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COMPLUTENSE

Market reforms and privatisation in the English National Health Service

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Abstract. The article examines developments in the marketisation and privatisation of the English National Health Service, primarily since 1997. It explores the use of competition and contracting out in ancillary services and the levering into public services of private finance for capital developments through the Private Finance Initiative. A substantial part of the article examines the repeated restructuring of the health service as a market in clinical services, initially as an internal market but subsequently as a market increasing opened up to private sector involvement. Some of the implications of market processes for NHS staff and for increased privatisation are discussed. The article examines one episode of popular resistance to these developments, namely the movement of opposition to the 2011 health and social care legislative proposals. The article concludes with a discussion of the implications of these system reforms for the founding principles of the NHS and the sustainability of the service

Keywords: NHS; privatisation; marketization; workforce; resistance.

[es] Mercado reforma y privatización en el Sistema Nacional de Salud inglés

Resumen. El artículo examina la evolución de la mercantilización y la privatización del Sistema Nacional de Sanidad (SNS) en Inglaterra, sobre todo desde 1997. Explora el uso de la competencia y la subcontratación de servicios auxiliares y el uso en los servicios públicos de financiación privada para desarrollos de capital a través de la Iniciativa de Financiación Privado. Una parte sustancial del artículo examina la repetida reestructuración del sistema de sanidad como un mercado de servicios clínicos, inicialmente como un mercado interior sino posteriormente como un mercado creciente apertura a la participación del sector privado. Algunas de las implicaciones de los procesos de mercado para el personal del NHS y de creciente privatización se discuten. El artículo examina un episodio de la resistencia popular a estas tendencias, es decir, el movimiento de oposición a la salud y las propuestas legislativas del SNS en 2011. El artículo concluye con una discusión de las consecuencias de estas reformas fundamentales del sistema nacional de sanidad y la sostenibilidad del servicio.

Palabras clave: SNS (Sistema Nacional de Sanidad); privatización; mercantilización; el personal; resistencia.

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1. Introduction

This article examines key developments in marketisation and privatisation in the English National Health Service (NHS). The paper does not attempt an evaluation of the effectiveness of the reforms but will assess their significance more broadly, including some of the implications for the workforce and for the founding principles of the NHS. The paper examines opposition to these policies, focussing on the mobilisation of resistance to the most recent development, namely the passing of the 2012 Health and Social Care Act under the Conservative-Liberal Democrat Coalition government.

The article will focus primarily on policy after the election of the Labour government in 1997 although some brief discussion of earlier developments will be necessary on occasion for context. As health has been a devolved policy since 2000, the developments described in this paper concern the English NHS only. First, the article will examine the marketisation and privatisation of the procurement policy for new large scale infrastructure projects, specifically the Private Finance Initiative in large hospital builds. The application of market processes to ancillary services and back-office functions will be discussed. The article then turns to the spreading out of market policies to embrace an ever widening range of clinical services. The extent of privatisation and some of the consequences for staff will be discussed. The paper provides an overview of the popular resistance to the most recent market restructuring and concludes with a discussion of the implications of these reforms for the founding principles and sustainability of the NHS. Marketisation is understood as the (re)structuring of services so that ‘purchasing’ organisations are separated from ‘providing’ organisations with these relating to one another through contracts for which providers must compete; the financial system is redesigned so that ‘the money follows the patient’. Privatisation refers to the transfer, on a temporary or permanent basis, of activities, staff, assets, responsibilities, funding, regulation or decision-making out of the public sector to private individuals or private organisations.

2. Capital investment and extending market forces in the procurement of new hospitals

In 1994, a new approach to capital investment, the Private Finance Initiative (PFI), was imposed as a requirement in NHS capital procurement processes, including for new hospital builds. Although initially a Conservative policy, it was the New Labour government elected in 1997 which championed it as the solution to finding finance for capital investment. PFI was described as a mechanism for leveraging private finance into public infrastructure development (Department of Health (DoH), 1997).

Under PFI, as part of the process of procurement, decisions about whether or not to build a new hospital are taken by individual NHS Trusts² which are looking to improve their own estate although in practice they need to be supported by local commissioning bodies. The individual Trust invites private sector consortia to bid to supply the new hospital. The NHS Trust enters into detailed negotiations with the preferred bidder. The consortium undertakes to design the hospital according to the output specification of the NHS Trust, to borrow finance to invest in its construction and to construct the hospital. The hospital once built is made available for use by the NHS Trust but the consortium of companies, or 'special purpose vehicle' (SPV - a specially created shell company) owns the hospital in that it has a right to the financial flows arising from it. This means that the NHS Trust must make payments to the SPV each year for the duration of the contract (typically around 30 years).³ Part of these payments is for the availability of the hospital and part is for the associated services such as maintenance, catering, help-desk support, cleaning, estates management or other facilities management services which form part of the contract. While the ownership and provision of these services are in private hands, the hospital Trust itself remains publicly managed and clinical services remain public.⁴

The attractiveness of PFI lay in the fact that capital investment under PFI does not immediately affect the most widely used measures of capital spending, net borrowing and the stock of national debt, despite the fact that PFI debts are owed by public sector bodies and underwritten by the state (Hellowell, 2014). This allowed the impression of greater fiscal prudence to be conveyed than was actually the case and so had political benefits. By 2014, there were 123 operational PFI projects with a capital value of around £12.1bn) and many run-down hospitals had been replaced (HM Treasury, 2014).

However, PFI entails much higher costs to the public sector for capital investment than was previously the case. These arise from the various factors including the higher cost of private borrowing, high levels of development costs (e.g. legal and financial advice) and the difficulties of predicting accurately at the

2 Legal entities providing, typically hospital, mental health and/or community services.

3 At the end of the contract period the hospital may or may not belong to the NHS Trust involved.

4 Historically, decisions about new hospital construction were taken as part of the planning process at regional level. Money would be made available to the region through the Health Department and if necessary the Treasury would borrow this money. The new hospital would be designed by experts within the NHS and its building would be contracted to a private construction company which would be paid upon completion of the building work. The new hospital would belong to the NHS and would be managed and maintained by NHS staff.

time of negotiation what the contract needs to cover throughout its duration resulting in costly modifications to the contract in later years (e.g. see Ruane, 2010a). Thus although the capital value of the 123 schemes mentioned above stood at £12.1bn, total repayments by the time they are made will amount to around £80bn according to official figures (HM Treasury, 2014). Because PFI repayments are underwritten in law, NHS Trusts must prioritise their PFI repayments above other demands on their revenue. As the capital element of the tariffs paid to hospitals for their clinical work does not reflect the full cost of PFI payments, there is evidence that PFI payments are an important part of budgetary pressures and NHS Trusts with large PFI schemes have become more vulnerable than others to falling into deficit (Pollock et al, 2011; Plimmer, 2014).

An example is the 600-bed Peterborough and Stamford Hospitals NHS Trust. The Trust began repayments on its PFI contract following the £335m construction of a new hospital and two new health centres in 2010. Payments amounted to around £45m per annum but the hospital faced a projected deficit of £50m each year on little more than £200m revenue and the economic regulator concluded in June 2013 that the Trust, although it worked well ‘clinically’, was financially unsustainable (BBC News, 2013; Edwards, 2013). Rising with inflation, payments could potentially reach a total of almost £2bn by the end of the 35 year contract.

PFI has also been held responsible for bed shortages in some Trusts (BBC News, 2000; Pollock and Price, 2013)⁵ and has distorted planning priorities by requiring patient care in the local system to be channelled to the PFI trust to ensure revenue is generated to make repayments. It stands in contradiction to other policies aimed at securing efficiencies and transferring a greater proportion of care out of hospitals and into community settings. It has removed hospitals from public ownership and to some extent concealed their ownership since the selling on of shares is difficult to track. Moreover their ownership is sometimes held by offshore companies which are structured to reduce their tax liabilities (Armitage and Holmes, 2014). It distracts managers from patient care and reduces the flexibility with which managers can direct aspects of the service where staff have been transferred (Ruane 2002).

PFI was revised under the Coalition government and PF2 has taken its place. This new version of PFI alters the types of investors providing the capital and changes the ratio of debt (in the form of bank loans or bond finance) to risk capital (or equity) (HM Treasury, 2012). However, although it has been presented by the Treasury as reducing the risk of schemes, financial analysis has indicated that it is likely to push up the cost of capital further and consequently the Trust repayments, making PF2 even more expensive than PFI (Hellowell, 2014).

⁵ A disproportionately high number of proposed closures in Accident and Emergency departments are accounted for by NHS Trusts with significant PFI schemes (The Telegraph, 2011).

3. The marketisation of non-clinical services

The first concerted application of market forces to staff within the NHS began in 1983 under Margaret Thatcher's administration when hospital managers were required to embark upon 'compulsory competitive tendering' to procure cleaning, catering and laundry services. The policy, along with its successor in the 1990s, 'market testing', was effective in reducing the direct costs of providing these services (Cm 2212, 1993), largely because private contractors offered workers poorer conditions of employment (HM Treasury, 1986). As these are labour intensive services, it had the effect of reducing the numbers of staff employed, increasing the workload on those remaining and consequently reducing the quality of work done. Around 108,000 jobs in cleaning, catering and laundry were lost between 1983 and 1992 (Kerr and Radford, 1994; Joint NHS Privatisation Research Unit, 1990).

In a context of funding constraints and efficiency initiatives and in which it was necessary to demonstrate that maximum value was being achieved, the momentum to 'market test' was sustained after New Labour's election. Ongoing pressure on the cost of these services held staffing numbers, wages and terms and conditions down and this was the case regardless of whether staff were transferred to a private company or remained as part of the 'in-house' bid.

The Private Finance Initiative created an additional policy context in which staff conditions were squeezed as an increasing range of non-clinical and ancillary services were seen by both private sector consortia and NHS Trust management as an aspect of PFI schemes where savings could be made (Ruane, 2002), facilitated by the prior weakening of trade union branches following fifteen years of competitive tendering. Under PFI, ancillary staff transferred to private sector companies at least until the 2002 Retention of Employment (RoE) deal created a way of keeping most ancillary staff in cleaning, catering, laundry, portage and security services in the public sector although under this model they are managed by the private sector.⁶ One analysis calculated in 2012 that around 29% of hospital facilities management was outsourced (CBI and Oxford Economics, 2012).

Over time, the range of services subjected to contracting-out processes, joint ventures or sell-offs expanded to include reception work, logistics and transportation of supplies, various back-office functions such as payroll and a number of semi-clinical services such as medical secretarial work, pathology laboratory and blood supply services.⁷ A recent example which reflects the drive to cut costs and the zealous extension of market competition is the contracting-out of general practice⁸ support services (including managing the transfer of patient records, administering payments to primary care suppliers and other back-office functions). Hoped-for cuts to the costs of these services were so deep (£40m from a

⁶ The RoE Model does not, however, safeguard NHS status for workers in IT, payroll, medical and patient records, central sterile supply service departments or switchboard and reception services where these face transfer under PFI (UNSON, 2014).

⁷ We should also mention briefly that by the mid-1990s a number of NHS functions had been sold off on a permanent basis including information systems and estates management which might be established as independent commercial businesses or sold off to existing enterprises.

⁸ General practitioners (GPs) are generalist family doctors providing family care through general practices or health centres.

£100m annual budget) that no public sector option was considered feasible (Williams, 2014a). With variation by area, some of these functions had already been contracted out to diverse organisations. However, as primary care services were now commissioned by NHS England, a national body, the mechanism existed to re-engineer them so that they could be configured – and thus contracted - on a national, regional or multi-regional basis. This allowed for a single, large, multi-year contract to be offered to provide these support services across England, a scale of contract considered more attractive than smaller scale opportunities by many private companies (Krachler and Greer 2015).

4. The marketisation of clinical services

A decisive shift in the delivery of health services occurred in the creation of market systems from the early 1990s. It is possible to construe the marketisation of clinical services in the NHS as taking place in three stages and this is used to organise the discussion here with greatest focus on the policies after 1997.⁹

4.1. The creation of an internal market 1991-1997

Until the early 1990s, the NHS was an integrated service in the sense that hospitals were run by health authorities within an hierarchical framework (national – regional – local – hospital) and were funded for their work not in a way relating directly to specified output but through a total sum of money, calculated annually through an incremental modification to the previous year's budget and passed down from the national level to the local level, to cover all activity. Under Conservative government reforms, hospitals were to be 'liberated' from their position in the hierarchy and were to lose the automatic allocation of cash for their overall activity. So-called purchasing organisations (purchasers) were to be separated from so-called providing organisations (providers). The new purchasers, District Health Authorities (DHAs) and GP Fundholders, would assess health need and contract with providers (e.g. hospitals and community units) for interventions and procedures to meet those needs. Hospitals would no longer be directly managed by DHAs but, as providers, would become self-governing NHS Trusts with greater freedoms to make their own decisions. Instead of receiving an annual financial allocation, they were to compete with each other, largely on the basis of price, for contracts from DHAs to provide health services (Cm 555, 1989; DoH, 1989).

4.2. Re-creating the market 2000-2010

In the run-up to the 1997 General Election, the Labour Party promised to abolish the internal market. It abolished GP fundholding in 1999 and moved away from competition. However, it retained the independent status of NHS Trusts and the

⁹ It should be noted there were modifications to the market and the intensity with which market forces were executed within each of these 'stages'.

purchaser-provider split. From the early 2000s Labour began to create the institutional structures of a competitive market. Purchasing was renamed 'commissioning' and was undertaken by local bodies covering a geographically defined area, Primary Care Trusts (PCTs). A new financial system was implemented in the NHS in 2004 which allowed payment for each specific procedure to flow to the provider of the procedure. At the same time, some limited patient choice pilots were introduced in London and, from 2006 onwards, all patients were able, at the point of referral for elective care, to choose from at least four providers and from 2008 from a list of nationally approved providers (Dixon et al, 2010). This list included NHS Trusts, numerous independent sector (i.e. for profit and not-for-profit) organisations and Labour's newly created 'NHS Foundation Trusts', apparently modelled on a Spanish forerunner, which had additional freedoms with regard to the services they provided and the financial and business undertakings they could enter into. This was effectively an 'any qualified provider' (AQP) policy, that is to say a model of competition whereby, from a register of approved providers, patients rather than commissioners chose the provider of the service.¹⁰

New Labour had actively to create a market in secondary care (Appleby, 2006; Leys and Player, 2011). As well as a contracting infrastructure, Labour's market-making included the creation of competitors. Foundation Trusts differed from NHS Trusts in several respects. Rather than being 'owned' by the Department of Health, they report to an independent regulator and are accountable to a local governing body elected by 'members' (local residents, patients, staff and other local stakeholders). They enjoy freedom from ministerial directives as well as substantial financial freedoms in relation to sales of assets, borrowing, investment, retention of surpluses and ways of incentivising staff (Baggott, 2007).

More radically, the Department of Health announced the establishment of independent sector 'Treatment Centres' (ISTCs) ostensibly to add to the capacity of the NHS (Cm 5503, 2002). These Treatment Centres offered fast track surgery in routine cases, along with some diagnostic services. Routine ophthalmology and orthopaedic surgery and cataract removals featured prominently but not exclusively in the services they provided (Player and Leys, 2008:8). In the event, the private companies which got these contracts were all based overseas and were trumpeted by the Secretary of State as offering capacity which was additional to that offered by the NHS. However, two factors give cause to question this assertion. The first is that these ISTCs were established in parts of the country where there were no waiting list problems which meant they created a competitive rather than supplementary presence (Health Select Committee (HSC), 2006). The second is that assurances initially given that the ISTCs would have to hire their own staff rather than pull staff out of the NHS were subsequently superseded by a policy which permitted the secondment of NHS staff (Player and Leys, 2008). The value for money assertions of the Department of Health could not be verified since the DoH refused to put the relevant figures into the public domain (HSC), 2006). While all NHS providers were subjected to uniform tariffs for procedures, ISTCs

¹⁰ Another model of competition, where the commissioner contracts out the provision of a service to an organisation on the basis of competitive bids for the contract, ran alongside this and was used in other aspects of health care.

were paid above this level and while NHS providers were paid only for the procedures they conducted, the first wave of ISTCs were guaranteed payment for a fixed number of procedures regardless of whether or not they actually performed them (Moore, 2008). In addition, the DoH guaranteed to buy back some of the Treatment Centres, removing or substantially reducing the risk to the private sector entailed in investing in the new facilities (Gainsbury, 2008). Overall, around £500m was given in public subsidies to these early ISTCs (Fotaki et al, 2013).

New Labour's market also required the construction of a patient population which was interested in choice or, more precisely, in a specific type of choice. This was essentially a market conception of choice (Fotaki, 2014): not the choice to discuss more fully different treatment options with an expert or to be assured of high quality care in local NHS institutions but a version of choice in which the consumer chooses from a number of suppliers. Patient choice had not historically been a dominant feature of the British NHS. Instead patients traded choice for free access to the treatment they needed from the local 'branch' of a cost-efficient and highly trusted National Health Service. A key founding principle of the NHS was that health care was allocated according to need and need alone. Research suggested patients held mixed views on the importance of choice to say the least (e.g. Fotaki et al, 2006) and ministers had to persuade NHS patients of the virtues of consumerism, for instance by disparaging the service as 'top-down', 'monolithic and 'one-size-fits-all', stifling diversity and choice (Milburn, 2001).

The assault on the cultural meanings given to health care was necessary to create a market in which people actually exercised a choice. However, the emphasis on choice also served as the surface construction of policy which covered over the underbelly of market competition, privatisation and profit making (or surplus extracting). Ministerial speeches couched developments not in terms of market efficiency but as 'modernisation' giving people a more personalised and convenient service and the choice they already expected in other areas of their lives (e.g. Milburn, 2003). Fixed tariffs per procedure (ITSCs notwithstanding) moved the system away from price competition. Instead, providers were expected to compete on efficiency and 'quality' and a selective amount of information began to be made publicly available relating to the performance of different Trusts and different surgeons (Lewis and Dixon, 2005).

Labour also applied market principles to primary care. A new GP contract in 2004 allowed PCTs to contract out GP services to 'Alternative Providers'. In ostensibly 'under-doctored areas', GP surgeries could be contracted out to private companies.¹¹ Across England, scores of contracts were let to alternative providers of primary care services under the Equitable Access Programme of 2007 (Roberts, 2014a). A move to reconfigure services by altering the boundary between hospital-based and community-based care through the creation of polyclinics or health centres also entailed competitive contracting out processes with a range of different organisations, including those in the non-profit and commercial sectors, awarded contracts (Kay, 2008).

¹¹ National Health Service (General Medical Services Contracts) Regulations 2004

The 2004 GP contract also permitted GPs, for the first time since the creation of the NHS, to drop the provision of services on a 24/7 basis. Ninety per cent of GP practices immediately abandoned responsibility for the provision of out-of-hours care, a responsibility they had found increasingly intolerable and burdensome (NAO, 2006; HSC, 2010a) and this figure has not substantially altered since (NAO, 2014). Primary Care Trusts faced the task of finding alternative providers of evening, overnight, weekend and statutory holiday primary care. This effectively led to the creation of a *de facto* market in these services. Some out-of-hours services were provided by groups of NHS GPs either as private companies or on a cooperative or social enterprise basis. Other providers were large commercial organisations such as Serco and Harmoni with a track record of contracting services from public agencies. This new market marked a shift towards the provision of medical care by overseas doctors employed on a locum basis by commercial providers (HSC, 2010a) and contributed further to a process in which out-of-hours care was increasingly given by nurses rather than GPs (NAO, 2006).

Labour planned also to apply market processes to community services such as health visiting, care for people with learning disabilities, district nursing and various types of therapeutic services (Cm 7432, 2008). Employed by the PCTs, these staff were initially at the heart of the organisation, then located in a provider 'wing' of the organisation, then at arms-length from the organisation and were then destined to be spun out as independent provider organisations in a new community services market. The anticipation of the 2010 General Election interrupted this process and under the Coalition government these services transferred in the first instance to one of the providing institutions of the NHS. From here, however, they have become subject to competitive contracting processes and, as discussed below, some of the largest private sector contracts within the NHS are in this sector.¹²

4.3. Restructuring the market 2010-present

Despite a pre-election promise to the contrary, the Coalition government prioritised a major restructuring of the health service, so that market forces were applied to a much wider range of health care in a context of more aggressive competition rules. Some of the main existing structures of the NHS were abolished after a period of double-running in which the newly emergent organisations operated in shadow form alongside them. Thus, Strategic (regional) Health Authorities and Primary Care Trusts (local) were abolished. Public health was taken out of the NHS and transferred into local authorities where it sits alongside other determinants of health such as urban planning and transport (though in a context of severe cuts to local authority funding).

The new principal commissioning bodies at a local level are 211 Clinical Commissioning Groups (CCGs) which are GP-led organisations and hold, across England, approximately 65% of the NHS budget (NHS England, 2013). They replace 152 Primary Care Trusts. They are composed of GP practices, typically within a particular geographical area, and are responsible for arranging most health

¹² Although Labour's market was primarily a 'provider' market, it should be noted that 14 organisations, including large US-based health insurance companies, were licensed in 2007 to 'assist' PCTs with commissioning.

care for the patients on the practice lists. They have some discretion as to which health services they wish to procure and they cover secondary care, mental health care and community-based services such as health visitors and therapists and ambulance services. They are required to engage in competitive processes in order to contract for health care except where a limited number of circumstances apply and they are prohibited in law from favouring one sector (e.g. the public sector) over another (e.g. the commercial sector).¹³ To strengthen CCGs in their commissioning role, commissioning support units offer a range of needs assessment and commercial services which can be bought in by the CCGs. Specialist services are commissioned by the local offices of a new quango called NHS England and primary care services by NHS England jointly with CCGs.

On the providing side of the market, any organisation can compete to provide health care and any organisation can apply to be licensed to offer services under the AQP provision. Thus, in theory in this revitalised market, small local charities and voluntary groups, large third sector not-for-profit organisations, social enterprises, small businesses, transnational corporations and public sector (NHS) organisations can all vie for business. They have the right to mount a legal challenge if they believe a commissioning organisation has not applied the rules of competition fairly. All NHS trusts are expected to become NHS Foundation Trusts with added freedoms regarding the services they provide and the financial undertakings they are able to enter into. NHS Foundation Trusts are also able to earn up to 49% of their revenue through private medicine and no longer need to focus primarily on NHS-funded patients. The longer-term expectation is that all NHS providers eventually become 'social enterprises' or 'mutuals' outside the public sector and some NHS trusts already have a 'mutual pathfinder' status.

The rules of competition are the responsibility of an 'economic regulator' which, under the auspices of the Competition and Markets Authority, defines the rules and enforces them, dispensing penalties for anti-competitive practices. It also plays a decisive role in acquisitions and mergers. The rules of competition are provided for in the 'Section 75 regulations'. These require CCGs to engage in competitive processes in the contracting of health care services in most instances. If NHS England or a CCG is accused of breaching the regulations (as has already occurred), it is the economic regulator's role to investigate the breach. There is a quality regulator which faces the daunting task of monitoring and inspecting all health and social care providers throughout England. Organisations seeking to provide services under AQP must be licensed by both the economic and quality regulators.

Potentially the most far-reaching element of the 2012 Health and Social Care Act, and the most symbolic, concerned the repeal of the legal duty of the Secretary of State to provide national health services in England - a duty which had existed since the birth of the NHS.

¹³ Some community services, at present a minority, are arranged through the Any Qualified Provider (AQP) process whereby registered organisations compete with each other to attract patients and CCGs pay those organisations according to the choices of patients for those specific providers. Other services are contracted out on a competitive bidding process.

5. Growing privatisation in clinical services

5.1. Hospital services

Although health authorities had been able to purchase services from private hospitals since 1981, the Conservative internal market of the 1990s did not greatly involve the private sector outside initiatives to reduce waiting lists (Givan and Bach, 2007). The internal market was overwhelmingly a system of contractual relationships and processes among public sector (NHS) organisations. The pathway to privatising clinical services was only really embarked upon within the context of New Labour's developing market structure. The NHS Plan of 2000 announced that the NHS would purchase health services from the private sector where it was advantageous and pragmatic to do so (Cm 4818, 2000). This was seen as a major watershed in the evolution of Labour's policy stance given its historic antagonism to the private health care sector. Labour's market structure enabled a diversity of organisations including commercial organisations to articulate with the NHS through the mechanism of the contract,¹⁴ particularly via the Extended Choice Network and Free Choice Network in the sphere of diagnostics and elective surgery, two fields of activity in which profit could be predictably made with limited risk. Inpatient mental health services have made significant use of independent sector providers for some years, reflecting a shortage of NHS capacity.

5.2. Community services

As mentioned above and originating under New Labour provisions, community based services such as therapists and health visitors as well as community hospital provision have been subjected to competitive market processes and this has resulted in some large scale transfers of provision to the private sector. An example is the £0.5bn contract awarded to Virgin Care in 2012 to provide all community services in North West and South West Surrey for a five year period and 2,500 staff transferred to the new employer. This included services in seven community hospitals, district nursing, health visiting, breast screening, wheelchair services, physiotherapy, prison health care and sexual health services (Adams, 2012).¹⁵ The new provider of these services retains the name of the previous provider, Surrey Community Health, arguably reducing the public visibility of the fact that these services have been transferred to a large private corporation.

¹⁴ It appears that the legislative basis for enabling transnational corporations and other profit making providers to be woven into a largely socialised health service as mainstream providers is an overlooked phrase in an obscure paragraph in the 2003 Health and Social Care (Community Health and Standards) Act (Section 175, para (2), subsection (b)) (Price, 2007).

¹⁵ At the time of writing, the Virgin Care website claimed the company provides 230 NHS and social care services across England, including primary care services (GP practices, urgent care centres, minor injury units, walk-in centres and prison care); intermediate care services (such as audiology, dermatology, ophthalmology, rheumatology, back and joint pain, ENT, ultrasound); and community services (such as those mentioned above plus neuro-rehabilitation, frail/elderly care, services for children with complex mental, physical and sensory learning difficulties and end of life care) (Virgin Care <http://www.virginicare.co.uk/about-us/>)

5.3. Out-of-hours primary care

NHS England does not collect data in relation to which organisations provide out-of-hours care. The National Audit Office reported, on the basis of 175 survey responses from a total of 211 CCGs, that commercial organisations held 31% of out-of-hours contracts in 2014 (with social enterprises, often former GP cooperatives, holding 49% and NHS bodies holding 20% of contracts) (NAO, 2014). This represents an increase on 2012 when an estimated one quarter of the English population was covered by a private out-of-hours provider (Primary Care Foundation, 2012). A 2015 analysis of patient survey data from 80,000 patients with recent experience of out-of-hours care found that on average commercial providers scored lowest on patient experience of care (Warren et al, 2015). An earlier assessment of private providers of out-of-hours care concluded that the service they provided was poorer than that of not-for-profit cooperatives run by GPs and NHS providers but was also more expensive than the not-for-profit cooperatives (Primary Care Foundation, 2012). The numbers of patients receiving care from out-of-hours providers has dropped markedly with 5.8m patients receiving such care in 2013/14 against 8.6m in 2007/8 (NAO, 2014). This decline has been attributed (NAO, 2014) to the triage system operated by another part of the urgent care system, the telephone helpline NHS 111, run through over 40 different contracts across England, a small number of which are for-profit contracts (Rimmer, 2012).

This has been an area of care dogged by scandal and criticism. Take Care Now, a company contracted by Cambridge Primary Care Trust to provide out of hours care, employed a German doctor who, on his first shift, killed a patient through the administration of an excessive dose of a drug with which he was not familiar. The investigation by the Care Quality Commission revealed numerous clinical and procedural weaknesses in the company (CQC, 2010) which was reported to be focussed primarily on cutting costs and expanding business rather than on the quality of patient care (Smith, 2010). Although the Primary Care Foundation (2012) reported overall improvement in out-of-hours services there have been numerous reports of dangerously low staffing levels in private providers. For example, just one doctor was reportedly available to 535,000 patients on some nights in Cornwall (Borland, 2012) in a service run by Serco which was also criticised for altering its reported performance data (PAC, 2013).

5.4. Expenditure on private provision

Calculating the extent of privatisation is complex. In an analysis of figures which pre-date the Coalition reforms, the Nuffield Trust reported that NHS spending on non NHS providers in 2011/12 was £8.67 billion (Arora et al, 2013) and £8.45bn of this was spent by Primary Care Trusts. Most of this (£5.22bn) was spent on private secondary care providers and accounts for most of the increase in spending on non-NHS providers in the previous five years, with £0.59bn spent on voluntary sector providers. The £8.67bn figure also appears to include £400m spent on out-of-hours providers (see Jones and Charlesworth, 2013:14 and HSCIC, 2012a) and £2.53bn

on services obtained via local authorities (Arora et al 2013). It excludes, however, spending on the vast majority of primary care (including prescribing costs) which is provided by GPs, dentists, opticians and pharmacists who are largely private contractors to the NHS or by the relatively new 'alternative' providers. This spending amounted to £21.6bn or 24% of PCT spending on NHS care (Jones and Charlesworth, 2013:14). These figures indicate that a little under a third of PCT spending (£91bn in total) goes to the private provision of clinical services. In addition to this, Trust providers spent a further £628.7m on PFI debt interest payments (which are increasing by about 18% each year) and £11.2bn on supplies and services (including drugs). These figures amount to around £42bn out of a total PCT spending on health in England of £91bn.¹⁶

It should be underscored that most of the spending on privately provided services and supplies (notably primary care, pharmaceuticals, supplies) is not new and does not result from marketisation since the 1990s. The new area of activity concerns spending on secondary care and community service provision. This is increasing rapidly (from £2.09bn in 2006/7 to £5.22bn in 2011/12 (Arora et al, 2013:14) but is still a small proportion of the overall NHS budget and is actually cited by the Department of Health as evidence that the NHS is *not* being privatised (Campbell, 2015).

A Freedom of Information request submitted by the *British Medical Journal* revealed that 33% of 3,492 contracts awarded by 182 CCGs between April 2013 and August 2014 had been awarded to the private sector. A further 10% had been awarded to voluntary and social enterprise providers and 2% to other providers such as joint ventures or local authorities (National Health Executive, 2014).¹⁷ The total value of all the contracts investigated was £10bn. Around £8.5bn worth of contracts went to NHS providers, £690m to voluntary and social enterprise providers and £490m to the private sector - 5% of the total. Private sector providers were most successful at winning contracts awarded via competitive tender - 80 compared with 59 won by NHS providers. Private firms were also more likely to win smaller contracts on an Any Qualified Provider basis, for services such as diagnostics, audiology, and podiatry in the community. A Centre for Health and the Public Interest investigation estimated that the NHS holds around 53,000 contracts with non-NHS providers, 15,000 of which are held by CCGs (CHPI, 2015).¹⁸

The challenges facing the private sector companies wishing to enter or expand in the NHS market remain considerable with uncertainties arising from periodic reorganisations and policy changes, commissioning practices, the scale of contracts, austerity funding and the competitiveness of NHS providers (on both cost and quality) frustrating the advance of privatisation (Krachler and Greer, 2015). Nonetheless, both the number of contracts awarded to private companies

¹⁶ Total departmental spending was £105.4bn in 2011/12 (Jones and Charlesworth, 2013). 6.1% of the NHS budget in 2013/14 was spent on commissioning private providers (Roberts, 2014b).

¹⁷ These included different types of contract to provide NHS clinical services, including those awarded to a single provider without the competitive procurement process of an open tender, those awarded via a competitive tendering process, and those awarded to multiple providers under Any Qualified Provider.

¹⁸ Most of these 53,000 contracts are with commercial providers but the exact proportion is not known (CHPI, 2015).

and the amount spent on private provision are rising and one estimate suggests spending on non NHS provision is rising twice as fast as the total budget (TUC, 2015).

5.5. Policy making

The advance of privatisation concerns not only the provision of services but also the process of policy-making. Throughout the past 15 years, private sector personnel have been appointed to positions in which they can facilitate or implement privatisation 'from the inside'. This can be seen in Labour's Partnerships UK, launched in 2000 and designed to capture and entrench expertise from the private financial sector to drive through the implementation of PFI, a notoriously complex policy (Ruane, 2010b). It can be seen in the 2003 establishment of the Commercial Directorate, staffed with individuals effectively on secondment to the Department of Health from private sector at a cost, per individual, of £1,000 - £2,000 each per day, to facilitate market creation and the process of bringing private sector providers into the NHS (Leys and Player, 2011:15). It can also be seen in some of the key institutions of the new post-2012 NHS market. NHS England which is mandated to run the NHS on behalf of the Secretary of State is headed by Simon Stevens who moved from his role as Executive Vice President of United Health Group to take the post. The economic regulator Monitor has a chief executive (David Bennett) and a managing director (Adrian Masters) who are both former senior directors of McKinsey (Private Eye, 2014). McKinsey is reported to have exercised considerable influence over sections of the 2011 Health and Social Care Bill and has been awarded a number of NHS contracts (Cave, 2011; Rose, 2012).¹⁹

It has become increasingly evident that tracking the privatisation of services presents a major challenge to those who want to monitor this level of detail. There is no national database which conveys a picture of the current and changing state of affairs. The notion of 'patchwork privatisation' a term coined in a campaigners' publication a decade ago (Nunns, 2006) remains apposite, with different services being contracted out to different providers at different speeds and on different scales in different parts of England.

6. The impact of privatisation on staff

It should be remembered that in many instances the use of competitive tendering and market testing did not result in privatisation. Instead, it might result in competitive bids being won by in-house teams (NAO, 1987; Givan and Bach, 2007) whose wages and terms and conditions were depressed, following the 1983 rescission of the Fair Wages Resolution of 1946 (Mohan, 1995). Most staff who have been affected directly are those outside clinical services, either NHS

¹⁹ All three individuals were involved in advising on or implementing Labour's market in the early 2000s with Stevens as health policy advisor to Tony Blair and David Bennett leading the No 10 Downing Street policy directorate and strategy unit, underscoring again the continuity of policy across different administrations. We also see here the 'revolving door' phenomenon whereby individuals pass back and forth across the state / private sector boundary altering the culture and functioning of state departments and regulatory bodies.

employees transferred to the private sector employers or new staff directly employed by the private contractor. As an example, the number of building services staff directly employed in the NHS declined almost 15% between 1995 and 2005 at the same time as the number of professional staff in the NHS rose by 33% (ICHSC, 2006).

As contracting out or transfer under PFI almost always occurs in a context of financial constraint and as a cost saving stratagem, staff find themselves reduced in number relative to the amount of work which has to be done. Their ability to perform the work to the standards they would wish is threatened and their own situation is also made more precarious. Although their trade unions have invoked legal protections and attempted to negotiate protective arrangements for transferred workers (Kerr and Radford, 1994), these staff had often been poorly paid and relatively easy to replace even before transfer though, as NHS employees, they did benefit from nationally negotiated wage settlements. The so-called TUPE protections²⁰ offered protection of terms and conditions and wages for transferring staff although it was possible for new employers to abandon these protections on economic, technical or organisational grounds. Additionally, transferred staff who subsequently change jobs or move to another private employer were likely to lose any protections they may have had including access to the NHS Pensions Scheme.

The introduction of multiple employers into the provision of services on a single site reduced trust, compromised accountability, undermined teamwork and resulted in a ‘two-tier workforce’, that is to say, the working alongside each other of workers in similar jobs on different wages, terms and conditions (Givan and Bach, 2007; Ruane, 2007). Where previously the NHS offered all employees relatively good pensions, competitive wages and continuity of employment across skill levels, the use of competition and the resulting decentralisation and fragmentation of employment have led to variations in employment practices resulting in reduced terms and conditions and loss of job security with a disproportionately heavy burden being borne by women (Givan and Bach, 2007). Over time, inequalities among workers increased (Ruane, 2007).

At the same time, some private employers improved their human resource practices as a result of their engagement with the public sector. Bach and Givan (2010) found that trade unions could, in some circumstances, exploit Labour’s avowed commitment that PFI would not be at the expense of workers’ conditions by demanding that the private employers treat staff reasonably. Effective campaigning by trade unions along with a recognition by government of the weaknesses of TUPE protections gave rise to a voluntary ‘Two-Tier Code’ in 2005 which required most new staff within private or third sector contractors to be employed on terms broadly comparable with (“no less favourable than”) those of public sector workers covered by Agenda for Change, the national framework for wage structures in the NHS (Grimshaw et al, 2007). However, some considered that the ‘Two-Tier Code’ offered weak protection. It was abandoned by incoming coalition government in 2010 (Santry, 2010).

²⁰ This refers to referring to Transfer of Undertakings (Protection of Employment) Regulations, replaced by Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014

Even when the Code was in place the Retention of Employment Agreement in force, the fragmentation caused by multi-employer working brought a number of inherent problems. One case study investigation explored relationships and practices in a PFI hospital, in which rank and file ancillary workers remained within the NHS but their supervisors and managers transferred to the soft facilities private provider. The researchers found fragmentation of the workforce across multiple employers blurred employment relationships and created inconsistencies and inequities in the way in which agreed human resource procedures were interpreted and implemented by the different employers (Marchington et al, 2011). Staff attitudes towards collaboration at work are conditional upon arrangements being consistent with fair treatment yet different custom and practice across the private and public sectors in the treatment of staff, especially approaches to performance management, contributed to perceived inequities. Opportunities for skills and career development which looked theoretically possible, were sometimes not realised in practice because of the reluctance of NHS staff to apply for promotions that would entail transferring to the private company with the associated uncertainty and loss of NHS pension. Developing identity and a commitment to the partnership were made more problematic by the high management turnover in the private company and by the stark contrast between the goals of the organisations with NHS staff perceived to be reluctant to sign up to the profit goals of the private sector. The researchers conclude that the challenges for human resource management in the management of cross-organisational working go beyond questions of culture and attitudes to problems inherent in managing employment where there is more than one employing organisation exercising influence (Grimshaw et al, 2010)

There is no obligation upon employers to recognise trade unions outside general employment law and recognition needs to be sought on an employer by employer basis (Unite, 2013). The sheer multiplicity of providers leads to both fragmentation of services and fragmentation of bargaining and undermines the sustainability of a national agreement on wages, term and conditions. While there has been only limited movement towards local bargaining on terms and conditions in NHS organisations even among Foundation Trusts which in principle can opt out, fragmentation of provision poses resource-intensive challenges for Trade Unions of recruiting new members, securing recognition and entering into bargaining across multiple sites many of which are less procedurally orientated than is the case in public sector industrial relations (Bach, 2011). The shift towards market systems leads to the reliance of NHS organisations on revenue generated from successful competition for contracts rather than the previous more predictable planned allocation of funding and vulnerability to decisions of the economic regulator regarding the level of tariffs which are increasingly squeezed in times of financial constraint. These factors increasingly set the key parameters shaping what can be achieved through bargaining or, more precisely, through the arm's-length bargaining mediated by the pay review bodies (Bach 2011).

In 2013, the NHS Pensions Scheme was opened up to employees who are compulsorily transferred to private providers although continued access to the Scheme is dependent upon the private employer meeting certain requirements. This

benefitted employees but simultaneously removed one of the most substantial political and economic obstacles to privatisation.

7. Some of the consequences of choosing the market

Although short-lived, the 1990s internal market enabled the Conservatives to establish the principle of the purchaser-provider split. Despite numerous subsequent reorganisations of the NHS, the enduring consequences of this decisive organisational shift are evident. After 1997, New Labour abolished GP fundholding but did not abandon the purchaser-provider split. It never reintegrated NHS trusts, and their management within a hierarchical framework was never restored. The establishment and retention of the purchaser-provider split, which has endured to this day, creates the skeletal framework for a market system which both New Labour and the Coalition government have elaborated. Thus not only was the principle of the purchaser-provider split embedded but with it the possibility of a market and through this it became possible to establish a health system which combined public funding with part-privatised provision. In the years following 1997, New Labour could have moved in another direction, away from the market. However, the marketisers, within the parliamentary party or advising ministers, prevailed. So, in the early to mid-2000s, New Labour confirmed the entrenchment of the market principle in health care, with the accompanying elements of contracting and competition, fatally damaging its ability to contest the Coalition government's legislative proposals after 2010 which ushered in a more far-reaching and all-encompassing market with legal protections for private providers

The restructuring of the NHS as a market established processes and structures which required new types of data and new skill-sets. The market required that organisations draw up contracts and in order to do so they had to know how much their services cost and what to charge for them.²¹ Discovering how much services cost required measuring various inputs which in turn required increasingly complex information and data management systems. Thus the creation of the market brought about a burgeoning in the resources required not only to run the market and manage it but also to address and solve a range of problems arising from it. In this way, the establishment of the market, competition and contracting provoked the emergence of a new set of system gaps or weaknesses: for instance, system weaknesses in contracting, measurement, data handling and data sharing.

The result was unsurprisingly a large expansion in the numbers of people employed in the NHS in administrative and management rather than clinical or caring roles. While the number of full time equivalent staff in Community and Hospital Health Services increased by 3% between 1999 and 2009, the full time equivalent number of staff in management and senior management roles increased by 6.2% and those in 'central functions' increased by 4.9% (HSCIC, 2012b). These figures do not tell us precisely how many staff were working in roles associated

²¹ Even under New Labour's market, where the price for procedures was fixed and competition was ostensibly on the grounds of efficiency and quality, the Department of Health had to collect information annually from NHS providers to discover what the costs of producing services were in order to arrive at a national 'average' which was used to fix the next year's tariffs.

exclusively with market-related functions (i.e. whose jobs would not have existed but for the market) but they do suggest that, as the NHS was restructured and reorganised on market lines, it required a disproportionately higher number of staff undertaking management functions.

As all of this indicates, the cost of running the health system has increased substantially over the period. The Health Select Committee reported in 2010 that the administrative costs of the NHS, based on unpublished research using 2003 data, amounted to 14% of the budget annually (Bloor et al, 2005; HSC, 2010b). This is a significant increase on 5-6% in the 1970s (Webster 1996) and before the subsequent roll-out of Labour's market. Calum Paton (2014) has estimated conservatively that the annual recurrent cost of the *market* aspect of the service is around £4.5bn. (He has also estimated that the cost of setting up the markets under New Labour and the Coalition government was £3bn each.)

The 1990s hospital trusts had considerable discretion regarding the terms and conditions upon which they employed staff although in practice most did not move away from nationally bargained conditions of work. They did however use their greater autonomy to alter or 're-engineer' elements of the labour process, including work organisation, skill mix, working time arrangements and the use of temporary contracts, altering the composition of the workforce as they did so (Grimshaw, 1999). Where previously staff had enjoyed relatively good conditions of work and continuity of employment, the creation of self-governing trusts in the 1990s saw the beginning of a process by which these have been eroded. Certainly, employment practices have had a 'harder' edge to them since then.

8. Popular resistance to marketisation and privatisation

One of the consequences of marketization and growing privatisation was the emergence of groups of citizens organising to resist further developments. This resistance was at its strongest and most coherent during the campaign to oppose the 2011 Health and Social Care Bill. This case study also demonstrates the resolute determination of government to persist with its marketisation programme regardless of the scale of opposition.

Popular resistance to the Coalition government's legislative proposals was organised in a networked and horizontal fashion typical of protest movements in the digital era (Castells, 2012; Mason, 2012; Scambler et al, 2014). Although somewhat patchy and often lacking in strong coordination and clarity of strategy, the relationships among campaigning organisations and campaigners were extensive enough to constitute a loosely connected opposition movement.

Outside the labour movement and professional organisations, several different hubs of activity contributed to lobbying, raising awareness and organising symbolic and other events. 'UKUncut' organised temporary occupations of banks (held responsible for the financial crash and austerity politics) or companies known to avoid taxes (held responsible for depriving public services of much-needed funding). 'Occupy' mounted a huge occupation of the courtyard in front of St Paul's Cathedral over several months and branded a one-day occupation of the bridge across the Thames at the Palace of Westminster. '38 Degrees', an

organisation linked to ‘members’ through an extensive e-list, emerged onto the activist scene and launched several innovative e-actions. ‘Keep Our NHS Public’ (KONP), a national umbrella campaign formed in 2005, brought expertise in relation to health policy *per se* to the resistance movement and comprised local groups and a national steering committee (itself arising from a partnerships of three pre-existing organisations plus senior members of the medical profession and academics) in a fairly loose network of collaboration and affiliation. By 2010, more than twenty local groups were affiliated to Keep Our NHS Public. A wider range of local, unaffiliated, anti-health service cuts groups also became active in the anti-reform campaign. These groups varied significantly in size, composition and leadership.

These organisations, along with individuals who did not readily belong to any of them, participated in an e-connected network, sometimes planning events and interventions together, sometimes supporting each other’s actions by sharing and disseminating information about them, sometimes operating independently.

With regard to the 2011 Health and Social Care Bill, the overall aim of this opposition movement was essentially a defensive one: to maintain the status quo as a minimum and to halt the passage of the legislation. Strategically, campaigners sought to create a cleavage between the dominant Conservative Party and junior Liberal Democrat Party in government; to forge an alliance with other opponents of the bill; to persuade the Labour Party to oppose the bill more vigorously; and to expose the dangers of the bill in order to widen public opposition and persuade wavering organisations to oppose.

The most significant feature of the political context was the status of the government as a coalition, the first British peacetime coalition government since the 1930s. This created a built-in fault-line in government and there was some speculation as to the stability of the arrangement, the likelihood of an early general election and the pressure points which might bring about change in government policy. One strategy for many campaigners was to peel the Liberal Democrats away from the Conservatives on the question of health reform. The intra-party split in the Liberal Democrats between the more left-leaning ‘social liberals’ and the more right wing ‘orange book liberals’ offered the prospect of party indiscipline as grassroots party pressure could be anticipated – and provoked – on a leadership which had moved rightwards on health. The campaign seized this opportunity by mounting a sustained lobbying of Liberal Democrat MPs and peers. This was particularly marked at moments in the parliamentary or party decision-making processes and took the form of direct pressure through letter writing and indirect pressure through lobbying of grassroots Liberal Democrat members. Briefing papers were produced and template letters were devised at various stages of the campaign and disseminated to groups and individuals across the country to increase the amount of correspondence and the pressure on Liberal Democrat parliamentarians and cross-bench (i.e. non-aligned) peers. The most intense pressure was reserved for the Liberal Democrat conferences. A fringe event jointly organised by KONP and the disaffected social liberal group within the Liberal Democrats, had the effect of stalling but not halting the passage of the bill. Despite the huge effort expended on this kind of parliamentary engagement, all but a tiny number of MPs and peers voted along party lines.

The creation of an alliance among opponents of the bill proved impossible. Both the parliamentary Labour Party and the Labour-affiliated trade unions retained a distance from the campaigning organisations, at least at a national level (locally there could be more collaboration). Labour's strategy was largely a parliamentary one aiming, by means of reasoned argument, to persuade Liberal Democrat MPs to vote against the bill and the parliamentary Labour Party's engagement with the public was weak (Ruane, 2012). Trade unions opposed the bill and produced useful briefing papers and campaign materials but their opposition had limited visibility to the public and they did not give leadership to the campaign of opposition. By March 2012 when the newly passed Act received royal assent, the majority of the main professional health associations had declared their opposition to the bill (including the Faculty of Public Health, the Royal College of Nursing, the College of Emergency Medicine and the vociferous Royal College of GPs) but often not until late in the process. Neither the Royal College of Physicians nor the Royal College of Surgeons in England opposed the bill. Perhaps most surprising was the persistent refusal of the leadership of the British Medical Association (BMA) to oppose the bill, until late in the campaign. The BMA acts as a trade union for doctors and has been historically a highly influential pressure group. It had previously indicated its opposition to advancing marketisation and privatisation (BMA, 2010). In several instances, professional organisations belatedly shifted to a stance of opposition to the bill following coordinated action by their grassroots members (see Davis and Wrigley, 2013).

The campaign to defeat the bill was non-violent and deployed an impressive array of actions, techniques and materials. Many of the methods used by campaigners were conventional in the sense of participating in the formal mechanisms of democratic involvement. KONP organisers produced a number of critiques, public letters, leaflets, briefing papers for use nationally or locally in raising public awareness. Several waves of large scale letter-writing to parliamentarians were coordinated. In addition, a range of more inventive and creative approaches was adopted. Local demonstrations and rallies were organised, often piggy-backing opposition to the legislation on top of opposition to anticipated local service cuts. Several occupations of banks were organised by UKUncut where 'hospitals' were set up; performances of specially written songs, poems and dances were staged outside the Department of Health or in other locations. One of the really notable features of the campaign was the re-emergence of the protest song, disseminated by YouTube, and ranging from the balladic to rap. 38 Degrees launched petitions designed to demonstrate extensive opposition to elements of the bill. It also raised tens of thousands of pounds from their 'members' to commission legal advice regarding the implications of the bill for accountability and competition law and to run a billboard campaign in London imploring the prime minister to listen to the bill's critics. The Occupy the Bridge demonstration, filming of which was widely disseminated through YouTube, attracted a few thousand participants and was one of the few campaign actions to achieve coverage in the mainstream media.

Explaining why the bill succeeded despite substantial opposition requires longer discussion but, in brief, contributory factors were: the ambiguity of the Labour Party's position given its previous record on marketisation and privatisation and its

parliamentary focus; the decision by the major trade unions not to prioritise the NHS bill in a context of multiple and simultaneous assaults on the welfare state and labour rights; the reluctance of trade unions to forge closer links with the non-union campaigning organisations, preventing the wider dispersal of the campaign's message; the excessive focus on the parliamentary process at the expense of building up distributed grass roots activity across the country; and the hesitancy on the part of professional organisations to engage in open political conflict with government. Campaigners also singled out the BBC for criticism, particularly its framing of the proposals, the absence of BBC expertise available to analyse the proposals and the extremely limited coverage given by the BBC to the campaigners' case and actions (Huitson, 2013).

9. Concluding discussion: what future for the integrity and sustainability of the NHS?

The privileging in this paper of pro-market and pro-privatisation policies serves to emphasise and illuminate a particular policy trajectory in which all three main British political parties are implicated even if in other aspects of health policy they differ.

Theorisations of these developments vary. Leys and Player (2011) believe policies since 2000 represent a dismantling of the NHS through a 'plot' – a plan of change the true meaning and consequences of which are hidden from the public and parliament. They acknowledge that not all those behind marketisation favoured privatisation instead believing that market processes and competition could be 'harnessed' in a 'managed and planned' way to improve efficiency and deliver a more personalised service. Other actors, including some politicians, leaders in the independent health sector and advisers from neoliberal think-tanks, were from the outset privatisers. Either way, Leys and Player suggest, the distinction became less relevant over time since marketisation increases the probability of privatisation. Klein (2013) believes no privatisation or destruction of the service is underway and that critics have exaggerated the importance of structural changes and ignored the effect of implementation processes and pre-existing occupational sub-cultures in frustrating government ambitions to make real changes. There is perhaps greater agreement among policy theorists that ideology especially within the Conservative Party plays a stronger role from 2010, with Taylor-Gooby and Stoker (2011) seeing the Coalition's programme of widespread restructuring and shrinkage of provision across the welfare state as motivated more by ideological convictions or political objectives than by economic or fiscal ones. Hunter (2013) believes ideological conviction, the revolving door phenomenon with senior managers passing to and fro across public and private boundaries and the close connections of private health care companies with management consultancy corporate donors to the Conservative Party are all relevant in understanding the drive to push through the 2011 Health and Social Care Bill.

Paton's (2014) analysis is more complex. A more detailed study of policy over the period would identify zig-zags and even contradictions, he claims. Paton believes health policy since the introduction of the internal market in the 1990s can be understood through combining a 'garbage can' model of policy with an

appreciation of the role of ideology. At various stages, a 'key idea' has emerged with policy 'solutions' being proffered by policy salesmen (advisers and think-tank health specialists) in response to ill-defined problems or unasked questions. Thus action occurs at a decision point when a powerful interest or advocate succeeds in labelling an issue or pseudo issue as a problem which must be solved. These decisions are short-termist and can be contradictory. Over time, though, and with hindsight, it is possible to see a clear privileging of the market as the main idea in reform. Paton posits that there is an overall ideological context, trend or bias in reform. The idea of the market has not become dominant because of a rational assessment of the evidence but because of a naïve anti-statism, especially a rejection of an often misleadingly defined 'centralist state'. Paton suggests this anti-statism was, initially, not primarily driven by a desire to benefit private interests but by politicians' beliefs about what is necessary to be 'relevant'. Over time, private interests have become more entrenched and more recent policy may, he concedes, have been more based on their overt role.

Although the continuity of pro-market and pro-private policies across Labour and Coalition governments should not be understated, one significant distinction lies in policies on access. Labour sought to enhance access through increasing the opening hours of some services (especially in primary care) and through an overall expansion in available services underpinned by the most generous funding regime in the history of the NHS (Cm 4818, 2000). The policies of the Coalition, however, are likely to reduce access over time (Pollock and Price, 2012). In the field of public health some services which used to be free at the point of use through the NHS have now transferred to local authorities and may be chargeable, impinging on access. Where Labour's market retained the legal duty of the Secretary of State to provide a comprehensive health service (operationalised through an extensive list of services), under the Coalition's market neither the Secretary of State nor the local CCGs have a legal duty to secure comprehensive health care. Instead, CCGs can decide what it is 'reasonable' to provide for the patients on their lists (Pollock and Price, 2012). Without a legal responsibility to *provide* comprehensive care, there can be no corresponding *entitlement* to it on the part of members of the public. This is where levels of funding for the service become important. Much of the additional expense of Labour's market was offset by very high increases in annual funding: 5.5% on average between 1997 and 2009 after inflation (Appleby, 2015). Under the Coalition (and now Conservative) government, however, austerity funding has afforded the NHS just 1% average annual real terms increases challenging the service to find over 3% annual cuts or efficiencies to deal with growing need and other cost pressures (Adams et al, 2012). As funding constraints bite, it is likely that gaps in provision will open up and patients will be faced with a choice between paying privately for the unfunded health care they need or going without. Thus, reforms apparently designed to change the market structure of the health system could usher in a change in both the coverage and the funding base of the health system

The gradual move to a defined package of care which may be the current direction of travel will allow politicians to claim NHS care is still free at the point of use but in reality citizens' entitlements will have been radically altered. Additionally where Labour's Primary Care Trusts commissioned services for the

whole resident population in a defined geographical patch, it can be argued (Pollock and Price, 2012) that the new CCGs are legally required to purchase care only for those on their lists and to provide no more than emergency care for those not on their lists. Thus, in terms of the founding principles of the NHS, universality, comprehensiveness, the allocation of health care according to need and access to health care free at the point of delivery, all appear to be under threat.

The NHS is run at arm's length through a quango, NHS England (in theory at least). Neither CCGs as commissioners nor providing organisations are accountable to the Secretary of State. Although health ministers may still be questioned in Parliament there is a growing range of activities in which ministers no longer intervene. There are also growing areas of data which are no longer collected nationally and which are therefore more difficult for academics, journalists or members of the public to obtain. Private organisations are not bound by the 2000 Freedom of Information Act and thus cannot be held to account in this way although public agencies which contract their services are required to make available to the public certain information about the contract. The resources private companies expend on providing services including bed numbers and staffing levels and details of the organisation of their work are protected from public scrutiny and often come to light only when something goes wrong. Because public bodies themselves are engaged in commercially sensitive activities they too may seek to keep certain information out of the public domain. Local health scrutiny committees cannot expect to be given commercially sensitive information. Thus market competition and commercialisation have weakened the accountability of the service.

The sustainability of the NHS is vulnerable for political rather than financial reasons. Financially, the service itself is not unfeasibly expensive. Department of Health expenditure in England for 2014/2015 was roughly £113bn²². The Nuffield Trust (Adams et al, 2012) has calculated that the service needs a real terms increase of 4% annually to continue to deliver services on the current basis in a context of health specific inflation, patient expectations and growing need (arising from changes in size and structure of the population changes, the profile of illness and technological innovation). Taking onto consideration average economic growth of around 2.0-2.5% each year (OBR, 2015), tax measures to raise the remaining necessary funds are entirely conceivable. The idea that the NHS is a funding 'black hole' is a fallacy.

The main threats to the NHS are political. One aspect of this is talking up a crisis in the sustainability of the service by invoking concerns around the ageing population, the changing burden of disease, funding constraints, lifestyle-related risks and rising public expectations (e.g. NHS England, 2013). Several organisations have suggested that the introduction of charges needs to be at least considered (e.g. NHS Confederation, 2013; Cawston and Corry, 2013) and/or that the service can be sustained only through radical restructuring which in practice entails the closure of whole hospital departments and the loss of thousands of beds (e.g. NHS England, 2014) and this policy is being pursued in many local health

²² The UK GDP is £1.823 trillion as estimated in April 2015 (IMF, 2015) *Report for selected countries*. International Monetary Fund.

economies. However, this is misleading. The additional revenue needed for the service annually is relatively modest and the NHS has been recognised as one of the most cost effective health services among developed countries (Davis et al, 2014). The NHS already has one of the lowest bed-per-head-of-population rates in the developed world (OECD, 2014). Nonetheless, alongside a drip-drip of negative news stories, repeated claims that the service cannot continue without radical change contribute to undermining public confidence in the affordability and sustainability of the NHS and help convince the public that change is not only inevitable but also desirable.

Policies pursued by government themselves contribute to undermining the service. The creation and retention of a market system reflects a deliberate policy choice to increase costs because of the infrastructure required to run the service as a market. The election of PFI as the means by which new facilities will be procured again reflects a political choice for a high cost option. Decisions about the funding level for the service are clearly political as are decisions about the structure of the tax system through which government revenues are raised. The Conservative government, elected in May 2015, has signalled its wish to move to a 'higher wage, lower tax, lower welfare country' (Osborne, 2015). Tax revenues in 2014/15 as a proportion of GDP were lower than in every year in the decade leading to the financial crash (HM Treasury, 2015:5). Policy decisions to reduce the tax take relative to what it would have raised (and to hold public sector wages down compounding the problem) compromise the ability of government to sustain the funding of its public services including the health service.

Looking to the policy framework beyond the UK, the impact of successive waves of marketisation has been to re-define health care as an economic activity and thus make it potentially vulnerable to the provisions of international trade and competition law. For instance, the new NHS market is overseen by the sector-specific economic regulator and the more generic UK competition authorities. Thus, it is likely that the NHS would fall within the purview of the Transatlantic Trade and Investment Partnership (TTIP) being negotiated between the EU and the US and enthusiastically supported by the main political parties at the time of writing. These provisions currently prevent preferential treatment being given to NHS providers and potentially prevent the renationalisation of the service where corporate interests are considered to be damaged by such a policy (Hilary, 2014).

Overall, then, the NHS in England looks as if it will continue to reduce the proportion of the service which is publicly provided and may make modest steps towards a stronger element for private funding. Both marketisation and privatisation look set to continue.

10. References

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