it is separated from "an analysis of the social form of capitalism") and narrow (as it reduces reification to a "phenomenon of intersubjectivity"<sup>212</sup>).

As alluded to above, Lukacs expanded Marx's ideas pertaining to commodity fetishism via the concept of reification. Lukacs' conception of reification was also influenced by Max Weber's theory of rationalization,<sup>213</sup> "a process whereby traditional activities are reorganised in terms of efficiency, measurability and means end rationality".<sup>214</sup> Lukacs stated that "men erect around themselves in the reality they have created and made,

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<sup>206</sup> Ibid at p109.

<sup>207</sup> Torrance, J. (1977) *Estrangement, Alienation and Exploitation: A Sociological Approach to Historical Materialism*. Basingstoke: Macmillan, p105.

<sup>208</sup> Hunt, A. (1985) 'The Ideology of Law', op cit., n.1 at p21.

<sup>209</sup> Honneth, A. (2008) *Reification: A New Look at an Old Idea*. Ganahl, J., Trans. Oxford: Oxford University Press, p56.

<sup>210</sup> Cook, D. (2004) *Adorno, Habermas and the Search for a Rational Society*. London: Routledge, p32.

<sup>211</sup> Ibid at p69.

<sup>212</sup> Chari, A. (2010) 'Towards a Political Critique of Reification: Lukacs, Honneth and the aims of Critical Theory'. *Philosophy and Social Criticism*, Vol.36(5), pp587-606 at p591.

<sup>213</sup> Jameson, F. (1979) 'Reification and Utopia in Mass Culture'. *Social Text*, No.1, pp130-148 at p130.

<sup>214</sup> Jameson, F. (2010) *Valences of the Dialectic*. London: Verso, p329.

a kind of second nature”.<sup>215</sup> For Lukacs, false consciousness consists in allowing this second nature “to exert a fetishistic dominance over our lives”.<sup>216</sup> For example, economies may be perceived to be autonomous and self-perpetuating rather than constituted by human practices.<sup>217</sup> Val Burris contends that Lukacs thought that reification was rooted in the objectification of labour and treated broader forms of reification (for example, science, law and philosophy) as purely derivative.<sup>218</sup> Todd Hedrick states that Lukacs recognised that “law (a) can be an institutional means for consolidating the results of the class struggle, which (b) subsequently obscures this class domination through the everyday operation of the legal system”.<sup>219</sup> Duncan Kennedy described this as the “legitimation effect”.<sup>220</sup> Klare argued that law makes the “historically contingent appear necessary”.<sup>221</sup> Nonetheless, as Sol Picciotto argued, it is “important to probe and expose the limits of law’s capacity to legitimise”.<sup>222</sup> Lukacs believed that bourgeois reified consciousness had contaminated the proletariat.<sup>223</sup> He thought that “only the consciousness of the proletariat [which he viewed as the subject/object of history] can point to the way that leads out of the impasse of capitalism”.<sup>224</sup> Lukacs’ conception of reification was criticised by Adorno, as it “presupposes the reconciliation of subject and object [in the

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<sup>215</sup> Lukacs, G. (1971) *History and Class Consciousness: Studies in Marxist Dialectics*. Livingstone, R., Trans. London: Merlin, p128.

<sup>216</sup> Hawkes, D. (2003) *Ideology*, op cit., n.105 at p110.

<sup>217</sup> Chari, A. (2010) ‘Towards a Political Critique of Reification’, op cit., n.212 at p589.

<sup>218</sup> Burris, V. (1988) ‘Reification: A Marxist Perspective’. *California Sociologist*, Vol.10(1), pp22-43 at p34.

<sup>219</sup> Hedrick, T. (2014) ‘Reification in and Through Law: Elements of a Theory in Marx, Lukacs and Honneth’. *European Journal of Political Theory*, Vol.13(2), pp178-198 at p190.

<sup>220</sup> Ibid at p192/Kennedy, D. (1997) *A Critique of Adjudication: fin de siècle*. Cambridge, MA: Harvard University Press, p236.

<sup>221</sup> Klare, K. (1982) ‘The Public/Private Distinction in Labour Law’. *University of Pennsylvania Law Review*, Vol.130, pp1358-1422 at p1358.

<sup>222</sup> Picciotto, S. (1997) ‘International Law: The Legitimation of Power in World Affairs’ in Ireland, P. and Laleng, P. (eds) *The Critical Lawyers Handbook 2*. London: Pluto, pp13-29 at p26.

<sup>223</sup> McDonough, R. (1980) ‘Ideology as False Consciousness: Lukacs’ in Centre for Contemporary Cultural Studies (ed) *On Ideology*. London: Hutchinson, pp33-44 at p39.

<sup>224</sup> Lukacs, G. (1971) *History and Class Consciousness*, op cit., n.215 at p76.

form of the proletariat] and thus relapses into idealism and fails to found a truly materialistic dialectic”,<sup>225</sup> as materialist thought would recognise “that thinking is not identical with its objects”.<sup>226</sup>

Chari identifies three modalities of reification within Adorno’s writings:<sup>227</sup> philosophical reification (identity thinking), social reification (instrumental rationality) and aesthetic reification. In respect of the latter, Adorno contended that the autonomy of artwork is a fetish but that the semblance of autonomy constitutes resistance to exchange.<sup>228</sup> I utilise the former two modalities within this dissertation. Instrumental rationality refers to means becoming ends in themselves. I examine whether the means adopted in NHS governance (quasi-markets and targets) have become ends in themselves. Identity thinking refers to the subsumption of objects under concepts with which they are not identical.<sup>229</sup> Adorno stated that, under capitalism, identity thinking “appears in the guise of the ubiquitous exchange principle”,<sup>230</sup> which equates unlike things,<sup>231</sup> corrupts “thought and behaviour, instincts and needs”<sup>232</sup> and generates alienation by reducing human bonds merely to commerce.<sup>233</sup> Adorno argued that “behind the reduction of men to agents and bearers of exchange value lies the domination of man

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<sup>225</sup> Rose, G. (1978) *The Melancholy Science: An Introduction to the thought of Theodor W. Adorno*. New York: Columbia University Press, p40.

<sup>226</sup> Jarvis, S. (1998) *Adorno: A Critical Introduction*. Cambridge: Polity Press, p54.

<sup>227</sup> Chari, A. (2015) *A Political Economy of the Senses*, op cit., n.129 at p144.

<sup>228</sup> Ibid at pp150-151.

<sup>229</sup> Cook, D. (2001) ‘Adorno, Ideology and Ideology Critique’, op cit., n.176 at p2.

<sup>230</sup> Cook, D. (2004) *Adorno, Habermas and the Search for a Rational Society*, op cit., n.210 at p49.

<sup>231</sup> Held, D. (2004) *Introduction to Critical Theory: Horkheimer to Habermas*. Cambridge: Polity Press, p220.

<sup>232</sup> Cook, D. (2004) *Adorno, Habermas and the Search for a Rational Society*, op cit., n.210 at p11.

<sup>233</sup> Ibid at p45/ Adorno, T. (1967) ‘Sociology and Psychology Part 1’. *New Left Review*, Vol. 46, pp67-81 at p74.



over man”.<sup>234</sup> According to Adorno, the formal principle of equivalence also predominated in law, which treated everyone alike, thereby promoting inequality by neglecting differences.<sup>235</sup> Harvey highlights the contradiction between use values and exchange values.<sup>236</sup> He contends that when states open arenas to “private capital accumulation and exchange value considerations” this may prove antagonistic to human need.<sup>237</sup> I assess whether NHS reforms have been, or may be, antagonistic to human need. Harvey notes that there is also a “gap between money and the value it represents”.<sup>238</sup> I assess whether healthcare providers are sufficiently reimbursed.

Adorno and Horkheimer critiqued the logic of the enlightenment whereby “anything which cannot be resolved into numbers and ultimately into one, is illusion”.<sup>239</sup> This logic pervades the phenomenon in global governance of the increased use of indicators,<sup>240</sup> which has derived largely from economics and business management.<sup>241</sup> Sally Engle Merry defines indicators as “statistical measures that are used to consolidate complex data into a single number or rank that is meaningful to policymakers and the public”.<sup>242</sup> Indicators are symptomatic of identity thinking as they evince a preference for superficial but standardized knowledge.<sup>243</sup> In the NHS,

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<sup>234</sup> Adorno, T. (1969-1970) ‘Society’. Jameson, F., Trans. *Salmagundi*, Vol.3 (10-11), pp144-153 at p148.

<sup>235</sup> Adorno, T. (1973) *Negative Dialectics*. Ashton, E., Trans. New York: Continuum, p309.

<sup>236</sup> Harvey, D. (2014) *Seventeen Contradictions and the end of Capitalism*. Oxford: Oxford University Press, p15.

<sup>237</sup> Ibid at p23.

<sup>238</sup> Ibid at p27.

<sup>239</sup> Adorno, T. and Horkheimer, M. (2010) *Dialectic of Enlightenment*. Cumming, J., Trans. London: Verso, p4.

<sup>240</sup> Davis, K. et al (2012) ‘Introduction: Global Governance by Indicators’ in Davis, K. et al (eds) *Governance by Indicators: Global Power Through Quantification and Rankings*. Oxford: Oxford University Press, pp3-28 at p4.

<sup>241</sup> Merry, S. (2011) ‘Measuring the World: Indicators, Human Rights and Global Governance’. *Current Anthropology*, Vol.52(3), pp83-95 at p83.

<sup>242</sup> Ibid at p86.

<sup>243</sup> Ibid.

indicators have been developed to facilitate performance measurement, target setting and patient choice. Michael Mandelstam describes targets and indicators as types “of misleading metonymy” as they “substitute the part of something for the whole”.<sup>244</sup> Gwyn Bevan and Christopher Hood note that what is omitted is assumed not to matter.<sup>245</sup> Indicators may lead to depoliticisation because, as Merry notes, they submerge the political under the technical.<sup>246</sup> However, Kevin Davis avers that there is scope for recontestation where debates emerge regarding what is measured by, the weighting criteria for and the embedded social or political theories of, indicators.<sup>247</sup> Targets may “become ends in themselves”<sup>248</sup> and impede other objectives (such as efficiency).<sup>249</sup> Both Charles Goodhart<sup>250</sup> and Donald Campbell<sup>251</sup> formulated laws that indicators are subject to corruption pressures. Marilyn Strathern restated such laws as: “when a measure becomes a target, it ceases to be a good measure”.<sup>252</sup> Although some consider that Adorno favoured non-identity thinking, Cook states that he thought that conceptual mediation was necessary for thinking, hence he favoured rational identity thinking, which seeks to determine whether concepts do justice to what they cover.<sup>253</sup> Adorno stated that the reduction of quality to quantity was a process of abstraction which “distances itself from the objects”.<sup>254</sup> Adorno averred that the

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<sup>244</sup> Mandelstam, M. (2007) *Betraying the NHS: Health Abandoned*. London: Jessica Kingsley, p56.

<sup>245</sup> Bevan, G. and Hood, C., ‘Have Targets Improved Performance in the English NHS?’ *British Medical Journal* 2006; 332:419.

<sup>246</sup> Merry, S. (2011) ‘Measuring the World’, op cit., n.241 at p88.

<sup>247</sup> Davis, K. et al (2012) ‘Introduction’ op cit., n.240 at p19.

<sup>248</sup> Fisher, M. (2009) *Capitalist Realism: Is there no alternative?* Winchester: Zero Books, p42.

<sup>249</sup> Vincent-Jones, P. (2006) *The New Public Contracting: Regulation, Responsiveness, Rationality*. Oxford: Oxford University Press, p165.

<sup>250</sup> Goodhart, C. (1984) *Monetary Theory and Practice: The UK Experience*. London: Macmillan, p96.

<sup>251</sup> Campbell, D. (2011) ‘Assessing the Impact of Planned Social Change’. *Journal of Multidisciplinary Evaluation*, Vol.7(15), pp3-43 at p34.

<sup>252</sup> Strathern, M. (1997) ‘Improving ratings’: Audit in the British University System’. *European Review*, Vol.5(3), pp305-321 at p308.

<sup>253</sup> Cook, D. (2001) ‘Adorno, Ideology and Ideology Critique’, op cit., n.176 at p5.

<sup>254</sup> Adorno, T. (2008) *Lectures on Negative Dialectics*, op cit., n.184 at p127.

“knowledge being sought in negative dialectics is qualitative”.<sup>255</sup> Consequently, I contend that voice is preferable to choice (which relies on superficial indicators) in efforts to empower patients.

Chari states that “neo-liberal domination is at the most basic level, a form of depoliticisation”.<sup>256</sup> Emma Ann Foster et al note that there are “many meanings and applications” of depoliticisation.<sup>257</sup> Although various conceptions of politics inform such definitions, I prefer Hay’s broad conception of politics as “the capacity for agency and deliberation in situations of genuine collective or social choice”.<sup>258</sup> Jessop contends that depoliticisation may occur on the levels of polity, politics and policy.<sup>259</sup> Jessop states that depoliticisation may involve a re-organisation of the division of political labour,<sup>260</sup> for example, through the delegation of power to ostensibly non-political bodies,<sup>261</sup> such as NHS England, which has also been described as institutional depoliticisation.<sup>262</sup> Matthew Flinders and Jim Buller note that such arrangements may make accountability more opaque.<sup>263</sup> They argue that the degree of depoliticisation is questionable when the independent body operates within a narrow and prescriptive policy framework set by ministers.<sup>264</sup> Flinders states that

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<sup>255</sup> Ibid at p141.

<sup>256</sup> Chari, A. (2015) *A Political Economy of the Senses*, op cit., n.129 at p22.

<sup>257</sup> Foster, E. et al (2014) ‘Rolling back to roll forward: Depoliticisation and the extension of government’. *Policy and Politics*, Vol.42(2), pp225-241 at p226.

<sup>258</sup> Hay, C. (2007) *Why We Hate Politics*. Cambridge: Polity Press, p77.

<sup>259</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises’ in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at pp96-97.

<sup>260</sup> Ibid at p101.

<sup>261</sup> Burnham, P. (2000) ‘Globalisation, depoliticisation and ‘modern’ economic management’ in Bonefield, W. and Psychopedis, K. (eds) *The Politics of Change: Globalisation, Ideology and Critique*. Basingstoke: Palgrave, pp9-30 at p23.

<sup>262</sup> Flinders, M. and Buller, J. (2005) ‘Depoliticisation, Democracy and Arena Shifting’ (Paper given at the SCANCOR/SOG Conference, Stanford University, 1-2 April 2005), p6.

<sup>263</sup> Ibid at p21.

<sup>264</sup> Ibid at p10.

depoliticisation often “involves the implicit (but rarely explicit) building of normative values” into institutional structures.<sup>265</sup> Jessop contends that depolitization may occur through the redrawing of the boundary between the political and the non-political, for example via:

“sacralisation, marketization, juridification, scientization (expertise), or in Foucauldian terms governmentalization, and self-responsibilization through disciplinary or government practices”.<sup>266</sup>

Jessop notes that the “demarcation of political and non-political spheres” may provoke controversy.<sup>267</sup> Lars Blichner and Anders Molander delineate five dimensions of juridification: firstly, constitutive juridification, where the legal system accrues competences through the establishment or alteration of norms constitutive of a political order; secondly, a process through which law comes to regulate an increasing number of different activities;<sup>268</sup> thirdly, a process through which conflicts are increasingly solved by or with reference to law;<sup>269</sup> fourthly, a process through which the legal system and profession acquire more power as contrasted with formal authority;<sup>270</sup> and fifthly, legal framing, a process by which people increasingly tend to think of themselves and others as legal subjects.<sup>271</sup> These dimensions of juridification

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<sup>265</sup> Flinders, M. (2004) ‘Distributed Public Governance in Britain’. *Public Administration*, Vol.82(4), pp883-909 at p902.

<sup>266</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation’, op cit., n.259 at p101/Jessop, B. (2016) *The State, Past, Present and Future*. Cambridge: Polity, p48.

<sup>267</sup> Ibid.

<sup>268</sup> Blichner, L. and Molander, A. (2008) ‘Mapping Juridification’. *European Law Journal*, Vol.14(1), pp36-54 at pp38-39.

<sup>269</sup> Ibid at p39.

<sup>270</sup> Ibid.

<sup>271</sup> Ibid.

correspond with what Burnham and Flinders and Buller describe as rules based depoliticisation.<sup>272</sup> I assess whether reforms have juridified the NHS in subsequent chapters.

Jessop states that depoliticalization may occur through the separation between the economy and the political sphere, constitutional law (such as the new constitutionalism identified by Stephen Gill<sup>273</sup>), the use of ostensibly non-political figures (for example, to provide information or make recommendations or decisions), sedimentation (routinization in policy formation and implementation and the thematization of issues as political or non-political<sup>274</sup>) and governmentalization.<sup>275</sup> Governmentalization involves the creation of conditions for technocratic decision making and/or self-responsibilization of individuals/groups, for example, through target setting<sup>276</sup> and new public contracting (rendering social agents responsible through contractual commitments and obligations).<sup>277</sup> The literature on depoliticisation has been criticised for overemphasising the novelty of the phenomenon and for demonising politicians and the state.<sup>278</sup> Hay contends that the internalization of pessimistic public choice assumptions by policymakers about their own motivations and pessimistic assumptions about their capacity to act (for example, in the face of perceived external constraints) has unleashed “a tide of depoliticising dynamics”.<sup>279</sup> Hay avers that for

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<sup>272</sup> Flinders, M. and Buller, J. (2005) ‘Depoliticisation, Democracy and Arena Shifting’, op cit., n.262 at p10/Burnham, P. (2000) ‘Globalisation, depoliticisation and ‘modern’ economic management’, op cit., n.261 at p21.

<sup>273</sup> Gill, S. (2008) *Power and Resistance in the new world order: 2<sup>nd</sup> edition*. Basingstoke: Palgrave, p79.

<sup>274</sup> Flinders and Buller describe this as preference shaping depoliticisation. See Flinders, M. and Buller, J. (2005) ‘Depoliticisation, Democracy and Arena Shifting’, op cit., n.262 at p15.

<sup>275</sup> Jessop, B. (2014) ‘Repoliticising depoliticisation’, op cit., n.259 at pp103-106.

<sup>276</sup> Ibid at p105.

<sup>277</sup> Vincent-Jones, P. (2006) *The New Public Contracting*, op cit., n.249 at p69.

<sup>278</sup> Fawcett, P. and Marsh, D. (2014) ‘Depoliticisation, governance and political participation’. *Policy and Politics*, Vol.42(2), pp171-188 at p185.

<sup>279</sup> Hay, C. (2007) *Why We Hate Politics*, op cit., n.258 at p151.

the literature concerning depoliticisation to develop, it must engage with empirical instances of politicising-depoliticising dynamics which reveal the limitations of existing theory.<sup>280</sup> Patrick Diamond identified, in his research regarding New Labour, a dialectical relationship between politicisation and depoliticisation as policymakers adopted a hybrid mix, accruing power to 'take credit' and giving it away ('blame-shifting').<sup>281</sup> I analyse the politicising-depoliticising dynamics of healthcare policy in subsequent chapters.

### Criticisms of Ideology

The concept of ideology has been subject to numerous criticisms. Firstly, some theorists have pronounced the end of ideology. Daniel Bell argued that "the ideological age has ended" as there is a "rough consensus among intellectuals on political issues".<sup>282</sup> Bell has been criticised for considering only the alleged exhaustion of nineteenth century left-wing ideas.<sup>283</sup> Marks argues that end of ideology arguments are themselves ideological as they sustain existing asymmetries of power by announcing "that Western political and economic institutions represent the consensus of nations and the culmination of historical processes".<sup>284</sup> Secondly, Pragmatists query whether theorists can "look down upon the ideologies of those he investigates

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<sup>280</sup> Hay, C. (2014) 'Depoliticisation as process, governance as practice: What did the 'First Wave' get wrong and do we need a 'Second Wave' to put it right'. *Policy and Politics*, Vol.42(2), pp293-311 at p308.

<sup>281</sup> Diamond, P. (2015) 'New Labour, Politicisation and Depoliticisation: The Delivery Agenda in public services 1997-2007'. *British Politics*, Vol.10(4), pp429-453 at p439.

<sup>282</sup> Bell, D. (2001) *The End of Ideology: On the Exhaustion of Political Ideas in the Fifties*. Cambridge, MA: Harvard University Press, pp402-403.

<sup>283</sup> Larrain, J. (1983) *Marxism and Ideology*, op cit., n.7 at p225.

<sup>284</sup> Marks, S. (2001) 'Big Brother is Bleeping us- with the Message that Ideology doesn't matter'. *European Journal of International Law*, Vol.12(1), pp109-123 at p114.

from a scientific vantage point”.<sup>285</sup> Karen Ng describes this paradox as the dialectics of immanence and transcendence.<sup>286</sup> Ng contends that the solution is to seek intramundane transcendence.<sup>287</sup> Adorno recognised that the problem of transcendent critique was that utopian ideas are easily characterised as arbitrary.<sup>288</sup> Adorno argued that critique must avail itself of norms which the society being critiqued would recognise as its own.<sup>289</sup> Jaeggi describes ideology critique as parasitic as it depends on norms that it does not generate by itself.<sup>290</sup>

Thirdly, postmodernists are sceptical of narratives, such as Marxism.<sup>291</sup> Michel Foucault argued that ideology is problematic as it stands in opposition to truth.<sup>292</sup> However, as Eagleton notes, ideologies may contain both true and false ideas.<sup>293</sup> Jaeggi states that ideologies “are simultaneously true and false, insofar as they correspond at once adequately and inadequately to reality”.<sup>294</sup> She notes that the norms which they are attached to may have unrealized truth content.<sup>295</sup> While postmodernists repudiate the notion of absolute truth, I agree with Eagleton that it “simply means that if a statement is true, then the opposite of it cannot be true at the same time, or true from some other point of view”.<sup>296</sup> Eagleton states that absolute truths are established by a taxing and messy business of argument, evidence,

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<sup>285</sup> Harris, J. (1997) *Legal Philosophies: 2<sup>nd</sup> edition*. Oxford: Oxford University Press, p271.

<sup>286</sup> Ng, K. (2015) ‘Ideology Critique from Hegel and Marx to Critical Theory’. *Constellations*, Vol.22(3), pp393-404 at p393.

<sup>287</sup> Ibid at p400.

<sup>288</sup> O’Connor, B. (2013) *Adorno*. Abingdon: Routledge, p45.

<sup>289</sup> Ibid.

<sup>290</sup> Jaeggi, R. (2009) ‘Rethinking Ideology’, op cit., n.3 at p71.

<sup>291</sup> Jameson, F. (2009) *Postmodernism, or the Cultural Logic of Late Capitalism*. London: Verso, p6.

<sup>292</sup> Foucault, M. (1980) *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*.

Gordon, C., et al Trans. Brighton: Harvester Press, p118.

<sup>293</sup> Eagleton, T. (2007) *Ideology: An Introduction*, op cit., n.89 at p222.

<sup>294</sup> Jaeggi, R. (2009) ‘Rethinking Ideology’, op cit., n.3 at p68.

<sup>295</sup> Ibid at p69.

<sup>296</sup> Eagleton, T. (2003) *After Theory*. New York: Basic Books, p105.

experiment and investigation, which is always open to revision.<sup>297</sup> Secondly, Foucault rejected ideology as it necessarily refers “to something of the order of a subject”.<sup>298</sup> I disagree with Foucault’s rejection of subjects because, as Adorno averred, “no matter how the subject is defined, existent being cannot be conjured away from it”.<sup>299</sup> Thirdly, Foucault rejected ideology “as it stands in a secondary position...to something which functions as its infrastructure”.<sup>300</sup> I repudiate this criticism as the base/superstructure metaphor is “now almost universally rejected by Marxists”.<sup>301</sup> Nonetheless, as Trevor Purvis and Alan Hunt contend, the concepts of ideology and discourse are potentially compatible.<sup>302</sup>

## Methods

In assessing the influence of neo-liberalism on successive governments, I examine relevant political science literature. In assessing the influence of the proposed micro-ideology of private healthcare companies on the NHS reforms, I examine relevant academic literature, newspaper articles and descriptions of such influence from the agents of such companies and opponents of the reforms. I also examine accounts of the reforms authored by politicians (such as Tony Blair’s description of New Labour’s reforms in his autobiography<sup>303</sup> and the writings of various ministers<sup>304</sup>) and senior

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<sup>297</sup> Ibid at pp105-109.

<sup>298</sup> Foucault, M. (1980) *Power/Knowledge*, op cit., n.292 at p118.

<sup>299</sup> Adorno, T. (2005) *Critical Models: Interventions and Catchwords*. Pickford, H., Trans. New York: Columbia University Press, pp249-250.

<sup>300</sup> Foucault, M. (1980) *Power/Knowledge*, op cit., n.292 at p118.

<sup>301</sup> Marsh, D. (1999) ‘Resurrecting Marxism’, op cit., n.22 at p322.

<sup>302</sup> Purvis, T. And Hunt, A. (1993) ‘Discourse, Ideology, Discourse, Ideology, Discourse, Ideology...’, *The British Journal of Sociology*, Vol.44 (3), pp473-499 at p498.

<sup>303</sup> Blair, T. (2010) *A Journey*. London: Hutchinson.

<sup>304</sup> Successive Secretaries of State for Health have written about their periods in office within Nuffield Trust (see: Timmins, N. (ed) (2013) *The Wisdom of the Crowd: 65 Views of the NHS at 65*. London:



NHS personnel (such as Nigel Crisp, NHS Chief Executive between 2000 and 2006<sup>305</sup>). In examining the policies and legal changes of successive governments, which have marketized and privatised the NHS, I analyse relevant election manifestoes, policy documents (and responses, for example from trade unions and professional organisations), speeches, bills and legislation. My analysis of discourse primarily follows John B. Thompson's depth hermeneutics approach. This involves determining the socio-historical conditions in which discourse is produced,<sup>306</sup> undertaking a discursive analysis (for example, of the narratives and the argumentative and syntactic structures within discourse)<sup>307</sup> and reconnecting discourse to relations of domination.<sup>308</sup> I also undertake what Williams described as an authentic historical analysis<sup>309</sup> by identifying the presence of dominant, residual and emergent norms.

I begin with Labour's '*NHS Plan*',<sup>310</sup> which marked a change in direction from previous Labour party policy, particularly regarding the involvement of the private sector in healthcare. Labour subsequently instituted a mimic-market in secondary care, thereby diverting resources away from patient's needs. I examine Labour's justifications for

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Nuffield Trust) and Health Foundation (see: Timmins, N. and Davies, E. (eds) (2015) *Glaziers and Window Breakers: The role of the Secretary of State for Health in their own words*. London: Health Foundation) publications.

<sup>305</sup> Who has written about the reforms during his tenure. See: Crisp, N. (2011) *24 hours to save the NHS: The Chief Executives Account of Reform 2000 to 2006*. Oxford: Oxford University Press.

<sup>306</sup> Thompson, J. (1984) *Studies in the Theory of Ideology*, op cit., n.82 at p11.

<sup>307</sup> Ibid at pp136-137.

<sup>308</sup> Ibid at p138.

<sup>309</sup> Williams, R. (1977) *Marxism and Literature*, op cit., n.124 at p121.

<sup>310</sup> Department of Health (2000) *NHS Plan. A Plan for Investment. A Plan for Reform*. London: HMSO.

this by analysing general policy documents<sup>311</sup> and speeches<sup>312</sup> and numerous documents concerning specific policies, such as independent sector treatment centres (ISTCs),<sup>313</sup> foundation trusts (FTs),<sup>314</sup> commissioning,<sup>315</sup> patient choice<sup>316</sup> and competition.<sup>317</sup> In respect of FTs, I also examine Alan Milburn's speech at the second reading of the relevant legislation in the House of Commons. In addition, I scrutinise legislation which implemented such policies, such as the Health and Social Care (Community Health and Standards) Act (2003). I also examine relevant documents regarding the creation of polyclinics,<sup>318</sup> which afforded private companies increased opportunities within primary care, and those concerning emergent norms, such as the reduction of health inequalities<sup>319</sup> and patient and public involvement.<sup>320</sup>

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<sup>311</sup> Such as Department of Health (2002) *Delivering the NHS Plan. Next Steps on Investment, Next Steps on Reform*. London: Stationery Office/ Department of Health (DOH) (2004) *The NHS Improvement Plan: Putting People at the Heart of Public Services*. London: DOH/ Department of Health (DOH) (2007) *Health Reform in England: Update and Next Steps*. London: DOH.

<sup>312</sup> For example, Blair, T. (2006) 'Speech to a meeting of the NHS Health Network Clinician Forum on 18 April 2006'. [On-line] Available: <http://www.nhshistory.net/tonyblair.htm> [Accessed: 14 February 2016].

<sup>313</sup> Namely: Department of Health (DOH) (2005) *ISTC Manual*. London: DOH/Department of Health (DOH) (2002) *Growing Capacity: A New Role for External Healthcare Providers in England*. London: DOH/Department of Health (DOH) (2002) *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*. London: DOH/Department of Health (DOH) (2005) *Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients*. London: DOH.

<sup>314</sup> For example, Department of Health (DOH) (2002) *A Guide to NHS Foundation Trusts*. London: DOH.

<sup>315</sup> For example, Department of Health (DOH) (2007) *World Class Commissioning: Vision*. London: DOH.

<sup>316</sup> Such as: Department of Health (DOH) (2003) *Choice, Responsiveness and Equity in the NHS and Social Care*. London: DOH/Department of Health (DOH) (2004) *"Choose and Book"-Patients Choice of Hospital and Booked Appointment: Policy Framework for Choice and Booking at the Point of Referral*. London: DOH/Department of Health (DOH) (2007) *Choice Matters: 2007-8: Putting Patients in Control*. London: DOH.

<sup>317</sup> For example, Department of Health (DOH) (2007) *Principles and Rules for Co-operation and Competition*. London: DOH.

<sup>318</sup> Namely: Department of Health (DOH) (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services*. London: DOH/Darzi, A. (2007) *Healthcare for London: A Framework for Action*. London: NHS London/Darzi, A. (2007) *Our NHS, Our Future. NHS Next Stage Review: Interim Report*. London: Department of Health/Department of Health (DOH) (2008) *High Quality Care for all: NHS Next Stage Review Final Report*. London: DOH.

<sup>319</sup> Such as Department of Health (DOH) (2003) *Tackling Health Inequalities: A Programme for Action*. London: DOH.

<sup>320</sup> Such as Department of Health (DOH) (2006) *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services A document for information and comment*. London: DOH.

I investigate Conservative policy prior to the 2010 general election by examining its legislative proposals<sup>321</sup> and David Cameron's 2006 Kings Fund speech.<sup>322</sup> I examine the Conservative-Liberal Democrat coalition's broad approach to public services, which included diversifying provision (which undermines risk pooling and cross subsidy within the NHS), by studying its programme for government<sup>323</sup> and the 'Open Public Services White Paper'.<sup>324</sup> I investigate the coalition's specific NHS reform proposals by analysing the white paper 'Equity and Excellence: Liberating the NHS',<sup>325</sup> and the government's response to consultations.<sup>326</sup> There was a legislative pause as the Health and Social Care (HSC) Bill proceeded through parliament. I examine the reports of the NHS Future Forum (NHSFF),<sup>327</sup> which conducted a listening exercise during the pause, and the coalition's response to such reports.<sup>328</sup> I also scrutinise speeches<sup>329</sup> and articles<sup>330</sup> defending the coalition's reforms. In chapter six, I examine the main provisions of the Health and Social Care (HSC) Act (2012), which has strengthened neo-liberal norms and undermines residual norms within healthcare. I

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<sup>321</sup> Conservative Party (2007) *NHS Autonomy and Accountability: Proposals for Legislation*. London: Conservative Party.

<sup>322</sup> Cameron, D. (2006) 'Speech to Kings Fund'. [On-line] Available: <http://www.theguardian.com/society/2006/jan/04/health.conservativeparty> [Accessed: 25 May 2016].

<sup>323</sup> HM Government (2010) *The Coalition: Our Programme for government*. London: Cabinet Office.

<sup>324</sup> HM Government (2011) *Open Public Services White Paper*. Norwich: Stationery Office.

<sup>325</sup> Department of Health (DOH) (2010) *Equity and Excellence: Liberating the NHS*. London: DOH.

<sup>326</sup> Department of Health (DOH) (2010) *Liberating the NHS: Legislative Framework and Next Steps*. London: DOH.

<sup>327</sup> Such as: NHS Future Forum (2011) *Choice and Competition: Delivering Real Choice: A Report from the NHS Future Forum*. London: Department of Health/NHS Future Forum (2011) *Summary Report on Proposed Changes to the NHS*. London: Department of Health.

<sup>328</sup> Department of Health (DOH) (2011) *Government Response to the NHS Future Forum Report*. Norwich: Stationery Office.

<sup>329</sup> Such as: Cameron, D. (2011) 'Speech on NHS reforms, Ealing hospital, West London 16 May 2011'. [On-line] Available: <http://www.newstatesman.com/uk-politics/2011/05/nhs-health-change-care> [Accessed: 7 June 2016]/Cameron, D. (2011) 'Speech on the future of the NHS: 7 June 2011'. [On-line] Available: <https://www.gov.uk/government/speeches/speech-on-the-nhs--2> [Accessed: 25 April 2016].

<sup>330</sup> Such as: Lansley, A., 'Why the health service needs surgery'. *Daily Telegraph*, 2 June 2011/Clegg, N. and Williams, S., 'Nick Clegg and Shirley Williams's Letter on Health Bill', *Guardian*, 27 February 2012.

also analyse policy documents relating to the information strategy that has been adopted<sup>331</sup> and relevant publications of national NHS bodies (in particular, recent documents compiled by NHS England focusing on integration<sup>332</sup>).

I assess whether the reforms have extended identity thinking (for example, by expanding the exchange principle) and instrumental rationality (by assessing relevant academic literature to determine whether the means adopted in NHS governance have become ends in themselves). In assessing the potentially depoliticising effects of the reforms, I examine relevant academic literature, parliamentary debates and newspaper articles<sup>333</sup> to determine whether issues have been, or are, politically contested. I also study relevant parliamentary debates and scrutiny (for example, select committee reports), academic critiques and media reports to evaluate implementation, opposition and resistance. In gauging public opinion, I rely on relevant surveys and opinion polls. I agree with Vicente Navarro that although academics must be cautious in relying on polls (for example, as responses may be influenced by phrasing) “they can still help us understand what people want”.<sup>334</sup>

## Conclusion

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<sup>331</sup> For example, Department of Health (DOH) (2012) *The Power of Information: Putting all of us in control of the health and social care information we need*. London: DOH.

<sup>332</sup> Namely: NHS England (2014) *Five Year Forward View*. London: NHS England/NHS England et al (2015) *Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21*. London: NHS England/NHS England (2017) *Next Steps on the Five Year Forward View*. London: NHS England.

<sup>333</sup> I searched Hansard (transcripts of parliamentary debates), newspaper archives (the British Newspaper Archive and Proquest European Newsstream) and Keele University’s on-line library search (powered by Ex Libris Primo) to identify relevant material.

<sup>334</sup> Navarro, V. (1993) *Dangerous to Your Health: Capitalism in Health Care*. New York: Monthly Review Press, p59.

In this chapter, I provided a concise overview of Marxist political philosophy, which informs the method (ideology critique) employed within this dissertation. Marxist legal theorists have sought to resolve problems relating to the base and superstructure metaphor (which I rejected) and how the law is determined. I analysed positive conceptions of ideology (for example, it has been conceived as a political tradition, a type of social cement and the ideas of a particular group) and negative conceptions (in which it is conceived as involving misrepresentations or mystification). Collins and Moxon utilised the former to explain how the law is determined. I argue that the current hegemonic ideology of neo-liberalism has influenced the examined reforms along with a posited micro-ideology of private healthcare companies. Nonetheless, neo-liberalism competes with residual and emergent forms. I outlined the modes (and their strategies) which may be employed in justifying reforms, which I identify in subsequent chapters. I also examined several modes of reification which may generate estrangement. In addition, I considered and repudiated criticisms of the concept of ideology.

In subsequent chapters, I analyse successive government reforms to the English NHS, since the year 2000, which have marketized the service and afforded private companies more opportunities to deliver clinical services. Such reforms are indicative of the third phase of neo-liberalism identified by Jamie Peck and Adam Tickell, namely roll-out-neo-liberalism,<sup>335</sup> which involves the state more actively using social policy to support capital.<sup>336</sup> In facilitating profit-making from publicly funded services<sup>337</sup> such

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<sup>335</sup> Peck, J. and Tickell, A. (2002) 'Neoliberalizing Space'. *Antipode*, Vol.34(3), pp380-404 at p389.

<sup>336</sup> Veitch, K. (2013) 'Law, Social Policy, and the Constitution of Markets and Profit Making'. *Journal of Law and Society*, Vol. 40(1), pp137-154 at p138.

<sup>337</sup> Navarro, V. (1976) *Medicine under Capitalism*. New York: Prodist, p216.

reforms redistribute wealth to the affluent<sup>338</sup> and may prove antagonistic to human need<sup>339</sup> as they undermine risk pooling and cross subsidy within the NHS, which have been important in its organisation on the basis of need.<sup>340</sup> There are four main strands to the analytical framework that I employ to analyse the successive reforms in the following chapters. Firstly, I assess the influence of the dominant ideology of neo-liberalism on the policies of successive governments (specifically healthcare policy and reform), primarily by reviewing political science literature. I also assess the influence of the posited micro-ideology of private healthcare companies on the reforms, through mechanisms such as direct advice, lobbying and the establishment of financial links with politicians and think tanks, by reviewing relevant literature (such as pertinent newspaper articles and critiques of the reforms by opponents, such as academics and trade unions). Secondly, I employ the ideological modes and strategies delineated by John B. Thompson,<sup>341</sup> in analysing relevant policy documents, articles and speeches, to identify the justifications for the reforms (for example, that such reforms would enhance quality and efficiency) in government discourse. I assess whether such justifications were contested and whether they are borne out in reality (for example, by reviewing relevant academic literature to determine whether such reforms have improved quality or efficiency). I also employ the authentic historical analysis advocated by Williams<sup>342</sup> to assess the presence (and potential undermining) of dominant, residual and emergent norms<sup>343</sup> in government and public discourse and

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<sup>338</sup> Woolhandler, S. and Himmelstein, D., 'Competition in a Publicly Funded Healthcare System', *British Medical Journal* 2007; 335:1126.

<sup>339</sup> Harvey, D. (2014) *Seventeen Contradictions and the end of Capitalism*, op cit., n236 at p23.

<sup>340</sup> Doctors for the NHS (2015) 'An NHS Beyond the Market'. [On-line] Available: <http://www.doctorsforthenhs.org.uk/nhs-threats/privatisation/an-nhs-beyond-the-market/> [Accessed: 16 October 2016].

<sup>341</sup> Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.9 at p60.

<sup>342</sup> Williams, R. (1977) *Marxism and Literature*, op cit., n.124 at p121.

<sup>343</sup> Ibid at p122.

legislation. In addition, I utilise residual and emergent norms as bases for conceiving alternatives to dominant neo-liberal norms.

Thirdly, I assess whether the reforms have translated neo-liberal political rationality into practice, taking into account Alan Hunt and Gary Wickham's insight that this involves attempt, incompleteness and resistance.<sup>344</sup> Fourthly, I assess the attempts of successive governments to reify both health and healthcare through various strategies. Such reification may cause estrangement, which, as Torrance noted, is the opposite of solidarity,<sup>345</sup> which was important in the creation and maintenance of the NHS. Such reifying strategies include the modes identified by Adorno, of which the two I employ are philosophical reification (identity thinking), for example through the extension of the exchange principle, the use of indicators and government efforts to interpellate patients as consumers (which is also indicative of the standardization strategy of the unification mode of ideology identified by Thompson<sup>346</sup>), and social reification (which refers to means, such as targets and markets, becoming ends in themselves).<sup>347</sup> In addition, I assess the potential for legal changes to reify social relations through what Kennedy described as law's "legitimation effect".<sup>348</sup> I also assess the success of government attempts to reify both health and healthcare through the strategies of depoliticization identified by Jessop, such as through efforts to shift the boundary between the political and non-political (for example, through marketization and juridification<sup>349</sup>), the re-organisation of the political division of labour

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<sup>344</sup> Hunt, A. and Wickham, G. (1994) *Foucault and Law: Towards a Sociology of law as Governance*. London: Pluto, pp102-104.

<sup>345</sup> Torrance, J. (1977) *Estrangement, Alienation and Exploitation*, op cit., n.207 at p315.

<sup>346</sup> Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.9 at p64.

<sup>347</sup> Chari, A. (2015) *A Political Economy of the Senses*, op cit., n.129 at p144.

<sup>348</sup> Kennedy, D. (1997) *A Critique of Adjudication*, op cit., n.220 at p236.

<sup>349</sup> In analysing potential juridification, I utilise the dimensions delineated by Blichner and Molander. See Blichner, L. and Molander, A. (2008) 'Mapping Juridification', op cit., n.268 at pp38-39.

(which Flinders and Buller describe as institutional depoliticisation<sup>350</sup>), constitutional law (such as the new constitutionalism identified by Gill<sup>351</sup>), the use of ostensibly non-political figures to make recommendations and governmentalization (such as through efforts to self-responsibilise citizens, for example in respect of health, and through the creation of conditions for technocratic decision making).<sup>352</sup>

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<sup>350</sup> Flinders, M. and Buller, J. (2005) 'Depoliticisation, Democracy and Arena Shifting', op cit., n.262 at p6.

<sup>351</sup> Gill, S. (2008) *Power and Resistance in the new world order*, op cit., n.273 at p79.

<sup>352</sup> Jessop, B. (2015) 'Repoliticising depoliticisation', op cit., n.259 at pp101-106.



## Chapter Three: New Labour and the NHS (Part One)

### Introduction

In this chapter, and the following three, I analyse the NHS reforms of successive governments. I assess the impact of such reforms on norms within, and the organisation of, the NHS. I contend that such reforms divert resources away from patient needs to market bureaucracies and the coffers of private companies. I evaluate the success of the strategies employed to legitimate and obscure such distributive effects. In this chapter and the next, I evaluate the influences on, and the ideas that motivated and sought to legitimise the policies and legal changes of, the Labour governments (1997-2010) regarding the NHS. I also consider the opposition and resistance to, and potential reifying effects of, Labour's reforms. In this chapter, I examine the influence of neo-liberalism and private healthcare companies on 'New' Labour's policies. The reforms analysed within this chapter are the private finance initiative (PFI), the '*NHS Plan*', the creation of Independent Sector Treatment Centres (ISTCs) and changes to the mechanisms for patient and public involvement. New Labour utilised numerous ideological modes (and their strategies) to justify its NHS reforms. It sought to portray them as being in the interests of everyone (taxpayers and patients) by stating they would enhance quality and value for money. New Labour claimed to be pragmatic, but exuded a preference for the private sector. It sought to decontest the meanings of terms, such as 'quality' and 'efficiency', by linking them to private sector involvement. However, such terms were recontested, as critics argued that private sector involvement in the NHS was detrimental to quality and efficiency.

New Labour narrativised itself, and its reforms, as modern, and the party's previous policies, and its left-wing critics, as outmoded, thereby seeking to naturalise its conception of modernity, in which there was no alternative within public services to the consumerism prevalent elsewhere within capitalist society. New Labour stated that it supported residual norms regarding the NHS, but its reforms undermined them, for example by reducing the NHS' comprehensiveness (thereby extending the exchange principle). New Labour's discourse co-opted emergent norms, such as reducing health inequalities and empowering patients, although the neo-liberal policies it pursued undermined them. As New Labour's policies failed to effectuate some of the normative elements of its discourse, such norms can be used to critique its reforms and to conceive alternatives. New Labour's attempts to depoliticise healthcare through the use of targets was unsuccessful. Targets did not cover, and were argued to have a detrimental effect on, rising hospital infections. Nonetheless, targets became ends to which patient needs were subordinated. New Labour also sought to reify health through its emphasis on individual responsibility.

### New Labour

At the general election in 1997, Labour won a majority of 179 in the House of Commons, ending eighteen years of Conservative government. It also won the general elections in 2001 and 2005, at which its majorities were reduced to 166 seats and then sixty-six seats respectively. Labour was one of several social democratic parties which

returned to power across Western Europe in the late 1990s, whose ideologies and policies had shifted from the traditional terrain of social democracy.<sup>1</sup> Andrew Rawnsley states that the trauma of four successive election defeats (1979, 1983, 1987 and 1992) led to a small group of modernisers at the apex of the party altering its image, philosophy and policies.<sup>2</sup> Alex Callinicos contends that the modernisers exploited the trauma, which made a “superficial and phoney” alternative to the Conservatives attractive.<sup>3</sup> Labour’s ‘modernisation’ began under Tony Blair’s predecessors, Neil Kinnock (Labour leader between 1983 and 1992) and John Smith (Labour leader between 1992 and 1994).<sup>4</sup> Richard Heffernan states that the term ‘modernisation’ was “a metaphor for the politics of catch up”<sup>5</sup> and that “where Thatcherism has led,...Kinnock, Smith and Blair followed”.<sup>6</sup> Thus as Colin Hay states, Labour reified the attitudinal preferences of voters which were viewed as a fixed constraint to which policy appeals must be oriented.<sup>7</sup>

The party was rebranded as ‘New’ Labour, to distinguish it from what Philip Gould (a political consultant and adviser) described as the “dogma”<sup>8</sup> of ‘Old’ Labour. Although

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<sup>1</sup> Glyn, A. and Woods, S. (2001) ‘Economic Policy under New Labour: How Social Democratic is the Blair Government?’ *Political Quarterly*, Vol.72(1), pp50--66 at p50.

<sup>2</sup> Rawnsley, A. (2001) *Servants of the People: The Inside Story of New Labour*. London: Penguin, pp3-4.

<sup>3</sup> Callinicos, A. (1996) *New Labour or Socialism*. [On-line] Available: <https://www.marxists.org/history/etol/writers/callinicos/1996/04/newlab.html> [Accessed: 14 February 2016].

<sup>4</sup> Fairclough, N. (2000) *New Labour, New Language*. London: Routledge, p84/ Ludlam, S. (2004) ‘Second Term New Labour’ in Ludlam, S. and Smith, M. (eds) *Governing as New Labour: Policy and Politics under Blair*. Basingstoke: Palgrave, pp1-15 at p3.

<sup>5</sup> Heffernan, R. (2001) *New Labour and Thatcherism: Political Change in Britain*. Basingstoke: Palgrave, p178.

<sup>6</sup> *Ibid* at p66.

<sup>7</sup> Hay, C. (1999) *The Political Economy of New Labour: Labouring under False Pretences?* Manchester: Manchester University Press, p67.

<sup>8</sup> Gould, P. (1998) *The Unfinished Revolution: How the Modernisers Saved the Labour Party*. London: Little Brown, p3.

Steven Fielding contends that the categories of 'Old' and 'New' Labour prevent comprehension of the continuities and changes within the party,<sup>9</sup> I use the term New Labour as it signifies Labour's neo-liberal incarnation.<sup>10</sup> John Clarke notes the significance of residualising discourses to political projects, which tell "the time in ways that locate critics, refusals and alternative imaginaries as belonging to the past".<sup>11</sup> He states that this was "a recurrent motif in New Labour discourse - indeed, time is inscribed into its very title".<sup>12</sup> Blair contended that ideology was dead,<sup>13</sup> although elsewhere he argued that Labour's ideology was outdated.<sup>14</sup> Labour's 1997 manifesto stated that New Labour was created "to meet the challenges of a different world".<sup>15</sup> It expressed the desire to end "the bitter political struggles of left and right".<sup>16</sup> Conflicts, such as "public versus private, bosses versus workers, middle class versus working class" were described as having "no relevance whatsoever to the modern world".<sup>17</sup> However, Callinicos notes that Labour's own commission on social justice revealed a growth of poverty and inequality undermining the notion that class divisions were receding.<sup>18</sup> Blair sought to weaken Labour's traditional trade union links "by raising election funding from wealthy entrepreneurs",<sup>19</sup> and amended clause four of Labour's

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<sup>9</sup> Fielding, S. (2003) *The Labour Party: Continuity and Change in the Making of 'new' Labour*. Basingstoke: Palgrave, p217.

<sup>10</sup> Lister, J. (2008) *The NHS After 60: For Patients or Profits?* London: Middlesex University Press, p5.

<sup>11</sup> Clarke, J. (2007) 'Citizen Consumers and Public Service Reform: At the Limits of Neo-liberalism'. *Policy Futures in Education*, Vol.5(2), pp239-248 at p248.

<sup>12</sup> Ibid.

<sup>13</sup> Freeden, M. (1999) 'The Ideology of New Labour'. *Political Quarterly*, Vol.70(1), pp42-51 at p42.

<sup>14</sup> Ibid at p43/Blair, T. (1995) *Let us Face the Future: The 1945 Anniversary Lecture*. London: Fabian Society, p4.

<sup>15</sup> Labour Party., 'Labour Party General Election Manifesto 1997 New Labour: Because Britain Deserves Better' in Dale, I. (ed) (2000) *Labour Party General Election Manifestoes 1900-1997*. London: Routledge, pp343-382 at p346.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Callinicos, A. (1996) *New Labour or Socialism*, op cit., n.3.

<sup>19</sup> Callinicos, A. (2001) *Against the Third Way*. Cambridge: Polity Press, p103.

constitution,<sup>20</sup> to “reassure big business and the financial markets that they would be safe under a Labour government”.<sup>21</sup>

The third way was proclaimed as New Labour’s philosophy, although Robin Cook (Foreign Secretary between 1997 and 2001) stated that it was dropped once it had outlived its novelty.<sup>22</sup> The notion of a third or middle way had emerged numerous times in the twentieth century.<sup>23</sup> Clarke et al stated that there was little acknowledgement from New Labour of the long history of the notion.<sup>24</sup> Both Norman Fairclough and Callinicos noted that Blair’s third way, which distinguishes between the old left and the new right, buried other distinctions.<sup>25</sup> Slavoj Zizek contended that “the true message” of Blair’s third way was “that there is no second way, no actual alternative to global capitalism”.<sup>26</sup> Andrew Gamble claims that New Labour was “committed to working within the constraints of neo-liberalism”.<sup>27</sup> In this respect, New Labour accepted the monetarist principle that the main aim of economic policy is a stable fiscal and

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<sup>20</sup> The original clause committing the party to the “common ownership of the means of production, distribution and exchange” (see Labour Party (1918) *Report of the Eighteenth Annual Conference*. London: Labour Party, p141) was amended. The party voted for a new clause, committing it to work for a dynamic economy “with a thriving private sector and high-quality public services where those undertakings essential to the common good are either owned by the public or accountable to them” (see Labour Party (1995) *Annual Conference 1994; Special Conference 1995: Report of Conference*. London: Labour Party, p307).

<sup>21</sup> Callinicos, A. (1996) *New Labour or Socialism*, op cit., n.3.

<sup>22</sup> Cook, R. (2003) *The Point of Departure*. London: Simon and Schuster, p37.

<sup>23</sup> Arestis, P and Sawyer, M. (2001) ‘The Economic Analysis Underlying the third way’. *New Political Economy*, Vol.6(2), pp255-278 at p255/Freeden, M. (1999) ‘The Ideology of New Labour’, op cit., n.14 at p44.

<sup>24</sup> Clarke, J. et al (2000) ‘Reinventing the Welfare State’ in Clarke, J, et al (eds) *New Managerialism, New Welfare?* London: Sage, p11.

<sup>25</sup> Ibid/Callinicos, A. (2001) *Against the Third Way*, op cit., n.19 at p114.

<sup>26</sup> Zizek, S. (2000) *The Fragile Absolute Or, Why is the Christian Legacy worth Fighting For?* London: Verso, p62.

<sup>27</sup> Gamble, A. (2009) *The Spectre at the Feast: Capitalist Crisis and the Politics of Recession*. Basingstoke: Palgrave, p106.

monetary policy to keep inflation low,<sup>28</sup> and was tax averse.<sup>29</sup> The economy grew under New Labour until the onset of the Great Recession (2008-09). Hay states that New Labour's neo-liberalism was normalized, as it was based on a conviction that continued neo-liberal reform was required to sustain "economic growth and competitiveness"<sup>30</sup> and that its political economy rested on an "appeal to globalisation as an external economic constraint".<sup>31</sup> Colin Leys contends that domestic policy was increasingly shaped by the market forces of the global political economy.<sup>32</sup> However, Hay states that there is no evidence that globalisation rendered social democratic governance anachronistic.<sup>33</sup>

Gamble states that New Labour was akin to orthodox social democratic governments in respect of its substantial investment in health and education.<sup>34</sup> Labour adhered to Conservative spending plans in its first two years in office.<sup>35</sup> Consequently, although it had pledged to save the NHS, the underinvestment in the service was not addressed in those years. Nigel Crisp states that it was questionable, in 1997, whether the NHS could survive, as standards and public support were falling.<sup>36</sup> In 2000, Blair pledged "to bring health spending up to the European Union average over five years".<sup>37</sup> The

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<sup>28</sup> Callinicos, A. (1996) *New Labour or Socialism*, op cit., n.3.

<sup>29</sup> Shaw, E. (2007) *Losing Labour's Soul? New Labour and the Blair Government 1997-2007*. Abingdon: Routledge, p157.

<sup>30</sup> Hay, C. (2005) 'The Normalizing role of rationalist assumptions in the institutional embedding of neo-liberalism'. *Economy and Society*, Vol.33(4), pp500-527 at pp503-504.

<sup>31</sup> Ibid at p519.

<sup>32</sup> Leys, C. (2001) *Market Driven Politics*. London: Verso, p6.

<sup>33</sup> Hay argues that states which violated the policy strictures associated with globalisation had attracted more foreign direct investment. See Hay, C. (2007) *Why We Hate Politics*. Cambridge: Polity Press, p131.

<sup>34</sup> Gamble, A. (2010) 'New Labour and Political Change'. *Parliamentary Affairs*, Vol.63(4), pp639-652 at p649.

<sup>35</sup> Klein, R. (2008) *The New Politics of the NHS*. Abingdon: Radcliffe, p189.

<sup>36</sup> Crisp, N. (2011) *24 hours to save the NHS: The Chief Executives Account of Reform 2000 to 2006*. Oxford: Oxford University Press, p1.

<sup>37</sup> Rawnsley, A. (2001) *Servants of the People*, op cit., n.2 at p337.

pledge was re-affirmed within the ‘*NHS Plan*’ and Derek Wanless’ report for the Treasury.<sup>38</sup> Consequently, Rorden Wilkinson described New Labour’s philosophy as “a kind of socialised neo-liberalism”.<sup>39</sup> Similarly, Robin Gauld states that healthcare policy in the UK, and elsewhere, has been influenced by socialised neo-liberalism.<sup>40</sup> Stuart Hall described New Labour as a hybrid, consisting of a dominant neo-liberal strand and a subordinate social democratic strand, necessary to maintain the loyalty of traditional supporters.<sup>41</sup> New Labour drew a distinction between persistent values and the changing means (such as markets) of enacting them in the modern world.<sup>42</sup> New Labour superficially articulated residual and emergent norms, which its neo-liberal policies undermined. Catherine Needham argues that New Labour did not critically engage with the fundamental contradictions between the state and the market.<sup>43</sup> Fairclough states that it sought “to reconcile in language what cannot be reconciled in reality”.<sup>44</sup> New Labour claimed to be pragmatic and interested in what works.<sup>45</sup> Blair stated that values had to be applied to “a changing world” and that what counted was what worked.<sup>46</sup> However, Clarke argues that far from being ‘pragmatic’, New Labour valorised the private, for example, by portraying the private sector as a site of dynamic innovation.<sup>47</sup>

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<sup>38</sup> Wanless, D. (2002) *Securing our Future Health: Taking a Long-Term View Final Report*. London: HM Treasury, p119.

<sup>39</sup> Wilkinson, R. (2000) ‘New Labour and the Global Economy’ in Coates, D. and Lawler, P. (eds) *New Labour in Power*. Manchester: Manchester University Press, pp136-148 at p138.

<sup>40</sup> Gauld, R. (2009) *The New Health Policy*. Maidenhead: Open University Press, p153.

<sup>41</sup> Hall, S. (2005) ‘New Labour’s Double Shuffle’. *Review of Education, Pedagogy and Cultural Studies*, Vol.27(4), pp319-335 at p329.

<sup>42</sup> Clarke, J. et al (2007) ‘Creating Citizen-Consumers? Public Service Reform and (Un)willing Selves’ in Massen, S. and Sutter, B. (eds) *On Willing Selves: Neo-liberal Politics vis-à-vis the Neuro-scientific Challenge*. Basingstoke: Palgrave, pp125-145 at p130.

<sup>43</sup> Needham, C. (2003) *Citizen-Consumers: New Labour’s Marketplace Democracy*. London: Catalyst Forum, p25.

<sup>44</sup> Fairclough, N. (2000) *New Labour, New Language*, op cit., n.4 at p158.

<sup>45</sup> Finlayson, A. (2003) *Making Sense of New Labour*. London: Lawrence and Wishart, p8.

<sup>46</sup> Blair, T., ‘In defence of Blairism, by Tony Blair’, *Spectator*, 09 December 2015.

<sup>47</sup> Clarke, J. (2004) ‘Dissolving the Public Realm? The Logics and Limits of Neo-liberalism’. *Journal of Social Policy*, Vol.33(1), pp27-48 at p42.

Peter Burnham described Blair's statecraft as the politics of depoliticisation.<sup>48</sup> Burnham states that that this was evident in New Labour's reassignment of tasks to ostensibly non-political bodies (for example, making the Bank of England operationally independent in respect of monetary policy<sup>49</sup>) and its attempt to restructure the public sector in line with new public management (NPM).<sup>50</sup> New Labour did not remove NPM,<sup>51</sup> rather, as Hall contended, its market fundamentalism became "the new common sense".<sup>52</sup> However, Sue Dopson et al contend that there was a shift to looser more network based models of management typical of network governance.<sup>53</sup> The terms "partnership"<sup>54</sup> and "collaboration"<sup>55</sup> were important in New Labour's governance. Labour had promised to abolish the Conservative's internal market (on the basis that it represented a bureaucratic waste<sup>56</sup>) but "cosmetically" removed some of its features<sup>57</sup> (such as GP fundholding<sup>58</sup>) and retained the split between purchasers and providers, which was "renamed commissioning".<sup>59</sup> Calum Paton contends that Labour retained the split to convince "the right-wing press that they were not 'Old

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<sup>48</sup> Burnham, P. (2001) 'New Labour and the Politics of Depoliticisation'. *British Journal of Politics and International Relations*, Vol.3(2), pp127-149 at p128.

<sup>49</sup> Ibid/Bank of England Act (1946), S.4(1) as amended by Bank of England Act (1998), S.10.

<sup>50</sup> Ibid at p139.

<sup>51</sup> Driver, S. (2008) 'New Labour and Social Policy' in Beech, M. and Lee, S. (eds) *Ten Years of New Labour*. Basingstoke: Palgrave, pp50-67 at p57.

<sup>52</sup> Hall, S. (2005) 'New Labour's Double Shuffle', op cit., n.41 at p328.

<sup>53</sup> Dopson, S. et al (2012) 'Organisational Networks- Can they deliver improvements in health care?' in Dickinson, H. and Mannion, R. (eds) *The Reform of Healthcare: Adapting and Resisting Policy Developments*. Basingstoke: Palgrave, pp91-108 at p93.

<sup>54</sup> Dickinson, H. (2014) *Performing Governance: Partnership, Culture and New Labour*. Basingstoke: Palgrave, p1.

<sup>55</sup> Paton, C. (2006) *New Labour's State of Health: Political Economy, Public Policy and the NHS*. Aldershot: Ashgate, p60.

<sup>56</sup> Greener, I. et al (2014) *Reforming Healthcare: What's the Evidence?* Bristol: Polity Press, p40.

<sup>57</sup> Bradshaw, P. and Bradshaw, G. (2004) *Health Policy for Healthcare Professionals*. London: Sage, p32.

<sup>58</sup> Health Act (1999), S.1.

<sup>59</sup> Timmins, N. (2012) *Never Again? The Story of the Health and Social Care Act 2012*. London: Kings Fund and Institute for Government, p21.



Labour' statist's".<sup>60</sup> Commissioning was given to 481 Primary Care Groups (PCGs) which contained an inbuilt majority of doctors.<sup>61</sup> PCGs evolved over time into Primary Care Trusts (PCTs).<sup>62</sup> In 2006, the number of PCTs was reduced from 303 to 152. The NHS Executive was dissolved and Health Authorities were reorganised into twenty-eight Strategic Health Authorities (SHAs)<sup>63</sup> (reduced to ten in 2006). Jo Maybin et al note that top-down management from SHAs was the principal means of accountability for PCTs.<sup>64</sup> There was concern about the lack of democratic control over PCTs. For example, Kate Hoey (Labour MP for Vauxhall since 1989) asked Alan Milburn (Secretary of State for Health between 1999 and 2003) why PCTs were not elected.<sup>65</sup> Milburn's response was that PCTs were "not at a suitable stage of development".<sup>66</sup> This implied that PCTs could be elected in the future, but this never occurred.

### Private Finance Initiative

The legal and financial obstacles to PFI schemes (which the Conservatives introduced in 1993), which were renamed public private partnerships (PPPs), were removed

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<sup>60</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England's Permanent Revolution*. London: Palgrave, p40.

<sup>61</sup> Paton, C. (1999) 'New Labour's Healthcare Policy: The New Healthcare State' in Powell, M. (ed) *New Labour, New Welfare State? The Third Way in British Social Policy*. Bristol: Polity Press, pp51-76 at p64.

<sup>62</sup> Paton, C. (2002) 'Cheques and Checks: New Labour's Record on the NHS' in Powell, M. (ed) *Evaluating New Labour's Welfare Reforms*. Bristol: Polity Press, pp127-144 at p128.

<sup>63</sup> National Health Service Reform and Health Care Professions (NHSRHCP) Act (2002), S.1.

<sup>64</sup> Maybin, J. et al (2011) *Accountability in the NHS: Implications of the government's reform programme*. London: Kings Fund, p13.

<sup>65</sup> H.C. Deb. 7 May 2003 Vol.404, Col.704.

<sup>66</sup> Ibid.

following Labour's election<sup>67</sup> and a Private Finance Panel, which advised the government, was replaced by a taskforce composed of industry representatives.<sup>68</sup> The UK played a prominent role in developing PPP policy and spreading it elsewhere.<sup>69</sup> PPPs removed capital investment from the government account, thereby reducing the public sector borrowing requirement.<sup>70</sup> Milburn's dictum "PFI or bust"<sup>71</sup> reified PPPs as the only way to build new infrastructure. By 2007, sixty-three PPP schemes were completed and twenty-two were under construction, while twenty-one publicly funded schemes had been sanctioned.<sup>72</sup> In primary care, 188 clinics and GP surgeries were built or were under construction, by 2007, through the Local Improvement Finance Trust (LIFT) programme which introduced private finance.<sup>73</sup> As PPPs were generally classified as procurement transactions, procurement law applied.<sup>74</sup> PPP schemes involve an availability fee (construction costs, interest) and facilities management (cleaning, lighting, etc.).<sup>75</sup> The buildings were leased to the public sector for periods between twenty-five and thirty-five years, following which they would revert to public control.<sup>76</sup> As mentioned in chapter two, where the state opens up arenas to private capital accumulation, this may prove antagonistic to human need.<sup>77</sup> In this respect, the profits of private companies took precedence over local people's needs in the

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<sup>67</sup> Shaw, E. (2007) *Losing Labour's Soul?*, op cit., n.29 at p82.

<sup>68</sup> Monbiot, G. (2000) *Captive State: The Corporate Takeover of Britain*. London: Pan Books, p86.

<sup>69</sup> Willems, T. and van Dooren, W. (2016) '(De)politicisation dynamics in Public Private Partnerships (PPP): Lessons from a Comparison between UK and Flemish PPP policy'. *Public Management Review*, Vol.18(2), pp199-220 at p210.

<sup>70</sup> Paton, C. (2006) *New Labour's State of Health*, op cit., n.55 at p80.

<sup>71</sup> Brindle, D., 'Budget 2: £1.3bn private finance for NHS hospitals'. *Guardian*, 4 July 1997.

<sup>72</sup> Thorlby, R. and Maybin, J. (2007) *Health and Ten Years of Labour Government*. London: Kings Fund, p8.

<sup>73</sup> Ibid.

<sup>74</sup> Braun, P. (2001) 'The Practical Impact of EU Public Procurement Law on PFI Procurement in the United Kingdom'. [On-line] Available: [https://www.nottingham.ac.uk/pprg/documentsarchive/phdtheses/phd\\_peter\\_braun\\_.pdf](https://www.nottingham.ac.uk/pprg/documentsarchive/phdtheses/phd_peter_braun_.pdf) [Accessed: 5 December 2016].

<sup>75</sup> Mohan, J. (2002) *Planning, Markets and Hospitals*. London: Routledge, p206.

<sup>76</sup> Shaw, E. (2007) *Losing Labour's Soul?*, op cit., n.29 at p82.

<sup>77</sup> Harvey, D. (2014) *Seventeen Contradictions and the end of Capitalism*. Oxford: Oxford University Press, p23.

development of PPPs. For example, George Monbiot noted that a leaked report concerning a scheme in Coventry indicated that it was devised to facilitate profit for private companies rather than to meet local needs.<sup>78</sup> The length of PPP contracts also constrained the government's ability to respond flexibly to changing health needs.<sup>79</sup> Monbiot contended that PPP costs were inflated to attract private investors.<sup>80</sup> For example, the costs of a new hospital in Worcester escalated by 188 percent during PFI negotiations resulting in beds being cut in nearby Kidderminster.<sup>81</sup> At the 2001 general election, Dr Richard Taylor (of the Health Concern party) was elected as MP for Wyre Forest as he promised to reverse such cuts.

Although ministers rationalized that PPPs would “bring money from the private sector into the” NHS, Monbiot noted that it would “instead drain money from the health service into the private sector”.<sup>82</sup> For example, some private companies were given subsidies through the ability of PFI consortia to sell off surplus land.<sup>83</sup> The government also rationalized that PPPs transferred risk to the private sector. Michael Meacher described this as a ‘mirage’, as governments would have little alternative but to bail out PFI contractors that went bankrupt.<sup>84</sup> Leys and Player state that PPPs were lucrative “for a host of banks, private equity financiers, construction companies and facilities management providers”.<sup>85</sup> However, John Lister notes that this meant that less money remained “to treat patients, pay clinical staff and develop modern,

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<sup>78</sup> Monbiot, G. (2000) *Captive State*, op cit., n.68 at p70.

<sup>79</sup> Ibid at p86/Meacher, M., ‘Picking up the tabs for the PFI’, *Times*, 14 December 2004.

<sup>80</sup> Monbiot, G. (2000) *Captive State*, op cit., n.68 at p76.

<sup>81</sup> Pollock, A. et al (2001) *Public Services and the Private Sector: A Response to the IPPR*. London: Catalyst, p37.

<sup>82</sup> Monbiot, G. (2000) *Captive State*, op cit., n.68 at p78.

<sup>83</sup> Ibid at p77.

<sup>84</sup> Meacher, M., ‘Picking up the tabs for the PFI’, op cit., n.79.

<sup>85</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin, p72.

appropriate services”.<sup>86</sup> Allyson Pollock et al state that PPPs entailed major reductions “in service provision, acute bed capacity, and clinical staffing”.<sup>87</sup> Mark Hellowell contends that trusts with PFI are more likely to run into financial difficulties.<sup>88</sup> For example, he notes that two large PFI contracts were an important contributing factor to the problems at South London Healthcare NHS Trust, which was dissolved in 2013.<sup>89</sup> PFI schemes have cost £301 billion for capital worth £54.7 billion.<sup>90</sup> The depoliticising dynamics of PPPs were that ministers lost direct control and parliament and citizens lost oversight and influence.<sup>91</sup> Peter Vincent-Jones argues that PFI may not have been adopted if there had been more scrutiny, consultation and debate.<sup>92</sup> The schemes generated controversy and criticism in academia and the press<sup>93</sup> and were opposed by Labour backbenchers (such as Meacher and John McDonnell<sup>94</sup>) and trade unions (which passed a motion criticising them at Labour’s annual conference in 2002<sup>95</sup>). However, unions engaged with schemes locally and negotiated for deals nationally.<sup>96</sup>

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<sup>86</sup> Lister, J. (2008) *The NHS After 60*, op cit., n.10 at p257.

<sup>87</sup> Pollock, A. et al., ‘Planning the new NHS: Downsizing for the 21<sup>st</sup> Century’. *British Medical Journal* 1999; 319: 179.

<sup>88</sup> Hellowell, M. (2014) *The Return of PFI- Will the NHS pay a higher price for new hospitals?* London: Centre for Health and the Public Interest, p5.

<sup>89</sup> *Ibid* at p6.

<sup>90</sup> El-Gingihy, Y. (2015) *How to Dismantle the NHS in 10 Easy Steps*. Winchester: Zero Books, p10.

<sup>91</sup> Willems, T. and van Dooren, W. (2016) ‘(De)politicisation dynamics in Public Private Partnerships (PPP)’, op cit., n.69 at p204.

<sup>92</sup> Vincent-Jones, P. (2006) *The New Public Contracting: Regulation, Responsiveness, Rationality*. Oxford: Oxford University Press, p315.

<sup>93</sup> *Ibid* at p210.

<sup>94</sup> McDonnell, J. (2007) *Another World is Possible: A Manifesto for 21<sup>st</sup> Century Socialism*. London: Labour Representation Committee, p14.

<sup>95</sup> Shaw, E. (2008) ‘New Labour and the Unions: The Death of Tigmoo?’ in Beech, M. and Lee, S. (eds) *Ten Years of New Labour*. Basingstoke: Palgrave, pp120-135 at p128.

<sup>96</sup> Ruane, S. (2007) ‘Acts of distrust? Support workers experiences in PFI hospital schemes’ in Mooney, G. and Law, A. (eds) *New Labour/Hard Labour: Restructuring and Resistance inside the Welfare Industry*. Bristol: Polity Press, pp75-92 at p89.

## NHS Plan

New Labour stated, in its first term, that there would be “no return to the old centralised command and control system in the NHS”.<sup>97</sup> Rudolf Klein contends that this system had never existed, and that, in 1997, the NHS was a “conglomerate of local services rather than a national one”.<sup>98</sup> Klein states that Labour sought to change this by creating “powerful instruments of central control”.<sup>99</sup> For example, National Service Frameworks (NSFs) were developed, the Commission for Health Improvement (CHI) was created to assess the clinical performance of NHS hospitals<sup>100</sup> and the National Institute for Clinical Excellence (NICE)<sup>101</sup> was established to diffuse and promote evidence regarding good practice to NHS bodies making decisions about medicines.<sup>102</sup> Klein avers that by the end of Blair’s premiership, the NHS had moved to a “pluralistic mimic-market model”.<sup>103</sup> Gauld notes that following the year 2000,

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<sup>97</sup> Department of Health (1997) *The New NHS: Modern, Dependable*. London: Department of Health.

<sup>98</sup> Klein, R. (2008) *The New Politics of the NHS*, op cit., n.35 at pp206-207.

<sup>99</sup> Ibid at p207.

<sup>100</sup> Health Act (1999), S.19(1). This was subsequently replaced with the Commission for Healthcare Audit and Inspection (CHAI) (also known as the Healthcare Commission) created by the Health and Social Care (Community Health and Standards) Act (2003), S.41(1). The Health and Social Care Act (2008), S.1(2) dissolved CHAI, the Commission for Social Care and Inspection and the Mental Health Act (1983) Commission and replaced them with the Care Quality Commission (CQC)(S.1(1)).

<sup>101</sup> NICE was established as a special health authority, as per the Secretary of State’s power to create such bodies (National Health Service Act, S.11(1), (2), (4) and Schedule 5 para.9(7)), via the National Institute for Clinical Excellence (Establishment and Constitution) Order 1999, SI 1999/220, R.2. It merged with the Health Development Agency, in 2005, creating the National Institute for Health and Clinical Excellence (NICE). It is now the National Institute for Health and Care Excellence (NICE), an executive non-departmental body (Health and Social Care Act (2012), S.232(1)). Matthew Wood argues that NICE successfully depoliticised health technology regulation as it was supported by a structure of formal institutional rules and informal norms that meant that ministers did not seek to intervene in its decision-making processes (Wood, M. (2015) ‘Depoliticisation, resilience and the herceptin post-code lottery crisis: Holding back the tide?’ *British Journal of Politics and International Relations*, Vol.17(4), pp644-664 at p661).

<sup>102</sup> Klein, R. (2008) *The New Politics of the NHS*, op cit., n.35 at p197.

<sup>103</sup> Ibid at p213.

competition and choice were gradually reintroduced.<sup>104</sup> Both Blair and Crisp state that radical changes began with the '*NHS Plan*'.<sup>105</sup>

The '*NHS Plan*', published by the Department of Health in 2000, following consultations with the public and NHS staff, outlined the government's NHS plans for the decade ahead. The authors included Milburn<sup>106</sup> and Simon Stevens (a policy advisor).<sup>107</sup> Much of the plan was implemented via the Health and Social Care (HSC) Act (2001) and the National Health Service Reform and Health Care Professions (NHSRHCP) Act (2002). The preface to the '*NHS Plan*' contained twenty-five signatures of endorsement<sup>108</sup> from the agents of numerous professional organisations and trade unions including the British Medical Association (BMA), Royal College of Nursing (RCN), Royal College of GPs (RCGP), Royal College of Midwives (RCW) and UNISON. Nonetheless, the plan was criticised by journalists (such as Monbiot<sup>109</sup>) and the Socialist Health Association (formerly the Socialist Medical Association).<sup>110</sup> The concordat that it announced with the private sector provoked criticism from Labour backbenchers, such as Tony Benn, who stated that it represented "the privatisation of the NHS",<sup>111</sup> and public sector trade unions, who feared that it would worsen staff

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<sup>104</sup> Gauld, R. (2009) *The New Health Policy*, op cit., n.40 at p141.

<sup>105</sup> Blair, T. (2010) *A Journey*. London: Hutchinson, p273/Crisp, N. (2011) *24 hours to save the NHS*, op cit., n.36 at p21.

<sup>106</sup> Klein, R. (2008) *The New Politics of the NHS*, op cit., n.35 at p216.

<sup>107</sup> Hughes, S., 'How the new NHS boss has helped to ruin health services on two continents', *Morning Star*, 1 November 2013.

<sup>108</sup> Mandelstam, M. (2011) *How we Treat the Sick: Neglect and abuse in our Health Services*. London: Jessica Kingsley, p18.

<sup>109</sup> Monbiot, G., 'The NHS is being Privatised'. *Guardian*, 21 December 2000.

<sup>110</sup> Pearce, U. (2000) 'Why Milburn's Concordat is Unhealthy'. [On-line] Available: <http://www.sochealth.co.uk/national-health-service/a-concordat-with-the-private-and-voluntary-health-care-provider-sector/benefits-and-disadvantages-of-the-concordat/> [Accessed: 04 November 2015].

<sup>111</sup> BBC., 'Labour unease at private health deal', 31 October 2000.

shortages.<sup>112</sup> The '*NHS Plan*' also announced the development of a new generation of Diagnostic and Treatment Centres (the first generation began in 1999) in partnership with the private sector.<sup>113</sup> These were subsequently renamed ISTCs.

The '*NHS Plan*' re-affirmed the aforementioned commitment to increase NHS investment. Between 2000/01 and 2007/08 there was an average annual growth rate in health spending of 7.8 percent, moving the UK closer to the European average.<sup>114</sup> However, capacity decreased with a fall in the average daily number of available beds in NHS hospitals in England of over 23,000 between 1997 and 2006-07.<sup>115</sup> The plan stated that there would be an increase in NHS staff but, although increases were achieved,<sup>116</sup> the UK continued to have fewer doctors and nurses per head than many European states.<sup>117</sup> Labour established a Royal Commission on long-term care for the elderly (the Sutherland Commission), which, in 1999, recommended that long-term care costs should be divided into personal care (which should be free), living and housing costs.<sup>118</sup> The recommendation was implemented in Scotland<sup>119</sup> but not in England, where health services continued to be transferred from the NHS to local authorities, which could charge for care.<sup>120</sup> In 2006, it was estimated that 40,000

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<sup>112</sup> Lister, J. (2007) *Health Policy Reform: Driving the Wrong Way? A Critical Guide to the Global 'Health Reform' industry*. London: Middlesex University Press, p106.

<sup>113</sup> Department of Health (2000) *NHS Plan. A Plan for Investment. A Plan for Reform*. London: HMSO, p44.

<sup>114</sup> Thorlby, R. and Maybin, J. (2007) *Health and Ten Years of Labour Government*, op cit., n.72 at p1.

<sup>115</sup> Godden, S. and Pollock, A., 'Independent Sector Treatment Centres: Evidence so far'. *British Medical Journal* 2008; 336:421.

<sup>116</sup> Thorlby, R. and Maybin, J. (2007) *Health and Ten Years of Labour Government*, op cit., n.72 at p7.

<sup>117</sup> Kings Fund (2005) *An Independent Audit of the NHS under Labour (1997-2005)*. London: Kings Fund, p4.

<sup>118</sup> Royal Commission on Long-Term Care of the Elderly (1999) *With Respect to old age: Long-Term Care-Rights and Responsibilities*. London: Stationery Office, pxvii.

<sup>119</sup> Community Care and Health (Scotland) Act (2002), S.1(1).

<sup>120</sup> Mandelstam, M. (2007) *Betraying the NHS: Health Abandoned*. London: Jessica Kingsley, p201.

people a year had to sell their homes to afford long-term care.<sup>121</sup> The ‘*NHS Plan*’ contained proposals for developing intermediate care.<sup>122</sup> Michael Mandelstam described this as “a cover under which vulnerable people with very considerable needs may be denied appropriate and effective healthcare”.<sup>123</sup> According to Mandelstam, by 2005 it was clear that many intermediate care services were not adequately funded to meet needs<sup>124</sup> and that the increase in intermediate care beds in residential homes did not match the number of NHS rehabilitation beds closed.<sup>125</sup> In 2001, Labour announced a policy of free nursing care. Mandelstam states that this was “set up deliberately as a vehicle for removing [the more extensive] free NHS care”.<sup>126</sup> Thus although New Labour stated that it was committed to persistent values, including the NHS’ founding principles, its reforms reduced the comprehensiveness of the service, thereby extending the ambit of the exchange principle (indicative of the identity thinking mode of reification).

### Performance Management

Mark Exworthy et al contend that the ‘*NHS Plan*’ instigated performance management in the NHS, with performance not simply being measured, but actively managed.<sup>127</sup>

Gwyn Bevan and Christopher Hood described New Labour’s NHS management

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<sup>121</sup> Nunns, A. (2006) *The Patchwork Privatisation of our Health Service: A User’s Guide*. London: Keep Our NHS Public, p8.

<sup>122</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p20.

<sup>123</sup> Mandelstam, M. (2007) *Betraying the NHS*, op cit., n.120 at p216.

<sup>124</sup> Ibid at p212.

<sup>125</sup> Ibid at p219.

<sup>126</sup> Ibid at p211.

<sup>127</sup> Exworthy, M. et al (2010) *Decentralisation and Performance: Autonomy and Incentives in Local Health Economies*. Southampton: National Coordinating Centre for the Service Delivery and Organisation, p69.



regime as one “of targets and terror”.<sup>128</sup> New Labour installed numerous targets, such as reducing waits for outpatient and inpatient appointments<sup>129</sup> and ending long waits (over four hours) in accident and emergency (A&E).<sup>130</sup> A traffic light scheme (later renamed a star rating system) of earned autonomy was introduced.<sup>131</sup> Providers which performed well in relation to targets gained more autonomy. For example, after 2003, hospitals with three star ratings could apply to become Foundation Trusts (FTs), while many zero star hospitals (such as Good Hope Hospital in Birmingham) were franchised out.<sup>132</sup> As mentioned in chapter two, indicators are indicative of identity thinking and have been criticised for evincing a preference for superficial knowledge.<sup>133</sup> The reliability of the star rating system was questioned by the Health Committee, which noted the instability in its results.<sup>134</sup> The star rating system was ultimately abolished and replaced by a framework of national standards overseen by the Healthcare Commission.<sup>135</sup> In 2004, the quality and outcomes framework (QOF) for GP practices was introduced, with budgets being determined by performance.<sup>136</sup> Alan Maynard contended that although QOF cost over a billion pounds, there was no evidence of any resulting health gain.<sup>137</sup> Carwyn Langdown and Stephen Peckham note that evidence is limited, due to methodological quality, but suggests that QOF led

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<sup>128</sup> Bevan, G. and Hood, C., ‘Have Targets Improved Performance in the English NHS?’ *British Medical Journal* 2006; 332:419.

<sup>129</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p131.

<sup>130</sup> *Ibid* at p13.

<sup>131</sup> Paton, C. (2002) ‘Cheques and Checks: New Labour’s Record on the NHS’, op cit., n.62 at p129.

<sup>132</sup> Pollock, A. (2003) *Foundation Hospitals and the NHS Plan*. London: UNISON, p6.

<sup>133</sup> Merry, S. (2011) ‘Measuring the World: Indicators, Human Rights and Global Governance’. *Current Anthropology*, Vol.52(3), pp83-95 at p86.

<sup>134</sup> Health Committee (2003) *Foundation Trusts, Second Report, House of Commons Session 2002-03, Vol.1*. London: Stationery Office, p28.

<sup>135</sup> Gauld, R. (2009) *The New Health Policy*, op cit., n.40 at pp55-56.

<sup>136</sup> Greener, I. et al (2014) *Reforming Healthcare*, op cit., n.56 at p43.

<sup>137</sup> Maynard, A. (2009) ‘The Need for Scepticaemia’. *British Journal of Healthcare Management*, Vol.15(8), p414.

to improvements in health outcomes for some conditions, such as diabetes, although the results were mixed for others.<sup>138</sup>

Crisp states that targets were advantageous as some (such as cardiac targets) helped to save lives and England improved faster than devolved areas (which adopted targets after England).<sup>139</sup> However, Crisp conceded that there were too many targets, that some were badly conceived and designed<sup>140</sup> and that a vital target, infection control, was absent from the '*NHS Plan*'.<sup>141</sup> Patrick Diamond notes that targets augment the core executive's power by enabling it to increase pressure on departmental ministers.<sup>142</sup> Targets may also depoliticise healthcare by transferring responsibility to front line agencies.<sup>143</sup> If targets are not achieved, governments may attribute this to organisational failures. However, Diamond notes that where targets are missed, "responsibility quickly reattaches itself to ministers".<sup>144</sup> Similarly, Clarke argued that the public continued to view responsibility for service provision (and service failures) as located with government.<sup>145</sup> Rises in infections, such as methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile, within English hospitals, which some attributed to targets,<sup>146</sup> politicised healthcare provision. Some

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<sup>138</sup> Langdown, C. and Peckham, S. (2013) 'The use of Financial Incentives to help improve Health Outcomes: Is the Quality and Outcomes Framework Fit for Purpose? A Systematic Review'. *Journal of Public Health*, Vol.36(2), pp251-258 at pp254-256.

<sup>139</sup> Crisp, N. (2011) *24 hours to save the NHS*, op cit., n.36 at p65.

<sup>140</sup> Ibid.

<sup>141</sup> Ibid at p69.

<sup>142</sup> Diamond, P. (2015) 'New Labour, Politicisation and Depoliticisation: The Delivery Agenda in public services 1997-2007'. *British Politics*, Vol.10(4), pp429-453 at p447.

<sup>143</sup> Ibid at p446.

<sup>144</sup> Ibid.

<sup>145</sup> Clarke, J. (2004) 'Dissolving the Public Realm? The Logics and Limits of Neo-liberalism', op cit., n.47 at p38.

<sup>146</sup> BBC., 'Hospital superbug infections rise', 24 July 2006.

targets became ends in themselves, and led to gaming,<sup>147</sup> with negative consequences for patients. For example, Mandelstam noted that the four hour A&E target “often led to chaos and substandard care” in other hospital departments.<sup>148</sup> Research indicates that targets engendered a culture of performance, in which “clinical priorities were subsumed in the need to meet particular indicators”,<sup>149</sup> and blame, which discouraged co-operative working.<sup>150</sup>

In contrast to their Conservative predecessor’s avoidance of the term inequality, New Labour set itself the target of reducing health inequalities.<sup>151</sup> It commissioned the Acheson report into health inequalities, which recommended a multi-faceted approach, including reducing income inequalities.<sup>152</sup> However, as Katherine Smith et al note, New Labour sought to address poverty but not reduce key material inequalities.<sup>153</sup> Schemes such as Sure Start (centres offering families support) and Health Action Zones (HAZs) were adopted, extra resources were allocated to deprived areas and public service agreement (PSA) targets were set.<sup>154</sup> Although early analyses indicated that health inequalities continued to widen,<sup>155</sup> a study based on more recent data suggests that Labour’s strategies reduced geographical health

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<sup>147</sup> Exworthy, M. (2010) ‘The Performance Paradigm in the English NHS: Potentials, Pitfalls and Prospects’. *Eurohealth*, Vol.16(3), pp16-19 at p17.

<sup>148</sup> Mandelstam, M. (2011) *How we Treat the Sick*, op cit., n.108 at p231.

<sup>149</sup> Exworthy, M. et al (2010) *Decentralisation and Performance*, op cit., n.126 at p72.

<sup>150</sup> Greener, I. (2008) ‘Decision Making in a time of Significant Reform’. *Administration and Society*, Vol.40(2), pp194-210 at p208.

<sup>151</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p131.

<sup>152</sup> Smith, K. et al (2016) ‘Background and Introduction’ in Smith, K. et al (eds)., *Health Inequalities: Critical Perspectives*. Oxford: Oxford University Press, pp1-21 at p13.

<sup>153</sup> *Ibid* at p15.

<sup>154</sup> Vizard, P. and Obolenskaya, P. (2013) *Labour’s Record on health (1997-2010) Working Paper 2*. London: London School of Economics, p95.

<sup>155</sup> See Health Committee (2009) *Health Inequalities, Third Report, House of Commons Session 2008-09, Vol.1*. London: Stationery Office, p5.

inequalities in life expectancy.<sup>156</sup> However, despite the correlation of “health inequalities with income inequality”,<sup>157</sup> the latter became a non-issue for New Labour.<sup>158</sup> Ultimately, addressing wealth inequalities would be necessary to tackle health inequalities.

Kevin Morell states that the notion that patients have a moral duty to take responsibility for their own health was another normative element within New Labour’s health policy literature.<sup>159</sup> For example, ‘*Tackling Health Inequalities*’ stated that individuals “have to be responsible for their own health...by making appropriate and informed lifestyle choices”.<sup>160</sup> Jennie Popay and Gareth Williams state that New Labour’s early interest in socio-economic determinants regressed to an emphasis on behaviour change “no less focused on personal responsibility than the policies of the Thatcher years”.<sup>161</sup> Although New Labour did not completely abrogate its responsibilities in promoting healthier lifestyles (for example, it adopted public health measures, such as a smoking ban in public places<sup>162</sup>) it failed to tackle income and wealth inequalities. New Labour’s moral rhetoric (designed to depoliticise health by portraying it as each individual’s responsibility), together with its attempts to interpellate patients as consumers, increasingly individualised health with the result that disease may become reified, its

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<sup>156</sup> Barr, B. et al, ‘Investigating the impact of the English health inequalities strategy: time trend analysis’. *British Medical Journal* 2017; 358:J3310.

<sup>157</sup> Paton, C. (1999) ‘New Labour’s Healthcare Policy’, op cit., n.61 at pp68-69.

<sup>158</sup> Mullard, M. and Swaray, R. (2008) ‘New Labour and Public Expenditure’ in Beech, M. and Lee, S. (eds) *Ten Years of New Labour*. Basingstoke: Palgrave, pp35-49 at p49.

<sup>159</sup> Morrell, K. (2006) ‘Policy as Narrative: New Labour’s Reform of the National Health Service’. *Public Administration*, Vol.84(2), pp367-385 at p381.

<sup>160</sup> Department of Health (DOH) (2003) *Tackling Health Inequalities: A Programme for Action*. London: DOH, p45.

<sup>161</sup> Popay, J. and Williams, G. (2009) ‘Equalizing the people’s health: A Sociological Perspective’ in Gabe, J. and Calnan, M. (eds) *The New Sociology of the Health Service*. Abingdon: Routledge, pp222-245 at p235.

<sup>162</sup> Health Act (2006), S.2.

social causes neglected and support for a universal and comprehensive system undermined. Distinguishing between responsible and irresponsible patients is indicative of the differentiation strategy of the ideological mode of fragmentation. It is often argued that patients deemed to have been irresponsible, such as the obese, should be denied NHS treatment.<sup>163</sup> Such arguments ignore the social causes of obesity. Ted Schrecker and Clare Bambra contend that obesity, rates of which have doubled in the UK in the neo-liberal era,<sup>164</sup> is, along with stress, austerity and inequality, a neo-liberal epidemic.<sup>165</sup> Deborah Prainsack and Alena Buyx note that references to lifestyle and personal responsibility are an “arbitrary choice among a myriad of risks that affect health” and flawed tools for priority setting.<sup>166</sup> Although New Labour’s discourse focused on personal responsibility, Clarke et al’s qualitative research indicated that the idea that autonomy and independence necessitated responsibility had not “effectively colonised common sense” as respondents kept alive complex discourses about inequalities and the challenges that they posed for public services.<sup>167</sup>

## Private Sector

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<sup>163</sup> See, for example, Platell, A., ‘Sorry, why should the NHS treat people for being fat’. *Daily Mail*, 27 February 2009.

<sup>164</sup> Schrecker, T. and Bambra, C. (2015) *How Politics Makes us Sick: Neo-liberal Epidemics*. Basingstoke: Palgrave, p23.

<sup>165</sup> Ibid at pviii.

<sup>166</sup> Prainsack, B. and Buyx, A. (2015) ‘Ethics of Healthcare Policy and the Concept of Solidarity’ in Kuhlmann, E. et al (eds) *The Palgrave International Handbook of Healthcare Policy and Governance*. Basingstoke: Palgrave Macmillan, pp649-664 at p661.

<sup>167</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers: Changing Publics and Changing Public Services*. London: Sage, pp83-84.

Hall stated that “nothing-however good or necessary” was allowed to happen under New Labour without “another dose of reform”.<sup>168</sup> The ‘*NHS Plan*’, stated that increased NHS investment “had to be accompanied by increased reform”,<sup>169</sup> provoking anger among socialists and social democrats within the Labour party.<sup>170</sup> In Labour’s first term, Blair wrote that “creating the NHS was the greatest act of modernisation ever achieved by a Labour government”.<sup>171</sup> However, the meanings of terms, such as ‘reform’ and ‘modernisation’, shifted in New Labour’s discourse to mean marketization and privatisation.<sup>172</sup> Fairclough avers that the term modernisation presents “highly contentious changes...as if they were purely technical and value-free updatings”.<sup>173</sup> The use of such terms was thus indicative of the euphemization strategy of the ideological mode of dissimulation.<sup>174</sup> The plan stated that both the private and voluntary sectors had “a role to play in ensuring that NHS patients get the full benefit from” extra investment.<sup>175</sup>

The narrative<sup>176</sup> justifying such reforms, in New Labour’s policy documents, was that society had changed<sup>177</sup> and that the NHS was outmoded and also needed to change.<sup>178</sup> Such change was presented as a self-evident necessity,<sup>179</sup> and a moral

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<sup>168</sup> Hall, S. (2005) ‘New Labour’s Double Shuffle’, op cit., n.41 at p331.

<sup>169</sup> Blair, T., ‘Foreword’ in Department of Health (2000) *NHS Plan. A Plan for Investment. A Plan for Reform*. London: HMSO, pp8-10 at p9.

<sup>170</sup> Ludlam, S. (2004) ‘Second Term New Labour’, op cit., n.4 at p3.

<sup>171</sup> Blair, T., ‘Foreword’ in Department of Health (DOH) (1997) *The New NHS, Modern Dependable*. London: DOH, pp2-3 at p2.

<sup>172</sup> Hall, S. (2005) ‘New Labour’s Double Shuffle’, op cit., n.41 at p331.

<sup>173</sup> Fairclough, N. (2000) *New Labour, New Language*, op cit., n.4 at p40.

<sup>174</sup> Thompson, J. (2007) *Ideology and Modern Culture*. Cambridge: Polity Press, p60.

<sup>175</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p96.

<sup>176</sup> Narrativization is a strategy of the legitimation mode of ideology. See Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.174 at p60.

<sup>177</sup> Prior, L. et al (2012) ‘The Discursive Turn in Policy Analysis and the Validation of Policy Stories’. *Journal of Social Policy*, Vol.41(2), pp271-289 at p285.

<sup>178</sup> Ibid at p276.

<sup>179</sup> Morrell, K. (2006) ‘Policy as Narrative’, op cit., n.159 at p379.

duty, as it was required to ensure that money was spent wisely.<sup>180</sup> According to the ‘*NHS Plan*’, the NHS was “too much the product of the era in which it was born” in respect of “its buildings, its ways of working, [and] its very culture”, in contrast to “the rest of society [which] has moved on”.<sup>181</sup> The plan noted that banks afforded customers twenty-four hour access to services in 2000 (compared to being open between 10am and 3pm in 1948), that society was more multicultural and diverse and that women constituted nearly half of the workforce (compared to a third in 1948).<sup>182</sup> The facts that NHS opening hours had never been restricted and that women and ethnic minorities were highly represented in the healthcare sector,<sup>183</sup> were ignored. The average age of NHS buildings was older than the NHS itself in 1997, but by 2005 less than a quarter of its buildings were that old.<sup>184</sup> The plan recognised the problems identified by the emerging consciousness (mentioned in chapter one) that “in 1948, deference and hierarchy defined the relationships between citizens and services”.<sup>185</sup> The plan proposed to alter the mechanisms for patient and public involvement, but New Labour began to prioritise choice (as opposed to voice) to empower patients.

The plan sought to naturalise<sup>186</sup> the relationship between patients and the NHS as one between consumers and a service. It emphasised that “we live in a consumer age” and that “today, successful services thrive on their ability to respond to the individual

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<sup>180</sup> Ibid at pp380-381.

<sup>181</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p26

<sup>182</sup> Ibid.

<sup>183</sup> Yar, M., Dix, D. and Bajekal, M. (2006) ‘Socio-Demographic Characteristics of the healthcare workforce in England and Wales- results from the 2001 census’. *Health Statistics Quarterly*, N.32, pp44-56 at p48 and p54.

<sup>184</sup> Kings Fund (2005) *An Independent Audit of the NHS under Labour (1997-2005)*, op cit., n.117 at p4.

<sup>185</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p26.

<sup>186</sup> A strategy of the reification mode of ideology. See Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.174 at p60.

needs of their customers”.<sup>187</sup> According to the plan, in the “era of mass production, needs were regarded as identical and preferences were ignored”.<sup>188</sup> The NHS had “been too slow”, the plan stated, “to change its ways of working to meet modern patient expectations for fast, convenient, twenty-four hour, personalised care”.<sup>189</sup> Clarke and Newman aver that New Labour’s discourse concerning modernisation attempted to “close off possible alternative forms of ‘being modern’” and “to enforce one configuration as the sole imaginable and desirable way of ‘living in the modern world’”.<sup>190</sup> Hall argued that the public sector was viewed as “inefficient and out of date, partly because it has social objectives beyond economic objectives and value for money”.<sup>191</sup> The plan implied that there was no alternative within public services to the consumerism prevalent elsewhere within capitalist society. Consumerism is indicative of identity thinking, and of the standardization strategy of the ideological mode of unification, as it homogenises people, thereby neglecting differences which may affect their ability to make choices.

The ‘*NHS Plan*’ repudiated Labour’s traditional hostility to private providers<sup>192</sup> and reneged on its 1997 manifesto commitment opposing the private provision of clinical services.<sup>193</sup> It proclaimed that a concordat (a non-legally binding agreement) would be agreed between the government and the Independent Healthcare Association

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<sup>187</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p26.

<sup>188</sup> Ibid.

<sup>189</sup> Ibid.

<sup>190</sup> Clarke, J. and Newman, J. (2004) ‘Governing in the Modern World’ in Steinberg, D and Johnson, R. (eds) *Blairism and the War of Persuasion: Labour’s Passive Revolution*. London: Lawrence and Wishart, pp53-65 at p63.

<sup>191</sup> Hall, S. (2005) ‘New Labour’s Double Shuffle’, op cit., n.41 at p324.

<sup>192</sup> Klein, R. (2007) ‘The New Model NHS: Performance, Perceptions and Expectations’. *British Medical Bulletin*, Vol.81-82 at pp39-50 at p42.

<sup>193</sup> Shaw, E. (2007) *Losing Labour’s Soul?*, op cit., n.29 at p108.



(IHA).<sup>194</sup> The government stated that the concordat would enable “the NHS to make better use of facilities in private hospitals-where this provides value for money and maintains standards of patient care”.<sup>195</sup> Tim Evans (lead negotiator of the IHA) believed that the concordat would ultimately lead to “a time when the NHS would simply be a kitemark attached to the institutions and activities of a system of purely private providers”.<sup>196</sup> Blair had met Evans on the BBC programme ‘*Newsnight*’, in February 2000, and was convinced by him that the private sector could provide additional capacity to help solve perennial winter crises.<sup>197</sup> Christoph Hermann notes that public concern with waiting lists was used to break the taboo on private companies providing NHS clinical care.<sup>198</sup> A circular which Frank Dobson (Secretary of State for Health between 1997 and 1999) had sent to hospital trusts making them wary about using private hospital beds was repealed and talks at Downing Street resulted in the concordat.<sup>199</sup>

In addition to Evans, there were various other private sector influences on New Labour’s NHS policies. As mentioned in chapter two, I posit that there is a micro-ideology of private healthcare companies, proponents of which advocate increased opportunities for such companies, which is in their material interests. Virgin compiled a report for the Department of Health, in 2000, which recommended improving customer service by establishing polyclinics and “a number of specialist hospitals

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<sup>194</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p12.

<sup>195</sup> Ibid.

<sup>196</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*, op cit., n.85 at p1.

<sup>197</sup> Pollock, A., ‘What Sicko doesn’t tell you...’. *Guardian*, 24 September 2007.

<sup>198</sup> Hermann, C. (2009) ‘The Marketization of Healthcare in Europe’ in Panitch, L. and Leys, C. (eds) *Morbid Symptoms: Health Under Capitalism*. London: Merlin, pp125-144 at p134.

<sup>199</sup> Hencke, D. (2000) ‘Chance chat over dinner led Blair to order u-turn on private beds’. *Guardian*, 28 July 2000. NB: Certain claims in this article were corrected the following day. See *Guardian*, ‘Corrections and Clarifications’, 29 September 2007.

concentrating solely on elective surgery”.<sup>200</sup> Virgin suggested that “private hospitals could be utilised for part of this work”.<sup>201</sup> It seems that Virgin used the report as an opportunity to recommend the expansion of openings for the private sector within the NHS, which it later exploited (Virgin took over several polyclinics in 2010<sup>202</sup>). Ian Smith, Chief Executive of General Healthcare Group (GHG) between 2004 and 2006, claims that he “had a role in shaping the healthcare reforms” of Blair’s government.<sup>203</sup> Smith advocated the dismantling of the “NHS monopoly”.<sup>204</sup> Blair stated that, following talks with the agents of independent providers, he “chafed increasingly at the restrictions placed in” their way.<sup>205</sup> Blair stated that “for public services to be equitable, and free at the point of use, they did not all need to be provided on a monopoly basis within the public sector”.<sup>206</sup> However, as Pollock et al noted, research in the United States (US) and Australia indicated that for-profit status adversely effects cost, quality and efficiency.<sup>207</sup> Pollock et al stated that government claims that it is quality, not the provider, that matters, has a simple logic to it, discouraging scrutiny and debate.<sup>208</sup>

New Labour’s health policy was also influenced by special advisers, such as Stevens and Julian Le Grand,<sup>209</sup> who were given an increased role due to the expansion of the

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<sup>200</sup> Virgin (2000) ‘Customer Service in the NHS’. [On-line] Available: [https://www.whatdotheyknow.com/request/virgin\\_atlantic\\_report\\_on\\_the\\_nh](https://www.whatdotheyknow.com/request/virgin_atlantic_report_on_the_nh) [Accessed: 11 November 2015], p11.

<sup>201</sup> Ibid.

<sup>202</sup> Robertson, A. (2013) ‘What was the real purpose of Virgin’s mysterious report into NHS customer service’. [On-line] Available: <http://www.opendemocracy.net/ournhs/andrew-robertson/what-was-real-purpose-of-virgins-mysterious-report-into-nhs-customer-service> [Accessed: 24 January 2014].

<sup>203</sup> Terra Firma., ‘Operating Partners’. [On-line] Available: <https://www.terrafirma.com/ian-smith.html> [Accessed: 23 August 2016].

<sup>204</sup> Smith, I. (2007) *Building a World-Class NHS*. Basingstoke: Palgrave, p4.

<sup>205</sup> Blair, T. (2010) *A Journey*, op cit., n.105 at p212.

<sup>206</sup> Ibid.

<sup>207</sup> Pollock, A. et al (2001) *Public Services and the Private Sector*, op cit., n.81 at p7.

<sup>208</sup> Ibid at p40.

<sup>209</sup> Hunter, D. (2016) *The Health Debate: 2nd edition*. Bristol: Policy Press, p113.

Number Ten Policy Unit under Blair's premiership.<sup>210</sup> In addition, New Labour was influenced by an article, by Richard Feacham et al, comparing a Californian Health Maintenance Organisation (HMO),<sup>211</sup> Kaiser Permanente, with the NHS.<sup>212</sup> This was cited in both Wanless' review and '*Delivering the NHS Plan*'.<sup>213</sup> Feacham et al asserted that the benefits of competition and choice meant that Kaiser outperformed the NHS in many respects, such as access to specialist diagnosis and treatment and hospital waiting times.<sup>214</sup> Feacham et al stated that the belief that the NHS was efficient and that poor performance in certain areas was largely explained by underinvestment, was incorrect.<sup>215</sup> However, Alison Talbot-Smith et al argue that Feacham et al overlooked numerous differences between Kaiser Permanente and the NHS (such as the populations served by each and the co-payments of Kaiser's patients) leading to methodological errors favouring the former.<sup>216</sup>

The '*NHS Plan*' stated that there had been an "uneasy truce"<sup>217</sup> and a "stand-off"<sup>218</sup> between the NHS and the private sector since 1948. It stated that "ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients" and that the NHS should therefore "engage more constructively with the

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<sup>210</sup> Richards, D. and Smith, M. (2004) 'The 'Hybrid State': Labour's Response to the Challenge of Governance' in Ludlam, S. and Smith, M. (eds) *Governing as New Labour: Policy and Politics under Blair*. Basingstoke: Palgrave, pp106-125 at p112.

<sup>211</sup> Introduced by the Health Maintenance Organisation Act (1973) to arrange health care for an insurance premium.

<sup>212</sup> Feacham, R., et al., 'Getting more for their dollar: A Comparison of the NHS with California's Kaiser Permanente'. *British Medical Journal* 2002; 324:135.

<sup>213</sup> Talbot Smith, A., et al (2004) 'Questioning the claims from Kaiser'. *British Journal of General Practice*, Vol.64 (503), pp415-421 at p415/Wanless, D. (2002) *Securing our Future Health*, op cit., n.38 at p109/Department of Health (2002) *Delivering the NHS Plan. Next Steps on Investment, Next Steps on Reform*. London: Stationery Office, p26.

<sup>214</sup> Feacham, R., et al (2002) 'Getting more for their dollar', op cit., n.212.

<sup>215</sup> Ibid.

<sup>216</sup> Talbot Smith, A., et al (2004) 'Questioning the claims from Kaiser', op cit., n.213 at p419.

<sup>217</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p29.

<sup>218</sup> Ibid at p96.

private sector”.<sup>219</sup> The use of military metaphors (“truce” and “stand-off”) and the concept of ideology, to connote left-wing dogma, implied that there was a self-defeating pugnacious attitude towards the private sector and that there were no legitimate grounds for scepticism regarding its role and effect. Dobson’s circular had deterred hospital trusts from using private hospital beds,<sup>220</sup> but the idea of a “stand-off” was misleading, because, as Stephen Driver noted, “the private sector had been informally working with the NHS for many years”.<sup>221</sup> The plan ignored some unconstructive private sector practices, such as its use of the NHS to indemnify itself against a calculable risk, namely medical complications requiring intensive care.<sup>222</sup> The Health Committee recommended that the NHS be compensated for the intensive care provided,<sup>223</sup> but no change was enacted. The areas earmarked for co-operative working were elective, critical and intermediate care.<sup>224</sup>

The government used the subject position of the taxpayer and the notion of value for money, within the concordat (which stated that the relationship between the NHS, and private and voluntary providers “must represent good value for money for the taxpayer”<sup>225</sup>), to suggest that the agreement would be in everyone’s interests (indicative of the universalization strategy of the legitimization mode of ideology<sup>226</sup>). The Health Committee determined that New Labour’s focus was initially on improving

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<sup>219</sup> Ibid.

<sup>220</sup> Hencke, D. (2000) ‘Chance chat over dinner led Blair to order u-turn on private beds’, op cit., n.199.

<sup>221</sup> Driver, S. (2008) ‘New Labour and Social Policy’, op cit., n.51 at p59.

<sup>222</sup> Health Committee (1999) *The Regulation of Private and Other Independent Healthcare, Fifth Report, House of Commons Session 1998-99, Vol.I*. London: Stationery Office, para. 132.

<sup>223</sup> Ibid.

<sup>224</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p97.

<sup>225</sup> Department of Health (DOH) (2000) *For the Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector*. London: DOH, para.1.2.

<sup>226</sup> Thompson, J. (2007) *Ideology and Modern Culture*, op cit., n.174 at p60.

access and that quality was prioritised following a national review in 2007.<sup>227</sup> Nonetheless, quality was alluded to in New Labour's discourse before 2007, which contained the assumption that private sector involvement would necessarily deliver value for money and high standards.<sup>228</sup> However, Dobson argued that the NHS was more efficient than the private sector<sup>229</sup> and the Health Committee's first report into private and voluntary healthcare, in 1999, highlighted additional clinical risks in the private sector.<sup>230</sup> Lister described the notion of superior quality in the private sector as a "bizarre and baseless ideological conviction".<sup>231</sup> According to Pollock et al, the concordat "was largely a dead letter" by the end of 2003 as the prices demanded by the private sector "proved so much higher than the cost of equivalent services provided by the NHS that the government could not defend accepting them".<sup>232</sup> Nonetheless, the private sector was afforded increased opportunities through the creation of ISTCs.

### Independent Sector Treatment Centres

According to Crisp, it became clear that the top-down management envisaged by the 'NHS Plan' "wouldn't work by itself at sufficient scale and with sufficient

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<sup>227</sup> Health Committee (2009) *NHS Next Stage Review, First Report House of Commons Session 2008-09, Vol.1*. London: Stationery Office, p3.

<sup>228</sup> Law, A. and Mooney, G. (2007) 'Strenuous Welfarism: Restructuring the welfare labour process' in Mooney, G. and Law, A. (eds) *New Labour/Hard Labour: Restructuring and Resistance inside the Welfare Industry*. Bristol: Polity Press, pp23-52 at p35.

<sup>229</sup> Dobson, F. (1999) 'A Modernised NHS' in Kelly, G. (ed) *Is New Labour Working?* London: Fabian Society, pp15-18 at p17.

<sup>230</sup> Health Committee (1999) *The Regulation of Private and Other Independent Healthcare*, op cit., n.222 at para.41.

<sup>231</sup> Lister, J. (2008) *The NHS After 60*, op cit., n.10 at p176.

<sup>232</sup> Pollock, A. et al (2005) *NHS PLC: The Privatisation of our Healthcare*. London: Verso, p72.

sustainability”.<sup>233</sup> Consequently, in April 2002, ‘*Delivering the NHS Plan*’ announced a wider reform programme.<sup>234</sup> Martin Powell et al note that whereas the ‘*NHS Plan*’ focused on giving patients more choice, ‘*Delivering the NHS Plan*’ promoted both choice and diversity.<sup>235</sup> In June 2002, the Department of Health stated that an increase in NHS activity would partly be achieved by “increasing productivity and by investment in existing NHS providers” but that “additional high quality, cost-effective health care capacity” was needed to reduce waiting times.<sup>236</sup> The Department stated that the objective was therefore “to shift towards greater plurality and diversity” in delivering elective surgery services.<sup>237</sup> The extra NHS investment was regarded as an opportunity “to bring new entrants...into the healthcare market without necessarily reducing budgets for existing providers”.<sup>238</sup> The hedge “necessarily” indicates that the Department was aware that more money for private providers would mean that less was available for NHS providers. Subsequently, the Department stated that a national capacity planning exercise indicated that additional capacity was required beyond the increased capacity planned by existing NHS providers, demonstrating the need “for a more ambitious role for the independent sector”.<sup>239</sup> The government therefore announced a procurement process for new ISTCs with the objectives that they “deliver value for money” and be “efficient, effective and fast”.<sup>240</sup>

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<sup>233</sup> Crisp, N. (2011) *24 hours to save the NHS*, op cit., n.36 at p49.

<sup>234</sup> Ibid.

<sup>235</sup> Powell, M. et al (2011) *Comparative Case Studies of Health Reform in England: Report Submitted to the Department of Health Policy Research Programme (PRP)*. London: Department of Health, pp48-49/ Department of Health (2002) *Delivering the NHS Plan*, op cit., n.213 at p3.

<sup>236</sup> Department of Health (DOH) (2002) *Growing Capacity: A New Role for External Healthcare Providers in England*. London: DOH, p2.

<sup>237</sup> Ibid.

<sup>238</sup> Ibid at p4.

<sup>239</sup> Department of Health (DOH) (2002) *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*. London: DOH, p4.

<sup>240</sup> Ibid at p5.

An *ISTC Manual* stated that ISTCs would “complement existing NHS services”.<sup>241</sup> A policy of additionality was adopted to prevent “a draining of NHS human resource capacity”,<sup>242</sup> although NHS staff could be seconded to work for some ISTCs.<sup>243</sup> In the second wave of ISTCs, the additionality policy only applied to shortage professions.<sup>244</sup> The first wave of the ISTC programme involved the creation of twenty-five centres (with Ramsay running nine and Care UK running five).<sup>245</sup> The second wave (announced in 2005, before an evaluation of the first wave) involved the creation of ten centres.<sup>246</sup> Although payments to ISTCs were based on the relevant national tariff, an additional provider specific premium was given to providers to encourage entry into the market.<sup>247</sup> Consequently, on average, providers received payments that were 11.2 percent greater than the NHS equivalent cost.<sup>248</sup> ISTC providers were afforded generous five year contracts with guaranteed numbers of patients, in contrast to NHS trusts, which were destabilised by payment by results (PBR), which is examined in chapter four, which engendered uncertainty about patient numbers.<sup>249</sup> The NHS agreed to buy ISTC buildings once contracts ended, if they were not renewed.<sup>250</sup>

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<sup>241</sup> Department of Health (DOH) (2005) *ISTC Manual*. London: DOH, p21.

<sup>242</sup> *Ibid* at p22.

<sup>243</sup> *Ibid* at p58.

<sup>244</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal: The NHS and Independent Sector Treatment Centres*. Monmouth: Merlin, p18.

<sup>245</sup> Department of Health (2010) ‘ISTC Wave 1 Contractual Information (as at 31 December 2009)’.

[On-line] Available:

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_114981.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114981.pdf) [Accessed: 02 November 2015].

<sup>246</sup> Department of Health (2010) ‘ISTC Phase 2 Contractual Information (as at 31 December 2009)’.

[On-line] Available:

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_114982.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_114982.pdf) [Accessed: 02 November 2015].

<sup>247</sup> Naylor, C. and Gregory, S. (2009) *Briefing October 2009 Independent Sector Treatment Centres*. London: Kings Fund, p3.

<sup>248</sup> *Ibid*.

<sup>249</sup> Davis, J., et al (2015) *NHS For Sale: Myths, Lies & Deception*. London: Merlin Press, p58.

<sup>250</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal*, op cit., n.244 at p56.

Player notes that PCTs were incentivised to ensure that patients chose ISTCs to stop them paying for services twice,<sup>251</sup> undermining the policy of patient choice (examined in chapter four).<sup>252</sup> Some PCTs offered GPs a financial payment for every patient they referred successfully to an ISTC. For example, Tameside and Glossop PCT offered £130.00 per patient.<sup>253</sup> Lister states that it was “clear that the private sector would concentrate on the most profitable and simple cases...leaving the NHS with an increasingly expensive caseload”.<sup>254</sup> Jacky Davis et al argue that there is much anecdotal evidence that ISTCs refused to treat unprofitable patients, such as the elderly and obese.<sup>255</sup> Rosemary Mason et al state that national data suggested that NHS organisations were treating a more complex case mix than their private sector counterparts.<sup>256</sup> Consequently, NHS hospitals were left with a residual case mix of more complex patients unsuitable for junior training.<sup>257</sup> Simon Turner et al argued that the effect of cherry-picking would be the displacement of profitable aspects of care to private companies “undermining how NHS trusts currently finance a more universal system of care”.<sup>258</sup> In this respect, the Royal College of Ophthalmologists warned, in

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<sup>251</sup> Player, S. (2008) ‘Darzi and Co: Corporate Capture in the NHS’. *Soundings*, N.40, pp29-41 at p31.

<sup>252</sup> Mason, A. et al (2010) ‘Private Sector Treatment Centres are treating less complex patients than the NHS’. *Journal of the Royal Society of Medicine*, Vol.103(8), pp322-331 at p331.

<sup>253</sup> *Ibid* at p32.

<sup>254</sup> Lister, J. (2008) *The NHS After 60*, op cit., n.10 at p230.

<sup>255</sup> Davis, J. et al (2015) *NHS For Sale*, op cit., n.249 at p165.

<sup>256</sup> Mason, A. et al (2010) ‘Private Sector Treatment Centres are treating less complex patients than the NHS’, op cit., n.252 at p328.

<sup>257</sup> Barsam, A. et al (2008) ‘A Retrospective Analysis to determine the effect of Independent Treatment Centres on the Case Mix for Microsurgical Training’. *Eye*, Vol. 22(5), pp687-690 at p688.

<sup>258</sup> Turner, S. et al (2011) ‘Innovation and the English National Health Service: A Qualitative Study of the Independent Sector Treatment Centre Programme’. *Social Science and Medicine*, Vol.73(4), pp522-529 at p528.



2006, that the diversion of funds away from NHS hospital eye services to ISTCs was threatening the provision of comprehensive ophthalmic care.<sup>259</sup>

The government narrativized ISTCs as a “significant part” of the waiting list reductions which had occurred by 2005.<sup>260</sup> However, the Health Committee (which investigated ISTCs in 2006) stated that it was “unclear” whether ISTCs had contributed, or whether “additional NHS spending and the intense focus placed on waiting list targets” were responsible.<sup>261</sup> The government rationalized that ISTCs were necessary to increase capacity. However, the Health Committee concluded that ISTCs had “not made a major direct contribution to increasing capacity”.<sup>262</sup> In addition, the Committee stated that it was not obvious that phase one ISTCs were required in every area in which they were built.<sup>263</sup> Jane Hanna (a former non-executive board member of South West Oxfordshire PCT) stated that non-executive board members had had their positions threatened unless they reversed their decision that an ISTC was not needed.<sup>264</sup> The Committee was also informed that a number of ISTCs were operating significantly below capacity and, according to NHS Elect (a network organisation), the ISTC programme led to an underutilisation of NHS treatment centres.<sup>265</sup> The Department of Health sought to portray ISTCs as being in everyone’s interests by claiming that they

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<sup>259</sup> Pollock, A., ‘NHS Privatisation keeps on failing patients- despite a decade of warnings’, *Guardian*, 15 August 2014.

<sup>260</sup> Department of Health (DOH) (2005) *Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients*. London: DOH, p7.

<sup>261</sup> Health Committee (2006) *Independent Sector Treatment Centres, Fourth Report, House of Commons Session 2005-06, Vol.I*. London: Stationery Office, p4.

<sup>262</sup> *Ibid* at p3.

<sup>263</sup> *Ibid* at p19.

<sup>264</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal*, op cit., n.244 at pp49-50/Health Committee (2006) *Independent Sector Treatment Centres, Fourth Report, House of Commons Session 2005-06, Vol. III*. London: Stationery Office, Ev.58-60.

<sup>265</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.I*, op cit., n.261 at p18.

“drive the adoption of good practice and innovation in the NHS”.<sup>266</sup> However, the Committee determined that it had “received no convincing evidence...that NHS facilities are adopting in any systematic way techniques pioneered in ISTCs”.<sup>267</sup> The private sector had thus been extolled without evidence.

The Health Committee noted that ISTCs had reduced the spot purchase price in the private sector and increased patient choice, but that “without information relating to clinical quality, patients” were “not offered an informed choice”.<sup>268</sup> The Healthcare Commission’s ISTC report, in 2007, noted that information about them was of poor quality and incomplete.<sup>269</sup> A follow up report, in 2008, noted that although there had been improvements in the quality of the data supplied by ISTCs, it remained insufficient for a comparative analysis with NHS providers.<sup>270</sup> There have been both favourable and unfavourable assessments of ISTC quality. It was reported that there were high revision rates in ISTCs compared to the NHS.<sup>271</sup> A special edition of the BBC’s ‘*Panorama*’ programme, in 2009, investigated the death of Dr John Hubley, from multiple organ failure, at an ISTC (Eccleshill Treatment Centre in Bradford) resulting from a delayed blood transfusion (as there was no blood on site, a porter had to acquire it from a nearby NHS hospital).<sup>272</sup> This indicated that such facilities were

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<sup>266</sup> Ibid at p3.

<sup>267</sup> Ibid.

<sup>268</sup> Ibid.

<sup>269</sup> Healthcare Commission (2007) *Independent Sector Treatment Centres: A Review of the Quality of Care*. London: Healthcare Commission, p8.

<sup>270</sup> Healthcare Commission (2008) *Independent Sector Treatment Centres: The Evidence So Far*. London: Healthcare Commission, p5.

<sup>271</sup> Boseley, S., ‘NHS Forced to Fix bungled private sector hip replacement operations’. *Guardian*, 10 March 2006.

<sup>272</sup> BBC., ‘John Hubley’s Faith in the NHS’. 30 September 2009.

not as adequately resourced as NHS facilities.<sup>273</sup> In 2013, the NHS paid Clinicenta (part of Carillion) £53 million to end a contract to run an ISTC in Stevenage after various clinical failings and the deaths of three patients following routine surgery.<sup>274</sup>

John Browne et al's pilot study found that, after adjusting for pre-operative characteristics, patients who underwent cataract surgery or hip replacement in ISTCs achieved a slightly greater improvement in functional status and quality of life (the opposite was true of patients undergoing hernia repair) than NHS patients.<sup>275</sup> In addition, patients treated in ISTCs were less likely to report post-operative problems for cataract surgery, hernia repair and knee replacement.<sup>276</sup> Following on from the pilot study, Jiri Chard et al found that patients who underwent hip or knee replacements in ISTCs had better outcomes than NHS patients in terms of severity of symptoms, health related quality of life and postoperative complications.<sup>277</sup> However, Chard et al stated that the differences "were small, their clinical relevance is slight and...could be attributable to differences in case mix that were not fully taken into account".<sup>278</sup> The Browne study has been cited as evidence that quality of care in ISTCs "is at least as good as",<sup>279</sup> "if not better" than,<sup>280</sup> the NHS. However, such conclusions did not

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<sup>273</sup> Sayers, K. (2009) 'Independent Sector Treatment Centres...Mickey Mouse?' *Journal of Perioperative Practice*, Vol.19(12), p416.

<sup>274</sup> Molloy, C. (2013) 'Paying for private failure in England's NHS again'. [On-line] Available: <https://www.opendemocracy.net/ournhs/caroline-molloy/paying-for-private-failure-in-englands-nhs-again> [Accessed: 08 March 2017].

<sup>275</sup> Browne, J. et al (2008) 'Case-mix & Patients reports of outcome in Independent Sector Treatment Centres: Comparison with NHS Providers'. *BMC Health Services Research*, Vol.8(78).

<sup>276</sup> Ibid.

<sup>277</sup> Chard, J. et al., 'Outcomes of Elective Surgery Undertaken in Independent Sector Treatment Centres and NHS providers in England: Audit of Patient Outcomes in Surgery'. *British Medical Journal* 2011;343:d6404.

<sup>278</sup> Ibid.

<sup>279</sup> Allen, P. and Jones, L. (2011) 'Diversity of Healthcare Providers' in Mays, N. et al *Understanding New Labour's Market Reforms of the English NHS*. London: Kings Fund, pp16-29 at p22.

<sup>280</sup> Brereton, L. and Vasoodeven, V. (2010) *The Impact of the NHS Market: An Overview of the Literature*. London: Civitas, p9.

consider Chard et al's subsequent study, and its proviso, or the other literature (cited above). Although there is ambiguity, in some instances quality in ISTCs may have been slightly better than in the NHS, whereas in others it was much worse (as indicated by Dr Hubley's death and the high revision rates). In addition, ISTCs did not perform as well as the NHS on the efficiency (examined below) and equity (as they appear to have refused to treat unprofitable patients) components of quality, identified by Avedis Donabedian.<sup>281</sup>

The Health Committee had stated, in 2002, that "it remains to be demonstrated that greater use of the independent sector poses no direct threat to resources in the public sector".<sup>282</sup> The Committee's ISTC report noted that the Department of Health had analysed the potential effect of ISTCs on NHS facilities but had failed to disclose the results.<sup>283</sup> Both UNISON<sup>284</sup> and the BMA<sup>285</sup> expressed concerns about the redistribution of resources from the NHS to ISTCs. The Committee stated that evidence regarding the threat of competition from ISTCs on the NHS was "largely anecdotal"<sup>286</sup> and expressed surprise that the Department of Health had not attempted to systematically "assess and quantify the effect of competition from ISTCs on the NHS".<sup>287</sup> The Committee recommended that the National Audit Office evaluate this,

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<sup>281</sup> Donabedian, A. (2003) *An Introduction to Quality Assurance in Health Care*. Oxford: Oxford University Press, p6.

<sup>282</sup> Health Committee (2002) *The Role of the Private Sector in the NHS, First Report, House of Commons Session 2001-02, Vol.I*. London: Stationery Office, para. 17.

<sup>283</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.I*, op cit., n.261 at p4.

<sup>284</sup> Health Committee (2006) *Independent Sector Treatment Centres, Fourth Report, House of Commons Session 2005-06, Vol.II*. London: Stationery Office, Ev.146.

<sup>285</sup> *Ibid* at Ev. 55.

<sup>286</sup> *Ibid*.

<sup>287</sup> *Ibid*.

but this was not heeded.<sup>288</sup> The Committee noted that there was “considerable scepticism about whether the ISTC programme represented value for money” (for example, both UNISON<sup>289</sup> and RCN<sup>290</sup> doubted this) but “found it difficult to make an assessment” as the Department did not provide it with detailed figures on the grounds of commercial confidentiality.<sup>291</sup> The involvement of the private sector therefore limited public oversight. Nonetheless, Pollock and Kirkwood analysed information pertaining to an ISTC in Angus, Scotland, run by Netcare, which was put into the public domain, and determined that as payment was based on referrals (rather than actual treatment) it may have been over-paid approximately £3 million in the first ten months of the contract.<sup>292</sup> If English ISTCs had performed similarly, £927 million may have been paid for patients who did not receive treatment.<sup>293</sup> This revelation generated public criticism of ISTCs and led to Nicola Sturgeon (Scottish Cabinet Secretary for Health and Wellbeing between 2007 and 2012) returning the services in question to the NHS.<sup>294</sup> It was subsequently determined that £462.4 million was squandered through “needless payments” written into ISTC contracts.<sup>295</sup>

Clarke et al note the difference between government rhetoric and the reality of government policies which may be due either to an implementation gap or because

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<sup>288</sup> Naylor, C. and Gregory, S. (2009) *Briefing October 2009 Independent Sector Treatment Centres*, op cit., n.247 at p6.

<sup>289</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.II*, op cit., n.284 at Ev.146.

<sup>290</sup> Ibid at Ev. 123.

<sup>291</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.I*, op cit., n.261 at p4.

<sup>292</sup> Pollock, A. and Kirkwood, G. (2009) ‘Independent Sector Treatment Centres: The First Independent Evaluation, a Scottish Case Study’. *Journal of the Royal Society of Medicine*, Vol. 102(7), pp278-286 at p278.

<sup>293</sup> Ibid.

<sup>294</sup> Pollock, A. and Kirkwood, G. (2009) ‘Evaluation of Contract in ISTCs’. *Journal of the Royal Society of Medicine*, Vol.102(12), pp505-506 at p505.

<sup>295</sup> Slater, E. (2011) ‘£500 Million Paid in botched NHS contracts to private companies’. [On-line] Available: <https://www.thebureauinvestigates.com/2011/05/25/500m-sweetener-paid-to-private-companies-to-treat-nhs-patients/> [Accessed: 12 January 2017].

government rhetoric acts as a smokescreen “concealing the ‘real intentions’ of the political project”.<sup>296</sup> In this respect, the Health Committee noted that many witnesses believed that Milburn “decided on an experiment to introduce private sector providers largely irrespective of any cost benefit analysis”.<sup>297</sup> New Labour appear to have intended to pursue the ISTC policy whether quality or value for money were achieved or not, hence their decision to announce a second wave before evaluation of the first wave. With regards to value for money, Player and Leys note that the Health Committee did not consider the opportunity cost of the £5.6bn diverted to ISTCs.<sup>298</sup>

Player and Leys contend that the Health Committee “failed to confront evidence” pointing “to the real aim of the ISTC programme”.<sup>299</sup> They argue that while it was presented as a means to shorten waiting times, it was, in reality, a critical step in converting the NHS into a market in which for-profit providers would compete with NHS providers.<sup>300</sup> Similarly, UNISON stated that “the future of ISTCs is about a sustainable market for the private sector”.<sup>301</sup> Player and Leys contended that the existing private sector could not provide the desired competition.<sup>302</sup> In this regard, Paul Corrigan (an adviser to Milburn) reportedly averred that the state had to actively create a market.<sup>303</sup> Although Milburn stated, during the 2001 general election, that Labour were not seeking “a mixed economy of healthcare”,<sup>304</sup> Shaw noted that it soon

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<sup>296</sup> Clarke, J. et al (2000) ‘Reinventing the Welfare State’, op cit., n.24 at p11.

<sup>297</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.I*, op cit., n.261 at p38.

<sup>298</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal*, op cit., n.244 at p31.

<sup>299</sup> *Ibid* at p2.

<sup>300</sup> *Ibid* at p1.

<sup>301</sup> Health Committee (2006) *Independent Sector Treatment Centres, Vol.II*, op cit., n.284 at Ev.146

<sup>302</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal*, op cit., n.244 at p73.

<sup>303</sup> Davis, J., et al (2015) *NHS For Sale*, op cit., n.249 at p54.

<sup>304</sup> White, M. and Wintour, P., ‘Milburn warns ‘blinkered left’ over NHS reforms’. *Guardian*, 30 May 2001.

became apparent that this was desired.<sup>305</sup> The government therefore engineered “the formation of a new kind of private healthcare provider, offering low-cost, high-volume treatments at prices competitive with those of NHS trusts”.<sup>306</sup> According to Player and Leys, UK based private providers (such as BUPA and Nuffield) missed out on the lucrative early ISTC contracts prompting them to restructure their businesses.<sup>307</sup> ISTCs acted as a “bridgehead” to increase private sector involvement within the NHS.<sup>308</sup> ISTCs were a precursor for a wider range of clinical activity under the Extended Choice Network (ECN), which comprised 149 privately run facilities by 2009,<sup>309</sup> and undertook £1 billion worth of NHS treatments.<sup>310</sup>

### Patient and Public Involvement

Sherry Arnstein’s model of citizen participation distinguished between non-participation (therapy and manipulation), tokenism (placation, consultation and informing) and citizen power (citizen control, delegated power and partnership).<sup>311</sup> Arnstein’s model has been criticised for not accounting for the comprehensiveness or depth of participation.<sup>312</sup> New Labour’s discourse contained the emerging norm of empowering patients and the public. However, Vincent-Jones argues that although

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<sup>305</sup> Shaw, E. (2007) *Losing Labour’s Soul?*, op cit., n.29 at p108.

<sup>306</sup> Player, S. and Leys, C. (2008) *Confuse and Conceal*, op cit., n.244 at p74.

<sup>307</sup> Ibid at p77.

<sup>308</sup> Ibid at p101.

<sup>309</sup> El-Gingihy, Y. (2015) *How to Dismantle the NHS in 10 Easy Steps*, op cit., n.90 at p8.

<sup>310</sup> Player, S. (2013) ‘Ready for Market’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS Was Betrayed and How We Can Save It*. London: Oneworld, pp38-61 at p51.

<sup>311</sup> Arnstein, S. (1969) ‘A Ladder of Citizen Participation’. *Journal of the American Planning Association*, Vol.35(4), pp216-224 at p217.

<sup>312</sup> Tritter, J. and McCallum, A. (2006) ‘The Snakes and Ladders of user involvement: Moving beyond Arnstein’. *Health Policy*, Vol.76(2), pp156-168 at p163.

voice was on the policy agenda, it was “narrowly conceived and restricted in scope”.<sup>313</sup> New Labour was “more interested in fostering consumerism than in strengthening civil society”<sup>314</sup> and had a “supermarketized vision of service user involvement”,<sup>315</sup> exemplified by its patient choice reforms (examined in chapter four). New Labour had pledged to strengthen Community Health Councils (CHCs).<sup>316</sup> However, the ‘*NHS Plan*’ announced their abolition and replacement by various other bodies.<sup>317</sup> Christine Hogg notes that this was not in the draft ‘*NHS Plan*’, hence many signatories were unaware they were endorsing it.<sup>318</sup> CHCs and the Association of Community Health Councils for England and Wales (ACHCEW) “campaigning vigorously against their abolition”<sup>319</sup> and many Labour backbenchers threatened to rebel.<sup>320</sup> Donna Covey (ACHCEW Director between 1998 and 2001) noted that there were worries about the independence of the new bodies and warned that separating scrutiny from monitoring and complaints could prevent the detection of broader patterns in healthcare.<sup>321</sup> Such opposition meant that CHC abolition was dropped from the bill which became the HSC Act (2001). Nonetheless, subsequent legislation facilitated the abolition of CHCs<sup>322</sup> which ceased operating in England in 2003 (they persist in Wales). Milburn contended that CHCs were “out of date”<sup>323</sup> and should be abolished as they had no role in primary

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<sup>313</sup> Vincent-Jones, P. (2006) *The New Public Contracting*, op cit., n.92 at p212.

<sup>314</sup> Coulter, A. (2011) *Engaging Patients in Healthcare*. Maidenhead: Open University Press, p168.

<sup>315</sup> Cowden, S. and Singh, G. (2007) ‘The ‘User’: Friend, Foe or Fetish? A Critical Exploration of User Involvement in Health and Social Care’. *Critical Social Policy*, Vol.27(1), pp5-23 at p6.

<sup>316</sup> Webster, C. (2002) *The National Health Service: A Political History 2<sup>nd</sup> edition*. Oxford: Oxford University Press, p245.

<sup>317</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p95.

<sup>318</sup> Hogg, C. (2009) *Citizens, Consumers and the NHS: Capturing Voices*. Basingstoke: Palgrave, p111.

<sup>319</sup> Baggott, R. (2005) ‘A Funny thing happened on the way to the forum: Reforming Patient and Public Involvement in the NHS in England’. *Public Administration*, Vol. 83(3), p533-551 at p 538.

<sup>320</sup> Parker, S., ‘The row over the abolition of Community Health Councils rages on’, *Guardian*, 8 January 2001.

<sup>321</sup> Covey, D., ‘Muzzling the Watchdog’, *Guardian*, 13 September 2000.

<sup>322</sup> NHSRHCP (2002), S.22.

<sup>323</sup> H.C. Deb. 20 November 2001, Vol. 375, Col.203.



care, could not inspect GP premises and had no rights of representation on NHS organisations.<sup>324</sup> Many MPs, including David Hinchliffe,<sup>325</sup> Sandra Gidley<sup>326</sup> and Paul Burstow,<sup>327</sup> noted that CHCs could simply have been given the powers mentioned by Milburn.

The changes required the Secretary of State to provide an Independent Complaints Advocacy Service (ICAS).<sup>328</sup> ICAS provides support to patients wishing to complain.<sup>329</sup> Initially, Citizens Advice had the contract to provide such services in six out of nine regions.<sup>330</sup> The advisory role of CHCs was rechannelled to Patient Advocate and Liaison Services (PALS) without legislation.<sup>331</sup> PALS have no statutory powers and are not independent (as they are accountable to the Chief Executive of the trust or PCT where they are provided).<sup>332</sup> Whereas CHCs had undertaken an annual casualty watch to assess casualty and emergency services, Charles Webster argued that PALS were “purposely designed to preclude any kind of co-ordinated effort liable to disconcert provider interests”.<sup>333</sup> Patients Forums, later renamed Patient and Public Involvement Forums (PPIFs), were established, for each NHS Trust<sup>334</sup> and PCT,<sup>335</sup> to

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<sup>324</sup> Ibid at Col.203-204.

<sup>325</sup> Ibid at Col.214.

<sup>326</sup> Ibid at Col.254.

<sup>327</sup> Ibid at Col.263.

<sup>328</sup> National Health Service (NHS) Act (1977), S.19A(1) as amended by Health and Social Care (HSC) Act (2001), S.12.

<sup>329</sup> Department of Health (DOH) (2004) *Independent Complaints Advocacy Service (ICAS) The First Year of ICAS: 1 September 2003-31 August 2004*. London: DOH, p1.

<sup>330</sup> Allsopp, J. and Jones, K. (2008) ‘Withering the Citizen, Managing the Consumer: Complaints in Healthcare Settings’. *Social Policy and Society*, Vol.7(2), pp233-243 at p239.

<sup>331</sup> Vincent-Jones, P. et al (2009) ‘New Labour’s PPI reforms: Patient and Public Involvement in healthcare governance?’ *Modern Law Review*, Vol.72(2), pp247-271 at p251.

<sup>332</sup> Hill, R. and Marks, W. (2003) *A Friend in Deed? A Survey of Patient Advice and Liaison Services (PALS)*. London: Association of Community Health Councils for England and Wales, p3.

<sup>333</sup> Webster, C. (2000) ‘Patient friends pushed aside by Labour’s PALS’. *Health Matters*, 43 (Winter 2000/1), 5.

<sup>334</sup> NHSRHCP Act (2002), S.15(1)(A).

<sup>335</sup> Ibid at S.15(1)(B).

monitor and review services,<sup>336</sup> obtain patients views<sup>337</sup> and provide advice, reports and recommendations.<sup>338</sup> The Commission for Patient and Public Involvement in Health (CPPIH)<sup>339</sup> was established to advise the Secretary of State about arrangements for public involvement<sup>340</sup> and the views of PPIFs<sup>341</sup> and provide staff<sup>342</sup> and set quality standards for PPIFs.<sup>343</sup> Angela Coulter contends that PPIFs had weaker powers and less independence than CHCs.<sup>344</sup> Anna Coote states that the quality of PPIFs “varied considerably”, with some being “vigorous advocates and watchdogs” and others being “unrepresentative local cabals, destructively critical, or just weak and ineffectual”.<sup>345</sup>

The role of Overview and Scrutiny Committees (OSCs) in local authorities was extended enabling them to review, scrutinise and make recommendations regarding health services.<sup>346</sup> NHS bodies must consult OSCs regarding “substantial changes in services”, which, Day and Klein note, is a “contested and malleable” concept.<sup>347</sup> Their research indicated that, in practice, OSCs based challenges on evidence rather than on “knee jerk opposition to change in principle”.<sup>348</sup> Jane Martin found that over one

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<sup>336</sup> Ibid at S.15(3)(A).

<sup>337</sup> Ibid at S.15(3)(B).

<sup>338</sup> Ibid at S.15(3)(C).

<sup>339</sup> Ibid at S.15(2).

<sup>340</sup> Ibid at S.20(2)(A).

<sup>341</sup> Ibid at S.20(2)(C).

<sup>342</sup> Ibid at S.20(2)(D).

<sup>343</sup> Ibid at S.20(2)(F).

<sup>344</sup> Coulter, A. (2011) *Engaging Patients in Healthcare*, op cit., n.314 at p168.

<sup>345</sup> Coote, A. (2006) ‘The Role of Citizens and Service Users in Regulating Healthcare’ in Andersson, E. et al (eds) *Healthy Democracy: The Future of Involvement in Health and Social Care*. London: Involve and NHS National Centre for Involvement, pp53-66 at p56.

<sup>346</sup> Local Government Act (2000), S.21 as amended by HSC Act (2001), S.7(1).

<sup>347</sup> Day, P. and Klein, R. (2007) *The Politics of Scrutiny: Reconfiguration in NHS England*. London: Nuffield Trust, pp17-18.

<sup>348</sup> Ibid at p17.

third of NHS bodies changed policies, procedures and services due to their scrutiny.<sup>349</sup> Sally Ruane stated that OSCs had teeth as they enabled citizens, in certain circumstances, to shape important decisions (such as halting plans to downgrade Horton General in Banbury in 2008).<sup>350</sup> However, the Francis Report (published following the public inquiry into Mid Staffordshire NHS FT<sup>351</sup>) concluded that OSCs scrutiny was “an unreliable detector of concerns”<sup>352</sup> and recommended that they be empowered to inspect providers.<sup>353</sup> The Independent Reconfiguration Panel (IRP) was established, in 2003, to advise the Secretary of State regarding contested proposals for changes to services. While the ‘*NHS Plan*’ intimated that OSCs could refer to the IRP,<sup>354</sup> this power was ultimately given to the Secretary of State.<sup>355</sup> In many cases, the Secretary of State decided to support local NHS proposals.<sup>356</sup> By 2007, the IRP had only made three adjudications.<sup>357</sup> The Health Committee determined that the failure of successive Secretaries of State to refer cases to IRP, along with their overturning of decisions and the timing of their interventions, had “undermined public confidence in the consultation process”.<sup>358</sup>

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<sup>349</sup> Martin, J. (2006) ‘A New Vision for Local Democratic Accountability of Healthcare Services’ in Andersson, E. et al (eds) *Healthy Democracy: The Future of Involvement in Health and Social Care*. London: Involve and NHS National Centre for Involvement, pp67-73 at p69.

<sup>350</sup> Ruane, S. (2014) *Democratic Engagement in the local NHS*. London: Centre for Health and the Public Interest, p10.

<sup>351</sup> The inquiry was established in June 2010 to investigate the poor care and high mortality rates at the hospital.

<sup>352</sup> Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. London: Stationery Office, p47.

<sup>353</sup> Ibid at p74.

<sup>354</sup> Department of Health (2000) *NHS Plan*, op cit., n.113 at p94.

<sup>355</sup> Day, P. and Klein, R. (2007) *The Politics of Scrutiny*, op cit., n.347 at p20.

<sup>356</sup> Ibid at p20.

<sup>357</sup> Ibid at p21.

<sup>358</sup> Health Committee (2007) *Patient and Public Involvement in the NHS, Third Report, House of Commons Session 2006-07, Vol.I*. London: Stationery Office, p81.

In 2006 an expert panel, reviewing patient and public involvement, criticised the over prescriptive and centralised model that had been adopted.<sup>359</sup> It recommended the creation of Local Involvement Networks (LINKs).<sup>360</sup> The Department of Health subsequently announced that CPPIH and PPIFs would be abolished and that LINKs would replace the latter.<sup>361</sup> CPPIH was not replaced hence patients were no longer represented at a national level<sup>362</sup>. Although there were also concerns with PALS and ICAS, neither was reformed.<sup>363</sup> LINKs were established by the Local Government and Public Involvement in Health (LGPIH) Act (2007). The Francis report contained a damning indictment of Labour's reforms.<sup>364</sup> It concluded that PPIFs and LINKs failed to deliver "an improved voice for patients and the public" in Stafford.<sup>365</sup> Hogg contended that by fragmenting arrangements for patient and public involvement, New Labour made introducing its market reforms easier.<sup>366</sup>

The HSC Act (2001), S.11,<sup>367</sup> required NHS bodies to consult on the planning of, and changes to, services. Perceived failures to do so could result in requests for judicial review. Mandelstam avers that "judicial review against the NHS is generally a blunt,

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<sup>359</sup> Department of Health (DOH) (2006) *Concluding the Review of Patient and Public Involvement Recommendations to Ministers from an Expert Panel*. London: DOH, p3.

<sup>360</sup> *Ibid* at p5.

<sup>361</sup> Department of Health (DOH) (2006) *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services A document for information and comment*. London: DOH, p7.

<sup>362</sup> Mold, A. (2015) *Making the Patient Consumer: Patient Organisations and Health Consumerism in Britain*. Manchester: Manchester University Press, p161.

<sup>363</sup> Vincent-Jones, P. et al (2009) 'New Labour's PPI reforms', *op cit.*, n.331 at p254.

<sup>364</sup> Newbigging, K. (2016) 'Blowin' in the wind: The Involvement of People who use services, carers and the public in health and social care' in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp301-322 at p306.

<sup>365</sup> Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, *op cit.*, n.352 at p46.

<sup>366</sup> Hogg, C. (2009) *Citizens, Consumers and the NHS*, *op cit.*, n.318 at p124.

<sup>367</sup> Subsequently consolidated into the National Health Service (NHS) Act (2006), S.242.

crude and unreliable tool”.<sup>368</sup> Nonetheless, threats to services, due to deficits in 2005/06, led many to seek judicial review.<sup>369</sup> Both Mandelstam and the Health Committee noted that NHS bodies often attempt to avoid obligations to consult, for example, by making small service cuts over time.<sup>370</sup> In *Smith v North East Derbyshire PCT*,<sup>371</sup> the duty to consult applied where a PCT proposed to run GP services through a private company.<sup>372</sup> Mandelstam contends that the duty was watered down by LGPIH Act (2007), S.233.<sup>373</sup> This provided that the duty may “be discharged simply by the provision of information” and only applies if it would impact the manner of delivery (at the point they are received by users) of, or the range of, services.<sup>374</sup> Both Mandelstam and the Health Committee concluded that the legislative change sought to remove case law relating to S.11.<sup>375</sup> The Health Committee determined that patient and public involvement had been conflated leading to “muddled initiatives and uncertainty”.<sup>376</sup> The former is a response to medical paternalism, while the latter draws on democratic theory.<sup>377</sup> Wanless noted that the national patient survey (introduced in 1997) indicated that there continued to be a lack of patient involvement in their own care.<sup>378</sup> Consequently, New Labour’s policies did not match the normative elements of its discourse in terms of enhancing patient and public voices. Such norms are therefore means of critiquing such policies and bases for conceiving alternatives.

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<sup>368</sup> Mandelstam, M. (2007) *Betraying the NHS*, op cit., n.120 at p35.

<sup>369</sup> Ibid.

<sup>370</sup> Mandelstam, M. (2009) *Community Care Practice and the Law: 4<sup>th</sup> Edition*. London: Jessica Kingsley, pp482-483.

<sup>371</sup> (2006) EWHC 1338.

<sup>372</sup> Mandelstam, M. (2009) *Community Care Practice and the Law*, op cit., n.370 at p479.

<sup>373</sup> Ibid.

<sup>374</sup> Ibid.

<sup>375</sup> Ibid/Health Committee (2007) *Patient and Public Involvement in the NHS*, op cit., n.358 at p79.

<sup>376</sup> Health Committee (2007) *Patient and Public Involvement in the NHS*, op cit., n.358 at p3.

<sup>377</sup> Fredriksson, M. and Tritter, J. (2017) ‘Disentangling Patient and Public Involvement in healthcare decisions: Why the difference matters’. *Sociology of Health and Illness*, Vol.39(1), pp95-111 at p96.

<sup>378</sup> Wanless, D. et al (2007) *Our Future Health Secured? A Review of NHS Funding and Performance*. London: Kings Fund, p193.

## Conclusion

In this chapter, I noted the influence of private healthcare companies and neo-liberalism on New Labour's NHS reforms. New Labour sought to portray its reforms as being in everyone's interests by claiming that they would increase quality and efficiency, terms which it sought to decontest by linking them to private sector involvement. However, such terms were recontested as critics averred that private sector involvement was detrimental to efficiency and quality. New Labour used residualizing discourse to differentiate its policies, characterised as modern, from previous Labour party policy and their opponents (including Labour backbenchers and trade unions), which were characterised as outmoded. It sought to naturalise its conception of modernity, in which there was no alternative within public services to the consumerism elsewhere within capitalist societies. New Labour's discourse included residual and emergent norms (such as reducing health inequalities and empowering patients). Such norms were undermined by New Labour's neo-liberal policies but provide a basis for critiquing New Labour's policies and conceiving alternatives. New Labour sought to depoliticise healthcare through the use of targets. Such targets did not cover, and were argued to have a detrimental effect on, rising infections, which repoliticised healthcare. New Labour's reforms reified healthcare by extending the exchange principle and through instrumental rationality, as means, such as targets, became ends in themselves to the detriment of patients.

## Chapter Four: New Labour and the NHS (Part Two)

### Introduction

In this chapter, I examine New Labour's creation of foundation trusts (FTs) and a mimic-market in secondary care and its creation of polyclinics in primary care. New Labour contended that FTs would lead to high standards, enable health inequalities to be tackled more effectively and facilitate genuine local ownership. However, FTs do not appear to outperform NHS trusts, the relationship between FTs and health inequalities were not clear to clinicians and managers<sup>1</sup> and scope for public influence over FTs is limited. New accountability mechanisms were introduced for FTs. FTs were somewhat successful in depoliticising healthcare, as many of their problems were dealt with without parliamentary or ministerial interference, although ministers often intervened, despite the law, in response to scandals.

The mimic-market in secondary care was effectuated by policies such as patient choice. However, Labour's attempts to interpellate patients as consumers faced recalcitrance (passive dissent).<sup>2</sup> There is evidence that the mimic-market became an end in itself to the detriment of patients. As the NHS became increasingly marketized, European Union (EU) competition and public procurement law (which may have

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<sup>1</sup> Powell, M. et al (2011) *Comparative Case Studies of Health Reform in England: Report Submitted to the Department of Health Policy Research Programme (PRP)*. London: Department of Health, p266.

<sup>2</sup> Clarke, J. (2007) 'It's not like Shopping': Citizens, Consumers and the reform of public services' in Bevir, M. and Trentmann, F. (eds) *Governance, Consumers and Citizens: Agency and Resistance in Contemporary Politics*. Basingstoke: Palgrave, pp97-118 at pp114-115.

locked in such reforms) became increasingly applicable, although scope existed for exceptions. The use of an ostensibly non-political figure, Lord Ara Darzi, to recommend polyclinics, did not successfully depoliticise the policy, which generated controversy as they threatened access to, and continuity of, care. New Labour asserted that it expected many polyclinic contracts to go to GP-led consortiums. However, the government liaised with the private sector about their procurement<sup>3</sup> and advised PCTs to set up bulk deals with private providers.<sup>4</sup> New Labour's policies were opposed by Labour backbenchers and increased marketization led to groups of citizens forming to protest against the changes.

### Foundation Trusts

New Labour created FTs<sup>5</sup> and Monitor, to regulate them,<sup>6</sup> via the Health and Social Care (Community Health and Standards) (HSC) Act (2003), which was subsequently consolidated into the National Health Service (NHS) Act (2006). According to Patricia Day and Rudolf Klein, ministers became convinced that the command and control model, adopted in Labour's first term, was managerially counterproductive as it stifled innovation, and politically counterproductive, as it centralised blame.<sup>7</sup> Ministers therefore decided to decentralise to insulate themselves from political exposure to day-

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<sup>3</sup> Nowotny, S., 'Revealed: NHS Secretly wooed Private firms over Polyclinics', *Pulse*, 7 October 2009.

<sup>4</sup> Iacobucci, G., 'Trusts told to offer firms bulk deals on Darzi Centres'. *Pulse*, 1 October 2008.

<sup>5</sup> Health and Social Care (Community Health and Standards) (HSC) Act (2003), S.1/National Health Service (NHS) Act (2006), S.30.

<sup>6</sup> HSC Act (2003), S.2/NHS Act (2006), S.31.

<sup>7</sup> Day, P. and Klein, R. (2009) *Governance of Foundation Trusts: Dilemmas of Diversity*. London: Nuffield Trust, p7.



to-day NHS problems.<sup>8</sup> Patrick Diamond contends that ministers wanted to reduce culpability for delivery<sup>9</sup> but were also desirous of restoring Labour's governing reputation.<sup>10</sup> The government stated that power "must be shifted towards frontline staff who understand patient's needs and concerns"<sup>11</sup> and to local communities to give them "real influence over their development".<sup>12</sup> The strategy of decentralising power was linked to the objective of reducing health inequalities. For example, Blair argued that uniform national services had "failed to combat" such inequalities and that communities and frontline staff should be empowered "to redesign, refocus and reprioritise programmes to tackle local need".<sup>13</sup>

The increased interest in decentralisation led to an "advisory group of academics and others with an interest in, or experience of, mutualism" being established.<sup>14</sup> Hazel Blears (Parliamentary Under Secretary of State at the Department of Health between 2001 and 2003) argued that "key parts of the public services should be made into mutual organisations owned and controlled by local people and by their users".<sup>15</sup> Day and Klein noted that mutualism "appeared to be an ideologically attractive formula" as it drew on the government's new emphasis of localism and traditional "left-wing advocacy of co-operative models".<sup>16</sup> However, unlike mutuals, FTs "are not owned by

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<sup>8</sup> Klein, R. (2006) 'The Troubled Transformation of Britain's National Health Service'. *The New England Journal of Medicine*, Vol.355(4), pp409-415 at p410.

<sup>9</sup> Diamond, P. (2015) 'New Labour, Politicisation and Depoliticisation: The Delivery Agenda in public services 1997-2007'. *British Politics*, Vol.10(4), pp429-453 at p436.

<sup>10</sup> Ibid at p447.

<sup>11</sup> Department of Health (DOH) (2001) *Shifting the Balance of Power within the NHS: Securing Delivery*. London: DOH, p5.

<sup>12</sup> Ibid.

<sup>13</sup> Blair, T., 'Foreword by the Prime Minister' in Department of Health (DOH) (2003) *Tackling Health Inequalities: A Programme for Action*. London: DOH, p1.

<sup>14</sup> Day, P. and Klein, R. (2009) *Governance of Foundation Trusts*, op cit., n.7 at p8.

<sup>15</sup> Blears, H. (2003) *Communities in Control: Public Services and Local Socialism*. London: Fabian Society, p1.

<sup>16</sup> Day, P. and Klein, R. (2009) *Governance of Foundation Trusts*, op cit., n.7 at p8.

their members”.<sup>17</sup> Ultimately, likening FTs to mutuals did not make “the notion of giving independence to providers acceptable to Labour party traditionalists”.<sup>18</sup> The FT policy was influenced by Milburn’s visit, in 2001, to the Fundacion Hospital in Alcorcon, Madrid, which was state owned but privately run.<sup>19</sup> The Fundacion Hospital had received the highest number of complaints for a hospital in Spain, in 2000, and the cheaper medical equipment at the hospital was blamed for an outbreak of hepatitis C, in September 2004.<sup>20</sup> According to Allyson Pollock, policy advisors, including Kaiser Permanente’s Chief Executive, and representatives of healthcare corporations, also helped to formulate the FT proposals.<sup>21</sup>

Milburn employed similar arguments for FTs as those utilised to justify the changes announced by the ‘*NHS Plan*’. The narrative was that FTs would modernise an outdated NHS. Milburn stated that:

“For the first time since 1948 the NHS will begin to move away from a monolithic centralised system towards greater local accountability and greater local control. Reform cannot be achieved by holding on to the monolithic centralised structures of the 1940s”.<sup>22</sup>

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<sup>17</sup> Allen, P. et al (2011) *Investigating the Governance of NHS Foundation Trusts: Final Report*. London: National Institute for Health Research Service Delivery and Organisation Programme, p14.

<sup>18</sup> Day, P. and Klein, R. (2009) *Governance of Foundation Trusts*, op cit., n.7 at p8.

<sup>19</sup> Bosanquet, N. (2007) ‘The Health and Welfare Legacy’ in Seldon, A. (ed) *Blair’s Britain*. Cambridge: Cambridge University Press, pp385-407 at p388/Carvel, J. and Tremlett, G., ‘Milburn Seeks Hospital Role Model in Spain’. *Guardian*, 6 November 2001.

<sup>20</sup> Maqueda, A., ‘From Spain, a not so healthy role model’. *New Statesman*, 11 October 2004.

<sup>21</sup> Pollock, A. (2003) *Foundation Hospitals and the NHS Plan*. London: UNISON, p8.

<sup>22</sup> Milburn, A., ‘Foreword’ in Department of Health (DOH) (2002) *A Guide to NHS Foundation Trusts*. London: DOH, pp3-4 at p4.

John Mohan noted the startling similarity between Conservative and New Labour arguments for NHS reform.<sup>23</sup> The NHS was portrayed as “monolithic” in Thatcherite discourse. For example, Oliver Letwin and John Redwood described it “as a bureaucratic monster”.<sup>24</sup> Milburn’s description of the NHS as a “monolithic centralised system” accepted the Thatcherite narrative, which Mohan argues was based on a mythical past.<sup>25</sup> Mohan contends that it was New Labour which had adopted highly centralist policies, such as targets.<sup>26</sup> Milburn sought to naturalise a consumer relationship between patients and the NHS, to which, he argued, there was no alternative. Milburn averred that the NHS was “formed in the era of the ration book” when “people expected little say and had precious little choice”.<sup>27</sup> He claimed that “today, we live in a different world”.<sup>28</sup> According to Milburn, “whether we like it or not, this is a consumer age” in which “people demand services that are tailored to their individual needs”.<sup>29</sup>

Milburn portrayed FTs as being in everyone’s interests (indicative of the universalization strategy of the ideological mode of legitimation) as he stated they would lead to “high standards, greater local accountability, genuine public ownership,

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<sup>23</sup> Mohan, J. (2003) ‘The Past and Future of the NHS: New Labour and Foundation Hospitals’. [Online] Available: <http://www.historyandpolicy.org/policy-papers/papers/the-past-and-future-of-the-nhs-new-labour-and-foundation-hospitals> [Accessed: 14 December 2015].

<sup>24</sup> Letwin, O. and Redwood, J. (1988) *Britain’s Biggest Enterprise: Ideas for Radical Reform of the NHS*. London: Centre for Policy Studies, p4.

<sup>25</sup> Mohan, J. (2003) ‘The Past and Future of the NHS’, op cit., n.23.

<sup>26</sup> Ibid.

<sup>27</sup> H.C. Deb.7 May 2003, Vol.404, Col.707.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

[and] greater emphasis on local service provision to tackle health inequalities".<sup>30</sup> FTs were in the interests of private companies which were afforded new opportunities (examined below). Milburn's claims that FTs were in everyone's interests have not been borne out. Milburn's claim that FTs would lead to high standards is belied by studies which indicate that FTs did not significantly affect financial management or performance<sup>31</sup> and did not affect the quality of care (as measured by methicillin-resistant staphylococcus aureus (MRSA) rates).<sup>32</sup> Rosella Verzulli et al found that although both FTs and non-FTs experienced better performance in terms of shorter waiting times, this reduction was higher for the latter than the former.<sup>33</sup> Alisa Cameron et al found that while the autonomy afforded by FT status was valued, there is no evidence that it improves performance.<sup>34</sup> The claim by Milburn, and others, that FTs would enable health inequalities to be more effectively tackled is undermined by Martin Powell et al's case study research which indicates that the links the government made between mechanisms, such as FTs, and outcomes, such as reducing health inequalities, were not clear to clinicians and managers.<sup>35</sup> Rather than reducing health inequalities, Pollock argued that the ability of FTs to generate surpluses threatened to destabilise health service provision and widen inequalities of access.<sup>36</sup> I argue below that scope for public influence over FTs is limited. FTs were part of New Labour's purported desire to decentralise power. However, Scott Greer and Margitta Matzke

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<sup>30</sup> Milburn, A., 'Foreword', op cit., n. 22 at p3.

<sup>31</sup> Marini, G. et al (2007) 'Foundation Trusts in the NHS: Does more Freedom make a difference?' *Health Policy Matters*, Issue 13/Verzulli, R. et al (2011) *Do Hospitals Respond to Greater Autonomy? Evidence from the English NHS: Research Paper 64*. York: Centre for Health Economics, p10

<sup>32</sup> Verzulli, R. et al (2011) *Do Hospitals Respond to Greater Autonomy?*, op cit., n.31 at p10.

<sup>33</sup> Ibid.

<sup>34</sup> Cameron, A. et al (2015) 'Increasing Autonomy in Publically owned Services: The Case of Community Health Services in England'. *Journal of Health Organisation and Management*, Vol.29(6) pp778-794 at p792.

<sup>35</sup> Powell, M. et al (2011) *Comparative Case Studies of Health Reform in England*, op cit., n.1 at p266.

<sup>36</sup> Pollock, A. et al., 'NHS and the Health and Social Care Bill: End of Bevan's Vision'. *British Medical Journal* 2003; 327: 982.

state that, by 2010, the NHS had weak territorial levels and strong nationwide regulators accountable to ministers.<sup>37</sup>

Milburn claimed that the FT reform was “every bit as radical and progressive as that which created the NHS”.<sup>38</sup> This exemplifies the euphemization strategy of the ideological mode of dissimulation. Stuart Hall noted that New Labour utilised spin to mobilize the positive resonances of concepts to mask the consistent shift from public to private, as concepts such as ‘change’ and ‘radical’ can point in any direction.<sup>39</sup> Milburn stated that the principles of the NHS were right,<sup>40</sup> but that it needed to change “how it works in practice”.<sup>41</sup> New Labour claimed to retain the traditional values of the NHS in an effort to obscure the fact that, as critics argued, its reforms overlooked<sup>42</sup> and squeezed out<sup>43</sup> its public service ethos. In this respect, Allen et al’s case study indicated that once trusts were elevated to FT status they became “more business focused”.<sup>44</sup>

FTs are public benefit corporations<sup>45</sup> authorised to provide goods and services for the provision of health care,<sup>46</sup> with a general duty to exercise their “functions effectively,

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<sup>37</sup> Greer, S. and Matzke, M. (2015) ‘Health Policy in the European Union’ in Kuhlmann, E. et al (eds) *The Palgrave International Handbook of Healthcare Policy and Governance*. Basingstoke: Palgrave, pp254-269 at p262.

<sup>38</sup> Milburn, A., ‘Foreword’, op cit., n. 22 at p4.

<sup>39</sup> Hall, S. (2005) ‘New Labour’s Double Shuffle’. *Review of Education, Pedagogy and Cultural Studies*, Vol.27(4), pp319-335 at p333.

<sup>40</sup> H.C. Deb.7 May 2003, Vol.404, Col.696.

<sup>41</sup> Ibid at Col.698.

<sup>42</sup> Eagle, A. (2003) *A Deeper Democracy: Challenging Market Fundamentalism*. London: Catalyst, p34.

<sup>43</sup> Cook, R., ‘A Manifesto like this would actually motivate our voters’. *Guardian*, 4 February 2005.

<sup>44</sup> Allen, P. et al (2011) *Investigating the Governance of NHS Foundation Trusts*, op cit., n.17 at p3.

<sup>45</sup> HSC Act (2003), S.1(1)/NHS Act (2006), S.30(1).

<sup>46</sup> HSC Act (2003), S.14(1)/NHS Act (2006), S.43(1).

efficiently and economically”.<sup>47</sup> This is indicative of depoliticisation through embedding normative values into the institutional structure of organisations.<sup>48</sup> Initially, only three star NHS trusts could apply for FT status.<sup>49</sup> This requirement was relaxed in November 2005.<sup>50</sup> Private companies could also apply for FT status.<sup>51</sup> However, in 2010, it was determined that no non-NHS organisations had applied.<sup>52</sup> FTs are permitted greater financial freedoms than NHS trusts, such as the power to borrow money<sup>53</sup> and to invest money,<sup>54</sup> for example, by forming a subsidiary or by entering into a joint venture.<sup>55</sup> For example, the Christie Clinic LLP is a joint venture between the Christie NHS FT and Healthcare America (HCA). Joint ventures are able to charge fees and make profits.<sup>56</sup> The statute enabled FTs to generate income from private patients, limited to the proportion of income derived from charges in the base financial year<sup>57</sup> (the first year it was an NHS trust, or the financial year ending 2003, if it was an NHS trust in that year).<sup>58</sup> FTs cannot dispose of protected property without Monitor’s approval.<sup>59</sup> However, the Health Committee noted that the distinction between regulated and unregulated assets allowed “scope for considerable discretion in” specifying essential services.<sup>60</sup> The creation of Monitor is indicative of institutional depoliticisation. Monitor

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<sup>47</sup> HSC Act (2003), S.39/NHS Act (2006), S.63.

<sup>48</sup> Flinders, M. (2004) ‘Distributed Public Governance in Britain’. *Public Administration*, Vol.82(4), pp883-909 at p902.

<sup>49</sup> Health Committee (2003) *Foundation Trusts, Second Report, House of Commons Session 2002-03, Vol.1*. London: Stationery Office, p6.

<sup>50</sup> Whitfield, D. (2006) *New Labour’s attack on Public Services*. Nottingham: Spokesman, p106.

<sup>51</sup> HSC Act (2003), S.5/NHS Act (2006), S.34/Pollock, A. and Price, D. (2003) ‘In Place of Bevan? Briefing on the Health and Social Care (Community Health and Standards) Bill 2003’. *Radical Statistics*, Issue 86, pp10-26 at p12.

<sup>52</sup> Department of Health (DOH) (2010) *Liberating the NHS: Legislative Framework and Next Steps*. London: DOH, p130.

<sup>53</sup> HSC Act (2003), S.17(1)/NHS Act (2006), S.46(1).

<sup>54</sup> HSC Act (2003), S.17(4)/NHS Act (2006), S.46(4).

<sup>55</sup> HSC Act (2003), S.17(5)/NHS Act (2006), S.46(5).

<sup>56</sup> Pollock, A. et al (2005) *NHS PLC: The Privatisation of our Healthcare*. London: Verso, p76.

<sup>57</sup> HSC Act (2003), S.15(2)/NHS Act (2006), S.44(2).

<sup>58</sup> HSC Act (2003), S.15(3)/NHS Act (2006), S.44(3).

<sup>59</sup> HSC Act (2003), S.16(1)/NHS Act (2006), S.45(1).

<sup>60</sup> Health Committee (2003) *Foundation Trusts*, op cit., n.49 at p48.

authorised FT applications<sup>61</sup> and determined what NHS services an area needed.<sup>62</sup> Monitor also had the power to intervene where FTs were deemed to be failing.<sup>63</sup> Monitor was independent of government regarding its regulatory decisions, but accountable to parliament for its performance and value for money.<sup>64</sup>

The HSC Act (2003) established a dual governance structure for FTs.<sup>65</sup> This consists of a board of governors (comprising elected and appointed members<sup>66</sup>) and a board of directors (comprising executive and non-executive directors<sup>67</sup>). Individuals can become FT members if they live locally, are employed by it, or use its services.<sup>68</sup> FTs draw the geographical boundaries of their constituencies, unlike other democratic organisations whose boundaries are determined by the Boundaries Commission.<sup>69</sup> According to Mohan, Labour was suggesting that community control could work “much as it did in the pre-NHS era”.<sup>70</sup> However, Mohan noted that large-scale community participation in raising funds within that era was accompanied by tokenistic representation on governing bodies.<sup>71</sup> There were “no minimum standards for involvement”.<sup>72</sup> Day and Klein state that this was because ministers “did not have high

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<sup>61</sup> HSC Act (2003), S.6/NHS Act (2006), S.33.

<sup>62</sup> HSC Act (2003), S.14 (7)/NHS Act (2006), S.43(6)/Pollock, A. and Price, D. (2003) ‘In Place of Bevan?’, op cit., n.50 at p13.

<sup>63</sup> HSC Act (2003), S.23/NHS Act (2006), S.52.

<sup>64</sup> Committee of Public Accounts (2014) *Monitor: Regulating Foundation Trusts, Fourth Report, House of Commons Session 2014-2015, Vol.I*. London: Stationery Office, p5.

<sup>65</sup> HSC Act (2003), S.6(2)(C)/NHS Act (2006), S.35(2)(C).

<sup>66</sup> HSC Act (2003), Schedule 1, para.7/NHS Act (2006), Schedule 7, para.7.

<sup>67</sup> HSC Act (2003), Schedule 1, para.16(1)(A) and (B)/NHS Act (2006), Schedule 7, para.16 (1)(A) and (B).

<sup>68</sup> HSC Act (2003), Schedule 1, para.3(1)(A), (B) and (C)/ NHS Act (2006), Schedule 7, para.3(1)(A),(B) and (C).

<sup>69</sup> Health Committee (2003) *Foundation Trusts*, op cit., n.49 at p15.

<sup>70</sup> Mohan, J. (2003) ‘The Past and Future of the NHS’, op cit., n.23.

<sup>71</sup> Ibid.

<sup>72</sup> Health Committee (2003) *Foundation Trusts*, op cit., n.49 at p16.

expectations”.<sup>73</sup> According to Pollock et al, “the problem of recruiting members from among the frail, less articulate or those who have to travel large distances for specialist services” was not recognised.<sup>74</sup> FT members are not required to be representative of the local population or answerable to it.<sup>75</sup> Many FTs have few members. For example, the membership of Milton Keynes Hospital FT consists of only 2.4 percent of the population that it serves.<sup>76</sup> The average turnout at FT elections is twenty percent.<sup>77</sup> One in five elections was uncontested in 2008/09, rising to thirty-one percent of those for staff governors.<sup>78</sup> Labour’s manifesto for the 2010 general election pledged to increase FT membership to over three million, but did not explain how this was to be achieved.<sup>79</sup> Pauline Allen et al determined that FTs enabled “variable and limited” patient and public involvement.<sup>80</sup> John Wright et al found evidence that governors were at risk of becoming owned by the management culture of FTs and suggested that policymakers train governors as “owls, rather than sheep and donkeys”.<sup>81</sup> Similarly, Josephine Ocloo et al determined that governors needed training, support and guidance regarding patient safety.<sup>82</sup>

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<sup>73</sup> Day, P. and Klein, R. (2009) *Governance of Foundation Trusts*, op cit., n.7 at p18.

<sup>74</sup> Pollock, A. et al., ‘NHS and the Health and Social Care Bill’, op cit., n.36.

<sup>75</sup> Ibid.

<sup>76</sup> Berry, R. (2014) ‘NHS Foundation Trusts- a Democratic Failure?’ [On-line] Available: <https://www.opendemocracy.net/ournhs/richard-berry/nhs-foundation-trusts-democratic-failure> [Accessed: 14 February 2016].

<sup>77</sup> Ibid.

<sup>78</sup> Santry, C., ‘MP Slams ‘uncontested’ FT governor elections’, *Health Services Journal*, 28 October 2009.

<sup>79</sup> Labour Party (2010) *Labour Party 2010 Manifesto A Future Fair for All*. Labour: London, p4.4.

<sup>80</sup> Allen, P. et al (2012) ‘Organisational Form as a Mechanism to involve Staff, Patients and Users in Public Services: A Study of the Governance of NHS Foundation Trusts’. *Social Policy and Administration*, Vol.46(3), pp239-257 at p252.

<sup>81</sup> Wright, J. et al (2011) ‘The New Governance Arrangements for NHS Foundation Trust Hospitals: Re-framing governors as meta-regulators’. *Public Administration*, Vol.90(2), pp351-369 at p367.

<sup>82</sup> Ocloo, J. et al (2014) ‘Empowerment or Rhetoric? Investigating the role of NHS Foundation Trust Governors in the governance of Patient Safety’. *Health Policy*, Vol.111(3), pp301-310 at p306.



The traditional accountability of NHS hospitals to the Department of Health was replaced by FT's accountability to their members, elected governors, Monitor,<sup>83</sup> PCTs and the Healthcare Commission.<sup>84</sup> John Reid (Secretary of State for Health between 2003 and 2005) confirmed that FTs "are independent of the department, and directly accountable to their local populations and to parliament".<sup>85</sup> Richard Lewis noted that this meant, in theory, no minister would have to defend healthcare professionals and managers in parliament.<sup>86</sup> Rachael Addicott and Francesca Frosini state that a deep clean directive issued by the Department of Health, following a scandal at Maidstone NHS Trust, in which ninety people died from clostridium difficile,<sup>87</sup> indicates that it had not fully loosened the reins of central control.<sup>88</sup> In response, William Moyes (Executive Chairman of Monitor between 2004 and 2010) complained, in a letter to David Nicholson (NHS Chief Executive between 2006 and 2011), that such instructions were not "consistent with the legislative framework".<sup>89</sup> Nonetheless, the strategy of depoliticisation appears to have been relatively successful because, as Moyes et al note, frequently cases of failure or potential failure of FTs "were managed without ministerial intervention or formal parliamentary interest".<sup>90</sup> However, Moyes et al state that major policy failures often lead to a return of top-down accountability.<sup>91</sup> For example, they argue that the case of Mid Staffordshire NHS FT shows that a Secretary

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<sup>83</sup> Lewis, R. (2005) *Governing Foundation Trusts: a new era for public accountability*. London: Kings Fund, p2.

<sup>84</sup> Health Committee (2003) *Foundation Trusts*, op cit., n.49 at p12.

<sup>85</sup> H.C. Deb. 11 October 2004, Vol.425, Col.4WS.

<sup>86</sup> Lewis, R. (2005) *Governing Foundation Trusts*, op cit., n.83 at p3.

<sup>87</sup> Timmins, N., 'Row erupts over health trusts', *Financial Times*, 20 February 2008.

<sup>88</sup> Addicott, R. and Frosini, F. (2012) 'Inside Foundation Trust Hospitals: Using archetype theory to understand how freedoms translate into practice' in Dickinson, H. and Mannion, R. (eds) *The Reform of Healthcare: Adapting and Resisting Policy Developments*. Basingstoke: Palgrave, pp139-150 at p145.

<sup>89</sup> Timmins, N., 'Row erupts over health trusts', op cit., n.87.

<sup>90</sup> Moyes, W. et al (2011) *Nothing to do with me? Modernising Ministerial Accountability for Decentralised Public Services*. London: Institute for Government, p32.

<sup>91</sup> Ibid at p34.

of State may consider themselves accountable and intervene, irrespective of the legal position, where a failing body threatens patient health or safety.<sup>92</sup> Alan Johnson (Secretary of State for Health between 2007 and 2009) was advised by Moyes that he was not responsible for dealing with the Mid Staffordshire scandal.<sup>93</sup> In reply, Johnson told Moyes to “piss off” as he would handle it.<sup>94</sup> Nicholas Timmins avers that ministerial behaviour trumps legislation.<sup>95</sup> The law may therefore be used to consolidate changes to public services, such as reducing ministerial responsibility, but it may not legitimise such changes where politicians and the public consider that ministers could or should intervene.

FTs provoked much opposition. In the cabinet, a dispute arose between Blair and Gordon Brown (Chancellor of the Exchequer between 1997 and 2007).<sup>96</sup> Brown was suspicious of giving greater autonomy to public agencies.<sup>97</sup> Eric Shaw states that Brown would not countenance granting FTs freedom to accumulate liabilities for which the Treasury would ultimately be responsible and was worried that FTs had an incentive to maximise private patient income and could financially destabilise PFI.<sup>98</sup> Andrew Rawnsley contends that the dispute was partly ideological, but also motivated by Brown’s desire “to make himself more popular within the Labour party at Blair’s

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<sup>92</sup> Ibid at p37.

<sup>93</sup> Johnson, A. (2015) ‘In their own words: Interviews with former Secretaries of State for Health’ in Timmins, N. and Davies, E. (eds) *Glaziers and Window Breakers: The role of the Secretary of State for Health in their own words*. London: Health Foundation, pp127-134 at p128.

<sup>94</sup> Ibid.

<sup>95</sup> Timmins, N. (2015) ‘History and Analysis’ in Timmins, N. and Davies, E. (eds) *Glaziers and Window Breakers: The role of the Secretary of State for Health in their own words*. London: Health Foundation, pp1-56 at p51.

<sup>96</sup> Ludlam, S. (2004) ‘Second Term New Labour’ in Ludlam, S. and Smith, M. (eds) *Governing as New Labour: Policy and Politics under Blair*. Basingstoke: Palgrave, pp1-15 at p8.

<sup>97</sup> Driver, S. (2008) ‘New Labour and Social Policy’ in Beech, M. and Lee, S. (eds) *Ten Years of New Labour*. Basingstoke: Palgrave, pp50-67 at p64.

<sup>98</sup> Shaw, E. (2007) *Losing Labour’s Soul? New Labour and the Blair Government 1997-2007*. Abingdon: Routledge, pp105-106.

expense”.<sup>99</sup> Ultimately, a compromise was reached, with Blair and Milburn winning on the principle that the best performing hospitals should be given more independence, while Blair caved into Brown regarding the central control of budgets.<sup>100</sup> Blair subsequently lamented that each NHS reform he pursued “was amended and adjusted; and occasionally-and each time to my chagrin-watered down”.<sup>101</sup>

At Labour’s conference in 2003, a union motion demanding that FTs be scrapped was carried, while a motion backing the government’s proposals for more choice in the NHS was defeated.<sup>102</sup> In parliament, FTs provoked the largest health policy rebellion ever by Labour MPs against their own government.<sup>103</sup> The government won the FT vote in November 2003 by seventeen votes.<sup>104</sup> Controversially, in votes on the FT legislation in both July and November 2003, Scottish Labour MPs helped to defeat rebellions, despite the fact that FTs were not being adopted in Scotland.<sup>105</sup> Some Labour backbenchers feared that if successful hospitals were awarded FT status and increased funding, it could accelerate the gap between them and the rest,<sup>106</sup> creating a two-tier health service.<sup>107</sup> Blair argued that two-tierism already existed, as the middle

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<sup>99</sup> Rawnsley, A. (2010) *The End of the Party: The Rise and Fall of New Labour*. London: Penguin, p78.

<sup>100</sup> Ibid at p81.

<sup>101</sup> Blair, T. (2010) *A Journey*. London: Hutchinson, p481.

<sup>102</sup> Brogan, B. et al., ‘Union Chiefs give Blair bloody nose’. *Telegraph*, 02 October 2003.

<sup>103</sup> Cowley, P. and Stuart, M. (2008) ‘A Rebellious Decade: Backbench Rebellions under Tony Blair, 1997-2007’ in Beech, M. and Lee, S. (eds) *Ten Years of New Labour*. Basingstoke: Palgrave, pp103-119 at p110.

<sup>104</sup> Ibid at p111.

<sup>105</sup> *Scotsman*., ‘Fury over ‘Lobby-Fodder’ Scots MPs’, 9 July 2003/BBC., ‘Labours NHS Plans Scrape through’, 19 November 2003.

<sup>106</sup> Ludlam, S. (2004) ‘Second Term New Labour’, op cit., n.96 at p7.

<sup>107</sup> An argument made, for example, by Frank Dobson. See H.C. Deb. 7 May 2003, Vol.404, Col.731.

class could afford to exit the NHS.<sup>108</sup> Mohan notes that New Labour politicians believed that increases in insurance coverage could engender a growing “reluctance to support public services”.<sup>109</sup> However, demand for private healthcare was relatively flat during the 2000s.<sup>110</sup> The incentive to go private was diminished because many believed that increased investment would lead to “great improvements”.<sup>111</sup> Some Parliamentarians<sup>112</sup> argued that FTs were necessary as NHS productivity had declined. The notion of declining NHS productivity in the 2000s became a “widely accepted fact”.<sup>113</sup> However, productivity actually increased.<sup>114</sup> Consonant with the above argument that FTs have not outperformed NHS trusts, Adriana Castelli et al’s research indicates that the latter tend to be more productive than the former.<sup>115</sup>

### Mimic-Market

In its second term, New Labour gradually introduced market-like mechanisms into the NHS.<sup>116</sup> Calum Paton identified four conflicting streams of policy steering within the NHS: the purchaser/provider split; targets; the new market; and, collaboration.<sup>117</sup>

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<sup>108</sup> Ludlam, S. (2004) ‘Second Term New Labour’, op cit., n.96 at p8.

<sup>109</sup> Mohan, J. (2002) *Planning, Markets and Hospitals*. London: Routledge, p223.

<sup>110</sup> Kings Fund (2014) *The UK Private Health Market*. London: Kings Fund, p2.

<sup>111</sup> An argument made, for example, by Angela Eagle. See H.C. Deb. 7 May 2003, Vol.404, Col.769.

<sup>112</sup> Such as Jon Owen Jones. See H.C. Deb. 7 May 2003, Vol.404, Col.778.

<sup>113</sup> Black, N. (2012) ‘Declining Health-Care Productivity in England: The Making of a Myth’. *The Lancet*, Vol.379(9821), pp1167-1169 at p1167.

<sup>114</sup> Ibid.

<sup>115</sup> Castelli, A. et al (2015) ‘Examining Variations in hospital productivity in the English NHS’. *European Journal of Health Economics*, Vol.16(3), pp243-254 at p249.

<sup>116</sup> Mays, N. et al (2011) ‘Return to the Market: Objectives and Evolution of New Labour’s Market Reforms’ in Mays, N. et al *Understanding New Labour’s Market Reforms of the English NHS*. London: Kings Fund, pp1-15 at p6.

<sup>117</sup> Paton, C. (2006) *New Labour’s State of Health: Political Economy, Public Policy and the NHS*. Aldershot: Ashgate, p134.

Paton explains New Labour's ever changing and accumulating policy with reference to the garbage-can model.<sup>118</sup> This views problems, politics and policies as separate streams.<sup>119</sup> Paton avers that the factors bringing the streams together leading to policy decisions are non-rational and contained within "ideological tramlines which are reinforced over time".<sup>120</sup> Paton states that the conditions for garbage-can policy-making were enabled by factors such as Labour's susceptibility to policy solutions indicating that it was not left-wing and the captivity of an insider policy community "with the 'reform' agenda in general and 'the market' in particular".<sup>121</sup> The Department of Health set out a coherent framework for the piecemeal reforms in '*Health Reform in England: Update and Next Steps*': demand side reforms (more choice and stronger voice); supply side reforms (more diverse providers); transactional reforms (money following patients); and, system management reforms concerning quality and safety.<sup>122</sup> Crisp stated that such reforms were "heavily influenced by economists".<sup>123</sup>

Alan Cribb contends that Labour were able to go further than their Conservative predecessors as they were perceived as ideological friends of the NHS.<sup>124</sup> However, as Sally Ruane notes, "one of the consequences of marketization and growing privatisation was the emergence of groups of citizens organising to resist further

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<sup>118</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England's Permanent Revolution*. London: Palgrave, p47.

<sup>119</sup> Ibid at p123.

<sup>120</sup> Ibid at p124.

<sup>121</sup> Ibid at p47.

<sup>122</sup> Department of Health (DOH) (2007) *Health Reform in England: Update and Next Steps*. London: DOH, p3.

<sup>123</sup> Crisp, N. (2011) *24 hours to save the NHS: The Chief Executives Account of Reform 2000 to 2006*. Oxford: Oxford University Press, p77.

<sup>124</sup> Cribb, A. (2008) 'Organizational Reform and health care goods: Concerns about marketization in the UK NHS'. *Journal of Medicine and Philosophy*, Vol.33(3), pp221-240 at p225.

developments”.<sup>125</sup> In 2005/06, numerous trusts reported deficits. Their finances had been detrimentally affected by PFIs, ISTCs and payment by results (PBR).<sup>126</sup> In response, Patricia Hewitt (Secretary of State for Health between 2005 and 2007) demanded that financial management override clinical objectives.<sup>127</sup> Michael Mandelstam and Colin Leys contend that the government’s concern to balance the books was due to its desire to facilitate competition.<sup>128</sup> PCTs were informed that they should, generally, not be employing staff or providing services directly<sup>129</sup> and many closed and diminished their community hospitals.<sup>130</sup> This provoked opposition from Community Hospitals Acting Nationally Together (CHANT), established by Conservative MP Graham Stuart in 2005, which “campaigned vigorously” against such closures.<sup>131</sup> Ruane noted that many services were centralised (for example, maternity services in Greater Manchester) despite the absence of clear evidence that this would benefit patients.<sup>132</sup> The financial strategies had apparently brought the NHS back into balance by 2008.<sup>133</sup> Keep Our NHS Public (KONP) was founded, in 2005, by the NHS Consultants Association,<sup>134</sup> the NHS Support Federation<sup>135</sup> and Health Emergency.<sup>136</sup> KONP co-ordinated campaigns across England,<sup>137</sup> including a rally

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<sup>125</sup> Ruane, S. (2016) ‘Market reforms and privatisation in the English National Health Service’. *Cuadernos de Relaciones Laborales*, Vol.34(2), pp263-291 at p280.

<sup>126</sup> Health Committee (2006) *NHS Deficits, First Report, House of Commons Session 2006-07, Vol.I*. London: Stationery Office, p30 and p38.

<sup>127</sup> Carvel, J., ‘NHS Told: Put Money before Medicine’. *Guardian*, 23 January 2006.

<sup>128</sup> Mandelstam, M. (2007) *Betraying the NHS: Health Abandoned*. London: Jessica Kingsley, p88/ Leys, C. (2006) ‘The Great NHS ‘Deficits Con’’. *Red Pepper*, 1 May 2006.

<sup>129</sup> Mandelstam, M. (2007) *Betraying the NHS*, op cit., n.128 at p76.

<sup>130</sup> Ibid at p91.

<sup>131</sup> Ibid at p106.

<sup>132</sup> Ruane, S. (2007) ‘Can we Safely Ditch the District General Hospital?’ *Radical Statistics*, Vol.95, pp26-30 at p29.

<sup>133</sup> Exworthy, M. et al (2010) *Decentralisation and Performance: Autonomy and Incentives in Local Health Economies*. Southampton: National Coordinating Centre for the Service Delivery and Organisation, p143.

<sup>134</sup> Which changed its name to Doctors for the NHS in 2014.

<sup>135</sup> Founded by Harry Keen in 1990.

<sup>136</sup> Established in 1984.

<sup>137</sup> BBC., ‘Rally plan for NHS reform meeting’, 29 November 2006.

outside parliament, in November 2006, to oppose cuts and privatisation.<sup>138</sup> KONP argued that the government was transforming the NHS into a tax-funded insurer through patchwork privatisation.<sup>139</sup> By 2010, 1,000 people had joined KONP and thirty-three local groups had been established.<sup>140</sup>

### Transactional Reforms and System Management

PBR, through which providers are paid according to a tariff, based on the applicable healthcare resource group (HRG), was gradually introduced from 2002.<sup>141</sup> Although PBR was adopted to increase efficiency, Pollock et al state that policymakers did not recognise that costs are also affected by “historical factors such as the cost of buildings and equipment and the mix of specialities and types of care provided”.<sup>142</sup> PBR (now known as the national tariff) has continued since 2010, but is not used for some services, such as community and mental health services, which proved difficult to create HRGs for.<sup>143</sup> A national study in 2016 found that the tariff was not appropriate for all the circumstances that it had been designed for (hence many providers may have been inadequately reimbursed) and that the allocation of financial risk was often dealt with outside the formal rules.<sup>144</sup> PBR created perverse incentives (for example,

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<sup>138</sup> BBC., ‘NHS rally told of cuts ‘disgrace’’, 1 November 2006.

<sup>139</sup> Nunns, A. (2006) *The Patchwork Privatisation of our Health Service: A User’s Guide*. London: Keep Our NHS Public, p3.

<sup>140</sup> Health Committee (2010) *Commissioning, Fourth Report, House of Commons Session 2009-10, Vol.II*. London: Stationery Office, Ev.129.

<sup>141</sup> Department of Health (2002) *Delivering the NHS Plan. Next Steps on Investment, Next Steps on Reform*. London: Stationery Office, p20.

<sup>142</sup> Pollock, A. et al (2003) ‘NHS and the Health and Social Care Bill’, op cit., n.36.

<sup>143</sup> Allen, P. and Petsoulas, C. (2016) ‘Pricing in the English NHS quasi-market: A National study of the allocation of financial risk through contracts’. *Public Money and Management*, Vol.36(5), pp341-348 at p343.

<sup>144</sup> Ibid at p347.

to discharge patients more swiftly<sup>145</sup>) and is estimated to have increased costs by around £100k to £180k in hospital trusts and from £90k to £190k in PCTs.<sup>146</sup> Commissioning for Quality and Innovation (CQUIN) was adopted (to overlay PBR),<sup>147</sup> in 2008, along with Patient Reported Outcome Measures (PROMS)<sup>148</sup> and quality accounts (QAs),<sup>149</sup> in an effort to improve quality.<sup>150</sup> Additionally, a never events framework was adopted.<sup>151</sup> The Health Committee expressed concern that such initiatives were not piloted or rigorously evaluated.<sup>152</sup> Such measures are indicative of identity thinking as the quality of the data produced is questionable. For example, Catherine Foot et al found that there was significant room for improving coding for QAs.<sup>153</sup>

## Commissioning

New Labour sought to improve commissioning through policies, such as practice based commissioning (PBC) and world class commissioning (WCC), and by encouraging PCTs to purchase expertise from outside agencies, via the Framework

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<sup>145</sup> Lister, J. (2008) *The NHS After 60: For Patients or Profits?* London: Middlesex University Press, p160.

<sup>146</sup> Marini, G. and Street, A. (2006) *The Administrative Costs of Payment by Results: Research Paper 17*. York: Centre for Health Economics, piii.

<sup>147</sup> Department of Health (DOH) (2008) *High Quality Care for all: NHS Next Stage Review Final Report*. London: DOH, p42.

<sup>148</sup> Ibid.

<sup>149</sup> Ibid at p11/Health Act (2009), S.8.

<sup>150</sup> Department of Health (2008) *High Quality Care for all*, op cit., n.147 at p42.

<sup>151</sup> National Patient Safety Agency (NPSA) (2009) *Never Events Framework 2009/10 Process and action for Primary Care Trusts 2009/10*. London: NPSA

<sup>152</sup> Health Committee (2010) *Commissioning, Fourth Report, House of Commons Session 2009-10, Vol.1*. London: Stationery Office, p63.

<sup>153</sup> Foot, C. et al (2011) *How do Quality Accounts Measure up?* London: Kings Fund, p21.



for External Support for Commissioners (FESC).<sup>154</sup> PBC was a voluntary scheme in which GPs were allocated indicative budgets to commission services for their patients. PCTs continued to contract the services.<sup>155</sup> Ian Greener and Russell Mannion contended that policymakers had not learned lessons from GP fundholding and that PBC would increase transaction costs and inequities in access and reduce patient satisfaction.<sup>156</sup> Most practices were involved in PBC, although nominally in some cases.<sup>157</sup> Many stakeholders believed that the signals from central government were that PBC was less important than other goals (such as targets).<sup>158</sup> Natasha Curry et al state that the lack of reliable quantified data means it is unclear whether PBC was cost-effective.<sup>159</sup> The belief that PCTs were too passive and had failed to improve service quality or the pattern of service provision led to WCC being introduced in 2007.<sup>160</sup> WCC was intended to lead to better health and well-being (including reduced health inequalities), better care and better value.<sup>161</sup> Eleven organisational competencies for commissioners were established (including stimulating the market and promoting improvements and innovations<sup>162</sup>), an assurance system was emplaced and support and development tools were provided.<sup>163</sup> Chris Naylor and Nick Goodwin found that PCTs deemed the competency framework to be useful but saw the assurance process as top-down and bureaucratic.<sup>164</sup>

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<sup>154</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at p14.

<sup>155</sup> Ibid at p13.

<sup>156</sup> Greener, I. and Mannion, R., 'Does Practice based commissioning avoid the problems of fundholding?' *British Medical Journal* 2006;333:1168.

<sup>157</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at p18.

<sup>158</sup> Curry, N. et al (2008) *Practice Based Commissioning: Reinvigorate, Replace or Abandon*. London: Kings Fund, p46.

<sup>159</sup> Ibid at p25.

<sup>160</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at pp27-28.

<sup>161</sup> Department of Health (DOH) (2007) *World Class Commissioning: Vision*. London: DOH, p1.

<sup>162</sup> Ibid at p5.

<sup>163</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at p46.

<sup>164</sup> Naylor, C. and Goodwin, N. (2010) *Building High Quality Commissioning: What Role Can External Organisations Play?* London: Kings Fund, p45.

In October 2007, Johnson approved a list of fourteen companies, including United Health and Humana, that would advise on and take over the commissioning of NHS services.<sup>165</sup> Lister likened this to putting Count Dracula in charge of a blood bank, as it involved a clear conflict of interest.<sup>166</sup> In 2010, seventy-six percent of PCTs confirmed that they were using external support.<sup>167</sup> Although competition was not compulsory, an EU public procurement directive,<sup>168</sup> (implemented into UK law via the Public Contract Regulations<sup>169</sup>) applied where external support was procured.<sup>170</sup> Naylor and Goodwin noted that external support was provided by various organisations and involved short-term consultancy, long-term joint delivery, outsourcing of discrete elements of the commissioning process or full outsourcing of most or all of the commissioning function.<sup>171</sup> The Health Committee stated that FESC was an expensive way of addressing PCT's shortcomings<sup>172</sup> and doubted the ability of PCTs to use external consultants effectively.<sup>173</sup> It estimated that the purchaser/provider split had increased transaction costs by fourteen percent and suspected that the Department of Health did "not want the full story to be revealed"

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<sup>165</sup> Pilger, J., 'John Pilger on how Labour's 'reforms' are destroying the NHS'. *New Statesman*, 1 November 2007.

<sup>166</sup> Lister, J. (2008) *The NHS After 60*, op cit., n.145 at p184.

<sup>167</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at p53.

<sup>168</sup> Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the Co-ordination of procedures for the award of public work contracts, public supply contracts and public service contracts, OJ L.134, 30 April 2004.

<sup>169</sup> Public Contract Regulations, SI 2006/5.

<sup>170</sup> UNISON (2008) *From Commissioning to Contract Evaluation: UNISON's Guide to Campaigning and Negotiating around Procurement*. London: UNISON, p63.

<sup>171</sup> Naylor, C. and Goodwin, N. (2010) *Building High Quality Commissioning*, op cit., n.164 at ppviii-ix.

<sup>172</sup> Health Committee (2010) *Commissioning, Vol.I*, op cit., n.152 at p53

<sup>173</sup> *Ibid* at p63.

as it did not provide clear and consistent information.<sup>174</sup> It concluded that if improvements in commissioning did not occur, the split should be abolished.<sup>175</sup>

The second dimension of juridification identified by Lars Blichner and Anders Molander, whereby law comes to regulate an increasing number of activities,<sup>176</sup> describes the effect of Labour's market reforms which meant that EU public procurement and competition laws became increasingly applicable to the English NHS. It has been argued, for example by Kyriaki-Korina Raptopoulou<sup>177</sup> and Tamara Hervey and Jean McHale,<sup>178</sup> that following privatisation an EU member cannot renationalise health services. Consequently, such laws could potentially constrain healthcare policymaking consonant with Stephen Gill's notion of new constitutionalism.<sup>179</sup> The EU has competencies relating to pharmaceutical regulation, recognition of professional qualifications<sup>180</sup> and public health.<sup>181</sup> Greer states that, consistent with neo-functional theory, the European Commission and decisions of the Court of Justice of the European Union (CJEU), created, without demand, other EU health policies.<sup>182</sup> The CJEU extended the EU's authority through decisions on patient

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<sup>174</sup> Ibid at p3.

<sup>175</sup> Ibid at p5.

<sup>176</sup> Blichner, L. and Molander, A. (2008) 'Mapping Juridification'. *European Law Journal*, Vol.14(1), pp36-54 at pp38-39.

<sup>177</sup> Raptopoulou, K. (2015) *EU Law and Healthcare Services: Normative Approaches to Public Health Systems*. AH Alphen aan den Rijn: Kluwer Law International, p116.

<sup>178</sup> Hervey, T. and McHale, J. (2015) *European Union Health Law: Themes and Implications*. Cambridge: Cambridge University Press, p545.

<sup>179</sup> Gill, S. (2008) *Power and Resistance in the new world order: 2<sup>nd</sup> edition*. Basingstoke: Palgrave, p79.

<sup>180</sup> Hancher, L. and Sauter, W. (2012) *EU Competition and Internal Market Law in the Health Sector*. Oxford: Oxford University Press, p2.

<sup>181</sup> Hervey, T. (2011) 'If only it were so simple: Public Health Services and EU Law' in Cremona, M. (ed) *Market Integration and Public Services in the European Union*. Oxford: Oxford University Press, pp179-250 at p181/Article 168 TFEU.

<sup>182</sup> Greer, S. (2006) 'Uninvited Europeanization: Neofunctionalism and the EU in health policy'. *Journal of European Public Policy*, Vol.13(1), pp134-152 at p140/Greer, S. (2009) *The Politics of European Union health policies*. Maidenhead: Open University Press, p3.

mobility, the working time directive<sup>183</sup> and the applicability of competition, public procurement and other internal market law.<sup>184</sup> Guglielmo Carchedi contends that spillover and spillback effects within the EU are influenced by class interests.<sup>185</sup> Commercial insurance companies and pharmaceutical corporations have exerted pressure for health services to be included within the single market<sup>186</sup> but many private health companies have preferred to lobby member states rather than the EU.<sup>187</sup> It was confirmed, in *Watts v Bedford PCT*,<sup>188</sup> that patient mobility case law applied to NHS systems.<sup>189</sup> English patients could therefore receive treatment in another member state and the UK government would be required to pay, if there had been undue delay.<sup>190</sup> The case law crystallized into the patient rights directive (PRD).<sup>191</sup> Raptopoulou states that PRD may harmonize the operation of healthcare services as it imposes responsibilities on the member state of treatment and gives the commission the (equivocal) competence to regulate the quality and safety of health services through European Reference Networks (ERNs).<sup>192</sup>

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<sup>183</sup> Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time, OJ L. 299, 18 November 2003.

<sup>184</sup> Greer, S. (2008) 'Choosing paths in European Union health policy: A Political analysis of a Critical Juncture'. *Journal of European Social Policy*, Vol.18(3), pp219-231 at p224.

<sup>185</sup> Carchedi, G. (2001) *For Another Europe: A Class Analysis of European Economic Integration*. London: Verso, p8.

<sup>186</sup> Saltman, R. and Vrangbaek, K. 'Looking Forward: Future Policy Issues' in Magnussen, J. et al (eds) (2009) *Nordic Health Care Systems: Recent Reforms and Current Policy Challenges*. Maidenhead: Open University Press, pp78-104 at p96.

<sup>187</sup> Greer, S. (2011) 'The Changing World of European Health Lobbying' in Coen, D. and Richardson, J. (eds) *Lobbying the European Union: Institutions, Actors and Issues*. Oxford: Oxford University Press, pp189-211 at p190.

<sup>188</sup> *The Queen, ex parte Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health* (2006), C-372/04, EU:C:2004:325.

<sup>189</sup> Hancher, L. and Sauter, W. (2012) *EU Competition and Internal Market Law in the Health Sector*, op cit., n.179 at p73.

<sup>190</sup> Veitch, K. (2012) 'Juridification, Medicalisation and the impact of EU law: Patient mobility and the allocation of scarce NHS resources'. *Medical Law Review*, Vol.20(3) pp362-398 at p377.

<sup>191</sup> Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross border healthcare, OJ L. 88, 04 April 2011.

<sup>192</sup> Raptopoulou, K. (2015) *EU Law and Healthcare Services*, op cit., n.177 at pp213-214.

The *Watts* case and the PRD are indicative of the first (constitutive juridification) and third (whereby conflicts are increasingly solved by or with reference to law) dimensions of juridification identified by Blichner and Molander.<sup>193</sup> In respect of the former, Kenneth Veitch contended that the expansion of EU law, through the creation of patient rights, threatened the community ethos on which the NHS was founded.<sup>194</sup> Similarly, John Harrington stated that health tourism poses a threat to the solidaristic basis of national healthcare systems.<sup>195</sup> In respect of the latter, Veitch contends that fundamental political issues, questions and conflicts pertaining to the liberalisation of hospital services were distorted, as the question of whether money should be diverted to providers abroad, and its consequent impact on government finances and healthcare planning, was converted into a question of the particular clinical needs of individual patients.<sup>196</sup> Veitch states that the rights created by *Watts* and the PRD are a means of increasing demand for cross-border services and the role of commercial providers.<sup>197</sup> Nonetheless, McHale notes that few patients seek treatment in other EU jurisdictions.<sup>198</sup>

EU member states can deliver public services through the public sector but, as Ben Collins notes, EU public procurement law and competition law become applicable

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<sup>193</sup> Blichner, L. and Molander, A. (2008) 'Mapping Juridification', op cit., n.176 at pp36-37.

<sup>194</sup> Veitch, K. (2012) 'Juridification, Medicalisation and the impact of EU law', op cit., n.190 at p391.

<sup>195</sup> Harrington, J. (2007) 'Law, Globalisation and the NHS'. *Capital and Class*, Vol.31(2), pp81-104 at p94.

<sup>196</sup> Veitch, K. (2012) 'Juridification, Medicalisation and the impact of EU law', op cit., n.190 at pp387-390.

<sup>197</sup> Ibid at p394.

<sup>198</sup> McHale, J. (2011) 'Health Care, the United Kingdom and the Draft Patient Rights Directive: One Small Step for Patient Mobility but a Huge Leap for a reformed NHS?' in van de Gronden, J. et al (eds) *Health Care and EU Law*. The Hague: TMC Asser Press, pp241-262 at p261.

once markets are used.<sup>199</sup> EU public procurement law was formulated to prevent discrimination on the grounds of nationality.<sup>200</sup> The aforementioned procurement directive distinguished between part A services (including management and procurement consultancy services) and part B services (including health and social care services).<sup>201</sup> Contracts relating to part B services were only subject to Article 23 (concerning technical specifications) and Article 35(4) (concerning notices) of the directive (as per Article 21). Nonetheless, contracting authorities were required to comply with the principles of the treaties<sup>202</sup> including the free movement of goods, persons, services and capital,<sup>203</sup> the right of establishment,<sup>204</sup> the freedom to provide services<sup>205</sup> and the principles deriving therefrom (transparency, equal treatment, non-discrimination, proportionality and mutual recognition).<sup>206</sup>

The procurement rules are not applicable if an authority decides to provide services in-house or if, as per the *Teckal*<sup>207</sup> case, it exercises control over the provider similar to its control over its own internal departments and the provider undertakes the

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<sup>199</sup> Collins, B. (2015) *Procurement and Competition Rules: Can the NHS be Exempted?* London: Kings Fund, p3.

<sup>200</sup> Ibid at p2.

<sup>201</sup> Outlined in Annex I and II of the Directive.

<sup>202</sup> The Treaty of Rome (Treaty Establishing the European Economic Community (TEEC)) (signed 25 March 1957; entered into force 1 January 1958) 298 U.N.T.S. 11, created the European Economic Community (EEC). The Treaty on European Union (TEU) (Maastricht Treaty) (signed 7 February 1992, entered into force 1 November 1993) OJ C [1992] 191/1, renumbered the TEEC and renamed it the Treaty Establishing the Economic Community (TEC). The Treaty of Lisbon amending the TEU and the TEC (Lisbon Treaty) (signed 13 December 2007; entered into force 1 December 2009) OJ C [2007] 306/1, renumbered the TEC and renamed it the Treaty on the Functioning of the European Union (TFEU) and also renumbered the TEU. Consolidated versions of the TFEU and TEU were published in 2016.

<sup>203</sup> Consolidated version of the TFEU, OJ C [2016] 202, Article 26(2).

<sup>204</sup> Ibid at Article 49.

<sup>205</sup> Ibid at Article 56.

<sup>206</sup> Directive 2004/18/EC, Recital 2, Preamble.

<sup>207</sup> *Teckal Srl v Comune di Viano and Azienda Gas-Acqua Consorziale (AGAC) di Reggio Emilia*, C-107/98, EU:C:1999:562.

essential part of its activities with the authority.<sup>208</sup> NHS contracts (which are not legally enforceable) between PCTs and NHS Trusts (not FTs) would therefore be exempt.<sup>209</sup> However, Timmins states that EU public procurement law was becoming more applicable as more care began to be bought through legally binding contracts.<sup>210</sup> The re-embedding of private law mechanisms, indicative of Scott Veitch et al's notion of a fifth epoch of juridification,<sup>211</sup> engaged EU law. Timmins stated that the more the private sector invested, the more likely they were to challenge non-compliance.<sup>212</sup> Greer contends that policymakers therefore engaged in Europe proofing, erecting defences against challenge by reducing the discretion of NHS actors by forcing them to comply with EU public procurement law.<sup>213</sup> Greer and Simone Rauscher state that Labour opted to force such law into health services, as it was a logical consequence of, and a means to lock in, a clinical services market.<sup>214</sup> The Co-operation and Competition Panel (CCP) was established, in 2009, to judge potential breaches<sup>215</sup> of guidance published in 2007,<sup>216</sup> which contained EU legal positions.<sup>217</sup>

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<sup>208</sup> Collins, B. (2015) *Procurement and Competition Rules*, op cit., n.198 at p5/Hancher, L. and Sauter, W. (2012) *EU Competition and Internal Market Law in the Health Sector*, op cit., n.180 at pp147-148.

<sup>209</sup> Brown, I. (2013) 'EU Competition law and the NHS'. [On-line] Available: <http://www.sochealth.co.uk/2013/03/11/eu-competition-law-and-the-nhs/> [Accessed: 13 November 2016].

<sup>210</sup> Timmins, N., 'More NHS services set to go out for tender', *Financial Times*, 17 May 2008.

<sup>211</sup> Veitch, S. et al (2012) *Jurisprudence: Themes and Concepts 2<sup>nd</sup> edition*. Abingdon: Routledge, p262.

<sup>212</sup> Timmins, N., 'European Law looms over NHS contracts', *Financial Times*, 16 January 2007.

<sup>213</sup> Greer, S. (2009) *The Politics of European Union health policies*, op cit., n.182 at p128.

<sup>214</sup> Greer, S. and Rauscher, S. (2011) 'When does market-making make markets? EU Health services policy at work in the United Kingdom and Germany'. *Journal of Common Market Studies*, Vol.49(4), pp797-822 at p812.

<sup>215</sup> Co-operation and Competition Panel (CCP)(2009) *Co-operation and Competition Panel begins work today*. London: CCP, p1.

<sup>216</sup> Department of Health (DOH) (2007) *Principles and Rules for Co-operation and Competition*. London: DOH.

<sup>217</sup> Owen, D. (2015) 'The EU has become an increasing danger to our NHS'. [On-line] Available: <https://www.opendemocracy.net/ourkingdom/david-owen/eu-has-become-increasing-danger-to-our-nhs> [Accessed: 27 June 2016].

EU competition law is designed to ensure that competition, where it exists, benefits consumers.<sup>218</sup> Elias Mossialos and Julia Lear aver that it is often unclear, from the complex case law, to what extent EU competition law is engaged when elements of competition are introduced.<sup>219</sup> A service is subject to the competition rules if it is economic and the provider is an undertaking.<sup>220</sup> Okeoghene Odudu states that activities are economic firstly, if an entity supplies goods or services to the market.<sup>221</sup> Secondly, an activity is economic if, absent legislative intervention, there is the potential to make profit,<sup>222</sup> as per the *Bettercare Group Limited*<sup>223</sup> case. Odudu states that this is a technical question (not normative or ideological) concerning whether a service could be provided merely to those that pay.<sup>224</sup> Odudu distinguished between smallpox immunisation,<sup>225</sup> which he contends would have to be provided to all, as eighty to eighty-five percent of a population would need to be immunised to achieve herd immunity, and hip replacements, which could, hypothetically, be provided only to fee-payers.<sup>226</sup>

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<sup>218</sup> Collins, B. (2015) *Procurement and Competition Rules*, op cit., n.199 at p2.

<sup>219</sup> Mossialos, E. and Lear, J. (2012) 'Balancing Economic Freedom against Social Policy Principles: EC Competition Law and national health systems'. *Health Policy*, Vol. 106(2), pp127-137 at p127.

<sup>220</sup> Greer, S. et al (2014) *Everything you always wanted to know about European Union health policies but were afraid to ask*. Brussels: World Health Organisation, p101.

<sup>221</sup> Odudu, O. (2011) 'Are State owned healthcare providers that are funded by general taxation undertakings subject to competition law?' *European Competition Law Review*, Vol.32(5), pp231-241 at p233.

<sup>222</sup> Ibid.

<sup>223</sup> *Bettercare Group Limited v Director General of Fair Trading* (Competition Commission Appeal Tribunal) (2002) CAT 7.

<sup>224</sup> Odudu, O. (2011) 'Are State owned healthcare providers that are funded by general taxation undertakings subject to competition law?' op cit., n.221 at p236.

<sup>225</sup> As the smallpox virus has been eradicated, except for samples retained at approved centres (World Health Assembly, *Resolution WHA 33.4: Global Smallpox Eradication*, 14 May 1980), this disease was chosen for illustrative purposes.

<sup>226</sup> Odudu, O. (2011) 'Are State owned healthcare providers that are funded by general taxation undertakings subject to competition law?' op cit., n.221 at p236.



The EU treaties do not define what constitutes an undertaking.<sup>227</sup> Odudu states that an entity may be considered an undertaking regarding some activities but not others, even if it is not for profit.<sup>228</sup> Odudu concluded that although English NHS hospitals are state owned and funded and provide universal coverage, free at the point of delivery, they “fall within the scope of EU competition law”.<sup>229</sup> In contrast, Simon Taylor states that it could be credibly argued that NHS providers are only economic operators concerning activities that have been exposed to competition.<sup>230</sup> There are exemptions to competition law. For example, Mossialos and Lear state that the service of general economic interest (SGEI) exception in Article 106(2) of the TFEU can be seen as a defence.<sup>231</sup> The courts will assess whether the measure relating to the SGEI is proportional.<sup>232</sup>

SGEI is part of a broader family of related and overlapping EU concepts. The other concepts include services of general interest (SGI), which is not part of any binding legal text, and social services of general interest (SSGI) and non-economic services of general interest (NESGI), which are mentioned in the Lisbon Treaty.<sup>233</sup> NESGIs “are, in principle, completely out of reach of the competition rules”.<sup>234</sup> Such concepts

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<sup>227</sup> Ibid at p232.

<sup>228</sup> Ibid.

<sup>229</sup> Ibid at p238.

<sup>230</sup> Taylor, S. (2015) ‘Competition in the new NHS- When should an NHS commissioner go out to tender for clinical services?’ [On-line] Available: <http://www.keatingchambers.com/wp-content/uploads/2016/02/Competition-in-the-new-NHS.pdf> [Accessed: 9 November 2016], p6.

<sup>231</sup> Mossialos, E. and Lear, J. (2012) ‘Balancing Economic Freedom against Social Policy Principles’, op cit., n.219 at p130.

<sup>232</sup> Ibid.

<sup>233</sup> Neergaard, U. (2013) ‘The Concept of SSGI and the asymmetries between free movement and competition law’ in Neergaard, U., et al (eds) *Social Services of General Interest in the EU*. The Hague: TCM Asser Press, pp205-244 at pp207-210/Lisbon Treaty, Protocol 26.

<sup>234</sup> Neergaard, U. (2013) ‘The Concept of SSGI and the asymmetries between free movement and competition law’, op cit., n.233 at p237.

are not integrated into the law of member states or common in national vocabularies.<sup>235</sup> Consequently, their applicability is unclear. Ulla Neergaard notes that the concept of solidarity (internal to member states) has also become increasingly significant in EU law, but that the degree of immunity it affords is unclear.<sup>236</sup> In 2006, the government commissioned, but did not publish, a legal opinion on the effect of EU law on the NHS.<sup>237</sup> Ken Anderson (Commercial Director at the Department of Health between 2003 and 2007) stated that once services are opened to competition “at some point European law will take over and prevail”.<sup>238</sup> Anderson averred that England had passed that point.<sup>239</sup> There appears to have been a lack of awareness of the potentially constraining effect of EU laws on NHS policymaking as it was not discussed in parliament prior to 2010. Nonetheless, some politicians were aware. For example, Frank Dobson advised Blair to seek an exemption for the NHS in the Lisbon Treaty,<sup>240</sup> but this did not materialise. I examine EU public procurement and competition law further in chapter six.

## Patient Choice

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<sup>235</sup> Bauby, P. (2013) ‘Unity and Diversity of SSGIs in the European Union’ in Neergaard, U., et al (eds) *Social Services of General Interest in the EU*. The Hague: TCM Asser Press, pp25-52 at p36.

<sup>236</sup> Neergaard, U. (2011) ‘EU Health Care in a Constitutional Light: Distribution of Competences, Notions of ‘Solidarity’ and Social Europe’ in van de Gronden, J. et al (eds) *Health Care and EU Law*. The Hague: TMC Asser Press, pp19-58 at pp48-49.

<sup>237</sup> Owen, D. (2015) ‘The EU has become an increasing danger to our NHS’, op cit., n.217.

<sup>238</sup> Ibid.

<sup>239</sup> Ibid.

<sup>240</sup> Dobson, F. (2013) ‘Parliamentarians’ in Timmins, N. (ed) *The Wisdom of the Crowd: 65 Views of the NHS at 65*. London: Nuffield Trust, pp39-42 at p41.

Catherine Needham found that the word ‘consumer’ appeared more frequently in New Labour’s policy texts for health than other policy areas.<sup>241</sup> As mentioned in chapter three, consumerism is indicative of identity thinking and the standardization strategy of the ideological mode of unification. Nonetheless, New Labour’s interpellation of patients as consumers faced recalcitrance.<sup>242</sup> NHS patients have always had choices, for example of their GP and to go private.<sup>243</sup> However, Marianna Fotaki notes that choice was not on the NHS policy agenda until the 1990s.<sup>244</sup> Alex Mold contends that since the 1990s, successive governments have prioritised choice above other patient rights.<sup>245</sup> Patient choice is indicative of the self-responsibilization tactic of depoliticisation because, as Veitch noted, it deflects possible criticism from the government’s management of public expenditure by passing responsibility onto patients.<sup>246</sup> Consumerism has reifying effects in rendering the collective consumption of services invisible and constructing “the public interest as a series of specific and individualised encounters”.<sup>247</sup> Labour’s 2001 manifesto promised to “give patients more choice”.<sup>248</sup> *‘Delivering the NHS Plan’* announced that patients who had waited six months for a heart operation could choose from various alternative providers (public or private) capable of offering earlier treatment.<sup>249</sup> Numerous pilot schemes

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<sup>241</sup> Needham, C. (2007) *The Reform of Public Services under New Labour: Narratives of Consumerism*. Basingstoke: Palgrave, p115.

<sup>242</sup> Clarke, J. (2007) “It’s not like Shopping”, op cit., n.1 at pp114-115.

<sup>243</sup> Greener, I. (2007) ‘Consumerism in Health Policy: Where did it come from and how can it work?’ in Hann, A. (ed) *Health Policy and Politics*. Aldershot: Ashgate, pp59-74 at p69.

<sup>244</sup> Fotaki, M. (2014) *What Market Based Patient Choice Can’t do for the NHS: The Theory and Evidence of how choice works in healthcare*. London: Centre for Health and the Public Interest, p6.

<sup>245</sup> Mold, A. (2015) ‘Complaining in the age of Consumption: Patients, Consumers or Citizens?’ in Reinartz, J. and Wynter, R (eds) *Complaints, Controversies and Grievances in Medicine: Historical and Social Science Perspectives*. Abingdon: Routledge, pp167-183 at p179.

<sup>246</sup> Veitch, K. (2010) ‘The government of health care and the politics of patient empowerment: New Labour and the NHS reform agenda in England’. *Law and Policy*, Vol.32(3), pp313-331 at p320.

<sup>247</sup> Clarke, J. (2004) ‘Dissolving the Public Realm? The Logics and Limits of Neo-liberalism’. *Journal of Social Policy*, Vol.33(1), pp27-48 at p39.

<sup>248</sup> Labour Party (2001) *Ambitions for Britain: Labour’s Manifesto 2001*. Labour: London, p22.

<sup>249</sup> Department of Health (2002) *Delivering the NHS Plan*, op cit., n.141 at p22.

were established,<sup>250</sup> such as the London Patient Choice Project (LPCP).<sup>251</sup> LPCP indicated that although reputation influenced patient's choices,<sup>252</sup> there was insufficient information on clinical quality and health outcomes.<sup>253</sup> The Department of Health concluded that choice was beneficial, before undertaking a national consultation in 2003, stating that it could improve access and reduce health inequalities.<sup>254</sup> Clarke et al note that New Labour sought "to disarm critics" by claiming that "choice could drive equality/equity".<sup>255</sup>

Simon Stevens and Zack Cooper and Julian Le Grand argued that choice could promote equity by putting pressure on low quality providers and furnishing poorer people with options only available to the middle class.<sup>256</sup> Le Grand averred that the models favoured by social democrats (trust and voice) would not generally deliver high quality, responsive, efficient or equitable services, but that "properly designed" choice and competition policies could.<sup>257</sup> Ian Greener and Martin Powell note that Le Grand portrayed patients as more willing to travel and use information than in his earlier work and had jettisoned his previous caveats (such as using agents to act on behalf of

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<sup>250</sup> Department of Health (DOH) (2007) *Choice Matters: 2007-8: Putting Patients in Control*. London: DOH, p6.

<sup>251</sup> Vizard, P. and Obolenskaya, P. (2013) *Labour's Record on health (1997-2010) Working Paper 2*. London: London School of Economics, p27.

<sup>252</sup> Burge, P. et al (2005) *London Patient Choice Project Evaluation: A Model of Patients Choices of Hospital from Stated and Revealed Preference Choice Data*. London: Rand, p60.

<sup>253</sup> Ibid at pxiii.

<sup>254</sup> Department of Health (DOH) (2003) *Choice, Responsiveness and Equity in the NHS and Social Care*. London: DOH, p3.

<sup>255</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers: Changing Publics and Changing Public Services*. London: Sage, p65.

<sup>256</sup> Stevens, S. (2003) 'Equity and Choice: Can the NHS offer both? A Policy Perspective' in Oliver, A. (ed) *Equity in Health and Healthcare*. London: Nuffield Trust, pp65-69 at p67/Cooper, Z. and Le Grand, J. (2008) 'Choice, Competition and the Political Left'. *Eurohealth*, Vol.13(4), pp18-20 at p19.

<sup>257</sup> Le Grand, J. (2007) *The Other Invisible Hand: Delivering Public Services Through Choice and Competition*. Princeton: Princeton University Press, p161.

patients).<sup>258</sup> John Spiers (a visiting fellow at the Institute of Economic Affairs) argued that choice was moral (as taking it away “undermines an individual’s dignity as a free, human person”) and instrumental (as it was “central to the power of change”).<sup>259</sup> Spiers lamented that New Labour’s NHS reforms did “not give the individual financially empowered choice”.<sup>260</sup> However, he thought that patient choice initiatives could open the door to patient fundholding.<sup>261</sup> Many argued that choice would widen inequalities.<sup>262</sup> Klein argued that “maximising individual patient choice is incompatible, given constrained budgets, with maximising the welfare of the patient population as a whole”.<sup>263</sup> Fotaki noted that patient choice would not reduce existing inequalities in geography or socio-economics affecting access.<sup>264</sup> Fotaki stated that policy narratives assumed that choice was a “highly rational process”<sup>265</sup> but that this had been challenged by theoretical developments and empirical evidence.<sup>266</sup> Paul Dorfman stated that the flight of ‘choosers’ could exacerbate inequalities for those not wishing, or unable, to travel, such as the sick and elderly.<sup>267</sup> Clarke et al concluded, from their qualitative research, that the notion that choice could drive equity had not “effectively colonised common sense”.<sup>268</sup> Blair also claimed that choice facilitates higher

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<sup>258</sup> Greener, I. and Powell, M. (2009) ‘The Other Le Grand? Evaluating the ‘Other Invisible Hand’ in Welfare Services in England’. *Social Policy and Administration*, Vol.43(6), pp557-570 at pp567-568.

<sup>259</sup> Spiers, J. (2008) *Who Decides Who Decides? Enabling choice, equity, access, improved performance and patient guaranteed care*. Oxford: Radcliffe, p50.

<sup>260</sup> Ibid at p87.

<sup>261</sup> Spiers, J. (2003) *Patients, Power and Responsibility: The First Principles of Consumer Driven Reform*. Abingdon: Radcliffe, p102.

<sup>262</sup> Shaw, E. (2007) *Losing Labour’s Soul?*, op cit., n.98 at p102.

<sup>263</sup> Klein, R. (2003) ‘A Comment on Le Grand’s paper from a Political Science Perspective’ in Oliver, A. (ed) *Equity in Health and Healthcare*. London: Nuffield Trust, pp36-39 at p39.

<sup>264</sup> Fotaki, M. (2007) ‘Patient Choice in Healthcare in England and Sweden: From Quasi- Market and back to Market? A Comparative Analysis of Failure in Unlearning’. *Public Administration*, Vol. 85(4), pp1059-1075 at p1069.

<sup>265</sup> Fotaki, M. (2010) ‘Individual Patient Choice in the English National Health Service: The Case for Social Fantasy Seen from Psychoanalytic Perspective’ in Currie, G. et al (eds) *Making Public Services Management Critical*. London: Routledge, pp176-191 at p176.

<sup>266</sup> Fotaki, M. (2007) ‘Patient Choice in Healthcare in England and Sweden’, op cit., n.264 at p1070.

<sup>267</sup> Dorfman, P. (2010) ‘From patients to consumers’ in Tritter, J. et al (eds) *Globalisation, Markets and Healthcare Policy*. Abingdon: Routledge, pp41-53 at p47.

<sup>268</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers*, op cit., n.255 at pp83-84

standards, but as Appleby et al noted, there is no inevitable link between choice and quality.<sup>269</sup> Mandelstam contends that nursing homes do not support the notion that markets operate to ensure the provision of good quality services.<sup>270</sup>

Blair argued, in a speech in 2006, that all developed countries were trying to deal with rising expectations, demands and cost pressures (ageing populations and technological advancements).<sup>271</sup> Such cost pressures were often cited by New Labour (and the subsequent coalition government) as reasons for reform.<sup>272</sup> The emphasis on alleged cost pressures caused by ageing populations may be used to differentiate citizens (a strategy of the ideological mode of fragmentation) into older people, with allegedly expensive health needs, and others, with less expensive health needs, which may undermine solidarity, something which the World Economic Forum<sup>273</sup> and McKinsey have envisaged.<sup>274</sup> The alleged burden of an ageing population is a myth because, as Jennifer Gill and David Taylor note, as people live longer, they tend to stay fitter.<sup>275</sup> Gill and Taylor calculated that the direct effects of an ageing population only increased costs by 0.2 percent per annum.<sup>276</sup>

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<sup>269</sup> Appleby, J. et al (2003) *What is the Real Cost of More Patient Choice?* London: Kings Fund, p35.

<sup>270</sup> Mandelstam, M. (2011) *How we Treat the Sick: Neglect and abuse in our Health Services*. London: Jessica Kingsley, p26.

<sup>271</sup> Blair, T. (2006) 'Speech to a meeting of the NHS Health Network Clinician Forum on 18 April 2006'. [On-line] Available: <http://www.nhshistory.net/tonyblair.htm> [Accessed: 14 February 2016].

<sup>272</sup> See, for example, *Evening Standard*, 'Hewitt Claims Reforms will Safeguard NHS'. 19 September 2006/Burnham, A., 'Reform is a Necessity'. *Public Private Finance*, 2 April 2007/Labour Party (2010) *Labour Party 2010 Manifesto A Future Fair for All*, op cit., n.76 at p4.2.

<sup>273</sup> An international organisation which promotes collaboration between the public and private sectors.

<sup>274</sup> World Economic Forum (WEF) and McKinsey (2013) *Sustainable Health Systems: Visions, Strategies, Critical Uncertainties and Scenarios*. Geneva: WEF and McKinsey, p17.

<sup>275</sup> Gill, J. and Taylor, D. (2012) *Active Ageing: Live Long and Prosper*. London: University College London, p2.

<sup>276</sup> Ibid.

Corinna Sorensen et al's literature review determined that technology could increase or decrease healthcare costs or be cost neutral.<sup>277</sup> There are different methodological approaches to evaluating the cost effect of technology: the residual approach, which assumes that technology is responsible for changes not accounted for by other quantifiable factors; the proxy approach, which involves using a proxy, such as research and development spending; and, case studies, which examine the costs of specific technologies.<sup>278</sup> The Organisation for Economic Co-operation and Development (OECD) determined that, of the 3.8 percent increase in UK health spending between 1970 and 2002, 1.5 percent was attributable to residuals (technology and relative prices).<sup>279</sup> However, the residual approach is an indirect measure, which may lead to overestimates.<sup>280</sup> Sorensen et al note that the proxy approach is only as good as the proxy indicator and that case studies suffer from sampling and generalizability problems.<sup>281</sup> Blair claimed that “greater competition between providers to improve both quality and efficiency” had changed a €3 billion deficit in Germany's statutory health insurance funds in 2003 into a €4 billion surplus in 2004.<sup>282</sup> However, such deficits arose despite competition between funds<sup>283</sup> and

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<sup>277</sup> Sorensen, C. et al (2013) 'Medical Technology as a key driver of rising health expenditure'. *ClinicoEconomics and Outcome Research*, Vol.5, pp223-234 at p226.

<sup>278</sup> Dybczak, K. and Pryzwara, B. (2010) *The Role of Technology in Healthcare Expenditure in the EU*. Brussels: European Commission, pp6-7.

<sup>279</sup> Organisation for Economic Co-operation and Development (OECD) (2006) *Projecting OECD health and long-term care expenditures: What are the main drivers?* OECD Economics Department Working Paper No.477. Paris: OECD, p33.

<sup>280</sup> Dybczak, K. and Pryzwara, B. (2010) *The Role of Technology in Healthcare Expenditure in the EU*, op cit., n.278 at p6.

<sup>281</sup> Sorensen, C. et al (2013) 'Medical Technology as a key driver of rising health expenditure', op cit., n.277 at p228.

<sup>282</sup> Ibid.

<sup>283</sup> Siadat, B. and Stolpe, M. (2005) 'Reforming Healthcare Finance: What can Germany learn from other countries?' Kiel Institute for World Economics, Policy Paper 5.

policies, such as limiting the range of benefits available, increasing co-payments and introducing charges for surgery visits, appear to explain the surplus.<sup>284</sup>

In 2004, the ‘*NHS Improvement Plan*’ stated that, by 2008, patients referred by their GP would be able to choose any provider that met NHS standards and tariffs<sup>285</sup> and predicted that the independent sector would “carry out up to fifteen percent of procedures per annum for NHS patients”.<sup>286</sup> The Department of Health rationalized that new market entrants would provide “additional new capacity” and act “as catalysts for innovation”.<sup>287</sup> It was subsequently announced that patients could choose between four to five hospitals, or suitable alternative providers, for numerous treatments, through Choose and Book (CAB), by December 2005.<sup>288</sup> CAB was part of the National Programme for IT (NPFIT), introduced in 2002, to provide central direction for IT development.<sup>289</sup> NPFIT sought to introduce an integrated care system, the NHS Care Records Service, consisting of a local detailed clinical record and a national summary clinical record.<sup>290</sup> Following a procurement process, in 2003-04, the Department of Health awarded five contracts (ten years in length) to four suppliers (British Telecom (BT), Accenture, Fujitsu and Computer Sciences Corporation) to deliver local care record systems.<sup>291</sup> NPFIT was beset by changing specifications,

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<sup>284</sup> Deutsche Bank (2014) *Statutory Health Insurance Scheme: Past Developments and Future Challenges*. Frankfurt: Deutsche Bank, p33.

<sup>285</sup> Department of Health (DOH) (2004) *The NHS Improvement Plan: Putting People at the Heart of Public Services*. London: DOH, p70.

<sup>286</sup> Ibid at p52.

<sup>287</sup> Ibid at p53.

<sup>288</sup> Department of Health (DOH) (2004) “*Choose and Book*”-*Patients Choice of Hospital and Booked Appointment: Policy Framework for Choice and Booking at the Point of Referral*. London: DOH, p3.

<sup>289</sup> National Audit Office (NAO) (2006) *Department of Health: The National Programme for IT in the NHS*. London: NAO, p1.

<sup>290</sup> Committee of Public Accounts (2007) *Department of Health: The National Programme for IT in the NHS, Twentieth Report, House of Commons Session 2006-07*. London: Stationery Office, p9.

<sup>291</sup> National Audit Office (NAO) (2011) *The National Programme for IT in the NHS: An update on the delivery of detailed care record systems*. London: NAO, p4.



technical challenges and clashes with suppliers (Accenture and Fujitsu departed in 2006 and 2008 respectively).<sup>292</sup> By January 2008, CAB was almost fully deployed, but utilisation was lower than expected.<sup>293</sup> The aim of a fully integrated electronic care records system was ultimately discarded.<sup>294</sup> NPFIT (which is estimated to have cost over £12 billion) was dismantled by the coalition, but component parts remain.<sup>295</sup> The Committee of Public Accounts determined that some of NPFIT's expected benefits may never materialise.<sup>296</sup>

In 2005 Labour stated that it wanted to continue to “encourage innovation and reform through the use of the independent sector” which, it rationalised, could “add capacity to, and drive contestability within, the NHS”.<sup>297</sup> As mentioned in chapter three, the arguments that the independent sector could encourage innovation and add capacity were undermined by the Health Committee's report into ISTCs. The increased involvement of the independent sector was opposed by UNISON which passed a motion at the 2005 Labour party conference attacking its growing role and the fragmentation and marketization of the NHS.<sup>298</sup> Nonetheless, Blair promised the NHS Partners Network (formed in 2005 to represent private healthcare companies<sup>299</sup>) more opportunities and predicted that private companies could provide up to forty percent

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<sup>292</sup> Wright, O., ‘NHS pulls the plug on its £11bn IT system’, *Independent*, 3 August 2011.

<sup>293</sup> National Audit Office (NAO) (2008) *The National Programme for IT in the NHS: Progress since 2006*. London: NAO, p13.

<sup>294</sup> Committee of Public Accounts (2011) *The National Programme for IT in the NHS: An update on the delivery of detailed care records systems, Forty-Fifth Report, House of Commons Session 2010-12*. London: Stationery Office, p3.

<sup>295</sup> Committee of Public Accounts (2013) *The Dismantled National Programme for IT in the NHS, Nineteenth Report, House of Commons Session 2013-14*. London: Stationery Office, p3.

<sup>296</sup> *Ibid.*

<sup>297</sup> Labour Party (2005) *Labour Party Manifesto 2005 Britain Forward not back*. Labour: London, p63.

<sup>298</sup> Shaw, E. (2007) *Losing Labour's Soul?*, op cit., n.98 at p96.

<sup>299</sup> The Independent Healthcare Association had been disbanded in 2004.

of NHS operations.<sup>300</sup> Patient choices were widened, in May 2006, as, in addition to local options, patients could choose from a national menu, the Extended Choice Network (ECN).<sup>301</sup> The NHS Choices website was launched, in June 2007, to inform choice.<sup>302</sup> Although it allowed patients to compare hospitals in terms of distance, travel, parking arrangements and Healthcare Commission rating, it contained limited and varied information about facilities, patient support and feedback.<sup>303</sup>

A Department of Health investigation, in 2007, revealed that “less than half of patients recall being offered a choice”.<sup>304</sup> Anna Dixon et al’s case study indicated that patients continued to rely on the advice and decisions of GPs<sup>305</sup> and that where they did make choices, they mostly opted for local providers.<sup>306</sup> Timothy Milewa argued that trends, such as levels of reported trust, complaints, litigation and collective mobilization, suggested an enhanced consumer consciousness.<sup>307</sup> However, Clarke et al’s qualitative research revealed that “people understand that the figure of the consumer references the experiences and practices of shopping and observe that their relationships to public services are never like that”.<sup>308</sup> Rather respondents saw

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<sup>300</sup> Mulholland, H. and agencies ‘Blair Welcomes Private Firms into NHS’. *Guardian*, 16 February 2006.

<sup>301</sup> Department of Health (DOH) (2007) *Choice Matters: 2007-8: Putting Patients in Control*. London: DOH, pp6-8.

<sup>302</sup> *Ibid* at p13.

<sup>303</sup> Dorfman, P. (2010) ‘From patients to consumers’, *op cit.*, n.267 at p43.

<sup>304</sup> Department of Health (DOH) (2007) *Report on the National Patient Choice Survey- March 2007*. London: DOH, p5.

<sup>305</sup> Dixon, A. et al (2010) *Patient Choice: How Patient’s Choose and How Providers Respond*. London: Kings Fund, p20.

<sup>306</sup> *Ibid* at p65.

<sup>307</sup> Milewa, T. (2009) ‘Health Care, Consumerism and the Politics of Identity’ in Gabe, J. and Calnan, M. (eds) *The New Sociology of the Health Service*. Abingdon: Routledge, pp161-176 at pp170-171.

<sup>308</sup> Clarke, J. et al (2007) ‘Creating Citizen-Consumers? Public Service Reform and (Un)willing Selves’ in Massen, S. and Sutter, B. (eds) *On Willing Selves: Neo-liberal Politics vis-à-vis the Neuro-scientific Challenge*. Basingstoke: Palgrave, pp125-145 at p136.

themselves as patients or as members of the public or local communities.<sup>309</sup> They perceived the term patient as one “which positively identified the process of developing and maintaining meaningful and productive relationships with health professionals”.<sup>310</sup> Consequently, they favoured what Annemarie Mol termed the ‘logic of care’ rather than the ‘logic of choice’.<sup>311</sup> Nonetheless, Clarke et al contended that patients were not content or passive but desired better healthcare.<sup>312</sup>

Dixon et al’s qualitative research indicated that patient choice did not significantly “impact on either the volume or quality of services”.<sup>313</sup> Laura Brereton and James Gubb argued that the mimic-market was “being distorted and or stifled”.<sup>314</sup> In contrast, Martin Gaynor et al stated that the reforms “resulted in significant improvements in mortality and reductions in length of stay”.<sup>315</sup> However, Pollock et al contended that Gaynor et al’s research lacked “plausibility and strength of association”, and noted that Gaynor et al relegated to a footnote the lack of a statistical association with other outcomes.<sup>316</sup> Cooper et al contended that Labour’s patient choice policies helped reduce acute myocardial infarction (AMI) deaths.<sup>317</sup> However, Pollock et al contended that Cooper et al exaggerated the effect of competition (because, as mentioned above, many patients did not exercise choice) and noted that AMI patients do not make

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<sup>309</sup> Ibid at pp136-137.

<sup>310</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers*, op cit., n.255 at p132.

<sup>311</sup> Mol, A. (2008) *The Logic of Care: Health and the Problem of Patient Choice*. Abingdon: Routledge, p ix.

<sup>312</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers*, op cit., n.255 at p135.

<sup>313</sup> Dixon, A. et al (2010) *Patient Choice*, op cit., n.305 at p33.

<sup>314</sup> Brereton, L. and Gubb, J. (2010) *Refusing Treatment: The NHS and Market Based Reform*. London: Civitas, pxiii.

<sup>315</sup> Gaynor, M. et al (2013) ‘Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service’. *American Economic Journal: Economic Policy*, Vol.5(4), pp134-166 at p163.

<sup>316</sup> Pollock, A. et al (2011) ‘No Evidence that Patient Choice in the NHS Saves Lives’. *The Lancet*, Vol.378(9809), pp2057-2060 at p2059.

<sup>317</sup> Cooper, Z. et al (2011) ‘Does Hospital Competition Save Lives? Evidence from the English NHS patient choice Reforms’. *The Economic Journal*, Vol.121(554), pp228-260 at p251.

choices.<sup>318</sup> Pollock et al concluded that Cooper et al mistook a statistical association for causation.<sup>319</sup> Nicholas Bloom et al contended that mortality rates improved due to increases in management quality resulting from the patient choice policies.<sup>320</sup> However, as Paton notes, hospitals are “notorious for their uneven performance across departments”.<sup>321</sup> Mays and Dixon doubted whether hospital management could have responded so swiftly to market policies and noted that the increasing NHS budget took “the edge off competitive pressures”.<sup>322</sup> Nonetheless, there is evidence that the mimic-market became an end in itself to the detriment of patient needs. Greener and Mannion’s ethnographic research at an NHS trust in Northern England indicates that the market reduced inter-organisational co-operation and introduced perverse incentives to put financial probity before local people’s needs.<sup>323</sup>

Although Brown was sceptical about using markets in the NHS,<sup>324</sup> once he became Prime Minister, in 2007, the reforms continued. Brown informed the Liaison Committee that his government had “been asking in people from the private sector to review what we can do to give them a better chance to compete for contracts”.<sup>325</sup> The PRCC,

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<sup>318</sup> Pollock, A. et al (2012) ‘Bad Science Concerning NHS Competition is being used to support the Controversial Health and Social Care Bill’. [On-line] Available: <http://blogs.lse.ac.uk/politicsandpolicy/bad-science-nhs-competition/> [Accessed: 14 February 2016].

<sup>319</sup> Pollock, A. et al (2011) ‘No Evidence that Patient Choice in the NHS Saves Lives’, op cit., n.316 at p2057.

<sup>320</sup> Bloom, N. et al (2015) ‘The Impact of Competition on Management Quality: Evidence from Public Hospitals’. *Review of Economic Studies*, Vol.82 (2), pp457-489 at p487.

<sup>321</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK*, op cit., n.118 at p171.

<sup>322</sup> Mays, N. and Dixon, A. (2011) ‘Assessing and Explaining the Impact of New Labour’s Market Reforms’ in Mays, N. et al *Understanding New Labour’s Market Reforms of the English NHS*. London: Kings Fund, pp124-142 at pp136-137

<sup>323</sup> Greener, I. and Mannion, R. (2009) ‘Patient Choice in the NHS: What is the effect of Choice Policies on Patients and Relationships in Health Economies?’ *Public Money and Management*, Vol.29(2), pp95-100 at p100.

<sup>324</sup> He had argued that markets could detrimentally affect “efficiency and equity”. See Brown, G. (2004) *A Modern Agenda for Prosperity and Social Reform*. London: Social Market Foundation, p27.

<sup>325</sup> Liaison Committee, *Minutes of Evidence*, 13 December 2007, HC 2007-08, Q3.

applicable from April 2008, stated that “commissioners and providers should foster patient choice”,<sup>326</sup> in acute elective services, of any willing provider.<sup>327</sup> However, in September 2009, Andy Burnham (Secretary of State for Health between 2009 and 2010) appeared to have announced a policy change by stating that “the NHS is our preferred provider”.<sup>328</sup> Subsequently, some PCTs determined that they could only accept bids from NHS organisations, prompting the NHS Partners Network to complain that this breached EU public procurement rules.<sup>329</sup> A CCP investigation was halted as the contentious procurements were suspended.<sup>330</sup> PCT procurement guidance, published in March 2010, clarified that “procurement should be non-discriminatory and transparent at all times, neither including nor favouring nor excluding any particular provider”.<sup>331</sup> Labour’s 2010 general election manifesto stated that patients would be given “the right in law to choose from any provider who meets NHS standards of quality at NHS costs when booking a hospital appointment”.<sup>332</sup> The preferred provider notion was thus indicative of the ideological mode of dissimulation,<sup>333</sup> as it sought to obscure the competition that had been emplaced in the NHS.

## Polyclinics

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<sup>326</sup> Department of Health (2007) *Principles and Rules for Co-operation and Competition*, op cit., n.216 at p4.

<sup>327</sup> Ibid at p10.

<sup>328</sup> Burnham, A. (2009) ‘Speech to Kings Fund 17 September 2009’. [On-line] Available: [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/MediaCentre/Speeches/DH\\_105366](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/MediaCentre/Speeches/DH_105366) [Accessed: 15 February 2016].

<sup>329</sup> Timmins, N., ‘Inquiry into NHS ‘preferred provider’ rule halted’. *Financial Times*, 4 March 2010.

<sup>330</sup> Ibid.

<sup>331</sup> Department of Health (DOH) (2010) *PCT Procurement Guide for Health Services*. London: DOH, p4.

<sup>332</sup> Labour Party (2010) *Labour Party 2010 Manifesto A Future Fair for All*, op cit., n.79 at p4.2.

<sup>333</sup> Thompson, J. (2007) *Ideology and Modern Culture*. Cambridge: Polity Press, p62.

New Labour also sought to facilitate opportunities for the private sector within primary care. The HSC Act (2003) ended the GP monopoly of primary care services.<sup>334</sup> The national contract for GPs was replaced by general medical services (GMS) contracts (between practices and trusts), alternative provider of medical services (APMS) contracts, locally negotiated personal medical services contracts and PCT medical services contracts.<sup>335</sup> Primary care services were unbundled (divided into saleable commodities)<sup>336</sup> into essential services, additional services and enhanced services, meaning that GPs were no longer required to provide patients with integrated and comprehensive services.<sup>337</sup> By March 2007, around thirty “companies had commercial contracts to provide primary care services in England through their ownership of seventy-four health centres and general practices”.<sup>338</sup> As the new GP contracts made out-of-hours cover optional, ninety percent of GPs opted out, consistent with the Department of Health’s expectations.<sup>339</sup> Stewart Player contends that this was desired, partly to encourage private provision.<sup>340</sup> The creation of polyclinics (also known as GP-led health centres and Darzi centres) also afforded opportunities for the private sector. As mentioned in chapter three, Virgin had recommended the creation of polyclinics. Ian Smith had also recommended the creation of larger health centres.<sup>341</sup>

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<sup>334</sup> National Health Service (NHS) Act (1977), S.16CC(2)(B) as amended by HSC Act (2003), S.174/NHS Act (2006), S.83(2)(B).

<sup>335</sup> Pollock, A. et al., ‘The Market in Primary Care’. *British Medical Journal* 2007; 335: 475.

<sup>336</sup> Pollock, A. (2006) ‘Privatising Primary Care’. *British Journal of General Practice*, Vol.56(529), pp565-566 at p565.

<sup>337</sup> Pollock, A. et al (2007) ‘The Market in Primary Care’, op cit., n.335.

<sup>338</sup> Pollock, A. (2006) ‘Privatising Primary Care’, op cit., n.336 at p565.

<sup>339</sup> Player, S. (2008) ‘Darzi and Co: Corporate Capture in the NHS’. *Soundings*, Vol.40, pp29-41 at p37.

<sup>340</sup> Ibid.

<sup>341</sup> Smith, I. (2007) *Building a World-Class NHS*. Basingstoke: Palgrave, p165.

The government announced its “intention to shift resources from acute to local settings”.<sup>342</sup> This shift was reaffirmed in the interim report<sup>343</sup> of a national review undertaken by Lord Darzi, a leading surgeon. Darzi’s involvement is indicative of Bob Jessop’s notion of attempted depoliticalization through the use of an ostensibly non-political figure to make recommendations.<sup>344</sup> However, this attempt was unsuccessful as Darzi’s proposals generated controversy. The national review followed Darzi’s review of healthcare in London. Darzi recommended the establishment of polyclinics within the capital.<sup>345</sup> Such polyclinics were to be the “main stop for health and well-being support” with a range of available services far exceeding “that of most existing GP practices”.<sup>346</sup> They would be open between eighteen and twenty-four hours a day and be staffed (typically) by twenty-five GPs, and other health professionals.<sup>347</sup> Polyclinics were portrayed as being in everyone’s interests as it was stated that they would be “more accessible and less medicalised than hospitals”.<sup>348</sup> Virginia Berridge noted that polyclinics were not a new idea as they had been proposed by both the Dawson report in 1920 and by Labour in 1945.<sup>349</sup> Darzi’s proposals were inspired by

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<sup>342</sup> Department of Health (DOH) (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services*. London: DOH, p148.

<sup>343</sup> Darzi, A. (2007) *Our NHS, Our Future. NHS Next Stage Review: Interim Report*. London: Department of Health, p32.

<sup>344</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises’ in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at p105.

<sup>345</sup> Darzi, A. (2007) *Healthcare for London: A Framework for Action*. London: NHS London, p10.

<sup>346</sup> *Ibid* at pp10-11.

<sup>347</sup> *Ibid*.

<sup>348</sup> *Ibid* at p10.

<sup>349</sup> Berridge, V., ‘Polyclinics: haven’t we been there before?’ *British Medical Journal* 2008; 336: 1161/ Ministry of Health (1920) *Interim Report on the future provision of Medical and Allied Services Cmnd 693*. London: HMSO, p25/Labour Party., ‘General Election Manifesto 1945 Let us Face the Future: A Declaration of Labour Policy for the Consideration of the Nation’ in Dale, I. (ed) (2000) *Labour Party General Election Manifestoes 1900-1997*. London: Routledge, pp51-60 at p58.

international examples of polyclinics.<sup>350</sup> In contrast, many states with polyclinics, such as Russia, were replacing them with GPs.<sup>351</sup> McKinsey also influenced Darzi's programme.<sup>352</sup> Darzi's report anticipated that some GP practices would remain separate from polyclinics, but could be networked, thereby enabling patients to use the extended facilities.<sup>353</sup> This hub-and-spoke model has been described as polysystems. Peckham et al stated that it was clear at the outset that the level of investment required meant that Darzi's ideal-type polyclinic was unlikely to materialise.<sup>354</sup> There was ultimately a shift from polyclinics to polysystems.<sup>355</sup> This is evident in a subsequent report published by NHS London.<sup>356</sup>

Darzi was made a peer, following the London review, and appointed Parliamentary Under Secretary of State at the Department of Health. In the interim report of Darzi's national review, it was stated that at least 100 new practices were required and that resources should be invested "to enable PCTs to develop 150 GP-led health centres".<sup>357</sup> The final report stated that such centres would help tackle health inequalities.<sup>358</sup> In addition, it announced pilots of personal health budgets<sup>359</sup> and the development of an NHS constitution.<sup>360</sup> The adopted constitution was criticised for not

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<sup>350</sup> Imison, C. et al (2008) *Under One Roof: Will Polyclinics Deliver Integrated Care?* London: Kings Fund, p1.

<sup>351</sup> Ershova, I. et al (2007) 'Polyclinics in London'. *The Lancet*, Vol.370(9603), pp1890-1891 at p1890.

<sup>352</sup> Davies, P., 'Behind Closed Doors: How Much Power does McKinsey Wield'. *British Medical Journal* 2012; 344: e2905.

<sup>353</sup> Darzi, A. (2007) *Healthcare for London*, op cit., n.345 at p94.

<sup>354</sup> Peckham, S. et al (2011) 'Community Nursing in Systems Reform: The London Polyclinic Experience'. *British Journal of Community Nursing*, Vol.16(6), pp293-297 at p295.

<sup>355</sup> Ibid.

<sup>356</sup> NHS London (2010) *Delivering Healthcare for London- an Integrated Strategic Plan 2010-2015*. London: NHS London.

<sup>357</sup> Department of Health (2008) *High Quality Care for all*, op cit., n.147 at p25.

<sup>358</sup> Ibid at p36.

<sup>359</sup> Ibid at p10.

<sup>360</sup> Ibid at p77.



creating any legal rights<sup>361</sup> and containing vague commitments (for example, to make decisions in “a clear and transparent way”).<sup>362</sup> The term polyclinic was replaced by GP-led health centre (indicative of the euphemization strategy of the ideological mode of dissimulation), in both the interim and final report for the national review, due to fears “that its very mention had become damaging”.<sup>363</sup> Ministers denied that polyclinics and GP-led health centres were identical, but opponents saw little difference.<sup>364</sup> In February 2008, it was confirmed that polyclinics were to be built throughout England.<sup>365</sup> Every PCT was required to establish one by April 2009.<sup>366</sup> The first seven polyclinics opened in London in April 2009<sup>367</sup> and “by mid-2010, 140 [PCTs nationwide]...had managed to establish something that answered to the name”.<sup>368</sup> PCTs which decided not to procure polyclinics were forced to acquiesce,<sup>369</sup> despite Darzi’s claim that they were not being imposed.<sup>370</sup> The Health Committee was unconvinced that all PCTs needed one.<sup>371</sup>

The Kings Fund described Darzi’s final report for the national review “as good news for patients”.<sup>372</sup> Player criticised the Kings Fund’s response for failing to mention commercialisation, an omission which he attributed to its close collaboration with the

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<sup>361</sup> Mandelstam, M. (2011) *How we Treat the Sick*, op cit., n.270 at p277.

<sup>362</sup> Health Committee (2009) *NHS Next Stage Review, First Report, House of Commons Session 2008-09, Vol.I*. London: Stationery Office, p50.

<sup>363</sup> Pulse., ‘Darzi drops all reference to p-word’. 9 July 2008.

<sup>364</sup> BBC., ‘Brown Slams GPs over Polyclinics’. 12 June 2008.

<sup>365</sup> Ibid.

<sup>366</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin, pp46-47.

<sup>367</sup> BBC., ‘Seven Polyclinics open in London’. 29 April 2009.

<sup>368</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*, op cit., n.366 at pp46-47.

<sup>369</sup> Nowotny, S., ‘DH Forces PCTs to Procure Polyclinics’. *Pulse*, 23 July 2008.

<sup>370</sup> BBC., ‘Hospital and GP Reforms ‘Flawed’’. 21 March 2008.

<sup>371</sup> Health Committee (2009) *NHS Next Stage Review, Vol.I*, op cit., n.362 at p4.

<sup>372</sup> Kings Fund (2008) ‘The Kings Fund Response to Lord Darzi’s NHS Next Stage Review’. [On-line] Available: <http://www.kingsfund.org.uk/press/press-releases/kings-fund-response-lord-darzis-nhs-next-stage-review> [Accessed: 14 February 2016].

private sector.<sup>373</sup> Player stated that the approval of the apparently independent Kings Fund was “a crucial source of legitimation for government policy”.<sup>374</sup> Nonetheless, a Kings Fund report, written by Candace Imison et al, undermined many of the justifications for polyclinics. While the government claimed that polyclinics would provide more accessible care, Imison et al noted that although access to some services (such as out-of-hours care) might improve,<sup>375</sup> there were risks to access to, and continuity of, care.<sup>376</sup> Research indicated that patients in small practices rated their access and continuity of care more highly,<sup>377</sup> and that although the quality of small practices varied, on average, they achieved slightly higher levels of clinical quality than larger practices in the quality and outcomes framework (QOF).<sup>378</sup> Londonwide Local Medical Committees (LMCs) contended that moving specialist outpatient services and investigative procedures from hospitals to polyclinics could lead to diseconomies of scale and increase demand.<sup>379</sup> Imison et al noted that there was little evidence that moving hospital services to community settings would be cheaper<sup>380</sup> and that evidence indicated that moving services from hospitals could decrease quality.<sup>381</sup> The Health Committee determined that evidence concerning

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<sup>373</sup> Player, S. (2008) ‘Darzi and Co: Corporate Capture in the NHS’, op cit., n.339 at p30.

<sup>374</sup> Ibid.

<sup>375</sup> Imison, C. et al (2008) *Under One Roof*, op cit., n.350 at p2.

<sup>376</sup> Ibid at p39.

<sup>377</sup> Roland, M., ‘Assessing the Options Available to Lord Darzi’. *British Medical Journal* 2008; 336: 625/Campbell, J. et al (2001) ‘Practice Size: Impact on Consultation Length, Workload and Patient Assessment of Care’. *British Journal of General Practice*. Vol.51(469) pp644-650 at p648.

<sup>378</sup> Roland, M. (2008) ‘Assessing the Options Available to Lord Darzi’, op cit., n.377/Doran, T. et al (2006) ‘Pay for Performance Programs in Family Practices in the United Kingdom’. *New England Journal of Medicine*, Vol.355, pp375-384 at p383.

<sup>379</sup> Londonwide LMCs (2008) *Listening to the Capital’s GPs: Londonwide LMC’s response to Healthcare for London’s ‘Consulting the Capital*. London: Londonwide LMCs, p13.

<sup>380</sup> Imison, C. et al (2008) *Under One Roof*, op cit., n.350 at p34.

<sup>381</sup> Ibid at p2.

quality and value for money at similar centres in Germany and the United States (US) was mixed.<sup>382</sup>

Many PCTs did not consult their local populations about developing polyclinics<sup>383</sup> or were not clear that they could be run by private providers.<sup>384</sup> The opposition to polyclinics satisfied Colin Barker's moral economy criteria.<sup>385</sup> Polyclinics threatened people's needs and opponents expressed a non-monetary counter-ethic emphasising the value of accessibility and continuity of care, something which was already known, practiced and valued. A Save Our Surgeries campaign opposing polyclinics was initiated by *Pulse* (a general practice magazine) and supported by the Conservatives, the Liberal Democrats, the British Medical Association (BMA) and the Patients Association.<sup>386</sup> In June 2008, there were protests outside more than 100 surgeries.<sup>387</sup> The BMA organised a petition, as part of its Support Your Surgery campaign, which attracted over a million signatures and was delivered to Downing Street.<sup>388</sup> Johnson dismissed the petition, asserting that patients had been "dragooned into signing" it.<sup>389</sup> A large alliance of GPs considered launching a legal challenge, but abandoned such plans as they feared that they could not afford to contest the policy.<sup>390</sup> Ministers were

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<sup>382</sup> Health Committee (2009) *NHS Next Stage Review, Vol.1*, op cit., n.362 at p47.

<sup>383</sup> Donnelly, L., 'Polyclinics will be imposed despite Ministers' Promises'. *Telegraph*, 2 August 2008.

<sup>384</sup> *Pulse*., 'PCTs 'Break Rules' over Darzi Centres'. 17 December 2008.

<sup>385</sup> Barker, C., 'A Modern Moral Economy? Edward Thompson and Valentin Voloshinov meet in North Manchester'. Paper presented to the conference on Making Social Movements: The British Marxist Historians and the study of social movements, Edge Hill College of Higher Education, June 26-28, 2002.

<sup>386</sup> Nowottny, S., 'Tories and Lib Dems back *Pulse*'s Save Our Surgeries Campaign'. *Pulse*, 23 April 2008.

<sup>387</sup> Nowottny, S., 'GP leaders rally for *Pulse* campaign'. *Pulse*, 18 June 2008.

<sup>388</sup> Nowottny, S., 'More than a million patients back BMA campaign'. *Pulse*, 12 June 2008.

<sup>389</sup> H.C. Deb. 17 June 2008, Vol.477, Col.830.

<sup>390</sup> *Pulse*., 'GPs had chance to block Darzi rollout'. 25 February 2009.

reportedly aware of the potential for legal challenges.<sup>391</sup> Camden KONP organised meetings, a march through Camden and a judicial review<sup>392</sup> following NHS Camden's decision to award a GP-led health centre contract to a private company before a public consultation had ended.<sup>393</sup> Subsequently, the relevant PCT conceded that it had acted unlawfully and agreed to consult on whether it should establish such a centre.<sup>394</sup>

During a debate concerning polyclinics, in the House of Commons, Johnson sought to portray opposition as inconsistent. Johnson argued that the government had been accused of trying to nationalise (by making GPs state employees) and privatise primary care.<sup>395</sup> Johnson claimed that the government expected that many contracts would “go to GP-led consortiums not private companies”.<sup>396</sup> However, this is indicative of the ideological mode of dissimulation, as it was belied by the fact that, in 2008, senior figures from private health providers, such as Assura Group, Care UK, General Healthcare Group and HCA, were invited to regular off-the-record briefings, held by NHS London, to provide advice on the tendering and procurement of London's polyclinics.<sup>397</sup> Such meetings were intended to “reassure the private sector about the government's commitment to opening up the market”.<sup>398</sup> In addition, ministers advised PCTs to get value for money by setting up bulk deals with private providers.<sup>399</sup> George

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<sup>391</sup> Ibid.

<sup>392</sup> Walker, T., ‘Camden NHS campaign stops private GPs threat’. *Socialist Worker*, 24 November 2009.

<sup>393</sup> Pulse., ‘PCT Faces High Court over Contract Award’. 21 October 2009.

<sup>394</sup> Iacobucci, G. (2009) ‘Case Puts Legality of Darzi rollout in doubt’. *Pulse*, 18 November 2009.

<sup>395</sup> H.C. Deb. 17 June 2008, Vol.477, at Col.819.

<sup>396</sup> Ibid at Col.829.

<sup>397</sup> Nowotny, S., ‘Revealed’, op cit., n.3.

<sup>398</sup> Ibid.

<sup>399</sup> Iacobucci, G., ‘Trusts told to offer firms bulk deals on Darzi Centres’, op cit., n.4.

Monbiot noted that although GPs could club together to tender to run polyclinics, corporations would have the advantage in the tendering process.<sup>400</sup>

Of the fifty-four polyclinic contracts concluded in January 2009, fourteen “had been won by private companies or groups led by the independent sector”.<sup>401</sup> Between then and April 2010, forty percent of the contracts awarded went to private sector companies.<sup>402</sup> Although Darzi claimed polyclinics would save money,<sup>403</sup> their funding per patient was almost three times as high on average as GMS practices.<sup>404</sup> Some NHS managers blamed polyclinics for deficits.<sup>405</sup> For example, NHS Bromley blamed its entire primary care deficit, in 2011, on its GP-led health centre contract, which had created artificial demand for services,<sup>406</sup> as per Londonwide LMC’s predictions. One company running a polyclinic in Suffolk agreed to alter its contract after accepting that it was hugely overpaid for consultations.<sup>407</sup> At the 2010 general election, Labour proposed creating a second wave of polyclinics.<sup>408</sup> The coalition formed following the election halted their development.<sup>409</sup> In 2011, it was reported that twenty-six percent of Darzi centres had “registered fewer than 500 patients” and that thirty-five percent had “registered fewer than 1,000 patients”.<sup>410</sup> Additionally, while “Darzi centres were set up to offer access to a GP seven days a week, from 8am to 8pm,...six PCTs said

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<sup>400</sup> Monbiot, G., ‘The Great Consolidation’, *Guardian*, 29 April 2008.

<sup>401</sup> Kirby, J. (2009) ‘Quarter of Polyclinics Privately Run’, *Independent*, 20 January 2009.

<sup>402</sup> Iacobucci, G., ‘Firms Overtake GPs in Darzi bids’. *Pulse*, 28 April 2010.

<sup>403</sup> Darzi, A. (2007) *Healthcare for London*, op cit., n.345 at p12.

<sup>404</sup> Iacobucci, G., ‘Darzi Centre Funding Dwarfs GMS Cash’. *Pulse*, 1 July 2009.

<sup>405</sup> *Pulse*., ‘Darzi Centres Fuelling PCT Deficits’. 26 January 2011.

<sup>406</sup> *Ibid*.

<sup>407</sup> Iacobucci, G., ‘Darzi Centre Becomes First to agree Pay Cut’. *Pulse*, 3 March 2010.

<sup>408</sup> Stirling, A., ‘Labour pledges to push through second wave of Darzi centres’, *Pulse*, 21 April 2010, p4.

<sup>409</sup> Quinn, I., ‘Lansley orders halt to all Darzi plans nationwide’. *Pulse*, 21 May 2010.

<sup>410</sup> Sell, S. (2011) ‘Exclusive—Patients Shun Wasteful Darzi Centres’. [On-line] Available: <http://www.gponline.com/News/article/1078318/exclusive-patients-shun-wasteful-darzi-centres/> [Accessed 20 December 2013].

their centre did not fulfil these criteria".<sup>411</sup> Ultimately, polyclinics were scrapped in 2011.<sup>412</sup> The nationwide network of polyclinics was dismantled before the contracts expired.<sup>413</sup> Leys and Player assert that the credit drought following the Great Recession (2008-2009) meant that there were no funds to meet the substantial cost of polyclinics<sup>414</sup> and that their termination was pragmatic, as they were wasting money and unpopular.<sup>415</sup>

## Conclusion

In this chapter, I examined the influences on, justifications for, opposition to, and effects of, New Labour's creation of FTs, polyclinics and a mimic-market in secondary care. New Labour claimed that FTs would lead to high standards, could reduce health inequalities and provide genuine local ownership. However, FTs do not appear to have outperformed NHS trusts, the links between FTs and health inequalities were not clear to clinicians and managers<sup>416</sup> and scope for public influence is limited. FTs were somewhat successful in depoliticising healthcare, although ministers intervened, despite the law, in response to scandals. New Labour's reforms facilitated a mimic-market in secondary care, which became an end in itself to the detriment of patients. Nonetheless, New Labour's interpellation of patients as consumers faced

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<sup>411</sup> Ibid.

<sup>412</sup> Broad, M. (2011) 'Government signals an end to Darzi centres'. [On-line] Available: <http://www.hospitaldr.co.uk/blogs/our-news/department-of-health-signals-the-end-of-darzi-centres> [Accessed: 26 January 2014].

<sup>413</sup> Pulse., 'Writing on the wall for Darzi Centres'. 16 February 2011.

<sup>414</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*, op cit., n.366 at p48.

<sup>415</sup> Ibid at p49.

<sup>416</sup> Powell, M. et al (2011) *Comparative Case Studies of Health Reform in England*, op cit., n.1 at p266.

recalcitrance.<sup>417</sup> As the NHS was increasingly marketized, EU public procurement and competition law (which could have locked in such reforms) became increasingly applicable, although scope existed for exceptions. Polyclinics threatened access to, and continuity of, care. Although New Labour claimed that it expected many polyclinic contracts to go to GP consortiums, it liaised with the private sector about their procurement<sup>418</sup> and advised PCTs to agree bulk deals with private providers.<sup>419</sup> The reforms faced opposition and led to groups of citizens forming to resist further developments.

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<sup>417</sup> Clarke, J. (2007) "It's not like Shopping", op cit., n.2 at pp114-115.

<sup>418</sup> Nowotny, S., 'Revealed', op cit., n.3.

<sup>419</sup> Iacobucci, G., 'Trusts told to offer firms bulk deals on Darzi Centres', op cit., n.4.

## Chapter Five: NHS Reforms since 2010 (Part One)

### Introduction

In this chapter and the next, I examine NHS reforms since 2010. I contend that the NHS' founding principles have been undermined by the Health and Social Care (HSC) Act (2012) and by insufficient funding. Governments since 2010 have used the deficit, which grew following the Great Recession (2008-09), to argue that there was no alternative to public sector cuts and reforms. Cuts to public health, social care and the NHS itself have put the service under pressure. I assess the influences on, justifications for and opposition to the HSC Act (2012) within this chapter. I analyse the impact of the legislation on the organisation of, and norms within, the NHS, and its potential reifying effects, in chapter six. I argue that private healthcare companies, and their representatives, exerted influence on the reforms through financial links, lobbying and direct advice.

The Conservative-Liberal Democrat coalition, formed in 2010, rationalized that their reforms were necessary firstly, as NHS productivity had declined. However, more detailed research indicates that it had increased. Secondly, the coalition claimed that the UK had comparatively poor health outcomes. However, it selectively chose health outcomes to portray the NHS negatively. Thirdly, the coalition claimed that the NHS would become unsustainable without reform. In contrast, critics argued that the reforms were a political choice and not a financial necessity. The coalition also drew



selectively on contested research to argue that the competition and choice its reforms would engender would be beneficial. The coalition claimed to support the NHS' founding principles, and that its reforms were in everyone's interests as they would empower patients and General Practitioners (GPs) and reduce costs. It also claimed that there was no alternative to increasing the diversity of health care provision to meet needs and reduce health inequalities. I refute such claims in chapter six. Several factors meant that the HSC Act (2012) was passed, despite opposition. The coalition undermined opposition through a listening exercise, after which it stated it was committed to integration (which its legislation made more difficult) and by falsely claiming that it's legislation had been substantially altered.

### Cameron's Conservatives

David Cameron became Conservative party leader following its third successive general election defeat in 2005. Tim Bale contends that the party never really modernized under William Hague (Conservative leader between 1997 and 2001), Iain Duncan Smith (Conservative leader between 2001 and 2003) or Michael Howard (Conservative leader between 2003 and 2005).<sup>1</sup> In contrast, Peter Kerr stated that Cameron's leadership campaign sought to "emulate Blair's success in providing the Labour party with its modernised, coherent and electorally presentable image".<sup>2</sup> Kerr et al contend that Cameron borrowed from Blair to a remarkable extent, for example

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<sup>1</sup> Bale, T. (2010) *The Conservative Party: From Thatcher to Cameron*. Cambridge: Polity Press, p20.

<sup>2</sup> Kerr, P. (2007) 'Cameron Chameleon and the current state of Britain's 'consensus''. *Parliamentary Affairs*, Vol.60(1), pp46-65 at p47.

in presenting himself as a “moderniser” and a “pragmatist”.<sup>3</sup> Cameron and George Osborne<sup>4</sup> were influenced by Philip Gould’s argument, in ‘*The Unfinished Revolution*’, that a political party could not be a hostage to its extremes if it wanted to gain power in modern Britain.<sup>5</sup> According to Mike Finn, by 2005, the Conservatives had suffered enough electoral trauma to modernise.<sup>6</sup> Cameron utilised the discourse of modernisation to legitimate a movement towards the purported centre ground.<sup>7</sup> However, Bale contends that Cameron only restyled (rather than re-engineered) his party.<sup>8</sup> While Cameron initially focused on areas such as the environment, the Great Recession influenced a return towards a more traditional Thatcherite or neo-liberal agenda.<sup>9</sup> Bale argues that Cameron did not lurch like other politicians, rather he calibrated.<sup>10</sup> For example, Cameron’s Conservative party presented itself as a progressive party.<sup>11</sup> Richard Seymour contends that without New Labour, which had captured terms such as “progressive” and “radical” for a right-wing agenda, “the grammar of progressive Toryism would not even be intelligible”.<sup>12</sup>

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<sup>3</sup> Kerr, P. et al (2011) ‘Theorising Cameronism’. *Political Studies Review*, Vol.9(2), pp193-207 at p199.

<sup>4</sup> Shadow Chancellor of the Exchequer between 2005 and 2010 and Chancellor of the Exchequer between 2010 and 2016.

<sup>5</sup> Finn, M. (2015) ‘The Coming of the Coalition and the Coalition Agreement’ in Seldon, A. and Finn, M. (eds) *The Coalition Effect 2010-2015*. Cambridge: Cambridge University Press, pp31-58 at p35.

<sup>6</sup> Ibid.

<sup>7</sup> Byrne, C, et al (2012) ‘Understanding Conservative Modernisation’ in Heppell, T. and Seawright, D. (eds) *Cameron and the Conservatives: The Transition to Coalition government*. Basingstoke: Palgrave, pp16-31 at p17.

<sup>8</sup> Bale, T. (2010) *The Conservative Party*, op cit., n.1 at p21.

<sup>9</sup> Kerr, P. and Hayton, R. (2015) ‘Whatever Happened to Conservative Party Modernisation?’ *British Politics*, Vol.10(2), pp114-130 at p115.

<sup>10</sup> Bale, T. (2010) *The Conservative Party*, op cit., n.1 at p382.

<sup>11</sup> Buckler, S. and Dolowitz, D. (2012) ‘Ideology Matters: Party Competition, Ideological Positioning and the Case of the Conservative party under David Cameron’. *British Journal of Politics and International Relations*, Vol.14(4), pp576-594 at p589.

<sup>12</sup> Seymour, R. (2010) *The Meaning of David Cameron*. Ropley: Zero Books, pp3-5.

The Conservative's commitment to the NHS was queried during the premierships of Margaret Thatcher and John Major (Prime Minister between 1990 and 1997) and during its period in opposition. Oliver Letwin (Shadow Chancellor of the Exchequer between 2003 and 2005) reportedly stated, in 2004, that the NHS would not exist within five years of a Conservative government.<sup>13</sup> In 2005 the party stated that, if elected, it would provide a contribution "based on half the cost of the NHS operation", to the estimated 220,000 people a year, without health insurance, who paid for important operations (the patient passport policy).<sup>14</sup> Following the general election defeat in 2005, many Conservatives, including future ministers, such as Michael Gove and Jeremy Hunt (Secretary of State for Health from 2012 onwards), argued that the state should no longer be a monopoly provider but a "funder and regulator to guarantee access to services".<sup>15</sup> However, once he became leader, Cameron "made strenuous efforts to demonstrate that" the Conservatives fully supported the NHS.<sup>16</sup> For example, the Conservatives named Aneurin Bevan as one of twelve great people who schoolchildren should study.<sup>17</sup>

Cameron stated that he knew "from personal experience just how important the NHS is to everyone".<sup>18</sup> Cameron's first son, Ivan, born in 2002, suffered from cerebral palsy

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<sup>13</sup> McSmith, A., 'Letwin: 'NHS will not exist under Tories'', *Independent*, 5 June 2004.

<sup>14</sup> Conservative Party (2005) *Are you thinking what we're thinking? It's time for action, election manifesto for the 2005 general election*. London: Conservative Party, p12.

<sup>15</sup> Carswell, D. et al (2005) *Direct Democracy: An Agenda for a new model party*. London: direct-democracy.co.uk, p77.

<sup>16</sup> Page, R. (2011) 'The Emerging blue (and orange) health strategy: Continuity or Change?' in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp89-104 at p90.

<sup>17</sup> Jones, G. and Martin, N., 'Tories Name the 12 who shaped our nation', *Telegraph*, 26 December 2006.

<sup>18</sup> Cameron, D. (2006) 'Speech to Kings Fund'. [On-line] Available: <http://www.theguardian.com/society/2006/jan/04/health.conservativeparty> [Accessed: 25 May 2016].

and Ohtahara syndrome (a progressive epileptic encephalopathy) and died in 2009.<sup>19</sup> Cameron used such experience to decontest the Conservative's commitment to the NHS, regarding which he stated there should be no question mark.<sup>20</sup> Bale states that Cameron's personal experience enabled him to garner "sympathy and credibility".<sup>21</sup> Finn notes that it was therefore difficult for opponents to "question his personal investment in the NHS".<sup>22</sup> Cameron averred that the NHS had suffered, historically, from an "overdose of ideology" with the left and right trying to get the private sector out and in respectively.<sup>23</sup> Cameron promised that he would not transform the NHS "into a system based on medical insurance", but remarked that Labour had "not gone far enough in giving a wide range of health providers the right to supply services to the NHS".<sup>24</sup> In 2007, the Conservatives published '*NHS Autonomy and Accountability: Proposals for Legislation*' ('NAAA'), which influenced the coalition's legislation and is considered below.

### The Coalition

The 2010 general election resulted in a hung parliament, following which the Conservatives and Liberal Democrats formed a coalition with a majority of eighty-

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<sup>19</sup> BBC., 'Cameron's 'beautiful boy' dies', 25 February 2009.

<sup>20</sup> Cameron, D. (2006) 'Speech to Kings Fund', op cit., n.18.

<sup>21</sup> Bale, T. (2010) *The Conservative Party*, op cit., n.1 at p316.

<sup>22</sup> Finn, M. (2015) 'The Coming of the Coalition and the Coalition Agreement', op cit., n.5 at p40.

<sup>23</sup> Cameron, D. (2006) 'Speech to Kings Fund', op cit., n.18.

<sup>24</sup> Ibid.

three.<sup>25</sup> It was Britain's first peacetime coalition since the 1930s.<sup>26</sup> Finn argues that Cameron and Clegg, who became Deputy Prime Minister, were "happier working together than they were with the right and left of their parties respectively".<sup>27</sup> Simon Lee notes the resonance between Cameron's liberal Conservatism and the economic liberalism of the Liberal Democrats 'Orange Book'.<sup>28</sup> The 'Orange Book' moved away from the state centred social democracy developed under Charles Kennedy's leadership (between 1999 and 2006).<sup>29</sup> For example, David Laws advocated replacing the NHS with a social insurance system.<sup>30</sup> Clegg also recommended breaking up the NHS.<sup>31</sup> Lee states that the 'Orange Book' signalled the Liberal Democrats potential to work with a modern Conservative party which subscribed more to the economic liberalism of Friedrich Hayek and Milton Friedman than the one nation Conservatism of Benjamin Disraeli or Harold Macmillan.<sup>32</sup> Many contributors to the 'Orange Book' played a leading role in the coalition negotiations and the staffing of its inaugural cabinet.<sup>33</sup> Matt Beech states that "at the core of the Liberal Conservatives and the supporters of Clegg" was:

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<sup>25</sup> Stuart, M. (2011) 'The Formation of the Coalition' in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp38-58 at p41.

<sup>26</sup> Bale, T. and Sanderson-Nash, E. (2011) 'A Leap of Faith and a Leap in the Dark: The Impact of Coalition on the Conservatives and Liberal Democrats' in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp237-250 at p237.

<sup>27</sup> Finn, M. (2015) 'Conclusion: The Net Coalition Effect' in Seldon, A. and Finn, M. (eds) *The Coalition Effect 2010-2015*. Cambridge: Cambridge University Press, pp601-607 at p601.

<sup>28</sup> Lee, S. (2011) 'We are all in this together': The Coalition agenda for British modernization' in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp3-23 at p4.

<sup>29</sup> Bale, T. and Sanderson-Nash, E. (2011) 'A Leap of Faith and a Leap in the Dark', op cit., n.26 at p238.

<sup>30</sup> Laws, D. (2004) 'UK health services: A Liberal agenda for reform and renewal' in Marshall, P. and Laws, D. (eds) *The Orange Book: Reclaiming Liberalism*. London: Profile Books, pp191-210.

<sup>31</sup> Woolf, M., 'Frontbencher calls for NHS to be broken up', *Independent*, 18 September 2005.

<sup>32</sup> Lee, S. (2011) 'We are all in this together', op cit., n.28 at p8.

<sup>33</sup> Ibid.

“more or less a [Keith] Joseph-Thatcher economic perspective which declares the primacy of the market over the welfare state, champions the private government of individuals over public government and reduces the efficacy of public administration to mere cost-benefit analysis”.<sup>34</sup>

The politics of the coalition was therefore a right-wing liberalism,<sup>35</sup> evincing “a continuity with the Thatcher and Major governments”.<sup>36</sup> The coalition lasted until the 2015 general election, at which the Conservatives won a majority of twelve in the House of Commons and were thus able to govern without the Liberal Democrats (who lost forty-nine of their fifty-seven seats). Cameron resigned after a majority of the electorate opted to leave the EU, in a referendum in June 2016, and was replaced by Theresa May. The 2017 general election also resulted in a hung parliament, following which the Conservatives governed with the support of the Democratic Unionist Party (DUP).

### Austerity

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<sup>34</sup> Beech, M. (2011) ‘A Tale of Two Liberalisms’ in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp267-280 at p278.

<sup>35</sup> Beech, M. (2015) ‘The Ideology of the Coalition: More Liberal than Conservative’ in Beech, M. and Lees, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp1-15 at p4.

<sup>36</sup> Beech, M. (2015) ‘The Coalition: A Transformative Government?’ in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp259-269 at p264.

The coalition stated that its primary mission was to clear the deficit, which had arisen, by the end of the parliament.<sup>37</sup> This was to be achieved through austerity, which involved a programme of public spending cuts (accounting for seventy-eight percent of deficit reduction<sup>38</sup>), tax increases and a “far reaching restructuring of state services involving significant transfers of responsibility from the state to the private sector and to the citizen”.<sup>39</sup> Kerr et al state that public sector cuts were a tactic of preference shaping depoliticisation,<sup>40</sup> as the narrative of the coalition was that the debt crisis was the result of the profligacy (in respect of public sector spending) of the Blair and Brown governments.<sup>41</sup> Mark Blyth contends that the notion that the sovereign debt crisis arose because states overspent was a misrepresentation of the facts.<sup>42</sup> The coalition thus transformed a crisis of capitalism<sup>43</sup> into a crisis of state overspending.<sup>44</sup> The notion that overspending was the problem was undermined by the fact that, prior to the recession, the Conservatives had pledged to match Labour’s public spending.<sup>45</sup> The coalition’s austerity policies were influenced by research<sup>46</sup> which has been

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<sup>37</sup> Beech, M. (2015) ‘The Ideology of the Coalition’, op cit., n.35 at p7.

<sup>38</sup> Gamble, A. (2012) ‘Economic Policy’ in Heppell, T. and Seawright, D. (eds) *Cameron and the Conservatives: The Transition to Coalition government*. Basingstoke: Palgrave, pp59-73 at p68.

<sup>39</sup> Taylor-Gooby, P. and Stoker, G. (2011) ‘The Coalition Programme: A New Vision for Britain or politics as usual’. *Political Quarterly*, Vol.82(1), pp4-15 at p4.

<sup>40</sup> Kerr, P. et al (2011) ‘Theorising Cameronism’, op cit., n.3 at p201.

<sup>41</sup> Tailby, S. (2012) ‘Public Service Restructuring in the UK: The Case of the English National Health Service’. *Industrial Relations Journal*, Vol.43(5), pp448-464 at p455.

<sup>42</sup> Blyth, M. (2013) *Austerity: The History of a Dangerous Idea*. Oxford: Oxford University Press, p5.

<sup>43</sup> The Great Recession has been variously attributed, in Marxist literature, to increased financialisation (see: Albo, G., et al (2010) *In and out of Crisis: The Global Financial Meltdown and Left Alternatives*. Oakland, CA: PM Press), overaccumulation (see: Foster, J. and Magdoff, F. (2009) *The Great Financial Crisis: Causes and Consequences*. New York: Monthly Review Press) and to a rise in the organic composition of capital (see: Kliman, A. (2011) *The Failure of Capitalist Production: Underlying Causes of the Great Recession*. London: Pluto).

<sup>44</sup> Seymour, R. (2014) *Against Austerity: How we can fix the crisis they made*. London: Pluto, p113.

<sup>45</sup> Tailby, S. (2012) ‘Public Service Restructuring in the UK’, op cit., n.41 at p455.

<sup>46</sup> Reinhart, C. and Rogoff, K. (2010) ‘Growth in a Time of Debt’. *American Economic Review*, Vol.100(2), pp573-578/Alesina, A. and Ardagna, S. (2009) ‘Legal Changes in Fiscal Policy: Taxes versus Spending’. National Bureau of Economic Research Working Paper No.15438.

discredited.<sup>47</sup> Blyth avers that austerity has not succeeded historically in promoting growth or reducing debts<sup>48</sup> and is an ideology “immune to facts and basic empirical refutation”.<sup>49</sup>

Jane Jones and Cathy McCormack identified the forging of a new morality, in government discourse, which misrepresented the cause of the Great Recession and stigmatised benefit recipients.<sup>50</sup> The latter involved the government employing a false distinction between strivers and skivers,<sup>51</sup> indicative of the ideological mode of fragmentation, to justify welfare cuts. David Stuckler and Sanjay Basu note that austerity has “severe and often deadly” side effects.<sup>52</sup> Similarly, Clare Bambra averred that the coalition’s austerity policies were likely to increase inequalities in mortality and morbidity.<sup>53</sup> In 2016, the British Medical Association (BMA) noted that household income had fallen, while food insecurity, mental health conditions and homelessness had risen.<sup>54</sup> It concluded that austerity had hampered progress in reducing poverty and inequality.<sup>55</sup> Lucinda Hiam et al noted that deaths in 2015 were substantially greater than in 2014 and that the increase had continued in 2016.<sup>56</sup> There was a spike

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<sup>47</sup> Brodie, J. (2015) ‘Income Inequality and the Future of Global Governance’ in Gill, S. (ed) *Critical Perspectives on the Crisis in Global Governance: Reimagining the Future*. Basingstoke: Palgrave, pp45-68 at p59.

<sup>48</sup> Blyth, M. (2013) *Austerity*, op cit., n.42 at pp4-5.

<sup>49</sup> Ibid at p226.

<sup>50</sup> Jones, J. and McCormack, C. (2016) ‘Socio-structural violence against the poor’ in Smith, K., et al (eds) *Health Inequalities: Critical Perspectives*. Oxford: Oxford University Press, pp238-251 at p245.

<sup>51</sup> Coote, A. and Lyall, S., ‘Strivers v Skivers: real life’s not like that at all’, *Guardian*, 11 April 2013.

<sup>52</sup> Stuckler, D. and Basu, S. (2013) *The Body Economic: Why Austerity Kills*. New York: Basic Books, p140.

<sup>53</sup> Bambra, C. (2013) ‘All in it Together? Health Inequalities, Austerity and the Great Recession’ in Wood, C. (ed) *Health in Austerity*. London: Demos, pp49-57 at p51.

<sup>54</sup> British Medical Association (BMA) (2016) *Health in all policies: Health, Austerity and Welfare reform: A Briefing from the board of science*. London: BMA, p1.

<sup>55</sup> Ibid.

<sup>56</sup> Hiam, L. et al (2017) ‘Why has mortality in England and Wales been increasing? An Iterative Demographic Analysis’. *Journal of the Royal Society of Medicine*, Vol.110(4), pp153-162 at p153.



in deaths in January 2015. Hiam et al state that the evidence points to a “major failure of the health system, possibly exacerbated by failings in social care”.<sup>57</sup> The coalition asserted that there was no alternative to fiscal retrenchment and that public expectations of “the future collective provision of welfare by the state should be reduced”.<sup>58</sup> However, as Lee argues, the choices about public spending were “quintessentially political choices, and not an unavoidable economic necessity”.<sup>59</sup> Lee highlighted that debt as a percentage of national income had rarely been lower in the past two centuries.<sup>60</sup> Andrew Gamble states that Western states are currently richer than when welfare states were introduced and could choose to spend more on them.<sup>61</sup> The BMA noted that, in contrast to England, other countries, such as Iceland, Canada, Sweden and Norway, had maintained high levels of public spending on social welfare and health to improve health outcomes and narrow health inequalities.<sup>62</sup> The cuts provoked much opposition and protest, for example, by groups such as UK Uncut, which argued that if unpaid taxes had been collected, they would have been unnecessary.<sup>63</sup>

Lee avers that from September 2013 onwards, Cameron and Osborne spoke of their “long-term economic plan” which recognised their failure to clear the deficit rhetorically and justified their “ambition to roll back the frontiers of the state further than had

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<sup>57</sup> Hiam, L. et al (2017) ‘What caused the spike in mortality in England and Wales in January 2015?’ *Journal of the Royal Society of Medicine*, Vol..110(4), pp131-137 at p135.

<sup>58</sup> Lee, S. (2011) ‘No Plan B: The Coalition agenda for cutting the deficit and rebalancing the economy’ in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp59-74 at p64.

<sup>59</sup> Ibid.

<sup>60</sup> Ibid.

<sup>61</sup> Gamble, A. (2016) *Can the Welfare State Survive?* Cambridge: Policy Press, p59.

<sup>62</sup> British Medical Association (2016) Health in all policies, op cit., n.54 at p1.

<sup>63</sup> Graeber, D. (2013) *The Democracy Project*. New York: Spiegel and Grau, p22.

previously been envisaged”.<sup>64</sup> Public spending is predicted to fall to 35.2 percent of GDP in 2019/20, the lowest level in eighty years.<sup>65</sup> John Appleby stated in 2014 that, taking inflation into account, NHS spending had increased by an average of 0.7 percent per year for six years, the lowest amount since the 1950s.<sup>66</sup> The NHS had thus not been adequately funded to maintain performance and grow services.<sup>67</sup> In addition, the quality, innovation, productivity and prevention (QIPP) efficiency plan identified £20bn worth of savings to be made within the NHS, by 2014,<sup>68</sup> through pay freezes, savings in back office functions and purchasing<sup>69</sup> and tariff reductions.<sup>70</sup> The plan was formulated by McKinsey on PowerPoint slides, which Allyson Pollock and David Price describe as “the electronic equivalent of the back of a cigarette packet”.<sup>71</sup> Appleby states that significant savings were delivered in the two years following 2010/11<sup>72</sup> but that performance subsequently deteriorated, evidenced by high waiting times, declining patient satisfaction and many hospitals reporting deficits.<sup>73</sup> The Centre for Health and the Public Interest (CHPI) notes that provider deficits are a

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<sup>64</sup> Lee, S. (2015) ‘Indebted and Unbalanced: The Political Economy of the Coalition’ in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp16-35 at p23.

<sup>65</sup> Ibid at p25.

<sup>66</sup> Appleby, J. (2014) ‘NHS Funding: Past and Future’. [On-line] Available: <http://www.kingsfund.org.uk/blog/2014/10/nhs-funding-past-and-future> [Accessed: 30 March 2016].

<sup>67</sup> Jacky Davis et al state that the NHS requires spending increases above inflation of three to four percent per annum. See Davis, J., et al (2015) *NHS for Sale: Myths, Lies & Deception*. London: Merlin Press, p12.

<sup>68</sup> Pollock, A. and Price, D., ‘David Owen’s NHS Bill offers a final chance to save our health service’. *New Statesman*, 29 January 2013.

<sup>69</sup> Gregory, S. et al (2012) *Health Policy under the coalition government: A mid-term assessment*. London: Kings Fund, p52.

<sup>70</sup> Lafond, S. et al (2014) *Into the Red? The State of the NHS’ Finances: An Analysis of expenditure between 2010 and 2014*. London: Nuffield Trust, p27.

<sup>71</sup> Pollock, A. and Price, D., ‘David Owen’s NHS Bill offers a final chance to save our health service’, op cit., n.68.

<sup>72</sup> Appleby, J. et al (2014) *The NHS Productivity Challenge: Experience from the front line*. London: Kings Fund, p3.

<sup>73</sup> Appleby, J. et al (2015) *The NHS under the Coalition government part two: NHS Performance*. London: Kings Fund, p4/Klein, R. (2015) ‘England’s National Health Service-broke but not broken’. *Millbank Quarterly*, Vol.93(3), pp455-458 at p456.

measure of the shortfall of resources in relation to patient need and not of management shortcomings.<sup>74</sup>

The pressures on the NHS were compounded by spending constraints and cuts in other areas, such as social care, housing and social security.<sup>75</sup> Although NHS England (NHSE) stated, in 2014, that there was a need for a radical upgrade in prevention and public health,<sup>76</sup> Osborne announced, in June 2015, a £200 million reduction in public health spending.<sup>77</sup> This has been described as a false economy.<sup>78</sup> David Hunter contended, in 2016, that “without new money in the form of raised taxes...it is inconceivable that the NHS can survive in its current state”.<sup>79</sup> Public spending on health, as a proportion of GDP, is expected to fall to 6.7 percent by 2020/21<sup>80</sup> leaving the UK behind many other advanced nations.<sup>81</sup> Jacky Davis et al note that Noam Chomsky stated that “the standard technique of privatisation” is to “defund, make sure things don’t work, people get angry, you hand it over to private capital”.<sup>82</sup> Similarly, John Lister states that the government’s “aim is to scale down public providers, downgrade and discredit public services and strengthen the position of private

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<sup>74</sup> Centre for Health and the Public Interest (CHPI) (2016) *Submission to the House of Lords Select Committee on the long-term sustainability of the NHS*. London: CHPI, p6.

<sup>75</sup> Coote, A. and Penny, J. (2014) *The Wrong Medicine: A Review of the Impacts of NHS Reform in England*. London: New Economics Foundation, p6/Jarman, H. and Greer, S. (2015) ‘The big bang: Health and Social Care reform under the coalition’ in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp50-67 at p57.

<sup>76</sup> NHS England (2014) *Five Year Forward View*. London: NHS England, p3.

<sup>77</sup> Hunter, D. (2016) *The Health Debate: 2<sup>nd</sup> edition*. Bristol: Policy Press, p63.

<sup>78</sup> Nuffield Trust, Health Foundation and Kings Fund (2015) ‘The Spending Review: What does it mean for health and social care?’ [On-line] Available:

<https://www.kingsfund.org.uk/publications/briefings-and-responses/spending-review-health-social-care> [Accessed: 22 November 2016], p6.

<sup>79</sup> Hunter, D. (2016) ‘The Slow Linger Death of the NHS: Comment on “Who Killed the English National Health Service?”’ *International Journal of Health Policy Management*, Vol.5(1), pp155-157 at p156.

<sup>80</sup> Nuffield Trust, Health Foundation and Kings Fund (2015) ‘The Spending Review’, op cit., n.78 at p2.

<sup>81</sup> Ibid at p4.

<sup>82</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.67 at p43.

companies such as Serco and Virgin”.<sup>83</sup> This explains government efforts to shift blame (examined in chapter six). Prior to the 2015 general election many senior doctors signed a letter criticising the coalition’s broken promises regarding the NHS, which, they contended, was “withering away”, as its core infrastructure was being eroded (through hospital and bed closures).<sup>84</sup> Colin Leys attributed such erosion to debt (especially in hospitals with PFI<sup>85</sup>), efficiency savings and new regulations (examined in chapter six).<sup>86</sup> More than 650 GP surgeries were closed, merged or taken over after 2010 and the Royal College of General Practitioners (RCGP) warned that a further 600 surgeries face closure by 2020.<sup>87</sup> In 2016, it was reported that as pressure on the NHS was increasing, private activity outside of the NHS had also increased (hence the exchange principle, indicative of identity thinking, has been extended) resulting in the profits of some companies doubling.<sup>88</sup>

### Public Service Reforms

Stuart Hall argued that the coalition was “arguably the best prepared, most wide ranging, radical and ambitious of the three regimes which since the 1970s have been

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<sup>83</sup> Lister, J. (2013) ‘Breaking the Public Trust’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp17-37 at p21.

<sup>84</sup> Abdullah, S. et al, ‘Senior doctors assess government’s record on the NHS- letter in full’, *Guardian*, 7 April 2015.

<sup>85</sup> The coalition developed PF2 to address the problems of PFI (HM Treasury (2012) *A New Approach to Public Private Partnerships*. London: HM Treasury, p27). Although PF2 sought to improve value for money, Mark Hellowell contends that in reducing the amount of funding from debt, the coalition increased the cost of capital (Hellowell, M. (2014) *The Return of PFI- Will the NHS pay a higher price for new hospitals?* London: Centre for Health and the Public Interest, pp12-14).

<sup>86</sup> Leys, C., ‘Why the NHS will go out with a whimper, not a bang’, *Guardian*, 15 May 2013.

<sup>87</sup> El-Gingihy, Y., ‘How the ‘humanitarian’ crisis in the NHS is paving the way for private healthcare’, *Independent*, 12 January 2017.

<sup>88</sup> Price, C., ‘From red to black: Private sector profiting as NHS crumbles’, *Pulse*, 17 October 2016.

maturing the neoliberal project”.<sup>89</sup> He stated that ideology was in the “driving seat” of the coalition’s policies, although this is “vigorously denied”, with the front-bench being populated by ideologues, such as Osborne, Gove and Andrew Lansley (Health Secretary between 2010 and 2012), who were “saturated in neoliberal ideas and determined to give them legislative effect”.<sup>90</sup> Christopher Byrne et al contend that Cameronite neo-liberalism<sup>91</sup> consisted of: the big society, the notion of giving power to the people<sup>92</sup> (which critics saw as a ruse to disguise spending cuts and privatisation<sup>93</sup>); freedom of information,<sup>94</sup> as a vehicle for cutting public spending by allowing citizens to scrutinise government finances;<sup>95</sup> and, depoliticisation (for example, the Office of Budget Responsibility (OBR) was established to provide independent economic forecasts).<sup>96</sup> Gus O’Donnell (Cabinet Secretary between 2005 and 2011) believed that Cameron’s team imbibed the message of Blair’s memoir, ‘*A Journey*’, not to squander time in a government’s first term when political capital is high.<sup>97</sup> Consequently, unlike New Labour’s cautious approach, the coalition “pressed ahead with its reform agenda in areas such as education, housing and social security (welfare) at breakneck speed”.<sup>98</sup> Nicholas Timmins opined that the coalition “launched

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<sup>89</sup> Hall, S. (2011) ‘The Neo-liberal Revolution’. *Soundings*, Vol.48, pp9-27 at p23.

<sup>90</sup> *Ibid.*

<sup>91</sup> Byrne, C, et al (2012) ‘Understanding Conservative Modernisation’, op cit., n.7 at p26.

<sup>92</sup> *Ibid.*

<sup>93</sup> Heywood, A. (2011) ‘The Big Society: Conservatism Reinvented?’ *Politics Review*, Vol.21(1), pp22-25 at p22/Finn, M. (2015) ‘Conclusion’, op cit., n.27 at p603/ Tailby, S. (2012) ‘Public Service Restructuring in the UK’, op cit., n.41 at p456.

<sup>94</sup> Byrne, C, et al (2012) ‘Understanding Conservative Modernisation’, op cit., n.7 at p26.

<sup>95</sup> Kerr, P. et al (2011) ‘Theorising Cameronism’, op cit., n.3 at p199.

<sup>96</sup> Byrne, C, et al (2012) ‘Understanding Conservative Modernisation’, op cit., n.7 at p26/Budget Responsibility and National Audit Act (2011), S.3(1).

<sup>97</sup> Seldon, A. (2015) ‘David Cameron as Prime Minister, 2010-2015: The Verdict of History’ in Seldon, A. and Finn, M. (eds) *The Coalition Effect 2010-2015*. Cambridge: Cambridge University Press, pp1-30 at p2/Blair, T. (2010) *A Journey*. London: Hutchinson.

<sup>98</sup> Page, R. (2011) ‘The Emerging blue (and orange) health strategy’, op cit., n.16 at p93.

easily the most ambitious programme for government since the Attlee administration of 1945”.<sup>99</sup>

Rajiv Prabhakar argues that the coalition arguably extended Blair’s approach to public service reform.<sup>100</sup> The coalition saw its healthcare reforms as a logical extension of those introduced under Blair’s premiership.<sup>101</sup> Many saw the reforms as evolutionary, as they extended the internal market reforms of the 1990s and New Labour’s reforms,<sup>102</sup> with continuity in a number of principles, such as competition, choice and provider plurality.<sup>103</sup> However, the coalition was perceived to be moving faster and further than previous governments.<sup>104</sup> Lansley entered office with a grand reform agenda developed in opposition.<sup>105</sup> Former Conservative minister Michael Portillo stated on the BBC’s *‘This Week’* programme that his party “did not believe that they could win the election if they told you what they were going to do”.<sup>106</sup> However, Timmins contends that Lansley’s opposition speeches, which “attracted relatively little

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<sup>99</sup> Timmins, N. (2012) *Never Again? The Story of the Health and Social Care Act 2012*. London: Kings Fund and Institute for Government, p54.

<sup>100</sup> Prabhakar, R. (2011) ‘What is the Legacy of New Labour?’ in Lee, S. and Beech, M. (eds) *The Cameron-Clegg Government: Coalition Politics in an age of Austerity*. Basingstoke: Palgrave, pp24-37 at p25.

<sup>101</sup> Department of Health (DOH) (2010) *Liberating the NHS: Legislative Framework and Next Steps*. London: DOH, p163.

<sup>102</sup> Miller, R. et al (2011) *Liberating the NHS: Orders of change?* Health Services Management Centre University of Birmingham Policy Paper 11, p16.

<sup>103</sup> Klein, R. (2015) ‘England’s National Health Service-broke but not broken’, op cit., n.73 at p455/Vizard, P. and Obolenskaya, P. (2015) *The Coalition’s Record on Health: Policy, Spending and Outcomes 2010-2015 Working Paper 16*. London: LSE, p106.

<sup>104</sup> Jarman, H. and Greer, S. (2015) ‘The big bang’ op cit., n.75 at p51/Hunter, D. (2011) ‘Change of government: One more big bang healthcare reform in England’s National Health Service. *International Journal of Health Services*, Vol.41(1), pp159-174 at p160/Stevens, S., ‘NHS reform is a risk worth taking’, *Financial Times*, 15 July 2010/Devlin, N. (2010) ‘The economics of a liberated NHS’. *Pharmaeconomics*, Vol.28(12), pp1075-1078 at p1075/Klein, R. (2016) ‘Foreword’ in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, ppix-xx at pxix.

<sup>105</sup> Jarman, H. and Greer, S. (2015) ‘The big bang’, op cit., n.75 at p51.

<sup>106</sup> Wrigley, D. (2013) ‘Parliamentary Bombshell’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp62-87 at p68.

media attention”, made his intentions clear.<sup>107</sup> The democratic mandate for the reforms was questioned as Cameron had promised that, if elected, there would “be no more of the tiresome, meddlesome, top-down re-structures that have dominated the last decade of the NHS”, one of a number of commitments which the Conservatives subsequently sought to erase from the internet.<sup>108</sup> Davis et al described the reforms as the “biggest top-down reorganisation in the history of the NHS”.<sup>109</sup> Similarly, David Nicholson (NHS Chief Executive and Chief Executive of NHSE between 2006 and 2014) described the reorganisation as “such a big change...you could probably see it from space”.<sup>110</sup> The Conservative manifesto did not clearly set out the intended reforms, although it contained a commitment to “decentralise power” within the NHS.<sup>111</sup>

### Equity and Excellence

In the coalition’s programme for government, Cameron and Clegg stated that the days of big government were over as “centralisation and top-down control” had failed.<sup>112</sup> In respect of the NHS, they stated that Conservative “thinking on markets, choice and competition” would be added to the Liberal Democrats “belief in advancing democracy

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<sup>107</sup> Timmins, N. (2012) *Never Again?*, op cit., n.99 at p26 and p29.

<sup>108</sup> Eaton, G., ‘The pre-election pledges that the Tories are trying to wipe from the internet’, *New Statesman*, 13 November 2013.

<sup>109</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.67 at p2.

<sup>110</sup> Nicholson, D. (2010) ‘Speech to the NHS Alliance Conference’. [On-line] Available: <http://www.healthpolicyinsight.com/?q=node/858> [Accessed: 12 June 2016].

<sup>111</sup> Conservative Party (2010) *Invitation to join the government of Britain: The Conservative Party Manifesto 2010*. London: Conservative Party, p45.

<sup>112</sup> Cameron, D. and Clegg, N., ‘Foreword’ in HM Government (2010) *The Coalition: Our Programme for government*. London: Cabinet Office, pp7-8 at p7.

at a much more local level” to produce a “radical” and “united vision”.<sup>113</sup> Although the coalition’s NHS reforms did not require legislation, Lansley wanted to use legislation to entrench them<sup>114</sup> and to ensure that a future health secretary could not dilute or modify them by administrative fiat.<sup>115</sup> The white paper ‘*Equity and Excellence: Liberating the NHS*’ (‘EAE’), which was heavily influenced by the aforementioned ‘NAAA’ proposals, was compiled soon after the coalition’s formation and published along with four consultation documents.<sup>116</sup> The notion that the NHS needed to be liberated stemmed from the Thatcherite conception that it was a “bureaucratic monster”.<sup>117</sup> Although the word ‘equity’ appeared in the title of the white paper, it was only mentioned twice in the document itself, which, Alan Maynard contended, indicated that the coalition was “not interested in equity”.<sup>118</sup> In contrast, Alex Mold notes that the word ‘choice’ appeared eighty-four times in ‘EAE’.<sup>119</sup> I contend, in chapter six, that the coalition’s reforms have had inequitable effects and that rather than liberating the NHS, they have centralised power and increased legal regulation. Following the responses to the consultation documents, ‘*Liberating the NHS: Legislative Framework and Next Steps*’ was published.

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<sup>113</sup> Ibid at p8.

<sup>114</sup> Timmins, N. (2012) *Never Again?*, op cit., n.99 at p139/Glennister, H. (2015) ‘The Coalition and Society (III): Health and Long-Term Care’ in Seldon, A. and Finn, M. (eds) *The Coalition Effect 2010-2015*. Cambridge: Cambridge University Press, pp290-317 at p293.

<sup>115</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one: NHS Reform*. London: Kings Fund, p9.

<sup>116</sup> Department of Health (DOH) (2010) *Transparency in Outcomes: A Framework for the NHS*.

London: DOH/Department of Health (DOH) (2010) *Commissioning for Patients*. London:

DOH/Department of Health (DOH) (2010) *Local Democratic Legitimacy in Health*. London:

DOH/Department of Health (DOH) (2010) *Regulating Healthcare Providers*. London: DOH.

<sup>117</sup> Letwin, O. and Redwood, J. (1988) *Britain’s Biggest Enterprise: Ideas for Radical Reform of the NHS*. London: Centre for Policy Studies, p4.

<sup>118</sup> Maynard, A. (2010) ‘The Maynard Doctrine: What does the White Paper mean? Incoherence and confusion- both opportunity and threat’. [On-line] Available:

<http://www.healthpolicyinsight.com/?q=node/677> [Accessed: 13 June 2016].

<sup>119</sup> Mold, A. (2015) *Making the Patient Consumer: Patient Organisations and Health Consumerism in Britain*. Manchester: Manchester University Press, p161.



The Conservatives had proposed to make the NHS “more accountable”,<sup>120</sup> in ‘NAAA’, by creating an NHS board, independent of the daily interference of ministers.<sup>121</sup> The notion of running the NHS through a board had often been advocated,<sup>122</sup> and rejected,<sup>123</sup> previously. The coalition programme stated that the aim was to free staff from “political micromanagement”.<sup>124</sup> ‘EAE’ proposed to “limit the power of ministers over day-to-day NHS decisions”<sup>125</sup> and create “more autonomous NHS institutions, with greater freedoms, clear duties and transparency in their responsibilities to patients and their accountabilities”.<sup>126</sup> It stated that an “independent and accountable NHS Commissioning Board” (later renamed NHSE) would be created.<sup>127</sup> It would be accountable to the Secretary of State through an outcomes framework.<sup>128</sup> ‘EAE’ stated that the board would “allocate and account for NHS resources”, lead on quality improvement, promote patient involvement and choice.<sup>129</sup> It would also commission specialised, primary care and family health services.<sup>130</sup> Scott Greer et al state that the intention of the “white paper appeared to be to establish the same type of relationship

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<sup>120</sup> Conservative Party (2007) *NHS Autonomy and Accountability: Proposals for Legislation*. London: Conservative Party, p9.

<sup>121</sup> Ibid at p5.

<sup>122</sup> See, for example, Pirie, M. and Butler, E. (1988) *The Health of Nations: Solutions to the Problem of Finance in the Health Sector*. London: Adam Smith Institute, p13.

<sup>123</sup> For example, Enoch Powell thought that it was impractical given the amount spent on the NHS. See Powell, E. (1976) *Medicine and Politics: 1975 and After*. Tunbridge Wells: Pitman Medical, p12.

<sup>124</sup> HM Government (2010) *The Coalition: Our Programme for government*. London: Cabinet Office, p26.

<sup>125</sup> Department of Health (DOH) (2010) *Equity and Excellence: Liberating the NHS*. London: DOH, p5.

<sup>126</sup> Ibid at p7.

<sup>127</sup> Ibid at p5.

<sup>128</sup> Department of Health (2010) *Liberating the NHS: Legislative Framework and Next Steps*, op cit., n.101 at p39.

<sup>129</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p5.

<sup>130</sup> Department of Health (DOH) (2010) *Liberating the NHS: Commissioning for Patients: A Consultation on Proposals*. London: DOH, p12.

between the Secretary of State and the health service which the Chancellor of the Exchequer has with the independent Bank of England”.<sup>131</sup>

‘NAAA’ proposed that Monitor be empowered as an economic regulator.<sup>132</sup> ‘EAE’ stated that Monitor would “become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services”.<sup>133</sup> In response, the BMA contended that rather than promoting competition, Monitor should focus on ensuring quality.<sup>134</sup> While ‘NAAA’ proposed extending FT freedoms,<sup>135</sup> ‘EAE’ stated that all trusts would have FT status “within 3 years”.<sup>136</sup> The coalition stated that it aimed to “create the largest social enterprise sector in the world” by increasing FT freedoms and enabling NHS staff “the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises”.<sup>137</sup> The coalition advocated mutualisation as a means of empowering healthcare professionals, but there were concerns that without legal safeguards, this could be a stepping stone to corporatisation.<sup>138</sup> ‘EAE’ announced that the “arbitrary [private patient] cap” for FTs would be removed.<sup>139</sup> Many respondents to ‘EAE’ were concerned that abolishing the cap could result in a

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<sup>131</sup> Greer, S. et al (2016) ‘The Central Management of the English NHS’ in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp87-104 at p89.

<sup>132</sup> Conservative Party (2007) *NHS Autonomy and Accountability*, op cit., n.120 at p5.

<sup>133</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p5.

<sup>134</sup> British Medical Association (BMA) (2010) *Equity and Excellence: Liberating the NHS BMA Response: Executive Summary*. London, BMA, p3.

<sup>135</sup> Conservative Party (2007) *NHS Autonomy and Accountability*, op cit., n.120 at p5.

<sup>136</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p36.

<sup>137</sup> Ibid at p5.

<sup>138</sup> McKee, M., ‘Mutual Ownership: Privatisation under a different name?’ *British Medical Journal* 2014;349:g5150.

<sup>139</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p36.

multi-tiered service.<sup>140</sup> 'EAE' stated that best practice tariffs would be introduced to pay providers for efficient care.<sup>141</sup> Although the Health and Social Care (HSC) Bill originally allowed for some price-based competition, it was noted, for example by the Royal College of Surgeons (RCS)<sup>142</sup> and Julian Le Grand,<sup>143</sup> that there is no evidence that this improves quality, hence the government relented. Nonetheless, Lucy Reynolds and Martin McKee noted that "only services paid for according to tariff will be protected from price-based competition".<sup>144</sup>

'NAAA' proposed furnishing primary care commissioners with responsibility for the majority of the NHS budget.<sup>145</sup> This proposal also appeared in the coalition programme<sup>146</sup> and 'EAE'.<sup>147</sup> The coalition stated that GPs working in consortia would commission services in order "to make decisions more sensitive and responsive to the needs and wishes of patients and the public".<sup>148</sup> Ian Greener notes that the coalition's narrative located GPs as shoppers on behalf of patients, but concealed the rationing that would result.<sup>149</sup> 'NAAA' proposed to extend patient choice.<sup>150</sup> The coalition

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<sup>140</sup> Royal College of Nursing (RCN) (2010) *Response to the NHS white paper 'Equity and Excellence: Liberating the NHS' (England)*. London: RCN, p30/Reay, K. and Fleming, D. (2010) *Written Response to Equity and Excellence: Liberating the NHS*. London: Unite, p1/British Medical Association (2010) *Equity and Excellence*, op cit., n.134 at p3.

<sup>141</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p25.

<sup>142</sup> Health Committee (2011) *Commissioning: Further Issues, Fifth Report, House of Commons Session 2010-11, Vol.II*. London: Stationery Office, Ev 152.

<sup>143</sup> Health and Social Care Bill Deb. 8 February 2011, Col.50.

<sup>144</sup> Reynolds, L. and McKee, M. (2012) 'GP Commissioning and the NHS Reforms: What lies behind the hard sell?' *Journal of the Royal Society of Medicine*, Vol.105(1), pp7-10 at p8.

<sup>145</sup> Conservative Party (2007) *NHS Autonomy and Accountability*, op cit., n.120 at p5.

<sup>146</sup> HM Government (2010) *The Coalition*, op cit., n.124 at p8.

<sup>147</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p4.

<sup>148</sup> Department of Health (2010) *Liberating the NHS: Commissioning for Patients: A Consultation on Proposals*, op cit., n.128 at p30.

<sup>149</sup> Greener, I. (2016) 'An argument lost by both sides? The Parliamentary debate over the 2010 white paper' in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp105-124 at p119.

<sup>150</sup> Conservative Party (2007) *NHS Autonomy and Accountability*, op cit., n.120 at p5.

programme stated that patients would be able to choose their GP<sup>151</sup> and any healthcare provider that meets NHS standards, within NHS prices.<sup>152</sup> 'EAE' claimed that individual patients would be empowered through shared decision making ("no decision about me without me"), control over their care records and choices of provider, consultant-led team, GP practice and treatment.<sup>153</sup> 'EAE' also stated that the collective voice of patients would be strengthened "through a powerful new consumer champion, Healthwatch England,<sup>154</sup> located in the Care Quality Commission (CQC)".<sup>155</sup>

Lansley stated that the process targets, introduced by New Labour, had "had a distorting effect on clinical priorities, disempowered healthcare professionals and stifled innovation".<sup>156</sup> Consequently, the coalition stated that it would remove "targets with no clinical justification".<sup>157</sup> It stated that it would move away "from centrally driven process targets" to "a relentless focus on outcomes and quality standards",<sup>158</sup> with greater use of patient reported outcome measures (PROMs) and patient experience surveys.<sup>159</sup> However, process targets have persisted since 2010.<sup>160</sup> The coalition programme stated that the government was committed to the "continuous

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<sup>151</sup> HM Government (2010) *The Coalition*, op cit., n.124 at p25.

<sup>152</sup> Ibid at p26.

<sup>153</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p3.

<sup>154</sup> 'NAAA' also recommended creating Healthwatch (See Conservative Party (2007) *NHS Autonomy and Accountability*, op cit., n.120 at p5).

<sup>155</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p3.

<sup>156</sup> Lansley, A., 'Foreword' in Department of Health (DOH) (2010) *Liberating the NHS: Transparency in outcomes- a framework for the NHS: A Consultation on Proposals*. London: DOH, pp3-4 at p3.

<sup>157</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p4.

<sup>158</sup> Department of Health (2010) *Liberating the NHS: Legislative Framework and Next Steps*, op cit., n.101 at p36.

<sup>159</sup> Department of Health (2010) *Equity and Excellence*, op cit., n.125 at p14.

<sup>160</sup> McCartney, M. (2016) *The State of Medicine: Keeping the Promise of the NHS*. London: Pinter and Martin Limited, p113.

improvement of the quality of services”, which, similarly to New Labour, it sought to achieve “through much greater involvement of independent and voluntary providers”.<sup>161</sup> The coalition claimed that its reforms would make the NHS “more economical with lower transaction costs”.<sup>162</sup> However, both the BMA and RCS stated that competition could lead to waste and inefficiencies.<sup>163</sup> Clare Gerada (RCGP Chair between 2010 and 2013) noted that tendering services was expensive and that money would be lost to patient care.<sup>164</sup>

### The Justifications for the Reforms

At the second reading of the HSC Bill in January 2011, Lansley sought to present the reforms as being in everyone’s interests (indicative of the universalization strategy of the ideological mode of legitimation) as they aimed to “empower” health professionals and patients, reduce costs and extend choice.<sup>165</sup> I contend, in chapter six, that such justifications have not been borne out. As mentioned in chapter four, New Labour used words, such as “modernisation”, to present its reforms as “technical and value-free updatings”,<sup>166</sup> which is indicative of the euphemization strategy of the ideological mode of dissimulation. Similarly, Cameron and Lansley stated that their reforms would

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<sup>161</sup> HM Government (2010) *The Coalition*, op cit., n.124 at p26.

<sup>162</sup> Department of Health (2010) *Liberating the NHS: Legislative Framework and Next Steps*, op cit., n.101 at p157.

<sup>163</sup> British Medical Association (2010) *Equity and Excellence*, op cit., n.134 at p4/Health Committee (2011) *Commissioning: Further Issues, Vol.II*. op cit., n.142 at Ev 151.

<sup>164</sup> Health and Social Care Bill Deb. 8 February 2011, Col.51.

<sup>165</sup> H.C. Deb. 31 January 2011, Vol. 522, Col.605-613.

<sup>166</sup> Fairclough, N. (2000) *New Labour, New Language*. London: Routledge, p40.

modernise the NHS.<sup>167</sup> The coalition outlined five principles underpinning their “modernisation” of public services: increasing choice (wherever possible); decentralising to the lowest appropriate level; openness to a range of providers; fair access; and, accountability to users and taxpayers.<sup>168</sup> The coalition’s discourse contained residual and emergent norms. For example, Cameron and Clegg asserted that “the promise of care based on need and not ability to pay is inviolable”<sup>169</sup> and that “inequalities in access to...decent healthcare...leaves our society less free, less fair and less united”.<sup>170</sup> However, I contend, in chapter six, that the coalition’s reforms undermine such norms. The coalition sought to naturalise (a strategy of the ideological mode of reification) diversity of provision by claiming that “there is no other way that we can hope to meet...needs and increasing expectations or ensure that services are appropriately tailored to meet the gap between the rich and the poor”.<sup>171</sup> However, diversity of provision may exacerbate health inequalities by undermining risk pooling and cross subsidy within the NHS.

The coalition rationalised that its reforms were needed to address declining NHS productivity. Lansley noted that, according to the Office for National Statistics (ONS), NHS productivity had fallen in every one of the past ten years.<sup>172</sup> Many of Lansley’s Conservative colleagues, such as Simon Burns,<sup>173</sup> Mark Simmonds,<sup>174</sup> Sarah

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<sup>167</sup> Cameron, D. (2011) ‘Speech on NHS reforms, Ealing hospital, West London 16 May 2011’. [Online] Available: <http://www.newstatesman.com/uk-politics/2011/05/nhs-health-change-care> [Accessed: 7 June 2016]/Lansley, A., ‘Why the health service needs surgery’. *Daily Telegraph*, 2 June 2011.

<sup>168</sup> HM Government (2011) *Open Public Services White Paper*. Norwich: Stationery Office, p8.

<sup>169</sup> Cameron, D. and Clegg, N., ‘Foreword’ in HM Government (2011) *Open Public Services White Paper*. Norwich: Stationery Office, pp4-5 at p5.

<sup>170</sup> *Ibid* at p4.

<sup>171</sup> HM Government (2011) *Open Public Services White Paper*, op cit., n.168 at p39.

<sup>172</sup> H.C. Deb. 31 January 2011, Vol.522, Col.607.

<sup>173</sup> Health and Social Care (Re-Committed) Bill Deb. 12 July 2011, Col.439.

<sup>174</sup> H.C. Deb. 31 January 2011, Vol.522, Col.636.

Wollaston,<sup>175</sup> Nick de Bois<sup>176</sup> and Earl Howe<sup>177</sup> repeated the notion as the HSC Bill went through parliament. However, as mentioned in chapter four, more detailed evidence indicates that productivity actually increased. Andrew Street and Padraic Ward utilised more comprehensive data than the ONS and reported, in 2009, that output growth had matched input growth between 2003/04 and 2004/05 and had exceeded it following 2004/05, due to increases in the number of patients being treated and improvements in the quality of care.<sup>178</sup> Subsequent research indicated that productivity had risen by eight percent between 2004/05 and 2010/11.<sup>179</sup> The ONS revised the analysis that Lansley had relied upon (on the basis of previously unmeasured activity and improved data sources) and estimated that productivity growth increased by 0.4 percent per year (rather than decreased by 0.2 percent) between 1995 and 2010.<sup>180</sup> Street notes that the media reported the ONS' statement that productivity was declining but that the revised figures "received virtually no attention".<sup>181</sup>

The coalition also rationalised that reform was necessary as it claimed that the NHS compared poorly with other health systems regarding outcomes. The Conservatives stated, in their 2010 manifesto, that deaths due to cancer, per 100,000 people, were higher in the UK than in other countries, such as Australia, Finland, Germany, Greece,

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<sup>175</sup> Ibid at Col.679.

<sup>176</sup> Ibid at Col.692.

<sup>177</sup> H.L. Deb. 11 October 2011, Vol.730, Col. 1469.

<sup>178</sup> Street, A. and Ward, P. (2009) *NHS Input and Productivity Growth 2003/4-2007/8: Research Paper 47*. York: Centre for Health Economics, p33.

<sup>179</sup> Bojke, C. et al (2013) *NHS Productivity from 2004/5-2010/11: Research Paper 87*. York: Centre for Health Economics, pii.

<sup>180</sup> Massey, F. (2012) *Public Service Productivity Estimates: Healthcare, 2010*. London: Office for National Statistics, p1.

<sup>181</sup> Street, A. (2013) 'What has been happening to NHS productivity?' [On-line] Available: <http://www.nuffieldtrust.org.uk/node/2899> [Accessed: 1 June 2016].

Spain and Sweden.<sup>182</sup> The Conservatives asserted that “someone in the UK is twice as likely to die from a heart attack [acute myocardial infarction (AMI)] as someone in France”, “survival rates for cervical, colorectal and breast cancer are amongst the worst in the OECD” and premature mortality rates from respiratory disease are worse than the EU fifteen average.<sup>183</sup> Cameron and Lansley claimed that if UK survival rates were at the EU average, there would be fewer deaths from cancer, respiratory disease and liver disease.<sup>184</sup> However, writing in the *British Medical Journal (BMJ)*, Appleby noted that the Conservatives had compared AMI deaths with France for just one year.<sup>185</sup> Appleby stated that the UK had had the largest fall, of any European country, in death rates from AMI between 1980 and 2006 and that, if trends continued, the UK would have lower death rates than France for AMI, by 2012, and for breast cancer, soon thereafter.<sup>186</sup> Appleby noted that differences in survival rates may reflect variations in how early diagnoses are made rather than the state of healthcare.<sup>187</sup> Davis et al state that Lansley and Cameron cherry picked statistics regarding clinical outcomes to present the NHS as a failing service.<sup>188</sup> Although Appleby undermined their claims, Davis et al noted that “few members of the public read” the *BMJ*, hence many believed that the NHS was failing and that the coalition’s reforms were necessary.<sup>189</sup>

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<sup>182</sup> Conservative Party (2010) *Invitation to join the government of Britain*, op cit., n.111 at p44.

<sup>183</sup> Conservative Party (2011) *Modernising the NHS: The Health and Social Care Bill*. [On-line] Available:

[https://www.webarchive.org.uk/wayback/archive/20110908004249/http://www.conservatives.com/News/News\\_stories/2011/01/Modernising\\_the\\_NHS.aspx](https://www.webarchive.org.uk/wayback/archive/20110908004249/http://www.conservatives.com/News/News_stories/2011/01/Modernising_the_NHS.aspx) [Accessed: 22 April 2016].

<sup>184</sup> H.C. Deb. 31 January 2011, Vol. 522, Col.605/Cameron, D. (2011) ‘Speech on NHS reforms Ealing hospital, West London 16 May 2011’, op cit., n.167.

<sup>185</sup> Appleby, J., ‘Does poor health justify NHS reform?’ *British Medical Journal* 2011;342:d566.

<sup>186</sup> Ibid.

<sup>187</sup> Ibid.

<sup>188</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.67 at p37.

<sup>189</sup> Ibid.



The coalition also rationalised that their reforms were necessary due to the increasing costs of technology, drugs and an ageing population. Lansley asserted that these meant that “doing nothing is not an option”.<sup>190</sup> He claimed that “if things carry on unchanged”, by 2030 real terms health spending would more than double to £230 billion.<sup>191</sup> Lansley’s opinion was that this amount was “something we simply cannot afford”.<sup>192</sup> Similarly, Jamie Fletcher and Jane Marriott described the unaffordability of the NHS as an “empirical fact”.<sup>193</sup> However, Appleby queried such logic, noting that £230 billion would be eighteen percent of current GDP while the economy is likely to grow in value over next twenty years, hence it is likely to be a smaller amount of GDP by then.<sup>194</sup> Pollock and Price remarked that those who question the affordability of free healthcare “are unable to explain why universal healthcare was instituted when the world’s economy was much smaller than it is today”.<sup>195</sup> They noted that the NHS was created when the UK was “literally bankrupt” and was being sustained in Scotland and Wales, hence arguments that it could not be sustained in England were “political not financial”.<sup>196</sup>

The coalition narrativized that the choice and competition that its reforms would engender would be beneficial. It claimed, contrary to the Health Committee’s

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<sup>190</sup> Lansley, A., ‘Why the health service needs surgery’, op cit., n.167.

<sup>191</sup> Ibid.

<sup>192</sup> Ibid.

<sup>193</sup> Fletcher, J. and Marriott, J. (2014) ‘Beyond the Market: The role of constitutions in healthcare system convergence in the United States of America and the United Kingdom’. *Journal of Law, Medicine and Ethics*, Vol.42(4), pp455-474 at p458.

<sup>194</sup> Appleby, J., ‘Can we afford the NHS?’, *The Lamp*, 1 August 2014.

<sup>195</sup> Pollock, A. and Price, D. (2013) *Duty to Care: In Defence of Universal Healthcare*. London: Centre for Labour and Social Studies, p4.

<sup>196</sup> Ibid.

evaluation, mentioned in chapter four, that the purchaser/provider split brought a “host of benefits”, such as encouraging “new innovative providers to compete for contracts”.<sup>197</sup> Hunter contends that ideologies and beliefs “draw selectively on ...evidence for support”.<sup>198</sup> In this regard, Cameron stated that “competition is one way we can make things work better for patients” and that this was not “ideological theory” as a London School of Economics study “found [that] hospitals in areas with more choice had lower death rates”.<sup>199</sup> The study cited by Cameron was the Zack Cooper et al study examined in chapter four.<sup>200</sup> Others, such as the Nuffield Trust,<sup>201</sup> Le Grand,<sup>202</sup> Lord Warner,<sup>203</sup> the NHS Future Forum (NHSFF),<sup>204</sup> Simon Stevens<sup>205</sup> and the Department of Health,<sup>206</sup> cited this study (and in some cases, the studies of Nicholas Bloom et al<sup>207</sup> and Martin Gaynor et al<sup>208</sup>) to justify their support for increased competition within the NHS. Greener et al argue that even if Cooper et al’s research is taken at face value, not all the structures in place after 2010 are the same as New

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<sup>197</sup> HM Government (2011) *Open Public Services White Paper*, op cit., n.168 at p29.

<sup>198</sup> Hunter, D. (2016) *The Health Debate*, op cit., n.77 at p16.

<sup>199</sup> Cameron, D. (2011) ‘Speech on the future of the NHS: 7 June 2011’. [On-line] Available: <https://www.gov.uk/government/speeches/speech-on-the-nhs--2> [Accessed: 25 April 2016].

<sup>200</sup> Cooper, Z. et al (2011) ‘Does Hospital Competition Save Lives? Evidence from the English NHS patient choice Reforms’. *The Economic Journal*, Vol.121(554), pp228-260.

<sup>201</sup> Nuffield Trust (2010) *NHS Resources and Reform: Response to the white paper Equity and Excellence: Liberating the NHS and the 2010 Spending Review*. London: Nuffield Trust, p3.

<sup>202</sup> Le Grand, J., ‘Will 1 April mark the beginning of the end of England’s NHS? No’. *British Medical Journal* 2013;346:f1975.

<sup>203</sup> Health and Social Care Bill Deb. 13 December 2011, Col.1179.

<sup>204</sup> NHS Future Forum (2011) *Choice and Competition: Delivering Real Choice: A Report from the NHS Future Forum*. London: Department of Health, p36.

<sup>205</sup> Stevens, S., ‘NHS reform is a risk worth taking’, op cit., n.104.

<sup>206</sup> Department of Health (DOH) (2011) *Extension of Any Qualified Provider: Impact Assessment*. London: DOH, p10.

<sup>207</sup> Bloom, N. et al (2015) ‘The Impact of Competition on Management Quality: Evidence from Public Hospitals’. *Review of Economic Studies*, Vol.82 (2), pp457-489.

<sup>208</sup> Gaynor, M. et al (2013) ‘Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service’. *American Economic Journal: Economic Policy*, Vol.5(4), pp134-166.

Labour's market, which was the subject of the study, hence it is unrealistic to assume that research translates from one period to another in a straightforward way.<sup>209</sup>

## Opposition

Rudolf Klein divided opponents of the HSC Bill into the indigent (those outraged at competition, choice and diversity of provider)<sup>210</sup> and the incredulous (those appalled by the scope, scale and demanding timetable of the changes),<sup>211</sup> although some critics fit both categories. Hunter notes that many opponents believed that competition, choice and provider diversity would erode the public service ethos of the NHS and reduce equity.<sup>212</sup> There were also concerns that it could fragment the workforce.<sup>213</sup> Kieran Walshe argued that there was little evidence that the reorganisation the legislation would engender would be beneficial, that the transitional costs could be between £2billion and £53billion at a time of unprecedented financial austerity and that structural change adversely affects service performance as it “absorbs a massive amount of time and clinical effort”.<sup>214</sup>

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<sup>209</sup> Greener, I. et al (2014) *Reforming Healthcare: What's the Evidence?* Bristol: Polity Press, pp121-122.

<sup>210</sup> Klein, R. (2013) 'The Twenty Year War over England's National Health Service: A Report from the battlefield'. *Journal of Health Politics, Policy and Law*, Vol.38(4), pp849-869 at p850.

<sup>211</sup> Ibid at p851.

<sup>212</sup> Hunter, D., 'Will 1 April mark the beginning of the end of England's NHS? Yes' *British Medical Journal* 2013;346:f1951.

<sup>213</sup> Pownall, H. (2013) 'Neoliberalism, Austerity and the Health and Social Care Act 2012: The Coalition government's programme for the NHS and its implications for the public sector workforce'. *Industrial Law Journal*, Vol.42(4), pp422-433 at p426.

<sup>214</sup> Walshe, K., 'Reorganisation of the NHS in England'. *British Medical Journal* 2010;341:c3843.

Sally Ruane states that the overall aim of the opposition to the HSC Bill was “essentially a defensive one: to maintain the status quo as a minimum and to halt the passage of the legislation”.<sup>215</sup> Ruane states that opposition strategies included campaigners attempting to create a cleavage between the coalition parties, the forging of alliances with other opponents, persuading Labour to vigorously oppose the bill and exposing “the dangers of the bill in order to widen public opposition and persuade wavering organisations to oppose”.<sup>216</sup> Ruane notes that many actions and techniques (formal and creative) were employed in the opposition campaign.<sup>217</sup> For example, Keep Our NHS Public (KONP) produced numerous “critiques, public letters, leaflets, [and] briefing papers” to raise public awareness.<sup>218</sup> In addition, UK Uncut occupied banks, 38 Degrees organised petitions and raised money to commission legal advice regarding the HSC Bill and some opponents performed songs and dances outside of the Department of Health.<sup>219</sup>

Ruane states that there were numerous contributory factors to the success of the legislation despite opposition.<sup>220</sup> One factor was Labour’s ambiguous position given its own record of NHS marketization and privatisation.<sup>221</sup> Greener states that Labour lacked “an alternative plan other than the status quo”.<sup>222</sup> Since the statute received royal assent, in March 2012, several private members bills, including the NHS

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<sup>215</sup> Ruane, S. (2016) ‘Market reforms and privatisation in the English National Health Service’. *Cuadernos de Relaciones Laborales*, Vol.34(2), pp263-291 at p281.

<sup>216</sup> Ibid.

<sup>217</sup> Ibid at p282.

<sup>218</sup> Ibid.

<sup>219</sup> Ibid.

<sup>220</sup> Ibid.

<sup>221</sup> Ibid/Pollock, A. and Price, D. (2013) *Duty to Care*, op cit., n.195 at p5.

<sup>222</sup> Greener, I. (2016) ‘An argument lost by both sides?’, op cit., n.149 at p113.

(Reinstatement) Bill, drafted by Roderick and Pollock,<sup>223</sup> have been introduced in parliament to amend it, but none have progressed. Another factor was the “excessive focus on the parliamentary process at the expense of building up distributed grass roots activity across the country”.<sup>224</sup> A third factor was that trade unions decided not to prioritise opposition to the bill in a context of multiple and simultaneous assaults on the welfare state and labour rights or to forge closer links with non-union campaigning groups, “preventing the wider dispersal of the campaign’s message”.<sup>225</sup> Davis et al aver that the unions were too “slow to develop any real campaign”.<sup>226</sup> Although a Trades Union Congress (TUC) rally was organised at Westminster Central Hall in March 2012, Davis et al contend that this “was too little too late”.<sup>227</sup> Ruane avers that there was a “hesitancy on the part of professional organisations to engage in open political conflict with government”.<sup>228</sup> Although the HSC Bill was opposed by most professional medical organisations,<sup>229</sup> Raymond Tallis contends that “the medical profession and other healthcare unions failed to mount...effective opposition”.<sup>230</sup> In addition, “the engagement of an enthusiastic minority”, such as the National Association of Primary Care (NAPC)’s chair Charles Alessi, enabled the government to claim that doctors supported the bill.<sup>231</sup> Davis et al argue that the BMA’s leaders

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<sup>223</sup> This was introduced by Caroline Lucas in March 2015 (National Health Service H.C. Bill (2014-15) [187]). It did not progress due to the proroguing of parliament. Lucas introduced the Bill again in July 2015 (National Health Service H.C. Bill (2015-16) [37]), but it was effectively filibustered at its second reading in March 2016. Margaret Greenwood introduced the Bill again in July 2016 (National Health Service H.C. Bill (2016-17) [51]) but it did not progress as parliament was prorogued.

<sup>224</sup> Ruane, S. (2016) ‘Market reforms and privatisation in the English National Health Service’, op cit., n.215 at p283.

<sup>225</sup> Ibid.

<sup>226</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.67 at p4.

<sup>227</sup> Ibid at p5.

<sup>228</sup> Ruane, S. (2016) ‘Market reforms and privatisation in the English National Health Service’, op cit., n.215 at p283.

<sup>229</sup> Jarman, H. and Greer, S. (2015) ‘The big bang’, op cit., n.75 at p53.

<sup>230</sup> Tallis, R. (2013) ‘Introduction’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp1-16 at p11.

<sup>231</sup> Davis, J. and Wrigley, D. (2013) ‘The Silence of the Lambs’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp88-120 at p112.

were frightened that opposition would “drag the BMA out of the corridors of power”.<sup>232</sup> In contrast, they note that RCGP’s leader, Gerada, was “not afraid to oppose the...reforms”.<sup>233</sup>

An Ipsos MORI survey in 2012 found that forty-two percent of respondents had not heard of the changes or did not know what they involved.<sup>234</sup> This may be because, as Tallis notes, apart from a few exceptions, the broadcast and print media failed to comprehend and communicate the proposed changes.<sup>235</sup> Similarly, Hunter argues that media coverage “failed to get to grips with the key issues”.<sup>236</sup> Oliver Huitson contends that the BBC, and other media, routinely regurgitated government press releases.<sup>237</sup> Some newspapers were biased in favour of the reforms. For example, David Worskett (Chief Executive of the NHS Partners Network between 2007 and 2013), orchestrated the publication of several articles within *The Telegraph* advising the government not to mollify their reforms.<sup>238</sup> Timmins concluded that, despite some protests and petitions, “the issue had not cut through deep to the British public”.<sup>239</sup> However, there was a “proliferation of local NHS campaigns and action groups” in opposition to the changes, which, Davis et al state, indicates that many people believed “that legitimate

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<sup>232</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.67 at p87.

<sup>233</sup> Ibid.

<sup>234</sup> Ipsos MORI (2012) *Public Perceptions of the NHS and Social Care*. London: Ipsos MORI, p22.

<sup>235</sup> Tallis, R. (2013) ‘Introduction’, op cit., n.230 at p11.

<sup>236</sup> Hunter, D. (2016) *The Health Debate*, op cit., n.77 at p116.

<sup>237</sup> Huitson, O. (2013) ‘Hidden in Plain Sight’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp150-173 at p168.

<sup>238</sup> *Social Investigations* (2012) ‘The Telegraph, the Think Tank and a very dodgy business’. [On-line] Available: <http://socialinvestigations.blogspot.co.uk/2012/08/the-telegraph-think-tank-and-very-dodgy.html> [Accessed: 2 February 2014].

<sup>239</sup> Timmins, N. (2012) *Never Again?*, op cit., n.99 at p121.

avenues of inquiry have been closed to them, leaving little option but to take to the streets in order to be heard”.<sup>240</sup>

The HSC Bill was rejected at the Liberal Democrats Spring Conference in 2011.<sup>241</sup> As a result, Clegg informed Cameron that he could not get his party to support the bill.<sup>242</sup> Clegg also reportedly accused Lansley of putting “the ideological cart before the political horse”,<sup>243</sup> which, David Owen notes, implies that Clegg’s opposition was tactical rather than ideological.<sup>244</sup> Cameron and Clegg were averse to the micro-management which they associated with New Labour.<sup>245</sup> Consequently, Anthony Seldon contends that some ministers, such as Lansley, were given “too much leeway”, and that Cameron failed “to understand precisely what Lansley was planning”.<sup>246</sup> Cameron reportedly admitted that he did not know what the legislation entailed.<sup>247</sup> Cameron’s response to Clegg’s concerns was a legislative pause, during which the government would consult on the bill.<sup>248</sup> Howard Glennerster describes the consultation as “a face-saving measure designed to placate a coalition partner”.<sup>249</sup> The listening exercise was led by NHSFF, a committee of “compliant health professionals”,<sup>250</sup> led by Steve Field (a former RCGP chairman).<sup>251</sup> NHSFF’s

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<sup>240</sup> Davis, J., et al(2015) *NHS for Sale*, op cit., n.67 at p103.

<sup>241</sup> Glennerster, H. (2015) ‘The Coalition and Society (III)’, op cit., n.114 at p297.

<sup>242</sup> Ibid.

<sup>243</sup> Owen, D. (2014) *The Health of the Nation: NHS in Peril*. York: Methuen and co, p48.

<sup>244</sup> Ibid at p49.

<sup>245</sup> Jarman, H. and Greer, S. (2015) ‘The big bang’, op cit., n.75 at p55.

<sup>246</sup> Seldon, A. (2015) ‘David Cameron as Prime Minister, 2010-2015’, op cit., n.97 at pp12-13.

<sup>247</sup> Davis, J., et al(2015) *NHS for Sale*, op cit., n.67 at p6/Smyth, C. et al., ‘NHS Reforms our worst mistake, Tories admit’. *Times*, 13 October 2014.

<sup>248</sup> Glennerster, H. (2015) ‘The Coalition and Society (III)’, op cit., n.114 at p297.

<sup>249</sup> Ibid at p298.

<sup>250</sup> Toynbee, P. and Walker, D. (2015) *Cameron’s Coup: How the Tories took Britain to the Brink*. London: Guardian Books, p217.

<sup>251</sup> Jarman, H. and Greer, S. (2015) ‘The big bang’, op cit., n.75 at p54.

involvement is indicative of attempted depoliticalization through the recommendations of ostensibly non-political figures.<sup>252</sup>

Despite the aforementioned opposition to the HSC Bill, Jason Glynos et al contend that the debate over alternative visions was marginalised by the notion of integration (which they describe as an empty signifier and master political logic), allowing the statute to proceed with its principal objectives largely intact.<sup>253</sup> Glynos et al state that the elevation of competition and choice to the status of a regulatory principle meant that the appeal to integration was required to legitimise the reforms.<sup>254</sup> Such appeals to integration are thus indicative of the euphemization strategy of the ideological mode of dissimulation. Glynos et al contend that the task of rendering competition and integration compatible, “whether knowingly or not, fell to NHSFF”.<sup>255</sup> NHSFF determined that the opposition to the legislation was “not merely political” as it stemmed from genuine fears concerning job prospects and the breaking up of the NHS.<sup>256</sup> NHSFF deemed that some concerns were misplaced and stemmed from the government’s failure to explain how the legislation would “help the NHS improve”.<sup>257</sup> NHSFF stated that some concerns were justified, such as insufficient safeguards against cherry-picking and a lack of clarity regarding whether competition would only exist when it served patients.<sup>258</sup> NHSFF commissioned a joint report with the Kings

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<sup>252</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises’ in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at p105.

<sup>253</sup> Glynos, J. et al (2014) ‘Logics of Marginalisation in health and social care reform: Integration, Choice and Provider Blind Provision’. *Critical Social Policy*, Vol.35(1), pp45-68 at p46.

<sup>254</sup> Ibid at p54.

<sup>255</sup> Ibid at p57.

<sup>256</sup> NHS Future Forum (2011) *Summary Report on Proposed Changes to the NHS*. London: Department of Health, p9.

<sup>257</sup> Ibid.

<sup>258</sup> Ibid.



Fund and the Nuffield Trust concerning integration, which was already a key concept in the work of both think tanks.<sup>259</sup> Glynos et al note that while both think tanks are not wholly uncritical of government policy, they accept the narrative that healthcare reform requires the creation of opportunities “for a wide range of organisations to provide services under conditions of formal equality”.<sup>260</sup> Such provider blind pluralism is silent on numerous dimensions, such as whether the NHS’ capacity to pool risk is protected from selective cherry-picking tendencies.<sup>261</sup> NHSFF concluded that the notion that competition and integration were opposing forces was a “false dichotomy”.<sup>262</sup> Glynos et al state that the concepts of competition and integration were rendered compatible by situating both within a regime of choice.<sup>263</sup> However, Bob Hudson noted that while collaboration through the market was not impossible, it was unlikely and that the most probable outcome as providers proliferated would be that integration was rendered more difficult.<sup>264</sup>

Glennister contends that none of NHSFF’s recommendations, which were almost wholly accepted, “changed the fundamentals”.<sup>265</sup> Lansley was reportedly clear that no real ground had been conceded.<sup>266</sup> Some saw the listening exercise as a sham, as

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<sup>259</sup> Glynos, J. and Speed, E. (2014) ‘Logics of Marginalisation in health and social care reform’, op cit., n.253 at p57/Goodwin, N. et al (2012) *A Report to the Department of Health and NHS Future Forum: Integrated care for patients and populations: Improving Outcomes by working together*. London: Kings Fund and Nuffield Trust.

<sup>260</sup> Glynos, J. and Speed, E. (2014) ‘Logics of Marginalisation in health and social care reform’, op cit., n.253 at p50.

<sup>261</sup> Ibid at pp62-63.

<sup>262</sup> Bubb, S., ‘Delivering Real Choice: Introduction to the Report by the Chair’ in NHS Future Forum (2011) *Choice and Competition: Delivering Real Choice: A Report from the NHS Future Forum*. London: Department of Health, p6.

<sup>263</sup> Glynos, J. and Speed, E. (2014) ‘Logics of Marginalisation in health and social care reform’, op cit., n.253 at p59.

<sup>264</sup> Hudson, B. (2013) *Competition and Collaboration in the new NHS*. London: Centre for Health and the Public Interest, p13.

<sup>265</sup> Glennister, H. (2015) ‘The Coalition and Society (III)’, op cit., n.114 at p298.

<sup>266</sup> Owen, D. (2014) *The Health of the Nation*, op cit., n.243 at p50.

groups opposing the reforms (such as RCGP, RCN and the BMA) were excluded,<sup>267</sup> while “the private health lobby worked with Downing Street behind the scenes to ensure that the new legislation went ahead”.<sup>268</sup> As a result of NHSFF’s recommendations, consortia were renamed CCGs to “reflect the important involvement of a range of health professionals”<sup>269</sup> and Monitor’s core duty was altered.<sup>270</sup> However, Polly Toynbee noted that there was only a grammatical change to Monitor’s role, “from ‘promoting competition’ to ‘preventing anti-competitive practices’, the same thing said backwards”.<sup>271</sup> The Department of Health also announced new safeguards against price competition, cherry-picking and privatisation.<sup>272</sup> In response to fears concerning privatisation, the Department stated that “any policy to increase or maintain the market share of any particular sector or provider” would be outlawed<sup>273</sup> and that NHSE would “promote innovative ways of demonstrating how care can be made more integrated for patients”.<sup>274</sup> The Department also announced that all trusts would be required to become FTs “as soon as clinically feasible”<sup>275</sup> and that the transitional period where Monitor retains specific oversight powers over FTs would be extended to 2016.<sup>276</sup>

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<sup>267</sup> *New Statesman*, ‘The Coalition’s Carelessness over the nation’s health’, 27 February 2012, p5.

<sup>268</sup> Boffey, D. and Robertson, A. (2012) ‘David Cameron is accused of a ‘sham listening exercise’ on NHS reform after links to lobbyist are revealed’, *Observer*, 25 November 2012.

<sup>269</sup> Department of Health (2011) *Government Response to the NHS Future Forum Report*. Norwich: Stationery Office, p16.

<sup>270</sup> *Ibid* at p5.

<sup>271</sup> Toynbee, P., ‘The only purpose of this upheaval is to bring the market into every aspect of the NHS’, *Guardian*, 16 March 2012.

<sup>272</sup> Department of Health (2011) *Government Response to the NHS Future Forum Report*, *op cit.*, n.269 at p5.

<sup>273</sup> *Ibid* at p43.

<sup>274</sup> *Ibid* at p45.

<sup>275</sup> *Ibid* at p59.

<sup>276</sup> *Ibid*.

Some senior Liberal Democrats claimed that the legislation had been substantially changed in an effort to diminish opposition. Such claims are indicative of the ideological mode of dissimulation as they sought to conceal, obscure and deny that the legislation had not been substantially altered. The Liberal Democrat peer Baroness Williams demanded, at the second reading of the bill in the House of Lords, in October 2011, that “major changes...be made”.<sup>277</sup> However, the following February, Williams stated in a letter (co-written by Clegg) to Liberal Democrat MPs and Lords that the party’s influence had led to amendments resulting in an “undoubtedly...better bill”.<sup>278</sup> Clegg and Williams claimed that “elements of Labour’s 2006 Health Act” such as “gold plated contracts for the private sector” had been changed (the ISTC contracts to which this refers had nothing to do with the Health Act) and that there were safeguards in the bill to prevent cherry-picking and to ensure that “private providers can only offer their services where patients say they want them”.<sup>279</sup> It has been argued that the Liberal Democrats had an ameliorating influence on the legislation.<sup>280</sup> However, many of Clegg’s and Williams’s assurances, such as the notion that the statute prevents cherry-picking, were rebutted by other Liberal Democrats, such as Charles West (a retired GP and Liberal Democrat candidate for Shrewsbury in 2010)<sup>281</sup> and Evan Harris (MP for Oxford West and Abingdon between 1997 and 2010).<sup>282</sup> The coalition dropped its commitment (made in November 2011) to pay providers at a reduced rate

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<sup>277</sup> H.L. Deb. 11 October 2011, Vol.730, Col.1515.

<sup>278</sup> Clegg, N. and Williams, S., ‘Nick Clegg and Shirley Williams’s Letter on Health Bill’, *Guardian*, 27 February 2012.

<sup>279</sup> *Ibid.*

<sup>280</sup> Fletcher, J. and Marriott, J. (2014) ‘Beyond the Market’, *op cit.*, n.193 at p461/Waller, P. and Yong, B. (2012) ‘Case Studies II: Tuition Fees, NHS reform and Nuclear Policy’ in Hazell, R. and Yong, B. (eds) *The Politics of Coalition: How the Conservative-Liberal Democrat Coalition Works*. Oxford: Hart Publishing, pp172-189 at p188.

<sup>281</sup> West, C. (2013) ‘A Failure of Politics’ in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp121-149 at p138.

<sup>282</sup> Harris, E., ‘The Health and Social Care Bill does not deliver Lib Dems’ prescription’. *Guardian*, 6 March 2012.

to prevent cherry-picking within a year.<sup>283</sup> Toynbee expressed shock and surprise at witnessing Williams and her fellow Liberal Democrats giving respectable cover to the Conservatives for extreme policies.<sup>284</sup>

### Corporate Influence

Many opponents of the bill were critical of the “massive lobbying effort” that private healthcare companies engaged in “to fundamentally change the NHS in their own interests”.<sup>285</sup> Colin Leys and Stewart Player state that there was a revolving door between government and businesses, with the Department of Health employing more people from private health companies and former ministers (including Alan Milburn and Patricia Hewitt) becoming paid advisers to businesses.<sup>286</sup> In 2014, Simon Stevens, previously a policy adviser to Blair and a senior executive at United Health, was appointed NHSE Chief Executive.<sup>287</sup> Whilst at United Health, Stevens was involved in a campaign, in the US, against a proposed public option of Obamacare, implemented via the Patient Protection and Affordable Care Act (2010).<sup>288</sup> The public option was withdrawn due to pressure from the insurance industry which wanted to

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<sup>283</sup> Gainsbury, S., ‘Proposals to block patient ‘cherry-picking’ dropped’. *Financial Times*, 2 October 2012.

<sup>284</sup> Toynbee, P., ‘The Failure to stop the Health Bill will come to define the Lib Dems’, *Guardian*, 8 March 2012.

<sup>285</sup> Cave, T. (2011) ‘Spinwatch investigation: NHS reforms plunged into fresh turmoil’. [On-line] Available: <http://www.spinwatch.org/index.php/issues/lobbying/item/5350-nhs-reforms-plunged-into-fresh-turmoil> [Accessed: 24 January 2014].

<sup>286</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin, pp90-95.

<sup>287</sup> Gallagher, P., ‘Is Simon Stevens really the right person to run the NHS?’, *Independent*, 24 October 2013.

<sup>288</sup> Hughes, S., ‘How the new NHS boss has helped to ruin health services on two continents’, *Morning Star*, 1 November 2013.

avoid government competition.<sup>289</sup> Stevens was also a founder member of the Alliance for Healthcare Competitiveness (AHC), which sought to force NHS privatisation through a proposed trade deal between the US and the EU (considered further in chapter six).<sup>290</sup> Private companies also hired lobbying agencies containing government insiders and paid think tanks close to the Conservatives.<sup>291</sup> Leys and Player state that there was “a policy-making community” within think tanks and internal institutions, such as the NHS Partners Network, “with increasing confidence and common understanding to convert the NHS into a market”.<sup>292</sup> In contrast, they contend that “the public has not been honestly informed of the motivations behind various” NHS reforms.<sup>293</sup> Similarly, Hunter states that those dismantling the NHS have operated by stealth.<sup>294</sup> This appears to be because governments perceive overt challenges to residual norms as being politically self-injurious.

As mentioned in chapter two, I posit that there is a micro-ideology of private health companies, proponents of which recommend enhancing opportunities for such companies in English healthcare as it is in the material interests of such companies. This micro-ideology exerted influence on policymakers through several mechanisms. For example, some private healthcare companies established financial links with politicians. Before the bill was passed, the *Daily Mirror* reported that forty peers had a

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<sup>289</sup> Waitzkin, H. and Hellander, I. (2016) ‘The History and future of neo-liberal health reform: Obamacare and its predecessors’. *International Journal of Health Services*, Vol.46(4), pp747-766 at p752.

<sup>290</sup> Hughes, S., ‘The NHS money boss who used to be a lobbyist trying to privatise your healthcare’, *Vice*, 21 November 2014.

<sup>291</sup> Cave, T., ‘Spinwatch investigation’, op cit., n.285.

<sup>292</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*, op cit., n.286 at pp89-90.

<sup>293</sup> Ibid at p2.

<sup>294</sup> Hunter, D. (2016) ‘The Slow Lingering Death of the NHS’, op cit., n.79 at p155.

financial interest in NHS privatisation.<sup>295</sup> *Social Investigations* ascertained that 147 Lords and seventy-three MPs had financial links to companies involved in healthcare.<sup>296</sup> In 2014, Unite found that private companies with links to twenty-four Conservative MPs and peers, who voted for the legislation, had won contracts worth £1.5bn in the past two years.<sup>297</sup> Unite subsequently reported that there were sixty-five Conservative MPs and six Liberal Democrat MPs, who had previous or current financial links to companies attempting to profit from the reforms.<sup>298</sup> The Department of Health paid McKinsey for consultancy services relating to the reforms.<sup>299</sup> According to official documents, released under the Freedom of Information Act (2000), many of the HSC Bill's "proposals were drawn up by McKinsey",<sup>300</sup> some of whose clients are benefiting from the reforms.<sup>301</sup> In addition, emails obtained by Spinwatch, revealed that McKinsey "offered to share information gained from its work on privatisation for the Department of Health with private health companies".<sup>302</sup> Many former employees of McKinsey have acquired important jobs relating to the reforms.<sup>303</sup> For example, David Bennett (a former senior adviser at McKinsey) was appointed Chief Executive of Monitor.<sup>304</sup>

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<sup>295</sup> *Daily Mirror*, 'NHS reforms D-day: 40 peers have "financial interest" in NHS privatisation, Mirror investigation shows', 12 October 2011.

<sup>296</sup> *Social Investigations* (2012) 'NHS Privatisation: Compilation of financial and vested interests'. [Online] Available: <http://socialinvestigations.blogspot.co.uk/2012/02/nhs-privatisation-compilation-of.html> [Accessed: 23 January 2014].

<sup>297</sup> Taylor, M., 'Companies with links to Tories 'have won £1.5bn worth of NHS contracts', *Guardian*, 4 October 2014.

<sup>298</sup> Unite the Union (2014) *Government Links to Private Healthcare*. London: Unite, p7.

<sup>299</sup> Boffey, D., 'NHS Reforms: American consultancy McKinsey in conflict-of-interest row', *Observer*, 5 November 2011.

<sup>300</sup> Rose, D., 'The Firm that hijacked the NHS: MoS Investigation reveals extraordinary extent of international management consultants role in Lansley's health reforms', *Mail on Sunday*, 12 February 2012.

<sup>301</sup> *Ibid.*

<sup>302</sup> *Ibid.*

<sup>303</sup> *Ibid.*

<sup>304</sup> Player, S. and Leys, C., 'McKinsey's unhealthy profits', *Red Pepper*, 4 July 2012.

Agents of the private sector have continued to advocate reforms since the legislation was passed. In April 2014, Lord Warner (Minister of State at the Department of Health between 2005 and 2007) co-authored a report for the think tank, Reform, suggesting a £10.00 monthly membership fee for the NHS and a charge of £20.00 a night for in-patient stays.<sup>305</sup> Warner has been a paid spokesperson for, and Reform is funded by, private healthcare companies.<sup>306</sup> Maynard notes that pharmaceutical companies have also funded think tanks, such as Reform, as the co-payments that they advocate would dissolve expenditure controls.<sup>307</sup> Davis et al state that introducing fees would be expensive to means test and may deter people from seeking treatment.<sup>308</sup> Davis et al describe introducing fees as a zombie idea, a policy which refuses to die despite being killed by evidence and which is kept alive by right-wing politicians and think tanks.<sup>309</sup> The coalition did introduce charges for non-EU nationals.<sup>310</sup>

## Conclusion

The coalition used the deficit which arose, following the Great Recession, to argue that there was no alternative to austerity and public service reforms. NHS spending

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<sup>305</sup> Warner, N. and O'Sullivan, J. (2014) *Solving the NHS Care and Cash Crisis: Routes to Health and Care Renewal*. London: Reform, p97.

<sup>306</sup> Hughes, S., 'He who pays the privateers peer', *Morning Star*, 4 April 2014.

<sup>307</sup> Maynard, A. (2007) 'Beware of the Libertarian Wolf in the Clothing of the Egalitarian Sheep: An Essay on the need to clarify ends and means' in McIntyre, D. and Mooney, G. (eds) *The Economics of Health Equity*. Cambridge: Cambridge University Press, pp77-100 at p83.

<sup>308</sup> Davis, J., et al(2015) *NHS for Sale*, op cit., n.67 at p44.

<sup>309</sup> Ibid at p45.

<sup>310</sup> Immigration Act (2014), S.38/ National Health Service (Charges to Overseas Visitors) Regulations, SI 2015/238.

increased marginally and cuts in other areas have increased pressures on the service. The coalition's NHS reforms were influenced by private healthcare companies, and their representatives, via financial links, lobbying and direct advice. The coalition claimed that the HSC Act (2012) would empower patients and GPs and reduce costs (which I refute in chapter six). The coalition rationalized that its reforms were necessary by cherry-picking clinical outcomes to misrepresent the NHS as a failing service, by erroneously claiming that NHS productivity had declined and by claiming that the political choice of reform was a financial necessity. The coalition cited contested research to justify increased choice and competition and claimed that there was no alternative to diversity of provision to reduce health inequalities. The coalition claimed that it supported the founding principles of the NHS, which Cameron used his own personal experience in an effort to decontest. I demonstrate, within chapter six, that the HSC Act (2012) undermines such principles. Several factors meant that the coalition's legislation succeeded despite opposition. The coalition sought to undermine opposition by misleadingly claiming that its legislation had been substantially altered and by expressing its commitment to integration.



## Chapter Six: NHS Reforms since 2010 (Part Two)

### Introduction

In this chapter, I examine the impact of the Health and Social Care (HSC) Act (2012) on the norms within, and organisation of, the NHS, and its potential reifying effects. I contend that although the coalition claimed to support the founding principles of the NHS (residual norms), these have been undermined by the HSC Act (2012). The statute facilitated the reduction of the comprehensiveness of the NHS and facilitates its further reduction as it removed the duty of the Secretary of State for Health to provide a comprehensive health service. The statute undermines equality of access, as it enables foundation trusts (FTs) to earn up to forty-nine percent of their income from fee paying patients. The statute also undermines universality, as it introduced eligibility criteria into the NHS. The statute extends the ambit of neo-liberal norms within the NHS, which is evident in the duties stipulated within it and in the competition effected by regulations passed pursuant to it. The statute also contains emerging norms, which are evident in the duties to reduce health inequalities stipulated within it and in its creation of Healthwatch to empower patients. However, the duties to reduce health inequalities are undermined by austerity and Healthwatch is perceived as toothless.<sup>1</sup> I argue that as public experience increasingly diverges from residual and emergent norms, a crisis of legitimacy may arise.

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<sup>1</sup> Davis, J., et al (2015) *NHS for Sale: Myths, Lies & Deception*. London: Merlin Press, p123.

The statute has rendered the NHS more opaque by making accountability more arcane and by facilitating increased private sector involvement in clinical service delivery. There is evidence that the market emplaced by the statute has become an end in itself, to the detriment of patients. If the lifestyle drift, which has coloured government discourse, colonises common sense, it may justify the tightening of eligibility criteria. However, attempts by commissioners to restrict access to services have faced resistance. Although the government attempted to pass responsibility to patients via the policy of patient choice, this has taken a backseat.<sup>2</sup> Government efforts to shift blame, for example by creating NHS England (NHSE), are unlikely to succeed as it retains important powers over the NHS (such as deciding its funding). Healthcare has been juridified as law increasingly regulates matters (such as privatisation) within the NHS. However, campaigners have kept the NHS highly politicised.

### The Impact of the HSC Act (2012) on norms within the NHS

#### Residual Norms

The HSC Act (2012) undermines the principle of equality of access, as it permits FTs to obtain up to forty-nine percent of their income from fee paying patients.<sup>3</sup> The previous cap had ranged from two to ten percent, with only five FTs with caps over

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<sup>2</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one: NHS Reform*. London: Kings Fund, p18.

<sup>3</sup> National Health Service (NHS) Act (2006), S.43(2A) as amended by Health and Social Care (HSC) Act (2012), S.164(1).

five percent.<sup>4</sup> Half of the members of the Board of Governors of an FT must agree to proposals to increase by five percent, or more, the proportion of income attributable to non-NHS services.<sup>5</sup> Allyson Pollock notes that the forty-nine percent rule is ambiguous, as there is no clear definition of income from non-NHS services.<sup>6</sup> Paul Burstow (Minister of State for Care Services between 2010 and 2012) claimed that the change would allow FTs to “earn more income to improve, expand or support NHS services”.<sup>7</sup> However, the provision has created a two-tier health service in which patients are offered the opportunity to self-fund their treatment “to jump the queue”.<sup>8</sup> The private patient income of many leading hospitals has risen by up to forty percent, resulting in declining standards for NHS patients.<sup>9</sup> In 2016, it was reported that the income received by FTs, from private patients, had risen by twenty-three percent in the last four years as waiting lists for non-paying patients had soared.<sup>10</sup>

The principle of universality has been undermined, as the statute introduced eligibility criteria into the NHS. It requires licence holders to set transparent eligibility and selection criteria,<sup>11</sup> and to apply them transparently.<sup>12</sup> Pollock predicted that this would

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<sup>4</sup> Curtis, P. (2012) ‘Will the Health Bill increase private activity in the NHS?’ [On-line] Available: <http://www.theguardian.com/politics/reality-check-with-polly-curtis/2012/jan/19/health-bill-private-patients> [Accessed: 1 March 2016].

<sup>5</sup> NHS Act (2006), S.43(3D) as amended by HSC Act (2012), S.164(3).

<sup>6</sup> Pollock, A. (2014) ‘Submission to Health Committee Enquiry: Public Expenditure on Health and Social Care’. [On-line] Available: [http://www.allysonpollock.com/wp-content/uploads/2014/11/AP\\_2014\\_Pollock\\_HealthCommitteePublicExpenditure.pdf](http://www.allysonpollock.com/wp-content/uploads/2014/11/AP_2014_Pollock_HealthCommitteePublicExpenditure.pdf) [Accessed: 26 May 2016], p4.

<sup>7</sup> Health and Social Care Bill Deb. 24 March 2011, Col.1076.

<sup>8</sup> McTague, T., ‘NHS reforms Scandal: Hospitals charging patients for treatment that used to be free’, *Daily Mirror*, 26 September 2013.

<sup>9</sup> Peate, I. (2014) ‘Privatisation by Stealth: Fragmentation of the NHS’. *British Journal of Nursing*, Vol.23(18), p971.

<sup>10</sup> Boffey, D., ‘NHS Cashes in on private payers as waiting lists soar’, *Observer*, 18 December 2016.

<sup>11</sup> HSC Act (2012), S.103(1)(A).

<sup>12</sup> *Ibid* at S.103(1)(B).

result in providers picking and choosing their patients and treatments.<sup>13</sup> Monitor was empowered to set and publish licence criteria,<sup>14</sup> revoke licences<sup>15</sup> and determine standard conditions.<sup>16</sup> The mandatory services under the FT authorisation system were re-designated as commissioner requested services (CRS). Monitor required commissioners to identify location specific services (LSS). These are services which would need to be maintained, due to the absence of alternative providers and the adverse impact on inequalities, if FTs were unable to pay their debts.<sup>17</sup> Pollock and Roderick argue that Monitor may have acted unlawfully by expecting CRS and LSS to converge, thereby reducing the core set of services provided by FTs.<sup>18</sup> In April 2016, Monitor was merged with the NHS Trust Development Authority to create NHS Improvement (NHSI).

The HSC Act (2012) facilitated the reduction of the comprehensiveness of the NHS. It abolished strategic health authorities (SHAs)<sup>19</sup> and primary care trusts (PCTs)<sup>20</sup> and replaced them with NHSE<sup>21</sup> and CCGs.<sup>22</sup> NHSE commissions primary care and specialist services. CCGs commission secondary care services, but have been able to apply for joint or delegated responsibility for some primary care commissioning

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<sup>13</sup> Pollock, A. (2015) 'Morality and Values in Support of Universal Healthcare must be Enshrined in Law'. *International Journal of Health Policy Management*, Vol.4(6), pp399-402 at p400.

<sup>14</sup> HSC Act (2012), S.86(1).

<sup>15</sup> Ibid at S.89.

<sup>16</sup> Ibid at S.94(1).

<sup>17</sup> Roderick, P. and Pollock, A., 'A Wolf in Sheep's clothing: How Monitor is using licencing powers to reduce hospital and community services in England under the guise of continuity'. *British Medical Journal* 2014;349:g5603.

<sup>18</sup> Ibid/Monitor (2013) *Guidance for Commissioners on ensuring the continuity of health care services: Designating Commissioner Requested Services and Location Specific Services*. London: Monitor, p4.

<sup>19</sup> HSC Act (2012), S.33(1).

<sup>20</sup> Ibid at S.34(1).

<sup>21</sup> NHS Act (2006), S.1H as amended by HSC Act (2012), S.9.

<sup>22</sup> NHS Act (2006), S1I as amended by HSC Act (2012), S.10.

since April 2015.<sup>23</sup> PCTs were required to provide or secure certain services (such as services concerning drug and alcohol misuse) on behalf of everyone in a defined geographical area.<sup>24</sup> CCGs are not legally required to secure such services.<sup>25</sup> CCGs are not obligated “to ensure provision to residents within an area except for a very limited range of services”.<sup>26</sup> The coalition transferred funding for public health from the NHS to local authorities<sup>27</sup> and established Public Health England (PHE), to improve health and well-being and reduce health inequalities, on a non-statutory basis.<sup>28</sup> Local authorities can make and recover charges (extending the exchange principle) in exercising their functions to improve public health.<sup>29</sup> The HSC Act (2012) facilitates the further reduction of the comprehensiveness of the NHS as it only requires the Secretary of State for Health to promote (not provide) a comprehensive health service.<sup>30</sup> It thus amended the duty in the NHS Act (2006) which had originally stated that they must provide or secure the provision of services in accordance with this Act (in S.1) and outlined such services (in S.3).

In an effort to obscure the change (indicative of the ideological mode of dissimulation), Andrew Lansley stated that the minister had “never had a duty to provide a comprehensive health service”.<sup>31</sup> Simon Burns (Minister of State for Health Services

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<sup>23</sup> Holder, H. et al (2015) *Risk or Reward? The Changing role of CCGs in general practice*. London: Kings Fund and Nuffield Trust, p4.

<sup>24</sup> National Health Service (functions of strategic health authorities and primary care trusts and administration arrangements) (England) Regulations, SI 2002/2548.

<sup>25</sup> Pollock, A. et al., ‘Health and Social Care Bill 2011: a legal basis for charging and providing fewer services to people in England’. *British Medical Journal* 2012;344:e1729.

<sup>26</sup> Pollock, A. and Price, D. (2013) *Duty to Care: In Defence of Universal Healthcare*. London: Centre for Labour and Social Studies, p13.

<sup>27</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p12.

<sup>28</sup> Health and Social Care Bill Deb. 1 March 2011, Col.390.

<sup>29</sup> Local Authority (Public Health Functions and entry to premises by Local Healthwatch Representatives) Regulations, SI 2013/351, R.9.

<sup>30</sup> NHS Act (2006), S.1(1) as amended by HSC Act (2012), S.1.

<sup>31</sup> H.C. Deb. 06 September 2011, Vol.532, Col.192.

between 2010 and 2012) stated that the duty to promote was the same as 1946 Act.<sup>32</sup> However, the 1946 statute required the Minister to “promote the establishment...of a comprehensive health service”, and to “provide or secure the effective provision of services” for that purpose.<sup>33</sup> Lansley also claimed that in respect of the duty to provide, which had been delegated to PCTs, “the situation will be legally unchanged” as the bill in “exactly the same way” passes the duty to NHSE and CCGs.<sup>34</sup> However, the legislation did not pass the duty “in exactly the same way”<sup>35</sup> as it decoupled S.1 and S.3 of the NHS Act (2006), which had previously been read alongside each other in the courts.<sup>36</sup> Unlike the Secretary of State and NHSE,<sup>37</sup> CCGs do not have a duty to promote a comprehensive health service<sup>38</sup> (although they must act consistently with the minister’s duty to do so<sup>39</sup>) and they are not accountable to the public for the way they spend money.<sup>40</sup> Viscount Hanworth contended that the amended clause allowed Jeremy Hunt to shift blame.<sup>41</sup> Nonetheless, Polly Toynbee and David Walker state that Hunt was told to muzzle his criticisms of the NHS, before the 2015 general election, after polling data indicated that it was rebounding on the government.<sup>42</sup>

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<sup>32</sup> Health and Social Care Bill Deb. 15 February 2011, Col.178.

<sup>33</sup> National Health Service (NHS) Act (1946), S.1(1).

<sup>34</sup> H.C. Deb. 6 September 2011, Vol.532, Col.192.

<sup>35</sup> Cragg, S. (2011) ‘In the matter of the Health and Social Care Bill 2011 and in the matter of the duty of the Secretary of State for Health to Provide a National Health Service: Further Advice’. [On-line] Available: <http://www.38degrees.org.uk/page/-/nhs/nhs-further-advice-duty-to-provide.pdf> [Accessed: 25 May 2016], p7.

<sup>36</sup> Select Committee on the Constitution (2011) *Health and Social Care Bill: Follow-up, Twenty-Second Report, House of Lords Session 2010-12*. London: Stationery Office, p5.

<sup>37</sup> Which is also required to promote a comprehensive health service, except in relation to the public health functions of the Secretary of State or local authorities, as per NHS Act (2006), S.1H(2) as amended by HSC Act (2012), S.9(1).

<sup>38</sup> Cragg, S. (2011) ‘In the matter of the Health and Social Care Bill and in the matter of the duty of the Secretary of State for Health to provide a National Health Service: Executive Summary of Opinion’. [On-line] Available: <https://www.scribd.com/doc/63727252/Legal-advice-on-the-Health-and-Social-Care-Bill> [Accessed: 25 May 2016], p1

<sup>39</sup> NHS Act (2006), S.3(1F)(A) as amended by HSC Act (2012), S.13.

<sup>40</sup> Leys, C. and Player, S. (2011) *The Plot Against the NHS*. Pontypool: Merlin, p137.

<sup>41</sup> H.L. Deb. 08 September 2016, Vol. 774, Col.1183.

<sup>42</sup> Toynbee, P. and Walker, D. (2015) *Cameron’s Coup: How the Tories took Britain to the Brink*. London: Guardian Books, p222.

The Secretary of State retains ministerial responsibility to parliament for the provision of the English health service.<sup>43</sup> However, as Grahame Morris noted, many of their functions have been given to other bodies.<sup>44</sup> The HSC Act (2012) furnished both NHSE and CCGs with the power to impose charges under S.7(2)(H) of the Health and Medicines Act (1988).<sup>45</sup> They are thus able “to determine which health care services will be provided and free, and which will not”.<sup>46</sup> Consequently, Pollock and Price note that parliament would “not be able to hold the Secretary of State to account for failures in the provision of health services”.<sup>47</sup> The statute also confers on the Secretary of State a duty to promote the autonomy of persons exercising functions in relation to the health service.<sup>48</sup> NHSE has a similar duty.<sup>49</sup> Such persons are free to exercise their functions, or provide services, in the manner they consider most appropriate,<sup>50</sup> and the Secretary of State must not place unnecessary burdens on any such person.<sup>51</sup> Stephen Cragg states that this means that they only have the power to intervene when it is “really needed” or “essential”.<sup>52</sup>

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<sup>43</sup> NHS Act (2006), S.1(3) as amended by HSC Act (2012), S.1.

<sup>44</sup> H.C. Deb. 20 March 2012, Vol. 542, Col. 701.

<sup>45</sup> NHS Act (2006), S.13W and S.14Z5 as amended by HSC Act (2012), S. 23 and S.25/Pollock, A. and Price, D. (2013) *Duty to Care*, op cit., n.25 at p20.

<sup>46</sup> Gaffney, A. (2014) ‘The Twilight of the British Public Health System?’ *Dissent*, Vol.61 (2), pp5-10 at p9.

<sup>47</sup> Pollock, A. and Price, D. (2013) *Duty to Care*, op cit., n.26 at p16.

<sup>48</sup> NHS Act (2006), S.1D as amended by HSC Act (2012), S.5.

<sup>49</sup> NHS Act (2006), S.13F(1) as amended by HSC Act (2012), S.23.

<sup>50</sup> NHS Act (2006), S.1D(1)(A) as amended by HSC Act (2012), S.5.

<sup>51</sup> NHS Act (2006), S.1D(1)(B) as amended by HSC Act (2012), S.5.

<sup>52</sup> Cragg, S. (2011) ‘In the matter of the Health and Social Care Bill and in the matter of the duty of the Secretary of State for Health to provide a National Health Service: Executive Summary of Opinion’, op cit., n.38 at p2.

In effectuating more competition within the NHS (examined below), the reforms alter the provision of healthcare within England (increasing private provision). In this respect, Mark Britnell (Global Head of Health at KPMG) told a meeting of hedge fund managers in New York, in 2010, that the NHS was in the process of becoming a “state insurer, not a state deliverer of care and that the reforms would show no mercy on the NHS”.<sup>53</sup> It has been argued that the statute may also lead to changes in funding. Pollock contends that the Secretary of State’s legal duty to provide an NHS throughout the UK enshrined social solidarity and was required to make universal health care a reality.<sup>54</sup> She argues that the only reason for removing the duty is that alternative funding (from private health insurance, charges or co-payments) will become necessary.<sup>55</sup> In this respect, personal health budgets (PHBs), which enable patients to agree with NHS bodies how money will be spent to address their individual needs, have been extended to around 10,000 patients.<sup>56</sup> NHSE wants to increase this to between 50,000 and 100,000 by 2020.<sup>57</sup> The Conservatives stated that they wanted to expand PHB use in their 2017 general election manifesto.<sup>58</sup> PHBs generated controversy after it was reported that some patients used them to purchase aromatherapy, singing lessons and games consoles.<sup>59</sup> The Netherlands, which introduced PHBs in 1997, was restricting them due to problems, such as increasing

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<sup>53</sup> Timmins, N. (2012) *Never Again? The Story of the Health and Social Care Act 2012*. London: Kings Fund and Institute for Government, p101.

<sup>54</sup> Pollock, A. (2015) ‘Morality and Values in Support of Universal Healthcare must be Enshrined in Law’, *op cit.*, n.13 at pp399-400.

<sup>55</sup> Pollock, A. (2014) ‘Submission to Health Committee Enquiry’, *op cit.*, n.6 at p8.

<sup>56</sup> Price, C., ‘Over 10,000 NHS patients now have personal health budgets’. *Pulse*, 19 January 2017.

<sup>57</sup> Limb, M. ‘NHS leader defends expansion of personal health budgets to 10,000 people by 2020’. *British Medical Journal* 2016;352:i552.

<sup>58</sup> Conservative Party (2017) *Forward, Together: Our Plan for a Stronger Britain and a Prosperous Future. The Conservative and Unionist Party Manifesto 2017*. London: Conservative Party, p69.

<sup>59</sup> Price, C. and Madsen, M., ‘Investigation: The Luxury Goods purchased with NHS money’, *Pulse*, 1 September 2015.



cost and fraud.<sup>60</sup> Peter Beresford argues that personal budgets have not worked in social care and that their use in the NHS is questionable, unless policymakers aim to use them as a stalking horse for a different kind of health service “based on charging, rationing and much more privatisation”.<sup>61</sup> Youssef El-Gingihy argues that PHBs are the logical end-point of turning patients into consumers as they will enable insurance for top-ups.<sup>62</sup> In this regard, John Spiers advocated health savings accounts to enable individuals to top-up spending.<sup>63</sup> Nonetheless, the HSC Act (2012) may not confer the diminution of the comprehensiveness of the NHS, or moves to an insurance type system with legitimacy, as such changes conflict with the moral economy concerning residual norms, identified in chapter two.

### Neo-liberal Norms

The statute extends the ambit of neo-liberal norms in the NHS. This is evident in the duties stipulated within it. For example, both NHSE and CCGs are required to exercise their functions “effectively, efficiently and economically”<sup>64</sup> and with a view to enabling patients to make choices.<sup>65</sup> NHSI is also required to promote the provision of health care services which are economic, efficient and effective.<sup>66</sup> This is indicative of depoliticisation through embedding normative values into the institutional structure of

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<sup>60</sup> Van Ginneken, E. et al., ‘Personal healthcare budgets: What can England learn from the Netherlands’, *British Medical Journal* 2012;344:E1383.

<sup>61</sup> Beresford, P., ‘Personal budgets don’t work: So why are we ignoring the evidence?’ *Guardian*, 25 May 2016.

<sup>62</sup> El-Gingihy, Y. (2015) *How to Dismantle the NHS in 10 Easy Steps*. Winchester: Zero Books, p64.

<sup>63</sup> Spiers, J. (2003) *Patients, Power and Responsibility: The First Principles of Consumer Driven Reform*. Abingdon: Radcliffe, p11.

<sup>64</sup> NHS Act (2006), S.13D and S.14Q as amended by HSC Act (2012), S.23 and S.25.

<sup>65</sup> NHS Act (2006), S.13I and S.14V as amended by HSC Act (2012), S.23 and S.25.

<sup>66</sup> HSC Act (2012), S.62(1)(A).

organisations.<sup>67</sup> Both NHSE and CCGs are required to ensure that their expenditures do not exceed the amount allotted to them.<sup>68</sup> The Secretary of State for Health,<sup>69</sup> NHSI,<sup>70</sup> NHSE and CCGs<sup>71</sup> are all required to improve, or have regard to the need to improve, the quality of services. As mentioned in chapter five, the coalition, like New Labour, sought to link quality with private sector involvement. Neo-liberal norms are also evident in the competition effected by the regulations passed pursuant to the statute. I examine the impact of the statute on both competition and choice within the following paragraphs.

The HSC Act (2012) requires NHSI to act with a view to preventing anti-competitive behaviour in the provision of health care services.<sup>72</sup> It conferred it concurrent functions (in relation to healthcare services in England) with the Office of Fair Trading (OFT),<sup>73</sup> namely those under part 1 of the Competition Act (1998)<sup>74</sup> (concerning anti-competitive practices as mentioned within S.2(1) of the Competition Act<sup>75</sup> or Article 101 Treaty on the Functioning of the European Union (TFEU)<sup>76</sup> and abuse of dominant position as mentioned within S.18 of the Competition Act<sup>77</sup> or Article 102 TFEU<sup>78</sup>) and those under part 4 of the Enterprise Act (2002)<sup>79</sup> (concerning market investigations).

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<sup>67</sup> Flinders, M. (2004) 'Distributed Public Governance in Britain'. *Public Administration*, Vol.82(4), pp883-909 at p902.

<sup>68</sup> NHS Act (2006), S.223C and S.223H as amended by HSC Act (2012), S.24 and S.27.

<sup>69</sup> NHS Act (2006), S.1A as amended by the HSC Act (2012), S.2.

<sup>70</sup> HSC Act (2012), S.62(1)(B).

<sup>71</sup> NHS Act (2006), S.13E(1) and S.14R as amended by HSC Act (2012), S.23 and S.25.

<sup>72</sup> HSC Act (2012), S.62(3).

<sup>73</sup> The Enterprise and Regulatory Reform Act (2013) abolished the OFT and the Competition Commission (S.26) and replaced them with the Competition and Markets Authority (S.25).

<sup>74</sup> Other than sections 31D(1) to (6), 38(1) to (6) and 51 as per HSC Act (2012), S.72(2).

<sup>75</sup> HSC Act (2012), S.72(2)(A).

<sup>76</sup> *Ibid* at S.72(2)(C)/Consolidated version of the Treaty on the Functioning of the European Union (TFEU), OJ C [2016] 202.

<sup>77</sup> HSC Act (2012), S.72(2)(B).

<sup>78</sup> *Ibid* at S.72(2)(D)/TFEU (2016) OJ C 202.

<sup>79</sup> Other than S.166 and S.171 as per HSC Act (2012), S.73(2).

An investigation, by the Department of Trade and Industry (DTI) and HM Treasury, into concurrent competition powers in 2006, concluded that sectoral regulation enabled markets to mature to the point where sector-specific regulation could be fully or partially withdrawn.<sup>80</sup> NHS commissioners are required to comply with the regulations which were passed pursuant to S.75 of the HSC Act (2012).<sup>81</sup> The regulations that were initially published pursuant to S.75 were amended due to opposition from campaigners and parliamentarians.<sup>82</sup> The Public Contract Regulations (PCR) (2004) apply to contracts prior to the 18<sup>th</sup> of April 2016. The Public Contract Regulations (PCR) (2015),<sup>83</sup> which implemented the 2014 EU directive on public procurement,<sup>84</sup> applies to contracts following that date. The directive removed the distinction between part A and part B services, hence contracting authorities are required to advertise all invitations to tender for health service contracts above specified thresholds in the Official Journal of the EU (OJEU) and to follow a specified procurement process.<sup>85</sup> The PCR (2015) contains exceptions. For example, it codified and modified the *Teckal* exemption.<sup>86</sup> In addition, services which can only be supplied by a particular economic operator are exempt.<sup>87</sup> However, Simon Taylor notes that this may have limited scope as recent evidence indicates that many providers are able

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<sup>80</sup> Department of Trade and Industry (DTI) and HM Treasury (2006) *Concurrent Competition Powers in Sectoral Regulation*. London: DTI, p14.

<sup>81</sup> National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) (S.75 Regulations), SI 2013/500.

<sup>82</sup> Molloy, C. (2013) 'Amend in haste, repent at leisure- NHS section 75 saga continues'. [On-line] Available: <https://www.opendemocracy.net/ourhhs/caroline-molloy/amend-in-haste-repent-at-leisure-nhs-section-75-saga-continues> [Accessed: 26 May 2016].

<sup>83</sup> Public Contracts Regulations, SI 2015/102.

<sup>84</sup> Directive 2014(24) EU of the European Parliament and of the Council of 26 February 2014 on Public Procurement and repealing directive 2004/18/EC, OJ L. 94, 28 March 2014.

<sup>85</sup> Collins, B. (2015) *Procurement and Competition Rules: Can the NHS be Exempted?* London: Kings Fund, p3.

<sup>86</sup> PCR (2015), R.12.

<sup>87</sup> PCR (2015), R.32(2)(B).

and willing to bid for various clinical services.<sup>88</sup> Contracting authorities with exclusive rights to protect services of general economic interest (SGEI) are also exempt<sup>89</sup>. Taylor notes that this may protect essential healthcare services, such as A&E.<sup>90</sup> The Procurement Lawyers Association (PLA) note that the government has not provided guidance on how the S.75 regulations and PCR (2015) interrelate.<sup>91</sup> PLA surmise that inconsistencies are likely to be resolved in favour of EU law due to its supremacy.<sup>92</sup>

It has been argued that the reforms “juridified” the NHS.<sup>93</sup> Anne Davies states that the second (increasing regulation of different activities) and fourth dimensions (the increased power of the legal system and legal professionals) of juridification, identified by Lars Blichner and Anders Molander,<sup>94</sup> are applicable to the HSC Act (2012) as it “involves much greater use of law to structure and regulate the NHS, in place of traditional mechanisms like ministerial direction”.<sup>95</sup> Davies avers that the reforms are also indicative of a further sense of juridification, identified by Scott Veitch et al, in which decisions that were previously a matter for government policy become shaped and governed by legal rules.<sup>96</sup> For example, Davies notes that the use of private firms

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<sup>88</sup> Taylor, S. (2015) ‘Competition in the new NHS- When should an NHS commissioner go out to tender for clinical services?’ [On-line] Available: <http://www.keatingchambers.com/wp-content/uploads/2016/02/Competition-in-the-new-NHS.pdf> [Accessed: 9 November 2016], p8.

<sup>89</sup> PCR (2015), R.11.

<sup>90</sup> Taylor, S. (2015) ‘Competition in the new NHS’, op cit., n.88 at p10.

<sup>91</sup> Procurement Lawyers Association (2016) ‘The Procurement and Competition regimes applicable to National Health Service Commissioners and Providers in England’. [On-line] Available: <http://procurementlawyers.org/wp-content/uploads/2016/09/0416-PLANHSWG.pdf> [Accessed: 08 March 2017], p13.

<sup>92</sup> Ibid at p25.

<sup>93</sup> Den Exter, A. and Guy, M. (2014) ‘Market Competition in Health Care Markets in the Netherlands: Some Lessons for England?’ *Medical Law Review*, Vol.22(2), pp255-273 at p259/Davies, A. (2013) ‘This Time It’s for Real: The Health and Social Care Act 2012’. *Modern Law Review*, Vol. 76(3), pp564-588 at p567.

<sup>94</sup> Blichner, L. and Molander, A. (2008) ‘Mapping Juridification’. *European Law Journal*, Vol.14(1), pp36-54 at pp38-39.

<sup>95</sup> Davies, A. (2013) ‘This Time It’s for Real’, op cit., n.93 at p567.

<sup>96</sup> Ibid.

within the NHS (which she contends is controversial and should be open to public debate) has now become a technical legal matter.<sup>97</sup> Davies examined three areas of juridification: “mergers between providers, other competition law requirements for providers [abuse of a dominant position and agreements to restrict competition], and the rules applicable to commissioners”.<sup>98</sup> I examine these areas in the following paragraphs.

Davies states that, prior to the HSC Act (2012), mergers, abuse of a dominant position and agreements to restrict competition were dealt with via the ‘PRCC’.<sup>99</sup> According to Davies, the HSC Act (2012) changed the position by accepting (implicitly) that competition law was already applicable to at least some aspects of NHS activity, by empowering Monitor as the sector regulator and by requiring providers to refrain from anti-competitive behaviour in licences.<sup>100</sup> Nonetheless, as EU competition law already applied to the NHS, the change in position was not a legal change but rather government acceptance that such law was applicable. Davies states that the CCP determined whether to approve mergers following a cost-benefit analysis.<sup>101</sup> In contrast, Davies notes that the HSC Act (2012) makes mergers involving FTs subject to the general law under Part 2 of the Enterprise Act (2002).<sup>102</sup> The result, according to Davies, would be “potentially serious consequences if a merger is found to be in breach of the rules”.<sup>103</sup> In 2013, a proposed merger between Royal Bournemouth and

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<sup>97</sup> Ibid.

<sup>98</sup> Ibid at p581.

<sup>99</sup> Ibid at pp581-582.

<sup>100</sup> Ibid at p582.

<sup>101</sup> Ibid at p581.

<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

Christchurch Hospitals and Poole Hospital Trusts failed as it was determined that it would reduce competition in Dorset. Polly Toynbee contends that this deterred other potential mergers which may have been in patient's interests.<sup>104</sup> However, Marie Sanderson et al state that following the decision, the NHS has avoided entanglement with competition law.<sup>105</sup> Monitor adopted the role of a translator between the NHS and competition authorities to prevent mergers "falling foul of the competition authorities".<sup>106</sup>

Davies notes that competition and public procurement law are mutually exclusive hence a body cannot be subject to both.<sup>107</sup> However, Davies states that this distinction was blurred by the 'PRCC' and the HSC Act (2012).<sup>108</sup> The S.75 regulations forbid commissioners from engaging in anti-competitive behaviour.<sup>109</sup> The PLA aver that it is arguable that NHS commissioners may be undertakings in some circumstances.<sup>110</sup> PLA note that the S.75 regulations arguably conflict with each other.<sup>111</sup> As a result, the amount of discretion that such regulations afford to commissioners, regarding the use of competition, is contested. Lock argues that the narrow test in R.5 (which states that commissioners may award contracts to a single provider where they are satisfied that only they are capable of providing the services<sup>112</sup>), emasculates R.2 (which states that

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<sup>104</sup> Toynbee, P., 'Competition is killing the NHS, for no good reason but ideology, *Guardian*, 15 November 2013.

<sup>105</sup> Sanderson, M. et al (2016) 'The Regulation of Competition in the National Health Service (NHS): What Difference has the Health and Social Care Act (2012) made?' *Health Economics, Policy and Law*, Vol.12(1), pp1-19 at p16.

<sup>106</sup> Ibid//Calkin, S., 'Bennett sets out new approach for merger and failure', *Health Services Journal*, 23 January 2014.

<sup>107</sup> Davies, A. (2013) 'This Time It's for Real', op cit., n.93 at p583.

<sup>108</sup> Ibid.

<sup>109</sup> S.75 Regulations, R.10.

<sup>110</sup> Procurement Lawyers Association (2016) 'The Procurement and Competition regimes applicable to National Health Service Commissioners and Providers in England', op cit., n.91 at p73.

<sup>111</sup> Ibid at p13.

<sup>112</sup> S.75 Regulations, R.5(1)(A).

commissioners must act to secure service-user's needs<sup>113</sup> and improve service quality<sup>114</sup> and efficiency<sup>115</sup>) and R.10<sup>116</sup> (which permits commissioners to engage in anti-competitive behaviour if it is in patient's interests for services to be provided in an integrated way<sup>117</sup> or for co-operation between providers to improve the quality of services<sup>118</sup>). Lock concluded that if more than one provider is capable of delivering the contract, commissioners must hold a competitive tender even if it is not in patient's interests.<sup>119</sup> In contrast, Albert Sanchez-Graells and Erika Szyszczak argued that the regulations may be incompatible with EU law by allowing patient interests to "trump pro-competitive requirements"<sup>120</sup>. PLA argue that Monitor's guidance<sup>121</sup> suggests that the starting point for commissioners, in determining whether or not to use competition, are R.2 and R.3 (which requires commissioners to procure services from one or more providers that are most capable of delivering the objectives outlined in R.2<sup>122</sup> and provide best value for money in doing so<sup>123</sup>) rather than R.5.<sup>124</sup>

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<sup>113</sup> Ibid at R.2(A).

<sup>114</sup> Ibid at R.2(B).

<sup>115</sup> Ibid at R.2(C).

<sup>116</sup> Lock, D. (2013) 'In the Matter of the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) (2013): Advice'. [On-line] Available: [https://s3.amazonaws.com/38degrees.3cdn.net/c9621f17e1890aa0e4\\_9qm6iy4ut.pdf](https://s3.amazonaws.com/38degrees.3cdn.net/c9621f17e1890aa0e4_9qm6iy4ut.pdf) [Accessed: 25 May 2016].

<sup>117</sup> S.75 Regulations, R.10(1)(A).

<sup>118</sup> Ibid at R.10(1)(B).

<sup>119</sup> Lock, D. (2013) 'In the Matter of the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) (2013)', op cit., n.116.

<sup>120</sup> Sanchez-Graells, A. and Szyszczak, E. (2014) 'Modernising Social Services in the Single Market: Putting the Market into the Social' in Beneyto, J. and Maillo, J. (eds) *Fostering Growth in Europe: Reinforcing the internal market*. Madrid: CEU Ediciones, pp69-96 at p78.

<sup>121</sup> Monitor (2013) *Substantive Guidance on the Procurement, Patient Choice and Competition Regulations*. London: Monitor.

<sup>122</sup> S.75 Regulations, R.3(3)(A).

<sup>123</sup> Ibid at R.3(3)(B).

<sup>124</sup> Procurement Lawyers Association (2016) 'The Procurement and Competition regimes applicable to National Health Service Commissioners and Providers in England', op cit., n.91 at p21.

Ham et al state that, despite Monitor's guidance, "there remains uncertainty...on when services need to go out to tender".<sup>125</sup> Dorota Osipovic et al found that commissioners have interpreted the rules differently.<sup>126</sup> There is evidence that the market established by the HSC Act (2012) has become an end in itself to the detriment of patients. A *HSJ* poll found that forty-six percent of respondents (103 respondents across ninety-three CCGs) stated that CCGs had not been able to change services as desired due to the regulations, or concerns about them, and twenty-nine percent stated that they had invited competition for services where they would not have done if not for the rules.<sup>127</sup> Thus although the amount of discretion that commissioners have is contested, it appears that, in practice, they have acted as though their discretion was curtailed. This may be because of the fear of legal challenges. A fifth of *HSJ*'s respondents stated that their CCG had been legally challenged.<sup>128</sup>

Nonetheless, there are countervailing factors to the use of competition. Firstly, Osipovic et al state that CCGs do not have sufficient resources to carry out numerous competitive procurement processes even if they wanted to.<sup>129</sup> Secondly, Nick Krachler and Ian Greer note that there has been a vigorous defence of the NHS by campaigners, such as Keep Our NHS Public (KONP), which has "kept healthcare policy highly politicised".<sup>130</sup> The number of local KONP groups more than doubled

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<sup>125</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p17.

<sup>126</sup> Osipovic, D. et al (2016) 'Interrogating institutional change: Actors' attitudes to competition and co-operation in commissioning health services in England'. *Public Administration*, Vol.94(3), pp823-838 at p830.

<sup>127</sup> West, D., 'CCGs open services to competition out of fear of rules'. *Health Services Journal*, 4 April 2014.

<sup>128</sup> Ibid.

<sup>129</sup> Osipovic, D. et al (2016) 'Interrogating institutional change', op cit., n.126 at p834.

<sup>130</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation? Profit-making in English health services after the 2012 Health and Social Care Act'. *Social Science and Medicine*, Vol.124, pp215-223 at p222.



following the HSC Act (2012). KONP collaborated with other groups to create Health Campaigns Together, which organised a march against cuts and privatisation, in London, in March 2017. Such groups have influenced commissioner's decisions. For example, campaigners prevented Virgin taking over children's health services in Bristol.<sup>131</sup> Thirdly, Krachler and Greer note that profitability for private companies is affected by uncertainty and a squeeze on prices due to austerity and limited budgets.<sup>132</sup> Colin Leys states that flat real terms health budgets from 2010 onwards put pressure on CCGs to award contracts to providers which make the lowest bids (which are not attractive to private companies).<sup>133</sup> Consequently, Leys states that there was relatively little protest from private companies when Monitor relaxed pressure on CCGs to tender all contracts in 2013.<sup>134</sup> Fourthly, some have interpreted the emphasis on integration in NHSE's '*Five Year Forward View*' ('FYFV'), which is examined further below, as a move away from competition. Commissioners in Pauline Allen et al's case study believed that it afforded them greater latitude in deciding whether to tender services.<sup>135</sup> The Select Committee on the Long-Term Sustainability of the NHS determined that the HSC Act (2012) was frustrating efforts to achieve further integration and the service transformation aims of '*FYFV*'<sup>136</sup> and recommended a public consultation concerning legislative modifications.<sup>137</sup> The Conservative party

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<sup>131</sup> Molloy, C., 'NHS Wreckers Play Hide and Seek', *Red Pepper*, 3 February 2016.

<sup>132</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation?', op cit., n.130 at pp216-217.

<sup>133</sup> Leys, C. (2016) 'The English NHS: From Market failure to trust, professionalism and democracy'. *Soundings*, Vol.64, pp11-40 at p15.

<sup>134</sup> Ibid.

<sup>135</sup> Allen, P. et al (2017) 'Commissioning through Competition and Co-operation in the English NHS under the Health and Social Care Act (2012): Evidence from a Qualitative Study of four Clinical Commissioning Groups'. *British Medical Journal Open* 2017; 7:e017745, p7.

<sup>136</sup> Select Committee on the Long-Term Sustainability of the NHS (2017) *The Long-Term Sustainability of the NHS and Adult Social Care Report of Session 2016-17*. London: House of Lords, p28.

<sup>137</sup> Ibid at p29.

states that it is open to both legislative and non-legislative changes to remove barriers to integrating care.<sup>138</sup>

An increased awareness of potential external constitutional constraints is evident since 2010. For example, Ed Miliband (Labour party leader from 2010 to 2015) asked David Cameron, at a session of Prime Ministers Questions, to confirm whether the HSC bill would make “health care subject to EU competition law for the first time in history?”<sup>139</sup> Miliband’s belief that the bill would lead to a change indicates a lack of awareness of the impact of Labour’s reforms, in the 2000s, regarding the increasing applicability (and potentially constraining effect of) EU law. Lansley argued that the bill was not extending either EU or domestic competition law.<sup>140</sup> He stated that “literally, our legislation cannot affect the extent of EU competition law”.<sup>141</sup> In contrast, his ministerial colleague Burns stated that “as NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition laws will increasingly become applicable”.<sup>142</sup> Lansley’s statements implied a passive role for the UK government (indicative of the passivization strategy of the ideological mode of reification), when, in reality, the increased competition in the NHS which the coalition’s reforms would effectuate would, in turn, extend the application of EU competition law to the NHS.

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<sup>138</sup> Conservative Party (2017) *Forward, Together*, op cit., n.58 at pp67-68.

<sup>139</sup> H.C. Deb. 16 March 2011, Vol.525, Col.293.

<sup>140</sup> Health Committee (2011) *Commissioning: Further Issues, Fifth Report, House of Commons Session 2010-11, Vol.II*. London: Stationery Office, Ev 92.

<sup>141</sup> *Ibid* at Ev 94.

<sup>142</sup> Health and Social Care Bill Deb. 15 March 2011, Col.718.

Under Miliband's leadership, Labour stated that it wanted to ensure full exemption for the NHS from EU public procurement and competition law.<sup>143</sup> Andy Burnham (Shadow Secretary of State for Health between 2011 and 2015) stated that the European Commission had confirmed that this could be done.<sup>144</sup> This conflicts with academic views (mentioned in chapter four) that such laws cannot be unapplied once they have become applicable. Nonetheless, as the UK electorate voted to leave the EU, in a referendum in June 2016,<sup>145</sup> the potential constraints that the EU placed on NHS policymaking may no longer apply. Whether Brexit will allow the UK to modify the arrangements relating to procurement and competition may depend on any agreement the UK reaches with the EU regarding their future trading relationship.<sup>146</sup> The UK is currently a party to the WTO government procurement agreement (GPA) through the EU, but will be required to apply for membership in its own right.<sup>147</sup>

The potential of EU laws to restrict NHS policymaking did not feature prominently in the referendum campaign in 2016, although it was noted by some leave campaigners, such as David Owen.<sup>148</sup> Nonetheless, there was concern prior to and during the referendum campaign that a potential trade deal between the US and the EU, known as the trans-Atlantic trade and investment partnership (TTIP), could restrict

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<sup>143</sup> Collins, B. (2015) *Procurement and Competition Rules*, op cit., n.85 at p1.

<sup>144</sup> Campbell, D., 'Key Labour NHS pledge impossible to deliver, says influential think tank', *Guardian*, 18 March 2015.

<sup>145</sup> Held as per the European Union Referendum Act (2015).

<sup>146</sup> McKenna, H. (2016) 'Five big issues for health and social care after the Brexit vote'. [On-line] Available: <https://www.kingsfund.org.uk/publications/articles/brexit-and-nhs> [Accessed: 19 March 2017].

<sup>147</sup> Arrowsmith, S. (2016) *The Implications of Brexit for the law on public and utilities procurement*. Abingdon: Achilles, p17. The original GPA (Agreement on Government Procurement (signed 15 April 1994; entered into force January 1996), 1915 U.N.T.S. 103) was signed in 1994. It was subsequently amended in 2014 (Revised Agreement on Government Procurement (adopted 2 April 2014; entered into force 6 April 2014), GPA 113).

<sup>148</sup> See Owen, D. (2016) *Europe Restructured: Vote to Leave*. York: Methuen, p139.

policymaking concerning the NHS. This is evident in the issue being raised in several newspaper articles<sup>149</sup> and numerous times within parliament.<sup>150</sup> In addition, 38 Degrees organised a petition against TTIP and raised public awareness via advertisements and leaflets.<sup>151</sup> There are similar concerns regarding the potential for post-Brexit trade deals to constrain NHS policymaking. Such concerns have been expressed by journalists, (such as George Monbiot<sup>152</sup>), trade union leaders, politicians,<sup>153</sup> numerous health professionals<sup>154</sup> and campaign groups, such as 38 Degrees. This contrasts with the ostensible lack of awareness of external constitutional constraints pertaining to the NHS, outside of academia, prior to 2010. Such increasing awareness of such potential constraints means that any prospective restrictions on NHS policymaking are likely to be politically contested. Consequently, the strategies of juridification and new constitutionalism do not appear to have been, and are not likely to be, successful in depoliticising neo-liberal alterations to the NHS.

If commissioners do utilise competition, this may involve contractors competing for a tender or a service being opened up to patient choice. The coalition stated that it wanted to phase in patient choice of any qualified provider (AQP), from 2012,<sup>155</sup> to

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<sup>149</sup> See for example, Johnston, I., 'NHS could be part-privatised if UK and EU agree controversial TTIP trade deal, expert warns', *Independent*, 21 February 2016.

<sup>150</sup> For example, it was alluded to several times during a debate concerning TTIP in December 2015. See: H.C. Deb. 10 December 2015, Vol.603, Col.1169-1219.

<sup>151</sup> Whalley, N. (2016) 'How 38 Degrees members helped stop TTIP'. [On-line] Available: <https://home.38degrees.org.uk/2016/08/31/38-degrees-members-helped-stop-ttip/> [Accessed: 24 August 2017].

<sup>152</sup> Monbiot, G., 'Sovereignty? This government will sell us to the highest bidder', *Guardian*, 27 July 2016.

<sup>153</sup> Edwards, P. (2017) 'Trump trade deal must not be used to sell off NHS, MPs and union tell May'. [On-line] Available: <https://labourlist.org/2017/01/trump-trade-deal-must-not-be-used-to-sell-off-nhs-mps-and-union-tell-may/> [Accessed: 28 August 2017].

<sup>154</sup> For example, many signed a letter demanding protection for the NHS from a potential trade deal between the UK and the US. See Macklin-Doherty, A. et al., 'We Stand Together Against Donald Trump's toxic agenda', *Guardian*, 1 February 2017.

<sup>155</sup> HM Government (2011) *Open Public Services White Paper*. Norwich: Stationery Office, p48.

empower patients and carers, improve outcomes, and enable service innovation.<sup>156</sup> The Department of Health outlined a list of potential services for priority implementation, including wheelchair services, podiatry services and musculoskeletal services for back and neck pain.<sup>157</sup> Lorelei Jones and Nicholas Mays note that there was confusion about the degree of freedom CCGs had in respect of AQP which meant that its use was not always well matched to local needs.<sup>158</sup> Only a minority of the 183 CCGs that responded to the *Health Services Journal (HSJ)* had opened services to AQP in 2014/15.<sup>159</sup> Although the Department of Health states that the policy has not changed, there have been no further mandatory requirements for commissioners to extend AQP since 2012/13.<sup>160</sup> Ham et al therefore concluded that AQP has taken a backseat.<sup>161</sup> Davis et al note that the reforms threaten many choices desired by patients, such as a good local hospital and a familiar GP.<sup>162</sup>

### Emergent Norms

The HSC Act (2012) also contains the emergent norms of reducing health inequalities and empowering patients and the public. It requires the Secretary of State to have regard to the need to reduce inequalities in exercising their functions.<sup>163</sup> NHSE and

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<sup>156</sup> Department of Health (DOH) (2011) *Operational Guidance to the NHS: Extending Patient Choice of Provider*. London: DOH, p4.

<sup>157</sup> Ibid at p5.

<sup>158</sup> Jones, L. and Mays, N. (2013) 'Early Experiences of any qualified provider'. *British Journal of Healthcare Management*, Vol.19(5), pp217-224 at p223.

<sup>159</sup> Williams, D., 'Exclusive: CCG Interest in 'any qualified provider' scheme dwindles', *Health Services Journal*, 11 September 2014.

<sup>160</sup> Ibid.

<sup>161</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p18.

<sup>162</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at pp51-52.

<sup>163</sup> NHS Act (2006), S.1C as amended by the HSC Act (2012), S.4.

CCGs are required to have regard to the need to reduce inequalities in access<sup>164</sup> and outcomes.<sup>165</sup> In addition, NHSE, CCGs and NHSI are required to exercise their powers with a view to ensuring that health services are provided in an integrated way where they consider that it would improve the quality (including outcomes) of such services,<sup>166</sup> reduce inequalities in respect of access<sup>167</sup> or reduce inequalities in outcomes.<sup>168</sup> NHSE and CCGs must also act with a view to securing that the provision of health services is integrated with the provision of health related services or social care services where the same criteria are met.<sup>169</sup> NHSI is required to have regard to NHSE's and CCG's duties to do the same.<sup>170</sup> However, Lynsey Warwick-Giles found that such duties had no meaning for the CCGs within her case study (three CCGs in Northern England) due to problems conceptualising health inequalities.<sup>171</sup> Martin Wenzl and Elias Mossialos aver that there has not been sufficient guidance on the equity duty and that it has not been implemented effectively.<sup>172</sup> The articulation and implementation into law of this norm, by the coalition, is thus superficial and is undermined by austerity policies, which, as noted in chapter five, are likely to increase health inequalities. Nonetheless, the fact that reducing health inequalities is now a legal norm means that it could be a potential ground of judicial review of decisions of

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<sup>164</sup> NHS Act (2006), S.13G(A) and S.14T(A) as amended by HSC Act (2012), S.23 and S.25.

<sup>165</sup> NHS Act (2006), S.13G(B) and S.14T(B) as amended by HSC Act (2012), S.23 and S.25.

<sup>166</sup> NHS Act (2006), S.13N(1)(A) and S.14Z1(1)(A) as amended by HSC Act (2012), S.23 and S.25 and HSC Act (2012), S.62(4)(A).

<sup>167</sup> NHS Act (2006), S.13N(1)(B) and S.14Z1(1)(B) (as amended by HSC Act (2012), S.23 and S.25) and HSC Act (2012), S.62(4)(B).

<sup>168</sup> NHS Act (2006), S.13N(1)(C) and S.14Z1(1)(C) (as amended by HSC Act (2012), S.23 and S.25) and HSC Act (2012), S.62(4)(C).

<sup>169</sup> NHS Act (2006), S.13N(2)(A),(B) and (C) and S.14Z1(2)(A), (B) and (C) (as amended by HSC Act (2012), S.23 and S.25) and HSC Act (2012), S.62(5)(A)(B)(C).

<sup>170</sup> HSC Act (2012), S.62(6)(A) and (B).

<sup>171</sup> Warwick-Giles, L. (2014) *An Exploration of how Clinical Commissioning Groups are tackling health inequalities*. [On-line] Available:

<https://www.escholar.manchester.ac.uk/api/datastream?publicationPid=uk-ac-man-scw:237616&datastreamId=FULL-TEXT.PDF> [Accessed: 30 March 2016], p181.

<sup>172</sup> Wenzl, M. and Mossialos, E. (2016) 'Achieving Equity in health service commissioning' in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp233-254 at p248.

statutorily obligated entities. It is also a means of critiquing government policy and thinking of alternatives.

The HSC Act (2012) stipulates that NHSE and CCGs must include prospective patients, for example, in the planning of their commissioning arrangements<sup>173</sup> and in the development and consideration of proposals which would affect the range, or manner of delivery, of services.<sup>174</sup> NHSI is required to secure that health care users and the public are involved to an appropriate degree in decisions (not related to particular cases) it makes about the exercise of its functions.<sup>175</sup> However, David Horton and Gary Lynch-Wood argue that whereas commissioners had previously been required to consult (and produce a report about their consultations) prior to making commissioning decisions, they now have the option of consulting, providing information, or using other ways to engage patients, which potentially weakens user engagement.<sup>176</sup> In 2014, the High Court determined that NHSE was flouting its obligations by imposing charges in primary care services without consulting.<sup>177</sup> Although citizens can request a judicial review in cases where bodies have not complied with their obligations, the coalition made this harder by reducing the time limit to make an application and removing the right to a hearing in some cases.<sup>178</sup> In 2013, the High Court determined that Trust Special Administrators (TSAs)<sup>179</sup> could not

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<sup>173</sup> NHS Act (2006), S.13Q(2)(A) and S.14Z2(A) as amended by HSC Act (2012), S.23 and S.25.

<sup>174</sup> NHS Act (2006), S.13Q(2)(B) and S.14Z2(B) as amended by HSC Act (2012), S.23 and S.25.

<sup>175</sup> HSC Act (2012), S.62(7).

<sup>176</sup> Horton, D. and Lynch-Wood, G. (2017) 'Rhetoric and Reality: User Engagement and Health Care Reform in England'. *Medical Law Review*, Forthcoming.

<sup>177</sup> Lintern, S., 'Exclusive: NHS England Primary Care Decisions 'Unlawful'. *Health Services Journal*, 24 November 2014/Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at p9.

<sup>178</sup> Pearce, U. (2014) 'Public Consultation in the NHS'. [On-line] Available: <http://www.sochealth.co.uk/2014/11/13/public-consultation-nhs/> [Accessed: 30 March 2016].

<sup>179</sup> Established by the Health Act (2009), S.16 to manage trusts that go into administration.

draw up plans other than for the trust for which they have been appointed.<sup>180</sup> In response, the coalition passed the Care Act (2014), which removed the obligation that the public must be consulted about TSA reports<sup>181</sup> and enables TSAs to recommend changes across a whole local health economy.<sup>182</sup> TSAs are required to ensure that trusts can pay their debts and have no complementary duty to plan health services for the population of an area on the basis of need.<sup>183</sup> The governing body of each CCG must have two lay members<sup>184</sup> and its meetings must be open to the public, except where this is not in the public interest.<sup>185</sup> Alison O'Shea et al's case study research found that public input at CCG board public meetings was tokenistic and that lay members did not constitute a powerful voice.<sup>186</sup>

The HSC Act (2012) created Healthwatch England<sup>187</sup> to enhance the collective voice of patients.<sup>188</sup> However, Pam Carter and Graham Martin note that Healthwatch has also been described as a consumer champion, which suggests a market orientation.<sup>189</sup> Charles West notes that there is a potential conflict of interest as Healthwatch is a committee of the Care Quality Commission (CQC),<sup>190</sup> which complaints may

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<sup>180</sup> Pollock, A. et al (2013) 'Planning for closure: The Role of Special Administrators in reducing NHS Hospital services in England'. *British Medical Journal* 2013;347:f7322/ R (*Lewisham Council and another*) v *Secretary of State for Health and Trust Special Administrator* (2013) EWHC 2329 (Admin).

<sup>181</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p37/NHS Act (2006), S.13Q(4) and S.14Z2(7) as amended by Care Act (2014), S.120 (15) and (16).

<sup>182</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p37/NHS Act (2006), S.65O(2) and (3) as amended by Care Act (2014), S.120(1).

<sup>183</sup> Pollock, A. et al (2013) 'Planning for closure', op cit., n.180.

<sup>184</sup> National Health Service (Clinical Commissioning Groups) Regulations, SI 2012/1631, R.11(3)(D) and (E).

<sup>185</sup> NHS Act (2006), Schedule 1A, para.8(3) as amended by HSC Act (2012), Schedule 2.

<sup>186</sup> O'Shea, A. et al (2017) 'Whose Voices? Patient and Public Involvement in Clinical Commissioning'. *Health Expectations*, Vol.20(3), pp484-494 at p491.

<sup>187</sup> HSC Act (2012), S.181.

<sup>188</sup> Department of Health (DOH) (2010) *Equity and Excellence: Liberating the NHS*. London: DOH, p3.

<sup>189</sup> Carter, P. and Martin, G. (2016) 'Challenges Facing Healthwatch, a new consumer champion in England'. *International Journal of Health Policy Management*, Vol.5(4), pp259-263 at p259.

<sup>190</sup> Health and Social Care (HSC) Act (2008), Schedule 1A as amended by HSC Act (2012), S.181.



implicate.<sup>191</sup> Such lack of independence led Davis et al to describe Healthwatch as toothless.<sup>192</sup> LINKs have been replaced by Local Healthwatch (LHW) organisations,<sup>193</sup> which are non-statutory bodies undertaking statutory functions.<sup>194</sup> Each local authority contracts an organisation to provide LHW.<sup>195</sup> Sally Ruane states that LHWs are under-resourced and suffer from role confusion.<sup>196</sup> Jonathan Tritter and Meri Koivusalo note that the voice of local communities has been stifled as LHWs are prohibited from advocating a change in law or policy.<sup>197</sup> LHWs are often separate from independent advocacy services, limiting the information that they receive.<sup>198</sup>

LHWs have seats on Health and Well Being Boards (HWBs), which each local authority must establish.<sup>199</sup> HWBs are required to encourage integrated working<sup>200</sup> and bring together bodies from the NHS, public health and local government to plan how to meet local health and care needs.<sup>201</sup> HWBs discharge the duties of local authorities and partner CCGs to undertake joint strategic needs assessments

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<sup>191</sup> West, C. (2013) 'A Failure of Politics' in Davis, J. and Tallis, R. (eds) *NHS SOS: How the NHS was betrayed – and how we can save it*. London: Oneworld, pp121-149 at p139.

<sup>192</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at p123.

<sup>193</sup> Local Government and Public Involvement in Health (LGPIH) Act (2007), S.221 as amended by HSC Act (2012), S.182.

<sup>194</sup> Department of Health (DOH) (2012) *Local Healthwatch-A Strong Voice for people- the policy explained*. London: DOH, p16.

<sup>195</sup> Ruane, S. (2014) *Democratic Engagement in the local NHS*. London: Centre for Health and the Public Interest, p6.

<sup>196</sup> Ibid.

<sup>197</sup> Tritter, J. and Koivusalo, M. (2013) 'Undermining Patient and Public Engagement and Limiting its Impact: The Consequences of the Health and Social Care Act 2012 on Collective Patient and Public Involvement'. *Health Expectations*, Vol.16(2), pp115-118 at p117/National Health Service Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations, SI 2012/3094, R.36(1)(A)(I) and (II).

<sup>198</sup> Health Committee, *Complaints and Raising Concerns*, 21 January 2015, HC 350 2014-15, CRC0109.

<sup>199</sup> HSC Act (2012), S.194(1).

<sup>200</sup> Ibid at S.195(1).

<sup>201</sup> Humphries, R. and Galea, A. (2013) *Health and Well Being Boards: One Year on*. London: Kings Fund, p3.

(JSNAs)<sup>202</sup> and to set out how identified needs will be addressed through joint health and well-being strategies (JHWSs).<sup>203</sup> Helen Gilbert et al found that respondents from LHWs perceived HWBs as forums for approval, precluding the opportunity for influence.<sup>204</sup> Richard Humphries and Amy Galea note that few HWBs have prioritised public engagement.<sup>205</sup> The scrutiny power of Overview and Scrutiny Committees (OSCs) was transferred to local authorities,<sup>206</sup> although they may choose to continue to operate OSCs.<sup>207</sup> In respect of Lansley's promise that patients would be central to clinical decisions, Anita Fatchett et al contend that it is unclear whether this was rhetoric or a serious promise and that much work is required to make it a reality.<sup>208</sup> Consequently, the new mechanisms have not enhanced the voice of patients or the public. Such norms are thus means of critiquing the coalition's policies and of conceiving alternatives.

### The Impact of the HSC Act (2012) on the Organisation of the NHS

As mentioned in chapter five, the coalition criticised Labour's top-down prescription and centralisation and stated that it wanted to decentralise power within the NHS. Greer et al state that the old Department of Health was spun off into new organisations,

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<sup>202</sup> LGPIH Act (2007), S.116 as amended by HSC Act (2012), S.192.

<sup>203</sup> LGPIH Act (2007), S.116A as amended by HSC Act (2012), S.193.

<sup>204</sup> Gilbert, H. et al (2015) *Local Healthwatch: Progress and Promise*. London: Kings Fund, p42.

<sup>205</sup> Humphries, R. and Galea, A. (2013) *Health and Well Being Boards*, op cit., n.201 at p15.

<sup>206</sup> NHS Act (2006), S.244 as amended by HSC Act (2012), S.190(2)(A).

<sup>207</sup> Communities and Local Government Committee (2013) *The Role of Local Authorities in Health Issues, Eighth Report, House of Commons Session 2012-13, Vol.1*. London: Stationery Office, p9.

<sup>208</sup> Fatchett, A. et al (2014) 'Putting Healthcare Policy into Practice'. *Journal of Community Nursing*, Vol. 28(1), pp76-78 at p78.

creating “the potential for incoherence, duplication and turf wars at the centre”.<sup>209</sup> In September 2016, Baroness Walmsley contended that it was still “unclear how the five national bodies [the National Institute for Health and Care Excellence (NICE), CQC, PHE, NHSE and NHSI] interact with each other, and where the Secretary of State comes into the picture”.<sup>210</sup> According to Calum Paton, the law of NHS structural change is that “the more decentralisation is sought or advertised, the more centralism occurs”.<sup>211</sup> Both austerity<sup>212</sup> and the government’s attempts to improve quality and safety following the Mid Staffordshire scandal<sup>213</sup> have been cited as reasons for the reassertion of control by the centre. Greer et al state that although there was a reduction of staff within the Department of Health, ministers maintained a grip on NHS policy (and shaped the functions and priorities of national bodies) through levers, such as the power of patronage, the power to set budgets and the ability to legislate to achieve ministerial priorities.<sup>214</sup> As the coalition’s reforms eliminated management below the central level and led to “much tighter central regulation of payers and providers”, Greer and Matzke state that they are consistent with the centralisation that occurred under Labour.<sup>215</sup> Collins argues that FTs have become increasingly micro-managed, thereby eroding the distinction between them and trusts.<sup>216</sup> Current NHS

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<sup>209</sup> Greer, S. et al (2014) *A Re-organisation you can see from space: The architecture of power in the new NHS*. London: Centre for Health and the Public Interest, p4.

<sup>210</sup> H.L. Deb. 08 September 2016, Vol. 774, Col.1201.

<sup>211</sup> Paton, C. (2013) ‘Never say never again: Re-forming and deforming the NHS’. *Health Economics, Policy and Law*, Vol.8(2), pp243-249 at p247.

<sup>212</sup> PricewaterhouseCoopers (PwC) (2016) *Redrawing the health and social care architecture*. London: PwC, p10.

<sup>213</sup> Exworthy, M. and Mannion, R. (2016) ‘Evaluating the impact of NHS reforms-Policy, Process and Power’ in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp3-16 at p12.

<sup>214</sup> Greer, S. et al (2016) ‘The Central Management of the English NHS’ in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp87-104 at pp90-91.

<sup>215</sup> Greer, S. and Matzke, M. (2015) ‘Health Policy in the European Union’ in Kuhlmann, E. et al (eds) *The Palgrave International Handbook of Healthcare Policy and Governance*. Basingstoke: Palgrave, pp254-269 at p262.

<sup>216</sup> Collins, B. (2016) ‘The Foundation Trust Model: Death by a thousand cuts’. [On-line] Available: <https://www.kingsfund.org.uk/blog/2016/02/foundation-trust-model> [Accessed: 03 May 2017].

governance has been described as being of the network form<sup>217</sup> as the centre is fragmented.<sup>218</sup> In the following paragraphs, I evaluate the creation of NHSE and CCGs, the use of indicators and privatisation in the NHS since 2010.

## NHS England

Matthew Flinders and Matthew Wood note that NHSE was introduced on the basis of explicit arguments of the need to depoliticise healthcare policy.<sup>219</sup> Much of NHSE's activity flows through its local area teams, which are accountable only upwards.<sup>220</sup> The Secretary of State is required to publish a mandate setting out objectives for NHSE,<sup>221</sup> keep under review the effectiveness of NHSE, and other national bodies<sup>222</sup> and publish an annual report on NHS performance.<sup>223</sup> Stephen Peckham notes that it is uncertain whether NHSE is accountable merely to its board or whether it also responds to political pressure from the public, the Department of Health and Parliament.<sup>224</sup> The Public Administration Select Committee determined, in 2014, that the relationship between the Secretary of State and NHSE was "still evolving".<sup>225</sup> As mentioned in chapter two, Flinders and Buller noted that where a principal-agent relationship is

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<sup>217</sup> Exworthy, M. and Mannion, R. (2016) 'Evaluating the impact of NHS reforms', op cit., n.213 at p10.

<sup>218</sup> Jarman, H. and Greer, S. (2015) 'The big bang: Health and Social Care reform under the coalition' in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp50-67 at p50/Greer, S. and Matzke, M. (2015) 'Health Policy in the European Union', op cit., n.215 at p262.

<sup>219</sup> Flinders, M. and Wood, M. (2014) 'Depoliticisation, governance and the state'. *Policy and Politics*, Vol.42(2), pp135-149 at pp135-136.

<sup>220</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at p138.

<sup>221</sup> NHS Act (2006) S.13A as amended by the HSC Act (2012), S.23.

<sup>222</sup> NHS Act (2006), S.247C as amended by the HSC Act (2012), S.52.

<sup>223</sup> NHS Act (2006), S.247D as amended by the HSC Act (2012), S.53.

<sup>224</sup> Peckham, S. (2014) 'Accountability in the UK Healthcare System: An Overview'. *Healthcare Policy*, Vol.10 (Special Issue), pp154-162 at p158.

<sup>225</sup> Public Administration Committee (2014) *Who's accountable? Relationship between government and arm's length bodies, First Report, House of Commons Session 2014-15*. London: Stationery Office, p3.

established, the independence of the latter is questionable.<sup>226</sup> In 2014, Simon Stevens (Chief Executive of NHSE from 2014 onwards) informed David Cameron that the NHS was facing an annual £30 billion shortfall by 2020 which required £15-16 billion to fill (with the rest met by efficiency savings). According to David Laws, Stevens was pressured to reduce the amount requested “to a more deliverable sum”.<sup>227</sup> Stevens subsequently asked for £8 billion. The articulation of the £8 billion figure by the ostensibly independent NHSE, served to depoliticise the resources required by the NHS, as the figure was widely accepted during the 2015 general election. However, the issue was repoliticised following Laws’ revelations and claims that the pledge will be unfulfilled.<sup>228</sup> Stevens was less pliant at a Committee of Public Accounts hearing, in January 2017, where he described Theresa May’s claim that the NHS was receiving the money that it had requested as “stretching it”.<sup>229</sup> Subsequently, Downing Street aides briefed against him.<sup>230</sup> It was reported that Stevens will continue outlining his views for NHS funding but will cease publicly advocating more money for social care, which had antagonised May.<sup>231</sup> NHSE’s Chief Executive thus appears to have the potential to both politicise (evidenced by Stevens publicly contradicting May) and depoliticise (evidenced by Stevens’ articulation of the £8 billion figure) healthcare policy.

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<sup>226</sup> Flinders, M. and Buller, J. (2005) ‘Depoliticisation, Democracy and Arena Shifting’ (Paper given at the SCANCOR/SOG Conference, Stanford University, 1-2 April 2005), p10.

<sup>227</sup> Walters, P., ‘Revealed: Tory ‘£8bn to save the NHS’ election con’, *Mail on Sunday*, 20 March 2016.

<sup>228</sup> In 2016 the Health Committee determined that total health spending would increase by £4.5 billion in real terms by 2021. See Health Committee (2016) *Impact of the Spending Review on Health and Social Care, First Report, House of Commons Session 2016-17*. London: Stationery Office, p28.

<sup>229</sup> Committee of Public Accounts, *Financial Sustainability of the NHS*, 11 January 2017, HC 887 2016-17, Q54.

<sup>230</sup> Campbell, D. and Stewart, H., ‘NHS Chief Simon Stevens refuses to buckle under No. 10 pressure’, *Guardian*, 12 January 2017.

<sup>231</sup> *Ibid.*

Timmins contends that Stevens is taking much of the heat in the current funding crisis and that depoliticisation has succeeded to the extent that Hunt “is apparently not responsible for what is happening on his watch”, despite his involvement in running the NHS (such as demanding performance updates from various national bodies).<sup>232</sup> However, this was belied by the aforementioned march against cuts and privatisation, in March 2017, attended by an estimated 250,000 people,<sup>233</sup> at which many of the demonstrator’s placards bore Hunt’s visage rather than Stevens’. In addition, Hunt has been at the centre of high-profile disputes, such as acrimonious negotiations regarding new contracts for junior doctors. Hunt sought to justify such contracts on the basis that they would address an alleged ‘weekend effect’ (a higher incidence of patients dying at the weekend), a notion which was based on flawed data.<sup>234</sup> While the existence of NHSE may enable the government to attempt to shift blame, the public do not appear to have shifted from blaming the government to blaming NHSE for NHS problems. This may be because the government retains significant powers over the NHS, such as determining its funding, the recent lack of which the public appear to regard as the cause of its difficulties.<sup>235</sup> Frank Dobson states that although, in law, the minister does not have direct responsibility “nobody believes it really, and he [Hunt] is clearly

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<sup>232</sup> Timmins, N., “Teflon’ Jeremy Hunt and the depoliticisation of the NHS’. [On-line] Available: <https://www.kingsfund.org.uk/blog/2017/02/teflon-jeremy-hunt-and-depoliticisation-of-nhs> [Accessed: 03 April 2017].

<sup>233</sup> Pells, R., ‘Thousands march in protest over plans for ‘unprecedented’ NHS cuts’, *Independent*, 04 March 2017.

<sup>234</sup> Li, L. and Rothwell, P., ‘Biases in detection of apparent “weekend effect” on outcome with administrative coding data: population based study of stroke’, *British Medical Journal* 2016;353:i2648/ McKee, M., ‘The weekend effect: now you see it, now you don’t’, *British Medical Journal* 2016;353:i2750.

<sup>235</sup> The British Social Attitudes Survey, in 2015, found a widespread feeling that the NHS was facing a funding problem. See Appleby, J. et al (2015) ‘Health’ in Curtice, J. and Ormston, R. (eds) *British Social Attitudes: the 32<sup>nd</sup> Report*. London: NatCen Social Research, pp102-121 at p111.

interfering all the time”.<sup>236</sup> Thus despite the legislative changes, the government continues to be viewed as responsible for “the success or failure of health policy”.<sup>237</sup>

### Clinical Commissioning Groups

As mentioned in chapter five, CCGs were established to empower GPs to commission services on behalf of their patients. In April 2013, 211 CCGs became operational.<sup>238</sup> All NHS GPs must belong to a CCG, although their involvement varies.<sup>239</sup> Kath Checkland et al note that CCGs differ in size, structure and the roles that GPs play.<sup>240</sup> Many GPs have conflicts of interest “ranging from directorships of local for-profit health care service companies to stock ownership in large national health care corporations”.<sup>241</sup> CCGs maintain registers of their members.<sup>242</sup> Members must declare any actual or potential conflict of interest.<sup>243</sup> Holly Holder et al note that such conflicts are often mitigated by conflicted GPs leaving the room and through the use non-clinicians to provide external scrutiny.<sup>244</sup> CCGs are regulated as market actors by NHSI, through a performance management regime run by NHSE<sup>245</sup> and also respond to their co-located local authority.<sup>246</sup> In 2016, twenty-six CCGs were deemed

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<sup>236</sup> Dobson, F. (2015) ‘In their own words: Interviews with former Secretaries of State for Health’ in Timmins, N. and Davies, E. (eds) *Glaziers and Window Breakers: The role of the Secretary of State for Health in their own words*. London: Health Foundation, pp93-100 at p98.

<sup>237</sup> Jarman, H., ‘The new NHS structure is unstable’, *Health Services Journal*, 13 February 2014.

<sup>238</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p12.

<sup>239</sup> Davies, A. (2013) ‘This Time It’s for Real’, op cit., n.93 at p573.

<sup>240</sup> Checkland, K. et al (2016) ‘Complexity in the new NHS: Longitudinal Case Studies of CCGs in England’. *British Medical Journal Open*, 2016;6:e010199, p6.

<sup>241</sup> Gaffney, A. (2014) ‘The Twilight of the British Public Health System?’, op cit., n.46 at p8.

<sup>242</sup> NHS Act (2006), S.14O(1) as amended by HSC Act (2012), S.25.

<sup>243</sup> NHS Act (2006), S.14O(3)(A) as amended by HSC Act (2012), S.25.

<sup>244</sup> Holder, H. et al (2015) *Risk or Reward?*, op cit., n.23 at p37.

<sup>245</sup> Davies, A. (2013) ‘This Time It’s for Real’, op cit., n.93 at p573.

<sup>246</sup> Peckham, S. (2014) ‘Accountability in the UK Healthcare System’, op cit., n.224 at p157.

inadequate and nine were placed in special measures.<sup>247</sup> From 2016/17 onwards, CCGs will be rated in twenty-nine areas underpinned by sixty indicators, which are available on the MyNHS website.<sup>248</sup> Rather than being empowered, as per the coalition's justifications for the reforms, a *Pulse* survey indicated that GPs did not feel more involved in commissioning under CCGs than they did under PCTs.<sup>249</sup>

Paton contends that empowering GPs to commission was contrary to the evidence, from GP fundholding, that GPs were not interested in, or good at, it.<sup>250</sup> A survey of GPs in East Lancashire identified several barriers to clinical engagement, such as lack of time and resources, the pressure of competing occupational demands and insufficient skills.<sup>251</sup> CCGs have various options regarding commissioning support, such as directly employing staff (which does not require tender) and contracting with support organisations.<sup>252</sup> Christina Petsoulas et al state that lack of resources meant that outsourcing was often the only option.<sup>253</sup> Initially many CCGs agreed temporary service level agreements (SLAs) with Commissioning Support Units (CSUs).<sup>254</sup> As

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<sup>247</sup> Roberts, N. (2016) 'Failing CCGs could be 'disbanded' as 26 declared inadequate under new ratings regime'. [On-line] Available: <http://www.gponline.com/failing-ccgs-disbanded-26-declared-inadequate-new-ratings-regime/article/1403113> [Accessed: 17 February 2017].

<sup>248</sup> NHS England (2016) 'NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17'. [On-line] Available: <https://www.england.nhs.uk/2016/07/operational-performance/> [Accessed: 17 February 2017].

<sup>249</sup> Mooney, H. (2014) 'GPs feel even less involved in commissioning one year after CCGs took control'. [On-line] Available: [http://www.pulsetoday.co.uk/news/commissioning-news/gps-feel-even-less-involved-in-commissioning-one-year-after-ccgs-took-control/20006240.article#.UzqLO\\_IdU6g](http://www.pulsetoday.co.uk/news/commissioning-news/gps-feel-even-less-involved-in-commissioning-one-year-after-ccgs-took-control/20006240.article#.UzqLO_IdU6g) [Accessed: 01 April 2014].

<sup>250</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England's Permanent Revolution*. London: Palgrave, p157.

<sup>251</sup> Ashman, I. and Willcocks, S. (2014) 'Engaging with Clinical Commissioning: The Attitudes of General Practitioners in East Lancashire'. *Quality in Primary Care*, Vol.22(2), pp91-99 at p92.

<sup>252</sup> Dunbar-Rees, R. and McGough, R., 'Challenges of EU Competition Law for general practice commissioning'. *British Medical Journal* 2011;342:d2071.

<sup>253</sup> Petsoulas, C. et al (2014) 'Views of NHS Commissioners on Commissioning Support Provision: Evidence from a Qualitative Study examining the early development of Clinical Commissioning Groups in England'. *British Medical Journal Open*, 2014;4:e005970, p5.

<sup>254</sup> NHS England (2014) 'Handbook for buying commission support from the Lead Provider Framework'. [On-line] Available: <https://www.england.nhs.uk/lpf/wp->



public procurement law applies, once SLAs ended, CCGs had to secure such support openly and transparently.<sup>255</sup> In February 2015, NHSE announced the organisations which had been approved to join the Commissioning Support Lead Provider Framework, including some CSUs, Capita and Optum (a subsidiary of United Health).<sup>256</sup> The latter has a history of multi-million fines for fraud in the United States (US).<sup>257</sup> Although the Department of Health stated that companies offering commissioning support are not permitted to work in areas where they also provide services, UNISON notes that there is nothing to stop them returning once a market has been created.<sup>258</sup> Stewart Player contends that CCGs often merely rubberstamp decisions made at the level of commissioning support.<sup>259</sup> Hence private companies may be making decisions for CCGs, which they can later exploit. The use of external support has negative effects in respect of efficiency (as it increases transaction costs) and accountability. Capita, operating as Primary Care Support England (PCSE), won the contract to provide primary care support services in 2015. From the outset, GPs and local medical committees (LMCs) identified serious issues with such support which have affected patient safety.<sup>260</sup>

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[content/uploads/sites/27/2014/11/lpf-handbook-buying-comm-support.pdf](https://www.nhs.uk/content/uploads/sites/27/2014/11/lpf-handbook-buying-comm-support.pdf) [Accessed: 4 December 2016].

<sup>255</sup> Ibid.

<sup>256</sup> NHS England (2015) 'NHS England launches new framework for commissioning support services'. [On-line] Available: <https://www.england.nhs.uk/2015/02/lpf-launch/> [Accessed: 22 February 2017].

<sup>257</sup> Hughes, S., 'The National Health Swindle', *Morning Star*, 13 March 2015.

<sup>258</sup> Health Committee (2011) *Commissioning, Third Report, House of Commons Session 2010-11, Vol.II*. London: Stationery Office, Ev 144.

<sup>259</sup> Player, S. (2016) 'Accountable Care'- The American Import that's the last thing England's NHS needs'. [On-line] Available: <https://www.opendemocracy.net/ournhs/stewart-player/accountable-care-american-import-thats-last-thing-englands-nhs-needs> [Accessed: 21 February 2017].

<sup>260</sup> British Medical Association (2017) 'Capita Service Failure'. [On-line] Available: <https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-current-issues/capita-service-failure> [Accessed: 23 February 2017].

CCGs are indicative of attempted depoliticisation through governmentalization.<sup>261</sup> The status of CCG members as health professionals, and emphasis on the self-responsibility of patients, could theoretically legitimise their decisions, for example, to restrict services. In practice, CCG decisions have generated opposition from professionals and the public. For example, North Eastern and Western Devon CCG abandoned plans to withhold surgery from smokers and obese patients following widespread professional criticism.<sup>262</sup> Public outcry meant that St Helens CCG reversed its plans to suspend non-emergency surgery for four months in 2016.<sup>263</sup> In 2017, the Royal College of Surgeons (RCS) described some CCGs decisions to reduce eligibility for hip and knee operations as having “no clinical justification”.<sup>264</sup> NHSE has advised CCGs that arbitrary rationing measures are not allowed and that NICE guidance should be followed.<sup>265</sup>

Kailash Chand (Deputy Chair of the BMA) argues that developments, such as the devolution of health service functions<sup>266</sup> to some English regions (such as Greater Manchester, London, Cornwall, Liverpool and the North East region) and the creation of integrated and accountable care organisations (ACOs), signal the demise of CCGs.<sup>267</sup> In transferring health service functions to local authorities, the Secretary of

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<sup>261</sup> Jessop, B. (2015) ‘Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises’ in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at p105.

<sup>262</sup> Kenny, C., ‘CCG backs down on plans to withhold surgery for smokers and obese patients’, *Pulse*, 12 December 2014.

<sup>263</sup> Donnelly, L., ‘Health bosses perform U-turn over plan to delay all non-urgent surgery’. *Telegraph*, 11 August 2016.

<sup>264</sup> BBC., ‘Cuts planned to Worcestershire hip and knee operations’, 27 January 2017.

<sup>265</sup> Donnelly, L., ‘Rationing rules restricting surgery to those in most pain must be axed, NHS officials rule’, *Telegraph*, 10 March 2017.

<sup>266</sup> Via the Cities and Local Government Devolution (CLGD) Act (2016), S.18.

<sup>267</sup> Chand, K., ‘Why STPs could spell the end of General Practice’, *Pulse*, 15 February 2017.

State must make provision about the standards and duties to be placed on that authority having regard to national standards and obligations.<sup>268</sup> Greg Dropkin avers that this facilitates deregulation as “having regard to” does not mean implementing or ensuring adherence to.<sup>269</sup> Although devolution has been justified on the basis of enhancing democracy, some argue that it has been adopted to shift blame.<sup>270</sup> Lisa Nandy notes that, so far, in Greater Manchester “the people remain largely shut out of the conversation”.<sup>271</sup>

NHSE’s ‘FYFV’ outlined several models of integrating care, such as multi-speciality care providers (MCPs) and the primary and acute systems model (PACS). MCPs involve extended groups of practices forming either as federations, networks or single organisations.<sup>272</sup> PACS involves single organisations providing NHS list based GP and hospital services together with mental health and community care services.<sup>273</sup> NHSE stated that “at their most radical PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget”, similar to ACOs in Spain, Singapore and the US.<sup>274</sup> ‘FYFV’ was influenced by Sir David Dalton’s review, in 2014, which identified several potential organisational forms, such as service level chains, multi-site trusts, integrated care organisations<sup>275</sup> and privately

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<sup>268</sup> CLGD Act (2016), S.18(1)(C).

<sup>269</sup> Dropkin, G. (2015) ‘The NHS is headed for a devolution iceberg-whilest MPs argue about deckchairs’. [On-line] Available: <https://www.opendemocracy.net/ournhs/greg-dropkin/nhs-is-headed-for-devolution-iceberg-whilest-mps-argue-about-deckchairs> [Accessed: 21 February 2017].

<sup>270</sup> Ashworth, J. (2017) ‘Foreword’ in Phibbs, T. (ed) *Local and National: How the Public Wants the NHS to be both*. London: Fabian Society, p3.

<sup>271</sup> Nandy, L. (2017) ‘Democracy at the core’ in Phibbs, T. (ed) *Local and National: How the Public Wants the NHS to be both*. London: Fabian Society, pp16-17 at p16.

<sup>272</sup> NHS England (2014) *Five Year Forward View*. London: NHS England, p19.

<sup>273</sup> Ibid at p20.

<sup>274</sup> Ibid at p21.

<sup>275</sup> Dalton, D. (2014) *Examining New Options and Opportunities for providers of NHS care: The Dalton Review*. London: Department of Health, p18.

run public hospitals.<sup>276</sup> Although members of the Dalton review's advisory panel were purportedly advising in a personal capacity,<sup>277</sup> documents obtained pursuant to the Freedom of Information Act (2000) indicate that Jim Easton was representing the NHS Partners Network,<sup>278</sup> whose members may benefit from some of the proposed organisational forms. 'FYFV' was also influenced by two reports<sup>279</sup> co-authored by the World Economic Forum and McKinsey, which advocated the reinvention of delivery systems through new models of care.<sup>280</sup>

In 2015, it was announced that in order to implement 'FYFV', five year STPs would be developed.<sup>281</sup> England was divided into forty-four STP footprints involving collaboration between statutory bodies to devise the plans.<sup>282</sup> Hugh Alderwick et al state that STPs represent a shift from competition to place based planning.<sup>283</sup> NHSE and NHSI defined the geographical boundaries of the footprints and identified STP leaders.<sup>284</sup> As STP decision making is not governed by statutory rules, Leys notes it is unclear who will be accountable.<sup>285</sup> Leys and John Lister both state that STPs are

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<sup>276</sup> Ibid at p26.

<sup>277</sup> Ibid at p50.

<sup>278</sup> Pegg, D., 'Private health lobby advised on NHS privatisation review', *Guardian*, 05 July 2015.

<sup>279</sup> Kibasi, T. et al (2012) *The Financial Sustainability of Health Systems: A Case for Change*. Geneva: World Economic Forum and McKinsey/World Economic Forum (WEF) and McKinsey (2013) *Sustainable Health Systems: Visions, Strategies, Critical Uncertainties and Scenarios*. Geneva: WEF and McKinsey.

<sup>280</sup> Player, S. (2017) 'The Truth about Sustainability and Transformation Plans'. [On-line] Available: <https://www.sochealth.co.uk/2017/05/25/truth-stps-simon-stevens-imposed-reorganisation-designed-transnational-capitalism-englands-nhs-stewart-player/> [Accessed: 28 May 2017].

<sup>281</sup> NHS England et al (2015) *Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21*. London: NHS England, p3.

<sup>282</sup> Campbell, D., 'STPs: Radical local modernisation plans or the end of the NHS as we know it?', *Guardian*, 7 September 2016.

<sup>283</sup> Alderwick, H. et al (2016) *Sustainability and Transformation Plans in the NHS: How are they being developed in practice?* London: Kings Fund, p7.

<sup>284</sup> Ibid at p4.

<sup>285</sup> Leys, C. (2016) *Can Simon Stevens' Sustainability and Transformation Plans save the NHS*. London: Centre for Health and the Public Interest, p7.

attempting to address problems resulting from inadequate funding.<sup>286</sup> The proposals include major service changes in hospitals, such as shifts of outpatient services, downgrading of some accident and emergency (A&E) departments and major reductions in bed numbers.<sup>287</sup> Lister notes that STPs centre on achieving drastic efficiency savings<sup>288</sup> but offer no convincing detail on reducing demand.<sup>289</sup> For example, many rely on public health action to reduce demand (but public health programmes are being cut<sup>290</sup>) and on the largely evidence-free notion that large investments in digital solutions can generate savings.<sup>291</sup> As demand for hospital care is rising,<sup>292</sup> Ham et al state that any proposals to reduce hospital capacity should be tested, if necessary, to destruction.<sup>293</sup> The development of STPs has been accompanied by controversy.<sup>294</sup> STPs have faced opposition from the public and local councillors.<sup>295</sup> The lack of public consultation, so far, has also been criticised.<sup>296</sup>

Stevens states that ACOs will be developed in between six and ten STP areas “effectively ending the purchaser/provider split”.<sup>297</sup> NHSE states that ACOs could

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<sup>286</sup> Ibid/Lister, J. (2016) ‘Jeremy Hunt’s solution for cash-strapped NHS trusts- cut 375 nurses each?’ [On-line] Available: <https://www.opendemocracy.net/john-lister/jeremy-hunt-s-solution-for-cash-strapped-nhs-trusts-cut-375-nurses-each> [Accessed: 16 November 2016].

<sup>287</sup> Edwards, N. (2016) *Sustainability and Transformation Plans: What we know so far. Discussion Paper*. London: Nuffield Trust, p5.

<sup>288</sup> Lister, J. (2016) ‘Joint Statement- Challenging the STPs’. [On-line] Available: <https://www.sochealth.co.uk/2016/09/19/joint-statement-challenging-stps/> [Accessed: 04 April 2017].

<sup>289</sup> Lister, J. (2017) *The Sustainability and Transformation Plans: A Critical Assessment*. London: Centre for Health and the Public Interest, p5.

<sup>290</sup> Ibid at p12.

<sup>291</sup> Ibid at p11.

<sup>292</sup> Kings Fund (2016) ‘The Kings Fund responds to reports on NHS Sustainability and Transformation Plans’. [On-line] Available: <https://www.kingsfund.org.uk/press/press-releases/kings-fund-responds-reports-nhs-sustainability-and-transformation-plans> [Accessed: 18 November 2016].

<sup>293</sup> Ham, C. et al (2017) *Delivering Sustainability and Transformation Plans: From Ambitious proposals to credible plans*. London: Kings Fund, p34.

<sup>294</sup> Ibid at p31.

<sup>295</sup> Lister, J. (2017) *The Sustainability and Transformation Plans*, op cit., n.289 at p11.

<sup>296</sup> For example, by Sarah Wollaston. See: H.C. Deb. 14 September 2016, Vol.614, Col.964.

<sup>297</sup> Committee of Public Accounts, *Integrated Health and Social Care*, 27 February 2017, HC 959 2016-17, Q90.

move beyond tariff payments.<sup>298</sup> Several vanguards have been established within England.<sup>299</sup> However, they could be challenged for evading competitive tendering processes.<sup>300</sup> Caroline Molloy states that the creation of insurance resembling purchasers (CCGs with narrowed risk pools) was stage one, and that integrating them with providers into managed care organisations, to control costs, is stage two.<sup>301</sup> Molloy states that managed care organisations are attractive to private providers which have experienced difficulties providing unrestricted services.<sup>302</sup> For example, Circle withdrew from a ten year contract to run Hinchingsbrooke hospital in Cambridgeshire, after three years, stating that its franchise was not “viable under current terms”.<sup>303</sup> NHSE’s Director of Strategy, Michael Macdonnell, has confirmed that STPs “offer private sector and third sector organisations an enormous amount of opportunity”.<sup>304</sup> Private companies are reportedly interested in filling a projected gap in STP funding.<sup>305</sup>

US ACOs have been described as the latest in a succession of unsuccessful fads aimed at containing costs.<sup>306</sup> The development of ACOs, within England, does not necessarily portend the end of competition, as they are not being developed in all STP

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<sup>298</sup> NHS England (2017) *Next Steps on the Five Year Forward View*. London: NHS England, p36.

<sup>299</sup> See NHS England (2016) *New Care Models: Vanguards- developing a blueprint for the future of the NHS and care services*. London: NHS England.

<sup>300</sup> Collins, B. (2016) *New Care Models: Emerging Innovations in governance and organisational form*. London: Kings Fund, p49.

<sup>301</sup> Molloy, C., ‘Deaf People to receive only one hearing aid- an insight into life after the NHS’, *Red Pepper*, 8 December 2014.

<sup>302</sup> Molloy, C., ‘It may not look like it, but Jeremy Hunt DOES have a plan for the NHS...’. [On-line] Available: <https://www.opendemocracy.net/ournhscaroline-molloy/it-may-not-look-like-it-but-jeremy-hunt-does-have-plan-for-nhs-0> [Accessed: 21 May 2007].

<sup>303</sup> BBC., ‘Hinchingsbrooke Hospital: Circle to withdraw from contract’, 09 January 2015.

<sup>304</sup> Abbott, D. (2016) ‘STPs-A Dagger Pointed at the Heart of the NHS’. [On-line] Available: [http://www.huffingtonpost.co.uk/diane-abbott/nhs-reform-stps\\_b\\_12004806.html](http://www.huffingtonpost.co.uk/diane-abbott/nhs-reform-stps_b_12004806.html) [Accessed: 16 November 2016].

<sup>305</sup> Forster, K., ‘Budget 2017: Philip Hammond accused of back-door NHS privatisation by funding ‘shady’ reform plans’, *Independent*, 9 March 2017.

<sup>306</sup> Marmor, T. and Oberlander, J. (2012) ‘From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy’. *Journal of General Internal Medicine*, Vol. 27(9), pp1215-1218 at p1215.

areas. Where ACOs are developed, there may be competition between private companies to manage them and between ACOs themselves. Nonetheless, such competition may be limited. For example, Howard Waitzkin and Ida Hellander note that, historically, competition between managed care organisations, such as Colombian *Entidad promotora de salud*<sup>307</sup> and US ACOs,<sup>308</sup> was constrained by consolidation in the private insurance industry.<sup>309</sup> In the US, managed care organisations have sought to exclude unprofitable patients.<sup>310</sup> In Latin America, managed care has resulted in restricted access for vulnerable groups and reduced spending for clinical services (due to administrative costs and investor returns).<sup>311</sup> Managed care may have similar results in England. Nonetheless, the experience of CCGs indicates that attempts to restrict access are likely to face opposition.

## Indicators

As mentioned in chapter five, the coalition stated that it wanted to move away from process targets and instead focus on outcomes.<sup>312</sup> It introduced an annually refined NHS outcomes framework,<sup>313</sup> expanded Labour's never events framework<sup>314</sup> and

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<sup>307</sup> Created by the Congress of the Republic of Colombia (1993) Law 100. By which the comprehensive social security system is created and other provisions. Bogota: Colombia, Article 156 (G).

<sup>308</sup> Introduced by the Patient Protection and Affordable Care Act (2010), S.2706 and S.3022 .

<sup>309</sup> Waitzkin, H. and Hellander, I. (2016) 'The History and future of neo-liberal health reform: Obamacare and its predecessors'. *International Journal of Health Services*, Vol.46(4), pp747-766 at p753.

<sup>310</sup> Himmelstein, D. et al (2003) *Bleeding the Patient: The Consequences of Corporate Healthcare*. Monroe, ME: Common Courage Press, p53.

<sup>311</sup> Iriart, C. et al (2001) 'Managed care in Latin America: the new common sense in health policy reform'. *Social Science and Medicine*, Vol.52(8), pp1243-1253 at p1248.

<sup>312</sup> Department of Health (DOH) (2010) *Liberating the NHS: Legislative Framework and Next Steps*. London: DOH, p36.

<sup>313</sup> Department of Health (DOH) (2010) *The NHS Outcomes Framework 2011/12*. London: DOH, p5.

<sup>314</sup> *Ibid* at p12.

empowered the NHS Information Centre<sup>315</sup> to collect and publish data submitted via an NHS Safety Thermometer,<sup>316</sup> which triggers payment under Commissioning for Quality and Innovation (CQUIN).<sup>317</sup> Appleby et al state that PROMs are also currently being used cautiously by commissioners as part of CQUIN payments.<sup>318</sup> Lansley announced, in 2010, that the forty-eight hour GP target and the eighteen week hospital target would be abolished and that the four hour A&E target would be relaxed and removed.<sup>319</sup> However, evidence that waiting times were increasing, meant that many targets were retained.<sup>320</sup> Natalie Berry et al contend that this demonstrates that it is politically and operationally difficult to alter targets “without risking a drop in performance, a political backlash or both”.<sup>321</sup> Christopher Ham et al state that the “difficulties of holding service providers to account against the high level outcomes framework” meant that process targets continued to be an important part of accountability.<sup>322</sup> In addition, Ham contends that there “appears to be an irresistible tendency for ministers to be want to be seen to be leading the NHS” which is impelled by the ultimate accountability of the Secretary of State to parliament and intense media scrutiny.<sup>323</sup> Stevens announced, in 2017, that the eighteen week requirement would

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<sup>315</sup> This was originally created as a special health authority (Health and Social Care Information Centre (Establishment and Constitution) Order SI 2005/499). It is now an executive non-departmental public body (HSC Act (2012), S.252(1)) and has been renamed NHS Digital.

<sup>316</sup> Department of Health (DOH) (2012) *Delivering the NHS Safety Thermometer: CQUIN 2012/13: A Preliminary Guide to measuring 'harm free' care*. London: DOH, p13.

<sup>317</sup> Gregory, S. et al (2012) *Health Policy under the coalition government: A mid-term assessment*. London: Kings Fund, p12.

<sup>318</sup> Appleby, J. et al (2016) *Using Patient Reported Outcomes to Improve Health Care*. Oxford: John Wiley and Sons, p48.

<sup>319</sup> Ramesh, R., 'NHS waiting time targets scrapped by Andrew Lansley', *Guardian*, 21 June 2010.

<sup>320</sup> Campbell, D. and Ball, J., 'NHS waiting times force coalition u-turn on targets', *Guardian*, 17 November 2011.

<sup>321</sup> Berry, N. et al (2015) *On Targets: How Targets can be most effective in the English NHS*. London: Health Foundation, p21.

<sup>322</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.2 at p56.

<sup>323</sup> Ham, C. (2014) *Reforming the NHS from within: Beyond hierarchy, inspection and markets*. London: Kings Fund, p15.



be significantly relaxed.<sup>324</sup> Clare Marx (President of RCS) noted that delays could have serious consequences for some patients.<sup>325</sup>

Hunt opined that while health ministers often wanted to foster local decision making, crises led them to “discover their inner Stalin”.<sup>326</sup> Hunt argued that intelligent transparency in respect of outcomes would make “true devolution of power” possible.<sup>327</sup> More data is being produced within the NHS, partly to facilitate patient choice. The coalition’s ten year framework for transforming information for health and care stated that patients would be able, by 2015, to access their GP records,<sup>328</sup> access clinical outcomes data<sup>329</sup> and book and cancel GP appointments online.<sup>330</sup> Since April 2012, patients have had a legal right to choose the consultant specialist at their first outpatient appointment.<sup>331</sup> NHSE announced that by the summer of 2013, consultant level quality and outcomes would be published for ten key specialities, to assist patient choice.<sup>332</sup> Peter Radford et al note that there were concerns that the publication of surgeon specific mortality data (SSMD) could lead to gaming, the passing of difficult cases to colleagues and complex cases not being undertaken.<sup>333</sup> In addition, they

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<sup>324</sup> Campbell, D., ‘NHS ‘waving white flag’ as it axes 18-week waiting time operation targets’, *Guardian*, 31 March 2017.

<sup>325</sup> Trigg, N., ‘NHS operations: waiting lists to rise in ‘trade-off’, boss says’, *BBC*, 31 March 2017.

<sup>326</sup> Hunt, J. (2015) ‘Making healthcare more human-centred and not system-centred’. [On-line] Available: <https://www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred> [Accessed: 24 November 2016].

<sup>327</sup> Ibid.

<sup>328</sup> Department of Health (DOH) (2012) *The Power of Information: Putting all of us in control of the health and social care information we need*. London: DOH, p7.

<sup>329</sup> Ibid at p60.

<sup>330</sup> Ibid at p25.

<sup>331</sup> Appleby, J. et al (2016) *Using Patient Reported Outcomes to Improve Health Care*, op cit., n.318 at p38.

<sup>332</sup> NHS England (2013) *Putting Patients First: The NHS England Business Plan for 2013/14-2015/16*. London: NHS England, p32.

<sup>333</sup> Radford, P. et al (2015) ‘Publication of surgeon specific outcome data: A review of implementation, controversies and potential impact on surgical training’. *International Journal of Surgery*, Vol.13, pp211-216 at p212.

questioned whether mortality (which is relatively infrequent) is the most appropriate outcome for measuring best practice and underperformance.<sup>334</sup> The results are not the responsibility of surgeons alone but depend on the wider hospital team<sup>335</sup> and resources.<sup>336</sup> In 2015 a number of Heart Surgeons asked Stevens to rethink the policy as it was causing colleagues to avoid risky operations.<sup>337</sup>

Choose and Book was replaced by a new electronic booking system. The MyNHS website presents data on seven key areas for each hospital in England, including the CQC inspection rating and staff<sup>338</sup> and inpatient friends and family test (FFT) scores.<sup>339</sup> A Nuffield Trust review, in 2013, found that many GPs thought that aggregate ratings for providers were of less value than more granular information.<sup>340</sup> Leys avers that it is not clear that such findings were taken into account, as in 2014 the CQC began issuing aggregate ratings.<sup>341</sup> Such aggregate ratings appear on the MyNHS website, although the CQC website also provides ratings for specific services. FFT, which was rolled out nationally from April 2013, enables patients to provide feedback.<sup>342</sup> In addition, patients can rate and comment on NHS hospitals on the NHS choices website.<sup>343</sup> FFT is based on a net promoter score (NPS) tool used in the

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<sup>334</sup> Ibid at p214.

<sup>335</sup> Ibid.

<sup>336</sup> Ibid/Westaby, S. et al (2016) 'Surgeon-specific mortality data disguise wider failings in delivery of safe surgical services'. *European Journal of Cardio-Thoracic Surgery*, Vol.47(2) pp341-345 at p345.

<sup>337</sup> Boseley, S., 'Surgeons ask NHS England to rethink policy of publishing patients' death rates', *Guardian*, 30 January 2015.

<sup>338</sup> FFT has been part of the NHS National Staff Survey in England annually since 2009.

<sup>339</sup> Glasper, A. (2015) 'Will MyNHS increase public confidence in care delivery?' *British Journal of Nursing*, Vol.24(2), pp114-115 at p114.

<sup>340</sup> Nuffield Trust (2013) *Rating Providers for Quality: A Policy worth Pursuing?* London: Nuffield Trust, p71.

<sup>341</sup> Leys, C. (2014) 'The Limits of Aggregate Performance Ratings'. [On-line] Available: <https://chpi.org.uk/blog/limits-aggregate-performance-ratings/> [Accessed: 24 March 2017].

<sup>342</sup> Appleby, J. et al (2016) *Using Patient Reported Outcomes to Improve Health Care*, op cit., n.318 at p32.

<sup>343</sup> Ibid.

private sector<sup>344</sup> and is intended to increase transparency and improve services.<sup>345</sup> The CQC received contrasting opinions regarding NPS. The Picker Institute advised that it was inappropriate for the NHS.<sup>346</sup> In contrast, Toby Knightley-Day stated that it would be useful together with the reason for the score.<sup>347</sup> However, participants in discussion groups, organised by Ipsos MORI, were concerned that comments could misrepresent or oversimplify what is occurring on wards.<sup>348</sup> They were also concerned that the classification system, in which 'likely to recommend' responses were regarded as neutral and 'neither nor likely to recommend' responses were regarded as detractors, did not accurately represent patient's views.<sup>349</sup>

A review in 2014 found that some trusts were not asking the follow-up question.<sup>350</sup> Staff viewed scores without feedback as abstract, as it was not clear which aspects of patients experience informed their ratings.<sup>351</sup> The review determined that FFT was a valuable tool for local improvement but was not fully succeeding in informing patient choice.<sup>352</sup> The review noted that results were affected by response rates (only a

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<sup>344</sup> NHS England (2014) *Review of the Friends and Family Test*. London: NHS England, p7.

<sup>345</sup> Ipsos Mori (2012) 'Scoring and Presenting the Friends and Family Test: A Review of options'. [On-line] Available: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214942/FFT-Ipsos-Mori-research-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214942/FFT-Ipsos-Mori-research-report.pdf) [Accessed: 15 November 2016], p1.

<sup>346</sup> Graham, C. and MacCormick, S. (2012) *Overarching questions for patient surveys: Development report for the Care Quality Commission (CQC)*. Oxford: Picker Institute, p4.

<sup>347</sup> Knightley-Day, T. (2012) 'A response to the Overarching questions for patient surveys: Development report for the Care Quality Commission (CQC)'. [On-line] Available: [http://www.friendsandfamilytest.co.uk/PDFS/June%202012\\_Assessment%20of%20CQC%20report.pdf](http://www.friendsandfamilytest.co.uk/PDFS/June%202012_Assessment%20of%20CQC%20report.pdf) [Accessed: 15 November 2016].

<sup>348</sup> Ipsos Mori (2012) 'Scoring and Presenting the Friends and Family Test', op cit., n.345 at p33.

<sup>349</sup> Ibid at p11.

<sup>350</sup> NHS England (2014) *Review of the Friends and Family Test*, op cit., n.344 at p11.

<sup>351</sup> Ibid at p12.

<sup>352</sup> Ibid at p42.

fraction of patients responded),<sup>353</sup> differences in timing<sup>354</sup> and could be gamed.<sup>355</sup> A simpler scoring mechanism has been introduced which presents results as a percentage of respondents who would, or would not, recommend the service.<sup>356</sup> The use of such measures is superficial because, as mentioned in chapter two, Theodor Adorno noted that the reduction of quality to quantity is a process of abstraction which “distances itself from the objects”.<sup>357</sup> I contend that voice is preferable to choice (which relies on such superficial measures) as a means of empowering patients.

## Privatisation

The coalition sought to decontest its reforms by vehemently denying accusations of NHS privatisation (indicative of the ideological mode of dissimulation). For example, Nick Clegg averred that “there will be no privatisation of the NHS”<sup>358</sup> and Lansley described accusations of privatisation as “ludicrous scaremongering”.<sup>359</sup> Rudolf Klein views privatisation as a matter of degree and states that, as the contracting out of services to private firms only increased from £6.6 billion in 2009 to £10 billion in 2014,

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<sup>353</sup> Ibid at p19.

<sup>354</sup> Ibid at p22.

<sup>355</sup> Ibid at p29.

<sup>356</sup> NHS England (2014) ‘Calculation and Presentation of Friends and Family Test Data’. [On-line] Available: <https://www.england.nhs.uk/ourwork/pe/fft/calculations/> [Accessed: 16 November 2016].

<sup>357</sup> Adorno, T. (2008) *Lectures on Negative Dialectics: Fragments of a Lecture Course 1965-1966*. Livingstone, R., Trans. Cambridge, Polity, p127.

<sup>358</sup> Duffet, H. (2011) ‘Nick Clegg’s speech on NHS reform’. [On-line] Available: <http://www.libdemvoice.org/nick-cleggs-speech-on-nhs-reform-24260.html> [Accessed: 2 February 2014].

<sup>359</sup> Trigg, N. (2011) ‘Critics renew attacks on NHS overhaul’. [On-line] Available: <http://www.bbc.co.uk/news/health-14794086> [Accessed: 26 January 2014].

the charge of privatisation is a “misuse of language”.<sup>360</sup> Hunter accused Klein of nitpicking and “semantic posturing”.<sup>361</sup> Martin Powell and Robin Miller state that as privatisation is a multidimensional concept, accounts vary of its “occurrence, chronology and degree”.<sup>362</sup> Nonetheless, the reforms fall within the WHO’s definition of privatisation (mentioned in chapter one). In 2015, it was reported that of 5071 contracts awarded by CCGs, forty percent went to private firms.<sup>363</sup> The increased involvement of private companies within the NHS is inimical to accountability and quality and may detrimentally affect NHS providers.

Privatisation renders healthcare more opaque, as private companies can use the NHS logo (hence patients may not know when they are providing services), hide their profits and outcomes behind commercial confidentiality<sup>364</sup> and are not subject to freedom of information requests.<sup>365</sup> Thus, as Ursula Pearce notes, “it will become increasingly difficult to know what exactly is being done with public money”.<sup>366</sup> Morris introduced the Freedom of Information (Private Healthcare Companies) Bill<sup>367</sup> in parliament, in 2013, to remedy this, but it did not progress. It also detrimentally affects accountability because the NHS is poorly equipped (for example, due to information asymmetry between commissioners and providers) to ensure that private providers deliver “safe,

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<sup>360</sup> Klein, R. (2015) ‘Rhetoric and Reality in the English National Health Service: Comment on “Who Killed the English National Health Service”’. *International Journal of Health Policy Management*, Vol.4(9), pp621-623 at p622.

<sup>361</sup> Hunter, D. (2013) ‘A Response to Rudolf Klein: A Battle may have been won but perhaps not the war’. *Journal of Health Politics, Policy and Law*, Vol.38(4), pp871-877 at p873.

<sup>362</sup> Powell, M. and Miller, R. (2013) ‘Privatizing the English National Health Service: An Irregular Verb?’ *Journal of Health Politics, Policy and Law*, Vol.38(5), pp1051-1059 at p1052.

<sup>363</sup> Campbell, D., ‘Far more NHS contracts going to private firms than ministers admit, figures show’, *Guardian*, 25 April 2015.

<sup>364</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at p103

<sup>365</sup> Ibid at p129.

<sup>366</sup> Pearce, U. (2014) ‘Public Consultation in the NHS’, op cit., n.178.

<sup>367</sup> Freedom of Information (Private Healthcare Companies) H.C. Bill (2013-14) [109].

high-quality care and good value for money”.<sup>368</sup> In this respect, the Centre for Health and the Public Interest (CHPI) found that of 15,000 contracts, only seven were terminated for poor performance, only 134 contract query notices had been issued and only sixteen CCGs had imposed financial sanctions on private providers.<sup>369</sup> This may increase the scope for fraud. Mark Button and Leys note that many companies engaged in fraud in the US (which is estimated to cost between \$80 and \$98 billion annually) are operating in England<sup>370</sup> but that policymakers neglected this issue.<sup>371</sup>

As noted throughout this thesis, increased private sector provision is often justified on the basis of improving quality. However, it negatively affects quality as private providers, such as Virgin, maximise profits by cutting costs.<sup>372</sup> Leys and Toft found that 6,000 NHS patients a year are admitted from private hospitals and that, between October 2010 and April 2014, there were 802 unexpected deaths and 921 serious injuries reported by private hospitals.<sup>373</sup> They note that CQC reports often identify problems with facilities or equipment which pose risks to patient safety.<sup>374</sup> The involvement of private providers negatively affects efficiency because, as Lister notes, market reforms “make the system more bureaucratic and more expensive to administer”.<sup>375</sup> Paton estimates the recurring annual costs of the current market as

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<sup>368</sup> Centre for Health and the Public Interest (CHPI) (2015) *The Contracting NHS: Can the NHS handle the outsourcing of Clinical Services?* London: CHPI, p5.

<sup>369</sup> Ibid.

<sup>370</sup> Button, M. and Leys, C. (2013) *Healthcare Fraud in the new NHS Market- a threat to patient care.* London: Centre for Health and the Public Interest, p4.

<sup>371</sup> Ibid at p12.

<sup>372</sup> Davis, J., et al (2015) *NHS for Sale*, op cit., n.1 at p77/Nunns, A. (2013) ‘The health hurricane: a year of destruction in the NHS’, *Red Pepper*, 11 February 2013.

<sup>373</sup> Leys, C. and Toft, B. (2014) *Patient Safety in Private Hospitals- the known and unknown risks.* London: Centre for Health and the Public Interest, p4.

<sup>374</sup> Ibid.

<sup>375</sup> Lister, J. (2012) ‘In Defiance of the evidence: Conservatives threaten to reform away England’s National Health Service’. *International Journal of Health Services*, Vol.42(1), pp137-155 at p140.

approximately £4 billion.<sup>376</sup> It also adversely affects the equity (as it leads to cherry-picking) and efficacy (as it may lead to overtreatment and needless treatment, as occurs in the US<sup>377</sup>) components of quality identified by Avedis Donabedian.<sup>378</sup> The increased amount of money going to private providers means that less is available for NHS providers, which may undermine cross subsidy. For example, Sarah Lafond et al found that relatively little of the £2bn for healthcare announced within George Osborne's 2014 autumn statement went to NHS providers,<sup>379</sup> while about forty-five percent went to non-NHS providers.<sup>380</sup>

Kenneth Veitch avers that although the NHS is still based on social solidarity,<sup>381</sup> it is now also a source "of economic growth for the private sector".<sup>382</sup> The state has thus bound the social and economic fates and well-being of citizens to that of the private sector and market mechanisms.<sup>383</sup> This is antagonistic to human need. Pollock notes that many private contracts are for community based services.<sup>384</sup> She contends that cuts, closures and the ideology of competition have meant that someone with a serious mental illness may have to travel hundreds of miles to receive care.<sup>385</sup> For example, many English patients with eating disorders have been sent to Scotland for

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<sup>376</sup> Paton, C. (2016) *The Politics of Health Policy Reform in the UK*, op cit., n.250 at p165.

<sup>377</sup> McCartney, M. (2016) *The State of Medicine: Keeping the Promise of the NHS*. London: Pinter and Martin Limited, p133.

<sup>378</sup> Donabedian, A. (2003) *An Introduction to Quality Assurance in Health Care*. Oxford: Oxford University Press, p6.

<sup>379</sup> Lafond, S. et al (2017) *A Year of Plenty? An analysis of NHS Finances and Consultant Productivity*. London: Health Foundation, p53.

<sup>380</sup> Ibid at p3.

<sup>381</sup> Veitch, K. (2013) 'Law, social policy and the constitution of markets and profit making'. *Journal of Law and Society*, Vol.40(1), pp137-154 at p152.

<sup>382</sup> Ibid at p153.

<sup>383</sup> Ibid at p147.

<sup>384</sup> Pollock, A. (2016) 'Interview' in McCartney, M. (2016) *The State of Medicine: Keeping the Promise of the NHS*. London: Pinter and Martin Limited, pp120-122 at p122.

<sup>385</sup> Ibid.

treatment.<sup>386</sup> Private companies have become the principal providers of some services.<sup>387</sup> Ian Greener states that it is “not clear what happens if” they “fail or decide to leave”.<sup>388</sup> Donald Longmore contends that it is highly unlikely that such services could revert to the NHS.<sup>389</sup>

## The End of the NHS?

Margaret McCartney avers that the tragedy is that the undermining of the NHS, by insufficient funding and privatisation, “may not be noticed widely enough-never mind protested against-until the NHS has become a carcass”.<sup>390</sup> McCartney states that the public needs to “demand that our politicians love it like they say they do”.<sup>391</sup> The articulation of residual and emergent norms in government discourse indicates that neo-liberalism has not been entirely successful in respect of health or healthcare. The gap identified by McCartney is significant because, as public experience increasingly diverges from such norms, there may be a crisis of legitimacy.<sup>392</sup> The government’s failure to adequately fund both the NHS and social care may become increasingly difficult politically.<sup>393</sup> This is evidenced by the controversy generated after the British

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<sup>386</sup> Marsh, S. and Campbell, D., ‘NHS England sending anorexic patients to Scotland for treatment’, *Guardian*, 11 December 2016.

<sup>387</sup> Speed, E. and Gabe, J. (2013) ‘The Health and Social Care Act for England 2012: The extension of new professionalism’. *Critical Social Policy*, Vol.33(3), pp564-574 at p568.

<sup>388</sup> Greener, I. (2015) ‘Wolves and the big yellow taxis: How would we know if the NHS is at deaths door? Comment on “Who Killed the English National Health Service?”’ *International Journal of Health Policy and Management*, Vol.4(10), pp687-689 at p688.

<sup>389</sup> Longmore, D. (2012) *A Witness Account of the rise and fall of the NHS*. Aylesbury: Shieldcrest, p301.

<sup>390</sup> McCartney, M. (2016) *The State of Medicine*, op cit., n.377 at p26.

<sup>391</sup> Ibid.

<sup>392</sup> Benbow, D. (2017) ‘The sociology of health and the NHS’. *The Sociological Review*, Vol.65(2), pp416-422 at p418.

<sup>393</sup> Ibid.



Red Cross diagnosed a “humanitarian crisis”, following the deaths of patients waiting on trolleys in hospital corridors.<sup>394</sup> Insufficient funding is also perceived as obstructing the Conservative’s “truly seven day NHS” policy.<sup>395</sup> Although, many primary care practices are collaborating to offer extended access, progress in relation to hospitals is unclear (due to the lack of publicly available data).<sup>396</sup> Growing dissatisfaction with government policy may explain the Conservative’s failure to retain their majority at the 2017 general election.

During the 2017 general election campaign, the Institute for Fiscal Studies (IFS) stated that the next parliament would be challenging for the NHS, regardless of the result, as the Conservatives and Labour had promised average spending increases of 1.2 percent and two percent a year, respectively, between 2016/17 and 2022/23.<sup>397</sup> If Labour had been elected in 2015 or 2017 there may have been administrative savings as both Miliband and Jeremy Corbyn (Labour leader from 2015 onwards) pledged to repeal the HSC Act (2012) and designate the NHS as preferred provider.<sup>398</sup> Although reforms have rendered the NHS more opaque, the solidarity that was important in its creation and maintenance persists. Nonetheless, I agree with Pollock that such solidarity must be enshrined in law. I support the NHS (Reinstatement) Bill, which

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<sup>394</sup> Campbell, D. et al., ‘NHS faces ‘humanitarian crisis’ as demand rises, British Red Cross warns’, *Guardian*, 6 January 2017.

<sup>395</sup> Conservative Party (2015) *Strong Leadership, A Clear Economic Plan, A Brighter more Secure Future*. London: Conservative Party, p37.

<sup>396</sup> McKenna, H. (2017) ‘Did the government meet its pledge to deliver seven day services?’ [On-line] Available: <https://www.kingsfund.org.uk/publications/articles/government-pledge-seven-day-services> [Accessed: 8 June 2017].

<sup>397</sup> Crawford, R. and Stoye, G. (2017) ‘Challenging Times ahead for the NHS regardless of who wins the election’. [On-line] Available: <https://www.ifs.org.uk/publications/9262> [Accessed: 7 June 2017].

<sup>398</sup> Labour Party (2015) *Britain can be better: The Labour Manifesto 2015*. London: Labour Party, p34/ Labour Party (2017) *For the many not the few. The Labour Party Manifesto 2017*. London: Labour Party, p69.

would reinstate the Secretary of State's duty to provide a comprehensive health service<sup>399</sup> and repeal the competition provisions of the HSC Act (2012).<sup>400</sup> However, it is also necessary to seek to realise emergent norms.

## Conclusion

In this chapter, I argued that the HSC Act (2012) undermines residual norms as it facilitated the reduction of the comprehensiveness of the NHS and facilitates its further abatement by changing the duty of the Secretary of State for Health, who is now only required to promote, not provide, a comprehensive health service. It also undermines universality, by introducing eligibility criteria, and equality of access, by enabling FTs to earn up to forty-nine percent of their income from fee paying patients. The statute extends the ambit of neo-liberal norms, which is evident in the duties it stipulates and in the competition it effectuates. The statute also incorporates emerging norms, such as reducing health inequalities (although this is undermined by austerity) and empowering patients (although the adopted mechanisms have been criticised). Although the coalition stated that it wanted to decentralise power within the NHS, it has been centralised, although the centre is fragmented. The use of targets has persisted and more superficial data is being produced. The NHS has been rendered more opaque and juridified and the costly market emplaced by the statute has become an end in itself. However, attempts to depoliticise healthcare have not succeeded, particularly because the government still determines NHS funding. The solidarity

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<sup>399</sup> National Health Service H.C. Bill (2016-17) [51], cl.1(1).

<sup>400</sup> Ibid at cl.18(3).

which was important in the creation and maintenance of the NHS endures. Although many citizens are unaware of the reforms, as public experience increasingly diverges from residual and emergent norms, a crisis of legitimacy may arise.

## Chapter Seven: Conclusion

### Introduction

I have undertaken a comprehensive ideology critique of NHS reforms in the neo-liberal era within this dissertation. This was intended to illuminate the contestation between dominant (neo-liberal), residual (including the NHS' founding principles, which I aver constitute a moral economy) and emergent norms (which developed in recognition of the limits and problems of welfare states). I argued that misrepresentations and mystification may legitimate and obscure legal changes to social relations. However, I found that misrepresentations in respect of healthcare have been contested and that the solidarity that was important in the creation and maintenance of the English NHS endures. Although residual and emergent norms persist (for example, they continue to be articulated within government discourse) they are undermined by dominant neo-liberal norms. As such norms are important components of legitimation, a crisis of legitimacy may arise as they are increasingly impeded.

### Reforms in the Neo-liberal Era

Neo-liberal ideology is currently the hegemonic ideology. Neo-liberals fetishise the market as necessary for freedom and have favoured alterations to public sector governance through increasing audit and marketization (through legal forms, such as

contract). Marketization facilitates privatisation. The neo-liberal era signals what Scott Veitch et al identified as a fifth epoch of juridification, which is characterised by a re-embedding of private law mechanisms in areas formerly considered public.<sup>1</sup> The NHS' founding principles are being undermined by market reforms which divert money away from the needs of patients to bureaucracies (required to administer quasi-markets) and the coffers of private companies, thereby impairing risk pooling and cross subsidy. Neo-liberals endeavour to turn citizens into entrepreneurs of their own health and their moral politics aims to exclude some from free health care. Reductions in the comprehensiveness of the NHS, and insufficient funding, mean that patients are increasingly paying for health care. Many fear that the reforms, and developments, such as the extension of personal health budgets (PHBs), may lead to health care increasingly being recommodified, which would exacerbate inequitable distribution.

The analytical framework that I utilised within this dissertation has enabled me to develop new insights into reforms to the English NHS since the year 2000 which have marketized the NHS and provided private healthcare companies with more opportunities to deliver clinical services within the NHS. I argued that the reforms are indicative of what Jamie Peck and Adam Tickell identified as the third phase of neo-liberalism, roll-out-neo-liberalism,<sup>2</sup> in which states directly use social policy to support capital,<sup>3</sup> although I noted important differences between the New Labour and Conservative-led governments within this era. The competition that the reforms have engendered has led to an increasing amount of the NHS budget going to private

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<sup>1</sup> Veitch, S. et al (2012) *Jurisprudence: Themes and Concepts 2<sup>nd</sup> edition*. Abingdon: Routledge, p262.

<sup>2</sup> Peck, J. and Tickell, A. (2002) 'Neoliberalizing Space'. *Antipode*, Vol.34(3), pp380-404 at p389.

<sup>3</sup> Veitch, K. (2013) 'Law, Social Policy, and the Constitution of Markets and Profit Making'. *Journal of Law and Society*, Vol. 40(1), pp137-154 at p138.

providers.<sup>4</sup> This is antagonistic to human need as it undermines risk pooling and cross subsidy within the NHS, which underpin a service provided in response to need.<sup>5</sup> I identified four main strands to my analytical framework within chapter two. The first strand involved assessing the influence of the dominant ideology of neo-liberalism and the posited micro-ideology of private healthcare companies on the healthcare reforms of successive governments. I assessed and summarised relevant political science literature to demonstrate how successive governments have adhered to neo-liberal economic policies and how their reforms have increasingly emplaced neo-liberal norms, such as efficiency, competition and choice, within public services, such as the NHS. I noted, in chapter three, that New Labour's philosophy was described as "socialised neo-liberalism",<sup>6</sup> as it was akin to orthodox social democratic governments in respect of its substantial investment in health and education.<sup>7</sup> In contrast, I explained, in chapter five, that the coalition's austerity policies have meant that, since 2010, the NHS has not been adequately funded to meet demand and grow services.<sup>8</sup> I mentioned, in chapter four, that Alan Cribb contended that New Labour were able to go further than their Conservative predecessors, in extending neo-liberal norms into the NHS, as they were perceived as ideological friends of the service.<sup>9</sup> I remarked, in chapter five, that the coalition's NHS reforms extended New Labour's reforms (with

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<sup>4</sup> The total amount was recently calculated as £12.7 billion. See Lafond, S. et al (2017) *A Year of Plenty? An Analysis of NHS Finances and Consultant Productivity*. London: Health Foundation, p3.

<sup>5</sup> Doctors for the NHS (2015) 'An NHS Beyond the Market'. [On-line] Available: <http://www.doctorsforthenhs.org.uk/nhs-threats/privatisation/an-nhs-beyond-the-market/> [Accessed: 16 October 2016].

<sup>6</sup> Wilkinson, R. (2000) 'New Labour and the Global Economy' in Coates, D. and Lawler, P. (eds) *New Labour in Power*. Manchester: Manchester University Press, pp136-148 at p138.

<sup>7</sup> Gamble, A. (2010) 'New Labour and Political Change'. *Parliamentary Affairs*, Vol.63(4), pp639-652 at p649.

<sup>8</sup> Davis, J., et al (2015) *NHS for Sale: Myths, Lies & Deception*. London: Merlin Press, p12.

<sup>9</sup> Cribb, A. (2008) 'Organizational Reform and health care goods: Concerns about marketization in the UK NHS'. *Journal of Medicine and Philosophy*, Vol.33(3), pp221-240 at p225.

continuity in principles such as competition, choice and provider plurality<sup>10</sup>) but that the coalition went further and faster than New Labour.<sup>11</sup> I chronicled how the agents of private healthcare companies, such as Virgin and General Healthcare Group (GHG), influenced successive reforms through various mechanisms, such as through direct advice (for example, Virgin's advice to Labour in 2000, considered in chapter three, and McKinsey's advice to the coalition regarding the Health and Social Care (HSC) Act (2012), considered in chapter five) and through establishing financial links with politicians (for example, I noted, in chapter five, that many parliamentarians had financial interests in NHS privatisation).

The second strand involved employing the ideological modes and strategies delineated by John B. Thompson to determine the justifications that successive governments used for their reforms in relevant policy documents, articles and speeches. I assessed relevant academic literature to ascertain whether such justifications were contested and whether they were borne out in reality. Although successive governments claimed that their reforms would enhance quality and efficiency, such claims were contested, and evidence suggests that the reforms have worsened efficiency (as the markets emplaced within the NHS have increased transaction costs) and quality. Successive governments sought to interpellate patients as consumers. However, this faced recalcitrance<sup>12</sup> and patient choice policies have

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<sup>10</sup> Klein, R. (2015) 'England's National Health Service-broke but not broken'. *Millbank Quarterly*, Vol.93(3), pp455-458 at p455/Vizard, P. and Obolenskaya, P. (2015) *The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015 Working Paper 16*. London: LSE, p106.

<sup>11</sup> See, for example: Jarman, H. and Greer, S. (2015) 'The big bang: Health and Social Care reform under the coalition' in Beech, M. and Lee, S. (eds) *The Conservative-Liberal Coalition: Examining the Cameron-Clegg government*. Basingstoke: Palgrave, pp50-67 at p51.

<sup>12</sup> Clarke, J. (2007) 'It's not like Shopping': Citizens, Consumers and the reform of public services' in Bevir, M. and Trentmann, F. (eds) *Governance, Consumers and Citizens: Agency and Resistance in Contemporary Politics*. Basingstoke: Palgrave, pp97-118 at pp114-115.

taken a backseat.<sup>13</sup> Successive governments sought to fragment patients by emphasising individual responsibility for health, but this has not successfully colonised common sense. Successive governments also sought to naturalise their reforms by arguing that there were no alternatives, but critics argued to the contrary. My utilisation of Williams' method of authentic historical analysis revealed that successive governments articulated residual norms (in an effort to mask the fact that their reforms undermined such norms) and emergent norms within their discourse, alongside dominant neo-liberal norms. Consequently, there is a gap between ideals and lived realities, which my ideology critique has illuminated. Such gaps have been theorised as spurs to change.<sup>14</sup> As public experience increasingly diverges from the residual and emergent norms articulated within government discourse there may be a legitimisation crisis. I argued that residual and emergent norms are bases for conceiving alternatives (which I consider further below) to dominant neo-liberal norms. My work contributes to the challenging of government discourse concerning both health and healthcare and, in Gramscian terms, may strengthen good sense, based on people's practical experiences, and inform political mobilization. My research affirms the continued relevance of the method of ideology critique, which other researchers may be able to utilise, in a similar fashion to me, to illuminate other policy areas and challenge dominant discourses.

The third strand of my analytical framework involved assessing the translation of neo-liberal political rationality into practice. In this respect, I determined that neo-liberal political rationality has not been perfectly translated into health and healthcare policies,

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<sup>13</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one: NHS Reform*. London: Kings Fund, p18.

<sup>14</sup> Horkheimer, M. (2013) *Eclipse of Reason*. London: Bloomsbury, p126/Unger, R. (1977) *Law in Modern Society: Toward a Criticism of Social Theory*. New York: Free Press, p153.



legislation and governance. For example, I mentioned, in chapter one, that inequality is a neo-liberal norm. While Thatcher's government assiduously avoided the term inequality (and attempted to bury the Black report on health inequalities),<sup>15</sup> New Labour set itself the goal of reducing such inequalities and the Conservative-Liberal Democrat coalition created statutory duties in this respect, although they have not been implemented effectively<sup>16</sup> and are undermined by austerity (which is likely to increase such inequalities<sup>17</sup>). In addition, successive governments validated the residual norm of equality of access (despite enacting reforms which undermine this norm). As mentioned above, while successive governments sought to extend patient choice within the NHS, this policy has currently taken a backseat,<sup>18</sup> although both NHS England and the current government are desirous of extending the use of PHBs. While the internal market was emplaced in the NHS, in the 1990s, to engender competition among NHS providers, the mimic-market introduced by Labour, in the 2000s, generated competition between NHS and private providers for some clinical services. The HSC Act (2012) facilitates the current market within the NHS, in which NHS and private providers are increasingly competing to deliver many services. Although the amount of discretion afforded to commissioners by the regulations passed pursuant to S.75 of the HSC Act (2012) is contested, many commissioners have acted as though such discretion was curtailed in practice (resorting to competition in instances where they would not have done so if not for the rules)<sup>19</sup> and private providers are

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<sup>15</sup> Williams, G. (2007) 'Health inequalities in their place' in Cropper, S. et al (eds) *Community Health and Well-being: Action Research on Health Inequalities*. Bristol: Policy Press, pp1-22 at p2.

<sup>16</sup> Wenzl, M. and Mossialos, E. (2016) 'Achieving Equity in health service commissioning' in Exworthy, M. et al (eds) *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press, pp233-254 at p248.

<sup>17</sup> Bamba, C. (2013) 'All in it Together? Health Inequalities, Austerity and the Great Recession' in Wood, C. (ed) *Health in Austerity*. London: Demos, pp49-57 at p51.

<sup>18</sup> Ham, C. et al (2015) *The NHS under the Coalition government part one*, op cit., n.13 at p18.

<sup>19</sup> West, D., 'CCGs open services to competition out of fear of rules'. *Health Services Journal*, 4 April 2014.

increasingly delivering NHS clinical services. Nonetheless, I identified countervailing forces to the current market, such as resource constraints,<sup>20</sup> the opposition of campaign groups such as Keep Our NHS Public (KONP),<sup>21</sup> and the recent emphasis on integration by NHS England (although the accountable care organisations that are being developed in some areas within England may furnish private companies with more opportunities).

The fourth strand of my analytical framework involved assessing the potential reifying effects of the reforms. Reification may cause estrangement, which, as John Torrance noted, is the opposite of solidarity<sup>22</sup> (which was important in the creation and maintenance of the NHS). I found evidence of philosophical reification, as the exchange principle has been extended (as the NHS' comprehensiveness has diminished and inadequate funding has detrimentally affected NHS performance, causing many patients to go private) and more superficial measures (such as inpatient friends and family test (FFT) scores) are being used. I also found evidence of social reification, as some means employed in NHS governance, such as targets and markets, have become ends in themselves, to the detriment of patients. For example, I noted, in chapter three, that Michael Mandelstam argued that the target requiring waits not exceeding four hours for patients in accident and emergency (A&E) detrimentally affected other hospital departments.<sup>23</sup> I argued that the potential for law

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<sup>20</sup> Osipovic, D. et al (2016) 'Interrogating institutional change: Actors' attitudes to competition and co-operation in commissioning health services in England'. *Public Administration*, Vol.94(3), pp823-838 at p830.

<sup>21</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation? Profit-making in English health services after the 2012 Health and Social Care Act'. *Social Science and Medicine*, Vol.124, pp215-223 at p220.

<sup>22</sup> Torrance, J. (1977) *Estrangement, Alienation and Exploitation: A Sociological Approach to Historical Materialism*. Basingstoke: Macmillan, p315.

<sup>23</sup> Mandelstam, M. (2011) *How we Treat the Sick: Neglect and abuse in our Health Services*. London: Jessica Kingsley, p231.

to legitimise reforms (by making them seem natural and unmediated by history and class dynamics<sup>24</sup>) is inhibited by the moral economy concerning the NHS' founding principles. In this respect, increased campaigning activity (evidenced by the increased number of local KONP groups), protests (such as the largest rally in the NHS' history in March 2017, organised by Health Campaigns Together) and an increase in the number of patients disagreeing with the sentiment that it does not matter who provides free services<sup>25</sup> (which may indicate increased public concern with the burgeoning private sector) suggests that legal changes have not, and may not, legitimise market reforms to English healthcare.

I also utilised the various strategies identified by Bob Jessop<sup>26</sup> to assess whether reforms have reified health and healthcare through depoliticization. I determined, in chapter four, that institutional depoliticization had somewhat succeeded in respect of New Labour's creation of Monitor to regulate foundation trusts (FTs), as many problems with such hospitals were dealt with without parliamentary or ministerial involvement, although some scandals (such as the Mid Staffordshire FT scandal) led to top-down accountability returning.<sup>27</sup> I argued, in chapter six, that the coalition created NHS England in an effort to shift blame concerning healthcare (which is pertinent as the NHS is not currently being adequately funded), but that this was

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<sup>24</sup> Hedrick, T. (2014) 'Reification in and Through Law: Elements of a Theory in Marx, Lukacs and Honneth'. *European Journal of Political Theory*, Vol.13(2), pp178-198 at p192.

<sup>25</sup> Appleby, J. et al (2015) 'Health' in Curtice, J. and Ormston, R. (eds) *British Social Attitudes: the 32<sup>nd</sup> Report*. London: NatCen Social Research, pp102-121 at p115/Ipsos MORI (2013) 'NHS Poll Topline Results' [On-line] Available: [https://www.ipsos.com/sites/default/files/migrations/en-uk/files/Assets/Docs/Polls/NHS\\_Questions\\_topline.pdf](https://www.ipsos.com/sites/default/files/migrations/en-uk/files/Assets/Docs/Polls/NHS_Questions_topline.pdf) [Accessed: 24 June 2017].

<sup>26</sup> Jessop, B. (2015) 'Repoliticising depoliticisation: theoretical preliminaries on some responses to the American fiscal and Eurozone debt crises' in Flinders, M. and Wood, M. (eds) *Tracing the Political: Depoliticisation, governance and the state*. Bristol: Policy Press, pp95-116 at pp101-106.

<sup>27</sup> Moyes, W. et al (2011) *Nothing to do with me? Modernising Ministerial Accountability for Decentralised Public Services*. London: Institute for Government, pp32-37.

unlikely to succeed as the government retains important powers over the NHS (such as determining its funding) while the public do not, so far, appear to be directing their ire for healthcare problems to NHS England rather than the government. I argued, in chapter six, that although business norms and legal rules increasingly govern behaviour within the NHS, healthcare remains highly politicised (despite strategies of marketization and juridification) as is evidenced by the activities of campaign groups, such as KONP.<sup>28</sup> I explicated that market reforms meant that the English NHS became subject to transnational legal rules, such as European Union (EU) public procurement and competition law. Nonetheless, I found that public awareness of the potential for external constitutional constraints to restrict NHS policy making appears to have increased (evident in the opposition to the proposed trans-Atlantic Trade and Investment Partnership (TTIP) between the United States (US) and the EU and potential post-Brexit trade deals) hence the strategy of new constitutionalism, identified by Gill,<sup>29</sup> does not appear to have been, and is not likely to be, successful in depoliticising market reforms to the NHS.

I found that the use of ostensibly non-political figures to make recommendations was unsuccessful in some instances (for example, I determined, in chapter four, that New Labour's use of a leading surgeon, Lord Ara Darzi, to recommend polyclinics did not depoliticise the controversial policy) but successful in other instances (for example, I noted, in chapter five, that Jason Glynos et al argued that the NHS Future Forum, established by the coalition, marginalised alternative visions during the listening

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<sup>28</sup> Krachler, N. and Greer, I. (2015) 'When does Marketization lead to Privatisation?', op cit., n.21 at p220.

<sup>29</sup> Gill, S. (2008) *Power and Resistance in the new world order: 2<sup>nd</sup> edition*. Basingstoke: Palgrave, p79.

exercise regarding the HSC Act (2012) by emphasising the concept of integration<sup>30</sup>. I mentioned, in chapter three, that John Clarke argued that the use of targets to self-responsibilise NHS actors had not succeeded as governments continued to be deemed responsible for healthcare failures.<sup>31</sup> I also noted that Clarke et al argued that New Labour's efforts to self-responsibilise patients for their own health had not colonised common sense.<sup>32</sup> Although lifestyle drift has coloured the discourse of successive governments, and others, I argued that opposition to the decisions of some Clinical Commissioning Groups (CCGs) to restrict access for some patients (such as smokers and the obese), by both the public and professionals, demonstrates that this remains contested. Ultimately, while healthcare has been rendered more opaque, I determined that the ostensible lack of success of many reifying strategies indicates that the solidarity that was important in the creation and maintenance of the NHS appears to endure. Consequently, as the justifications for successive reforms have been contested and many strategies to reify healthcare have not succeeded, the undermining of the NHS through inadequate funding and privatisation may become increasingly difficult politically. My study has primarily focused on government discourse. Further qualitative research (for example, interviews with members of the public) may enhance understanding of the persistence of solidarity and the impact of government discourse on public attitudes.

## Alternatives

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<sup>30</sup> Glynos, J. et al (2014) 'Logics of Marginalisation in health and social care reform: Integration, Choice and Provider Blind Provision'. *Critical Social Policy*, Vol.35(1), pp45-68 at p46.

<sup>31</sup> Clarke, J. (2004) 'Dissolving the Public Realm? The Logics and Limits of Neo-liberalism'. *Journal of Social Policy*, Vol.33(1), pp27-48 at p38.

<sup>32</sup> Clarke, J. et al (2007) *Creating Citizen-Consumers: Changing Publics and Changing Public Services*. London: Sage, pp83-84.

Residual and emergent norms continue to inspire alternatives to recent market reforms. Alternatives are essential in challenging the naturalisation of neo-liberalism and may find a receptive audience if the post-capitalist interregnum has dawned.<sup>33</sup> Many of the provisions of the NHS (Reinstatement) Bill are necessary to prevent the covert undermining of the NHS, such as reinstating the Secretary of State's duty to provide a comprehensive health service,<sup>34</sup> removing competition<sup>35</sup> and centralising and reducing PFI debt.<sup>36</sup> Ultimately, the aim should be to completely decommodify healthcare and remove private companies. In addition, efforts should be made to realise emergent norms, such as empowering patients and the public and reducing health inequalities. NHS marketization was justified on the basis of empowering patients by increasing choice. However, as Alex Mold notes, "choice was an attractive way to package NHS reform: it was not always about giving the patient more to choose from".<sup>37</sup> I aver that voice is preferable to choice. The NHS (Reinstatement) Bill proposes abolishing NHS Improvement (NHSI),<sup>38</sup> NHSE<sup>39</sup> and CCGs<sup>40</sup> and replacing them with a National Health Service England Authority (NHSEA), with several regional offices,<sup>41</sup> and Health Boards, to assess needs and plan services.<sup>42</sup> It would re-

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<sup>33</sup> Streeck, W. (2016) 'The post-capitalist interregnum'. *Juncture*, Vol.23(2), pp68-77.

<sup>34</sup> National Health Service H.C. Bill (2016-17) [51], cl.1(1).

<sup>35</sup> *Ibid* at cl.18(3).

<sup>36</sup> *Ibid* at cl.21.

<sup>37</sup> Mold, A. (2015) *Making the Patient Consumer: Patient Organisations and Health Consumerism in Britain*. Manchester: Manchester University Press, p170.

<sup>38</sup> National Health Service H.C. Bill (2016-17) [51], cl.18(1).

<sup>39</sup> *Ibid* at cl.8(1).

<sup>40</sup> *Ibid* at cl.13(1).

<sup>41</sup> *Ibid* at cl.8(2).

<sup>42</sup> *Ibid* at cl.9(1).

establish Community Health Councils (CHCs) for the area of each Health Board.<sup>43</sup> However, CHCs were “never intended as democratic control or accountability”.<sup>44</sup>

Diane Longley argued that politics is missing from the NHS’ structure.<sup>45</sup> Although health service functions have been devolved to some regions, such as Greater Manchester, this has been a largely technocratic process so far.<sup>46</sup> I argue that enhancing public participation in NHS decision-making may reduce alienation. In 2000, a commission, established by the Association of Community Health Councils for England and Wales (ACHCEW), chaired by Will Hutton, recommended directly involving the public in running the NHS or in electing its decision makers<sup>47</sup>, as Fred Messer and the Campaign for a Democratic Health Service advocated. The commission noted that local and regional governments were involved in running healthcare in other countries, such as Finland, Norway and Sweden,<sup>48</sup> and concluded that elections to Health Authorities would enhance knowledge of health issues.<sup>49</sup> Experiments with elections to health boards, in both Scotland<sup>50</sup> and Canada, were abandoned due to low turnouts. Nonetheless, in Scotland elections enhanced the diversity of views within boards and increased the degree of challenge.<sup>51</sup> Members of

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<sup>43</sup> Ibid at cl.17(1).

<sup>44</sup> Hogg, C. (1986) *The Public and the NHS*. London: Association of Community Health Councils for England and Wales, p33.

<sup>45</sup> Longley, D. (1993) *Public Law and Health Service Accountability*. Buckingham: Open University Press, p98.

<sup>46</sup> Harrop, A. and Phibbs, T. (2017) ‘Introduction: Time to Transform’ in Phibbs, T. (ed) *Local and National: How the Public Wants the NHS to be both*. London: Fabian Society, p4.

<sup>47</sup> Hutton, W. (2000) *New Life for Health: The Commission on the NHS Chaired by Will Hutton*. London: Vintage, p6.

<sup>48</sup> Ibid at p70.

<sup>49</sup> Ibid at p80.

<sup>50</sup> Health Boards (Membership and Elections) (Scotland) Act (2009), S.4(1)/ Health Boards (Membership and Elections) (Scotland) Act 2009 (Commencement No.1) Order, SSI 2009/242, R.2(A) and (B).

<sup>51</sup> Greer, S. et al (2012) *Health Board Elections and Alternative Pilots: Final Report of the Statutory Evaluation*. Edinburgh: Scottish Government Research, p49.

district health boards in Saskatchewan believed that elections increased local control over health services.<sup>52</sup> In contrast, Robin Gauld's research into elected boards in New Zealand suggests that other channels may be required to enhance public participation.<sup>53</sup> Increased democratic deliberation in the NHS may enhance social learning<sup>54</sup> and legitimacy. The experience of FT boards of governors demonstrates that efforts must be made to ensure that participants are representative and adequately informed or trained. If healthcare is decentralised to enhance democracy, strong solidarity mechanisms must also be emplaced to ensure that equity is not detrimentally affected.<sup>55</sup>

As mentioned in chapter one, Lesley Doyal and Imogen Pennell argued that a socialist medical service would demystify medical knowledge.<sup>56</sup> Successive reforms within England have focused on external stimuli (such as markets and targets). However, analysis suggests that successful healthcare institutions mobilize the intrinsic motivation of staff (providing them with the skills to review and change services)<sup>57</sup> and engage patients in decision making.<sup>58</sup> Successive governments stated that they wanted to enhance patient involvement, but a gap between rhetoric and reality persists. Ceri Butler and Trisha Greenhalgh note that there is “no easy formula” for

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<sup>52</sup> Lewis, S. et al (2001) 'Devolution to democratic health authorities in Saskatchewan: an interim report'. *Canadian Medical Association Journal*, Vol.164(3), pp343-347 at p344.

<sup>53</sup> Gauld, R. (2010) 'Are elected health boards an effective mechanism for public participation in health service governance?' *Health Expectations*, Vol.13(4), pp369-378 at p371.

<sup>54</sup> Vincent-Jones, P. (2011) 'Embedding Economic Relationships through social learning? The Limits of Patient and Public Involvement in Healthcare governance in England'. *Journal of Law and Society*, Vol.38(2), pp215-244 at p241.

<sup>55</sup> Alves, J. et al (2013) 'Efficiency and Equity Consequences of Decentralisation in health: An Economic Perspective'. *Revista Portuguesa de Saude Publica*, Vol.31(1), pp74-83 at p80.

<sup>56</sup> Doyal, L. and Pennell, I. (1983) *The Political Economy of Health*. London: Pluto, p294.

<sup>57</sup> Timmins, N. and Ham, C. (2013) *The Quest for integrated health and social care: A Case Study in Canterbury, New Zealand*. London: Kings Fund, p46.

<sup>58</sup> Collins, B. (2015) *Intentional Whole Health System Redesign: Southcentral Foundation's 'Nuka' system of care*. London: Kings Fund, p62.



successfully involving users.<sup>59</sup> Rocco Palumbo argues that patient empowerment will require enhancing the health literacy of both individuals (the ability to access, understand, process and use health information to make adequate decisions) and organisations (encouraging patient engagement in the design and delivery of care).<sup>60</sup>

The NHS is utopian in providing a partial solution (decommodifying health care) to capitalist social relations and their impact on health. Class inequalities in health persist despite its creation, indicating that further state intervention in capitalist production is necessary. The welfare state is contradictory as it has stabilised capitalism but also has the potential to undermine it, as it evinces a different logic to capitalist production (being organised on the basis of need rather than profit). The examined market reforms have neutered the NHS' subversive character and threaten patient needs. Aneurin Bevan described the NHS as a first fruit.<sup>61</sup> The market reforms should be reversed to prevent the fruit rotting before it has ripened. If the market reforms are reversed and the NHS is democratised it may inspire the blossoming of similar fruits.

## Conclusion

In conclusion, although ideology critique is eschewed by many contemporary critical theorists, my own particular use of the method, within this dissertation, indicates its

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<sup>59</sup> Butler, C. and Greenhalgh, T. (2011) 'What is already known about involving users' in Greenhalgh, T. et al (eds) *User Involvement in Health Care*. Oxford: Blackwell, pp10-27 at p23.

<sup>60</sup> Palumbo, R. (2017) *The Bright Side and Dark Side of Patient Empowerment: Co-Creation or Co-Destruction of Value in the Healthcare Environment*. Cham: Springer, p65.

<sup>61</sup> Bevan, A. (1950) *Democratic Values*. London: Fabian Society, p14.

continued relevance in delineating the gap between ideals and lived realities. Although the norms of the dominant neo-liberal ideology, such as competition and choice, increasingly govern behaviour within the NHS, residual and emergent norms persist. Residual and emergent norms are undermined by dominant norms, but enable the critique of government policy and provide a basis for conceiving alternatives. As governments continue to give validity to such norms, a crisis of legitimacy may arise as public experience increasingly diverges from them. I argued that legislation which undermines residual norms should be amended, that the NHS should be democratised to empower patients and the public and that governments must increasingly intervene in capitalist production to address health inequalities.

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