
An Outline of Marketisation Processes in the English NHS On The Basis of Marketization Theory

Final Report for the Research Project “The Effects of Marketization on Societies: The case of Europe (TEMS)” Led by Professor Ian Greer at the University of Greenwich

Report written by Nick Krachler, Associate Consultant at the University of Greenwich

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1. Introduction: Marketisation Phases and Forms in the English NHS

In March 2013, 1.57 million people were employed by the NHS in the United Kingdom (Office for National Statistics 2013: 8) while in March 2012 669,593 nurses, midwives and health visitors were registered (RCN 2012: 6; that is to say, around 40% of the NHS workforce belongs to the nursing profession). Net satisfaction with the way the NHS is operated has been positive since 2003 with a figure of just below 40% in 2012 (see Appendix 1). It has one of the best performances in terms of health outcomes in Europe despite considerably lower overall expenditure than many other countries (as a percentage of GDP, the UK spent 8.7% versus France’s 11.2% in 2011; Appleby 2011). At the same time, however, the NHS has regularly been reorganised since 1974 with at least 15 major reorganisations in the past 30 years and few systematic reviews of the benefits accrued from these reorganisations (Walshe 2010).

Equally since 1983, the NHS has been incrementally marketised with the intensity of marketisation increasing from the Conservative Government (1979-1997) via New Labour (1997-2010) to its completion with the current Coalition Government’s Health and Social Care Act 2012. Despite this (or perhaps rather: in order for this to happen), its fundamental character of being a universal, tax-financed health system which is free at the point of delivery has not been changed.

The forms that marketisation has taken across this period have varied from consumerism, general management, competitive tendering and cost-cutting to increased contractualisation, performance management, market entry creation for private providers and finally, relinquishing accountability and handing over a large amount of decision-making power to GP-led consortia. These processes have primarily occurred in the English NHS, since it covers 85% of the UK population (Heins/Parry 2011: 382) and devolution in 1999 has led to a reversal of marketisation processes in Scotland and Wales (Leys/Player 2011: 150-153). The

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1 The notion of marketisation employed here refers to the conceptualisation by Greer and Doellgast understanding marketisation as constituted by a transaction “in which actor choices are made purely on the basis of price, the good or service in question is standardized, exchanges are frequent, and competition is open to a wide range of participants” (2013: 3). Marketisation in this sense leads to moves from cooperative decision-making and influencing (“voice”) to an exit from such arrangements (ibid.: 9), as well as changing the nature of economic activity from a productive type to a non-productive type accompanied by private regulation (ibid.: 11).

2 In a review of evidence regarding explanations of the “Scottish Effect”, which refers to the fact that Scotland has had the highest mortality rate in the whole of Europe since 1950 (McCartney et al. 2012: 460), the authors find no evidence of particularly poor performance of the Scottish NHS (ibid.: 464). The most convincing evidence is found for a higher prevalence of negative health behaviours (ibid.: 466) combined with the impact of Thatcher’s “neoliberal political attack” (Collins/McCartney 2011: 510f.) leading to deindustrialisation, higher unemployment and the privatisation of council housing. In this sense, Thatcher’s neoliberal reforms had a detrimental impact on Scottish health via structural changes which did not affect the NHS.
following analysis of marketisation processes in the NHS will therefore focus only on the English NHS and on the most pronounced reorganisations. After laying out each government’s contributions to the marketisation of the NHS, a review of the effects of these measures on voice and on productive economic activity will conclude the essay.


From its creation in the 1946 National Health Service Act until 1974 the NHS’s history boasts little in the way of marketisation. Up until the international crisis of 1973, which led to the decline in general economic growth and of profit rates in real production (Harvey 2005: 158), the NHS was dominated by technocracy, rational planning and general Keynesian policymaking (Klein 2006: 46). The relevant actors were civil servants and ministers, the medical profession, other clinical staff and ancillary workers (ibid.: 52). The 1970s were primarily relevant as the decade in which the NHS workforce became increasingly militant (see section 5 below). However, following the international oil crisis in 1973, the Conservative Government, which was in power from 1970 to 1974, implemented a reorganisation of the NHS in 1974 starting the move to using reorganisations as a means to increase efficiency. Along with a system of three tiers (Regional, Area and District Health Authorities) in which each tier had professional advisory committees, the 1974 reorganisation created Community Health Councils (CHCs; Klein 2006: 69). CHC staff were appointed up to 50% by local authorities, one sixth by the Regional Health Authorities and one third was chosen by local voluntary bodies. They were designed to give voice to patients understood as consumers by being able to raise concerns over issues in all NHS hospitals via the referral of proposals to the Department of Health and Social Security (DHSS; ibid.: 84). CHCs were abolished in New Labour’s NHS Plan in 2000.

Apart from the introduction of reorganisations as a mechanism for efficiency increases and CHCs as a form of consumerism, the most fundamental contributions to marketisation by the Conservatives in the 1980s were the introduction of General Management via the 1983 Griffiths Report and a DHSS directive issued in 1983 to all health authorities stipulating that all ancillary services were to be put up for competitive tendering amounting to 12% of NHS expenditure (ibid.: 128). The Griffiths Report was an inquiry into management structures in the NHS led by the then managing director of Sainsbury’s Roy Griffiths with a team of 3

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3 A more detailed chronological listing of each government’s measures is presented in Appendix 2.
4 Available online under: http://www.nhshistory.net/griffiths.html (last seen 05.09.13).
(Gorsky 2013: 89). Its main conclusions were that general management structures should be established at all levels of the NHS and that an NHS Management Board be set up. Overall, the implementation of the recommendations was ineffective, since only 12% of the new general managers came from outside the NHS due to the NHS’s low remuneration (ibid.: 103). However, the long-term impact was fundamental, since a function dedicated to cost-cutting, efficiency increases and workforce management was created, and an attack launched on the dominance of the medical profession. Whereas before the introduction of general management, patient needs and quality standards were determined solely by the medical profession (ibid.: 121), general managers from 1983 onwards had to incorporate an orientation towards consumers, and a staff reduction of between 0.75% and 1% via manpower targets was mandated by the DHSS in 1983 (Seifert 1992: 32). Furthermore, despite leaving the clinical aspects of service provision within the authority of doctors and nurses, the overall operations management of hospitals was placed into the realm of general management by the 1983 reforms (Kowalczyk 2002: 120). Regarding the contracting out of ancillary services, the immediate effect was equally weak, as only 18% of contracts were won by private entities (Klein 2006: 128); the long-term impact, however, was also fundamental, as it called the security of public sector employment into question and led to the reduction of ancillary workers from 260,000 in 1981 to 120,000 in 1994 (Leys/Player 2011: 24).

The most fundamental change brought about by the Conservatives was, however, the creation of an internal quasi-market through the National Health Service and Community Care Act in 1991. Firstly, this meant that the functions of purchasing and providing were split, secondly, the option of becoming fundholders was given to general practitioners (GPs) and thirdly, hospitals were turned into self-governing trusts the boards of which were named by and accountable to the Secretary of State for Health, and which could deviate from national pay agreements for consultants (Klein 2006: 156). The purchaser/provider split meant that GPs and District Health Authorities (DHAs) would purchase services from hospitals or local authorities on behalf of their patients via contracts. Fundholding meant that GPs could receive budgets for the whole year, which they would administer at their discretion resulting in the possibility of earning surpluses (which they could keep and reinvest in their practice). Trust status for hospitals resulted in the possibility of competition in secondary care, as GPs could also purchase from private providers, but trusts were not able to retain surpluses, as they were publicly owned and their surpluses returned to the government (Propper/Bartlett 1997: 15).

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5 The remaining general managers were existing administrators (66%), clinicians (15%) and nurses (10%) (Gorsky 2013: 103).
It should be noted that the 1991 internal market can be characterised as a quasi-market, since trusts had little incentive to achieve surpluses, they were highly regulated, were not able to compete on prices (ibid.: 17) and DHAs could not switch providers themselves, as their impact on public health would have been too great (ibid.: 19). Furthermore, DHAs were instructed to bail out failing trusts (Le Grand et al. 1998: 131) and overall, there was only little measurable change due to the internal market in terms of efficiency, equity, quality, choice and accountability (ibid.: 129). However, in their study of 4 different trusts, Lloyd and Seifert showed that the internal market had negative effects on workforce management (particularly in terms of work intensification, the lack of filled vacancies, and measures to reduce absenteeism) (1995: 373), as well as flexibilising employment conditions for new staff (ibid.). What is more, the internal market had intensified the tendency already visible in the 1974 reorganisation of increasing administrative costs which rose from 9% of total revenue in 1988/89 to 12% in 1994/95 (Le Grand et al. 1998: 121). Lastly, the use of fundholding had created financial incentives for GPs and contracts were introduced as a central coordination mechanism throughout the NHS. Though competition was limited, it was in 1991 that first elements of it were introduced.

3. The Labour Governments and Marketisation: 1997-2010

Labour’s first White Paper in 1997 entitled “The new NHS: modern, dependable”6 retained the split between purchaser and provider by creating Primary Care Groups (PCGs; groups of GPs that could gain more independence by turning their PCG into a Primary Care Trust). PCGs effectively meant the universalisation of GP fundholding (Klein 2006: 193), since they received allocated budgets calculated via a weighted capitation formula (meaning resources calculated per person and weighted for average age and mortality in the geographic region of the PCG; Pollock/Price 2011: 301). Apart from this, an increase in targets and performance management was established via Public Service Agreements in 1998 (Gay 2005). From 2000 to 2002, New Labour implemented their “The NHS Plan. A plan for investment. A plan for reform”7 which further intensified performance management, but also raised annual real expenditure by 6% leading to 50,000 more doctors and 100,000 more nurses and midwives (Tailby 2012: 451). In addition, it shifted the GPs contracting partner from the Secretary of

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6 Available online under: http://www.archive.official-documents.co.uk/document/doh/newnhs/contents.htm (last seen 05.09.13).
State to PCTs (Heins/Parry 2011: 388) and introduced Treatment Centres, renamed in 2002 to “Independent Sector Treatment Centres” (ISTCs; Bishop/Waring 2011: 319). ISTCs are private organisations (for-profit, social enterprises or charitable organisations) that provide elective services. By 2007/2008 there had been 34 ISTCs providing only 1.8% of elective care (ibid.). Though the numerical impact of ISTCs remains relatively small, they constitute a first entry point for private providers in secondary care.

In 2003, a further major push in the direction of marketisation in secondary care came via the Health and Social Care (Community Health Standards Act) 2003 which introduced the possibility of foundation trust status and payment by results. Foundation trusts are owned by the state, but designed to be more autonomous (like ISTCs), since they are not accountable to the Secretary of State for Health, they can keep surpluses, may borrow from any lender (though the height of borrowing is limited by Monitor) and have a board of governors voted in by local people (Allen 2009: 380). Furthermore, they can deviate from national agreements in paying consultants and their resources are allocated using ‘payment by results’, which refers to payments for each treatment determined by national tariffs, rather than in lump sums for a lot of patients (creating an increase in payment costs, but also more payment accuracy). By 2011, around 125 of 200 NHS hospital trusts had acquired the status of foundation trusts (Leys/Player 2011: 23). In essence, foundation trust status allows hospital trusts to act more flexibly and more competitively while being regulated by Monitor, an agency, instead of directly by the state.

Marketisation processes in primary care were complemented in 2004 by creating market entry for private primary care providers via the 2004 GP General Medical Services (GMS) agreement. Before the 2004 GMS agreement, GPs remuneration was set by a national agreement called “The Red Book” (Pollock/Price 2011: 298). Essentially, the GMS agreement contained four separate contracts: a Personal Medical Services contract, originally signed in 1998 but revised in 2004, a PCT Medical Services contract (regulating the salaries of directly employed GPs), a GMS contract and an Alternative Provider of Medical Services contract (allowing flexible salaries for GPs and employment of private sector GPs, as well as the ability to contract extra services such as immunisation). The GMS Agreement was regulated by the Quality and Outcomes Framework [clinical targets determining remuneration and set by the Department of Health (DoH)] (Heins/Parry 2011: 388). Furthermore, the GMS Agreement meant that GPs could opt out of out-of-hours coverage which could be contracted to private providers. This was accepted by the British Medical Association (BMA) and since the targets set by the DoH initially were low, GPs average income rose from £81,596 in
2003/2004 to £110,004 in 2005/2006 (ibid.: 389). However, the result was the effective dissolution of the GPs’ monopoly on primary care provision with 30 companies owning 74 centres and holding primary care contracts by March 2007 (Pollock et al. 2007: 475). Moreover, there is a tendency of contractors to draw up agreements rather than commissioners due to commissioners’ lacking expertise (ibid.: 477) and the duty for GPs to provide a comprehensive primary care service was called into question, since GPs would provide only the services agreed with their PCTs (ibid.: 476).

A further noteworthy contribution by New Labour to marketisation is the competitive tendering process established in 2006 for the Hinchingbrooke Hospital in the “Hinchingbrooke Next Steps” initiative. The hospital was deemed to be underperforming and a tendering process for the operation of the hospital by private companies was launched leading to Circle receiving the contract in 2010 (Leys/Player 2011: 50) and starting operation in February 2012. Though this is the first NHS hospital to be run by a private company, this avenue for extraction may be significant in the coming months and years, as the Coalition Government has recently announced a report detailing that 14 trusts have high mortality rates (BBC News 2013a).

Another move towards marketisation was the DoH’s “Necessity – not nicety” in 2009 which laid out a new commercial operating model for the NHS. Apart from creating “regional commercial support units” (DoH 2009: 5) which were designed to “provide commercial support to commissioners to ‘stimulate the market’” (ibid.) as well as to drive efficient procurement and effective contract management for the NHS, and to generally support providers and commissioners, the main aim was “Ensuring that the third and private sectors have a clear and visible point of commercial contact in each region” (ibid.: 8). A Co-Operation and Competition Panel was established (ibid.: 14) and, after union resistance to the initial plans, an agreement was reached to allow contracting out of community health services after two long-term instances of under-performance (Tailby 2012: 455). This final major move clearly marked New Labour’s commitment to promoting competition and the commercialisation of healthcare in the NHS with the creation of dedicated institutions.

4. The Coalition Government and Marketisation: 2010-present

As New Labour had fundamentally built on the Conservatives’ 1991 reform, so has the Coalition Government built on New Labour’s marketisation legacy. Most clearly was the
Coalition Government’s directive to PCTs to stop employing community health staff resulting in 10% joining social enterprises, 77% going to NHS or foundation trusts, 8% employed at local authorities and 3% working as freelancers (Leys/Player 2011: 159, endnote 18). However, the most fundamental change the Coalition Government has introduced is the creation of Clinical Commissioning Groups (CCGs) in the Health and Social Care Act 2012. In the area of primary care, all GPs must join CCGs which are GP-led, but may also include hospital consultants, nurses and laypeople. CCGs are accountable to a Health Commissioning Board appointed by the Secretary of State for Health (but not directly to the State Secretary) and can freely determine which services to provide, which to contract on behalf of their patient list and whom to contract (Tailby 2012: 459). One major difference from PCGs is that CCGs are not fixed geographically, but can accept patients from anywhere in England and only have a responsibility for local residents in terms of emergency care (Pollock/Price 2011: 300). This will lead to inaccurate health equity data (Pollock et al. 2012) and allow CCGs to choose their patients more indiscriminately. In terms of secondary care, all hospital trusts are required to become foundation trusts, the amount of income derived from private patients has been raised to 49% and Monitor will take over regulating secondary care as well as determining the upper limited for the price of hospital treatments (thereby allowing for price competition) (Tailby 2012: 459). Further regulation is provided by the Care Quality Commission, which has, however, had a significant reduction in personnel from 2,900 in 2005 to 2,100 in 2010 (Leys/Player 2011: 127). The overall result of the Health and Social Care Act 2012 is the severance of primary care from direct state control and accountability, the bestowment of a high degree of autonomy to primary and secondary care providers in terms of staff remuneration, whom and what to contract; weak regulation through understaffed agencies and the completion of the incremental contractualisation process started by the 1991 reform moving healthcare from national to EU jurisdiction under commercial law9 (Pollock et al. 2007: 477).

5. The Effects of Marketisation on Voice: A Reduction Without Linearity

The above outlined marketisation processes have generally led to a tendency to exit cooperative arrangements, though New Labour put new emphasis on cooperation alongside

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9 Though there is no political plan to integrate healthcare policy in the EU, the court rulings of the European Court of Justice (ECJ) have created a slowly emerging European-wide internal market by interpreting national regulations on healthcare provision as trade barriers to the free movement of people and services (Sindbjerg Martinsen 2005: 1040).
performance management. The effects on voice can be viewed across the dimensions of consumerism, pay determination, professional voice, equality measures and litigation, industrial action and campaigning.

Regarding consumerism, an overall tendency to reduce voice is discernible, though the level of voice has never been high. Essentially, before the Conservatives introduced the Community Health Councils as part of the 1974 restructuring, patient/consumer voice had no institutional place (Klein 2006: 57). This was primarily due to the fact that knowledge in the NHS was defined around expertise which could not be judged by any other group except professionals (ibid.: 58). Community Health Councils meant a substantial increase in consumer voice, since they had the ability to refer any plans in the NHS to the DoH for review and local authorities appointed 50% of their members while one sixth was chosen by Regional Health Authorities and one third by local voluntary organisations (ibid.: 70). Though Community Health Councils did not have veto power, their ability to refer plans gave them the ability to defer the introduction of plans. This was more than Local Involvement Networks (LINks) were capable of, which replaced Community Health Councils in 2003 (Leys/Player 2011: 117) and essentially constituted one major form of New Labour Consumerism. LINks had the ability to voice concerns about plans to NHS Management (ibid.), but lacked any ability to impact directly upon plans in the form of deferral. Apart from LINks, New Labour set up a national patient survey (Klein 2006: 198) and NHS Direct (ibid.: 206), a callcenter designed to give information and advice to patients. Though these are devices for voicing and addressing patient concerns, they constitute a form of “top-down consumerism” (ibid.: 169), essentially limiting any direct impact patients may have.

Top-down consumerism, as it is understood here, refers to the attempt by governments to empower consumers and enhance consumer choice while effective practice is constituted by government mandate, structural limitations and/or the strong influence on patient choice and purchasing by GPs. Since the creation of the NHS, there has always been an emphasis on patient choice with a development of incremental increases in consumer choice (Greener 2009: 320). As part of a logic of marketisation, two main models can be distinguished: firstly, the Conservative Government’s 1989 model in which GPs purchased on behalf of patients, but patients could perform an exit by switching GP (ibid.: 321) or secondly, the New Labour model after the introduction of the NHS Plan in 2000 which was based on GP purchasing on behalf of patients with, however, the addition of patients being able to choose the treatment time and hospital (ibid.: 318). To this end, a policy of giving patients five elective provider options (with one having to be an ISTC) was implemented in 2005 (Tailby 2012: 451). This
type of policy is highly limited, since the private healthcare provider industry is concentrated nationally with five providers (GHG, Spire, HCA, Nuffield and Ramsay) sharing 77.2% of the private market share in 2010 (OFT 2011: 78). Additionally, from a geographical point of view, most private health providers are concentrated in the north and east of England with many other areas existing in which there is only one private health provider located within a 30-minute driving distance (ibid.: 6). Since most patients make their choice based on geographical proximity (ibid.: 84), this means that the effective choice of providers is highly limited due to market structures.

A more fundamental limitation on consumer choice in healthcare is, however, related to its nature: since information regarding the quality of healthcare provision is highly asymmetrical and based on unique expertise, the principal (patient) is not able to judge the actions of the agent (GP) when purchasing services or advice on selecting treatment and providers types is given (Allen 2013: 5). This means that it is still essentially GPs who have a strong bearing on the choices made by consumers meaning that any consumer choice has a top-down structure with the top being constituted by professional knowledge. All in all, this means that despite the ability to choose being mandated from above by the Labour Government from 2005 onwards, the actual consumer choice was always limited by geographical dispersion, private healthcare market concentration and by inherent healthcare market information asymmetries. Though the notion of assigning patients personal budgets with which they can directly buy their own treatments (which might represent effective consumerism) has been discussed (without being implemented as policy) (Leys/Player 2011: 64), so far no ‘bottom-up’ consumerism has been established in the NHS. In this sense, the interpretation of the NHS as a “consumer-controlled market” (Gingrich 2011: 90) in the NHS can be said to be overstated due to the general prevalence of top-down consumerism since 1989 onwards.

From April 2013, “Health and Wellbeing Boards”\(^\text{10}\) have taken on their statutory functions which include providing a forum for local involvement, bringing together councils and clinical commissioning groups, and providing a form of influence on commissioning decisions. Their minimum make-up is: 1 locally elected representative, 1 representative of Healthwatch, 3 local authority directors (for children’s services, adult social services and public health) and 1 representative of each clinical commissioning group. From their make-up it is clear that Health and Wellbeing Boards have a highly limited scope for patient voice, since there is only one representative (which may not be a layperson, but an official) and one representative from Healthwatch, an organisation designed to survey the general population...

\(^{10}\) The following information is taken from the following government website: http://healthandcare.dh.gov.uk/hwb-guide/ (last seen 05.09.13).
regarding health topics. Moreover, it is unclear how their strategic function will impact on commissioning decisions, since no mandate to adhere to their recommendations has been specified. Lastly, the make-up of the Boards essentially signals that local government officials and representatives from clinical commissioning groups will have the dominant voice. Overall, then, there has been a decline in voice with regard to consumerism and the changes made from Community Health Councils over LINks and top-down consumerism to Health and Wellbeing Boards.

The dimension of pay determination boasts three stages moving from the Whitley system to a failed attempt at decentralisation to partnership arrangements in Pay Review Bodies and the Agenda for Change.

Essentially, pay was determined for all NHS staff by the Secretary of State who followed recommendations from Whitley Councils and Pay Review Bodies (Seifert 1992: 40). From 1948 and up until the Conservatives introduced the internal market in 1991, pay was determined for 40% of NHS staff via national collective bargaining and unrelated to performance (Lloyd/Seifert 1995: 360). This system was known as the “Whitley system” since it followed the recommendations of the Whitley reports in 1916 establishing a clear role for trade unions within negotiations over pay and conditions. The Whitley system was comprised of a General Whitley Council11, which determined general working conditions for all staff (including grading structure, working hours and emergency duties) and pay for 40% of NHS staff with the remaining 60% of staff pay determined by Pay Review Bodies (Seifert 1992: 223). Excluded from this combined system of Whitley and Pay Review were engineers, plumbers, electricians and senior managers whose pay was determined locally (ibid.: 224).

Pay Review Bodies constitute a forum in which representatives of stakeholders (mostly management, professional associations and trade unions) meet before a review board and present evidence concerning pay determination. Upon this evidence, the Bodies give a recommendation to the Secretary of State who finally determines pay. Pay Review Bodies essentially constitute “a form of permanent and compulsory arbitration which operates within cash limits imposed by the government” (Seifert 1992: 257) meaning that the industrial relations partners do not bargain directly with one another (as was the case in the Whitley

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11 The General Whitley Council was complemented by 9 functional councils for various occupations including Administrative and Clerical, Ambulance, Ancillary, Dental (Local Authorities), Medical and (Hospital) Dental, Nurses and Midwives, Optical, Pharmaceutical, Professional and Technical ‘A’ and Professional and Technical ‘B’ councils (Seifert 1992: 224f.). These functional councils were a more decentralised version of the General Council and fulfilled the function of coming to agreements which were passed on to the General Council (except for the doctors’ functional councils which only met formally without coming to agreements). The agreements from both council types needed the approval of the Secretary of State before being implemented by health authorities (ibid.: 225).
system regarding working conditions and pay for 40% of NHS staff), but interact with an independent (though governmental) review board. The principle, therefore, of pay review bodies is consultation rather than negotiation (Bach/Kessler 2012: 140).

First introduced to in the early 1960s to subdue pay disputes with dentists and doctors (Seifert 1992: 277), the principle of pay determination within these bodies was extended to nurses, midwives, health visitors and allied health professions in 1982 with a threat to exclude any unions taking industrial action against the move, essentially in the hope of splitting professional associations and militant trade unions (ibid.: 278). Despite being a response to heightened industrial action in the 1970s and early 1980s, this extension amounted to a decline in voice, since the Whitley system of pay determination covered substantially less NHS staff from 1982 onwards. A further attempt was made by the Conservatives to decentralise pay negotiation and bargaining, and to empower local management with the 1991 internal market reforms (ibid.: 294), which were, however, fought off successfully by unions (ibid.: 354) and the Whitley system along with Pay Review Bodies remained active for most trusts (Lloyd/Seifert 1995: 362).

This show of union voice was followed by another one prompting the introduction of the “Agenda for Change” by New Labour. There had been labour unrest in parts of Cumbria, since ancillary workers were earning substantially more than qualified nurses due to labour supply shortages and New Labour’s response was to draft an agreement in 1999 which, after a further 4 years of negotiations with trade unions, was agreed upon in 2004 (Bach/Kessler 2012: 67) and implemented in 2006. Agenda for Change replaced 650 staff grades with a band layering from 1 to 9 with incremental pay progression within each band being pre-determined. A fundamental shift was the linking of pay to performance for all staff covered under the Agenda for Change (ibid.: 64), since part of the Agenda was the introduction of a Knowledge and Skills Framework which prescribed what skill level an NHS employee must demonstrate to progress. Its second characteristic apart from determining pay progression is therefore an integrated skills and career development process which demonstrated New Labour’s transcendence of New Public Management by emphasising national pay frameworks, career progression, target-setting and partnership (ibid.: 48).

Though the skill development aspect of the Agenda for Change is limited, since only 61% of NHS staff reported having had a performance development review in 2007 (ibid.: 53), pay was not linked to qualification and progression remained hampered due to a lack of investment in the creation of new positions (Grimshaw 2009: 455), the Agenda for Change resulted in significant pay increases for many NHS occupations. Directly after its
introduction, pay increased by 23.7% for cleaners, by 10.5% for healthcare assistants, primarily due to Unison’s strong campaign for the improvement of low-wage workers (ibid.: 452); the share of low-wage employment for healthcare assistants dropped from 18.2% in 2006 to 14.1% in 2008 (ibid.: 453) and registered nurses enjoyed an annual increase of 4.2% from 2002/2003 to 2007/2008 (Bach/Kessler 2012: 60). In terms of pay, this means that industrial relations and markets were relatively de-coupled for directly employed NHS staff\footnote{They are only “relatively” de-coupled, since the overall net effect of the introduction of a national minimum wage and the Agenda for Change was a reduction of the overall share of low-wage work by a relatively small amount (0.9%) from 2001 to 2008 (Grimshaw 2009: 440).}. From 2007 onwards, the Pay Review Body for nurses, midwives, health visitors and allied health professions was extended to encompass all non-medical occupations in the NHS Pay Review Body (Grimshaw 2009: 447), abolishing the Whitley system (and with it national collective bargaining), and universalising consultation in pay review bodies for all NHS staff. After Unison (2008) was able to show that the Agenda for Change had led to a two-tier workforce, since new recruits in contracted out services were not TUPE-protected, New Labour introduced the Two-Tier Code in 2005. The Two-Tier Code meant that NHS conditions were extended to staff which were not protected by the Transfer of Undertaking (Employment Protection) Regulations first introduced in 1981 (Tailby 2012: 454). Though there are substantial problems in monitoring its implementation and it does not apply to workplaces without transferred NHS staff (Grimshaw 2009: 447f.), in terms of actively influencing policy, the Two-Tier Code represents the largest achievement by trade unions under New Labour (Bach/Kessler 2012: 150).

Apart from the Agenda for Change and the Two-Tier Code, New Labour pushed direct staff involvement in the forms of newsletters, face-to-face briefings, staff magazines and meeting summaries (ibid.: 134) as well as generally instituting partnership over negotiation (ibid.: 129). Partnership assumed a unitarist perspective and denoted close cooperation between management and labour (potentially without labour representatives). It found its manifestation in the NHS Social Partnership Forum from 2007 to 2010 (Tailby 2012: 454), which was essentially ineffective, since it had little access to ministers and could not monitor or enforce the execution of its agreements via other bodies (Bach/Kessler 2012: 142). Though 30% of all partnership agreements under New Labour were established in the health and social care sector (ibid.: 140), the general move from negotiation to consultation within pay determination and partnership arrangements under New Labour constituted an overall deterioration in the quality of voice despite instituting a pay system monetarily beneficial to non-medical staff.
The Coalition Government has so far not changed the overall pay system enshrined in the Agenda for Change, though some changes regarding a slow-down in progression for Band 5s and above Band 8s, as well as reduced sickness pay in certain circumstances have been established (NHS Staff Council 2013). The more fundamental change has been the replacement of the Two-Tier Code with the “Principles of Good Employment Practice” (Cabinet Office 2010) which are voluntary and comprise 6 principles, out of which only principle 3 refers to newly hired recruits in supplier firms: “new entrants should have fair and reasonable pay, terms and conditions” (ibid.; original emphasis). The terms “fair” and “reasonable” are not further specified, nor do they constitute the same terms and conditions between new recruits and TUPE-protected staff. Moreover, all other principles refer to good management practice emphasising employee engagement to raise labour productivity. Essentially, the principles flexibilise employment relations and dissolve the achievements of the Two-Tier Code (and with it, the union voice sedimented within the Code). In terms of pay, the Coalition Government has limited pay increases to 1% (Office of Manpower Economics 2013: vii) essentially rendering the work of the NHS Pay Review Body highly constrained. Furthermore, 8842 registered nurse positions have been cut in the NHS since 2010 (Keogh 2013: 12) indicating that the Coalition Government’s policy has been to reduce the pay bill by capping it and simultaneously cutting positions. Overall, then, the Coalition Government’s changes have resulted in a decrease of voice regarding pay determination and working conditions, the latter particularly due to the abolishment of the Two-Tier Code.

Turning now to the voice of professionals, a general decrease can be attested for most professionals though with strong resistance by them and a high increase in GPs’ voice through the creation of Clinical Commissioning Groups. This point refers primarily to the medical profession and to nurses. Bevan had essentially allowed the medical profession to be the major representative voice in all NHS committees, since the BMA was conservative and highly opposed to any plans for nationalising healthcare provision (Seifert 1992: 64). This meant that, apart from civil servants and ministers, doctors had the highest impact on policy within the NHS up until the voice of the medical profession was curtailed by the introduction of general management through the 1983 Griffiths Report (though, as outlined above, it was fairly ineffective). This constitutes the primary decrease in professional voice by the Conservatives.

New Labour started regulating doctors after a scandal in Bristol in 1997 in which doctors continued to condone and administer detrimental treatment despite being informed of its negative impact by implementing monitoring standards in all trusts (Klein 2006: 199) and
establishing annual appraisals and disciplinary procedures for doctors, as well as Assessment and Support Centres to which doctors could be referred (ibid.: 200). Moreover, as showed above, it was in 2004 when the BMA accepted the GMS agreement that the remuneration of GPs fundamentally changed to targets-based payment instead of fixed national agreements diminishing GPs’ monopoly on primary care. Though the GPs have lost their monopoly, the Health and Social Care Act 2012 has resulted in a great increase in their voice, in so far as it places almost all purchasing power into their hands, since before, Strategic Health Authorities also had purchasing powers and were accountable to the Secretary of State, but these are now abolished. GPs are not directly accountable to the Secretary of State and it is also in this sense that they enjoy more autonomy. It is unclear how GPs will deal with this sudden increase in voice and purchasing power, but evidence from newspaper articles indicates that some GPs have embraced this new purchasing function, essentially giving up their clinical work, whilst others see this move sceptically, experiencing disillusionment at their lack of power in preventing major strategic decisions (Soteriou 2013).

With regard to nurses, their professional ethos based on autonomy and clinical outcomes can constitute a barrier for the effective transfer of NHS staff to ISTCs (which is necessary for a growing private sector in healthcare). In their case study of an ISTC, Bishop and Waring showed that the NHS nursing staff was difficult to control by the ISTC management and did their work as they had in their NHS hospital (2011: 323). Evidence has also been presented that New Labour’s policy to “empower” staff by extending their work tasks to include managerial and administrative tasks (Cooke 2006: 227) was consistently resisted by senior nurses (ibid.: 233), which was in part attributed to nurses’ professional ethos resisting managerialism, but also management’s lack of on-the-ground supervision and control of nurses (ibid.: 236).

In terms of equality and diversity measures, it was particularly New Labour that advocated such principles as a general policy (Bach/Kessler 2012: 73). Especially pay inequality led to a large amount of litigation with, for example, 1600 women at two hospitals in Cumbria receiving a pay claim of £300 million (ibid.: 56). The heightened consumerism also led to patients making more demands on nurses, which generally increased the work effort of nurses (Bolton 2002: 133). In this sense, New Labour policy led both to an increase in voice regarding inequality and diversity issues, and consumer demands. Overall, professional voice remains heard particularly with the introduction of Clinical Commissioning Groups, though parts of the medical profession have suffered a decrease by measures introduced by the
Conservatives and New Labour, and nurses have faced the increased burden of consumer demands.

Voice enacted in the form of industrial action has a slightly different logic than simply reacting to marketisation pressures. Indeed, the ascendance of militancy in the NHS started in the early 1970s, that is to say, around a decade before the first large marketisation measures were introduced; it reached a high point at the end of the 1980s and has reduced from New Labour’s government onwards.

The major unions representing worker and professional interests in the NHS are the BMA for doctors, UNISON (earlier NUPE and COHSE), the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM) for nurses and Unite, the GMB and the Union of Shop, Distributive and Allied Workers (USDAW) particularly for ancillary workers. Therefore, the union landscape in the NHS is fragmented and especially contradictory in terms of professional associations (generally eschewing militancy and aiming to pursue their vested interests) and trade unions (advocating the possibility of industrial action, militancy and working class ideology). Within a national health service, however, the general problem of all worker interest representation is to be able to strike a “balance between alienating community support and hurting the employer without hurting the patients” (Seifert 1992: 270).

This contradictory relationship of industrial action within a national health service is exemplified by the nursing professions fragmentation between UNISON and the RCN which is of special importance, since, as stated above, the nursing profession constitutes roughly 40% of NHS staff. Despite a general renewal in nursing militancy since the 1980s (Briskin 2011: 487), the RCN has persisted in refusing to engage in industrial action, particularly strike action, despite the amendment of its rule 12 in 1995 to include the possibility of industrial action (Jennings/Western 1997: 280). This union fragmentation is compounded by nurses’ general attitudes towards industrial action, which gravitate between militancy and passivity (McKeown/Stowell-Smith/Foley 1999: 145).

In spite of these barriers, the NHS was laden with industrial action between 1972 and 1989. The first major strike action was taken by ancillary workers in 1972 when, following a one-day strike and a ballot, they struck for six weeks. Though they were unsuccessful in attaining their pay demands, the relevant unions achieved membership increases and a steward network was created (Seifert 1992: 263). In 1975, the tactics of the medical profession were revolutionised to incorporate industrial action when junior hospital doctors started taking strike action across England against unpaid overtime and long working hours (Treloar 1981). As part of the Winter of Discontent which brought down the Labour Government in 1979,
COHSE and other unions struck to advance the interests of ancillary workers and ambulance staff with a one-day strike and subsequent further actions (Seifert 1992: 267). Nurses had struck for one day in 1982 and pursued 5 months of further actions resulting in the highest number of days lost due to industrial action in the NHS during the 1980s (610,150) (ibid.: 271) and the establishment of a separate Pay Review Body (see above). Nurses struck once more for one day in 1988 against the threat of withdrawing special duty payments (Jennings/Western 1997: 279). Their strike was supported by marches boasting 43,000+ people in London and Glasgow (Briskin 2011: 493).

However, after the introduction of Pay Review Bodies and their universalisation in the Agenda for Change, industrial action has substantially decreased. Two reasons account for this decline: one is that the increase in contracting out especially of ancillary services means that more workers are placed in asymmetrical labour relations meaning that they are not in direct contact with their actual employer (the NHS), since they are periodically managed directly by different contractors (Wills 2009: 442); the second factor is the increase in Partnership arrangements which led to certain parts of the union movement advocating influence via cooperation rather than militancy while also running fierce campaigns against government plans (Bach/Kessler 2012: 147).

Since around 2006 with the NHS Together campaign supported also by the BMA (Heins/Parry 2011: 391), it has become increasingly clear that all unions (professional and militant) understand the NHS to be in a crisis and at an important juncture. This was expressed particularly clearly in all interest groups’ broad opposition to the Health and Social Care Act 2012 (Leys/Player 2011: 144). Alongside these union campaigns, an increase in community organising has also occurred with the “Keep our NHS Public” campaign and many hospitals having a campaign dedicated to defending its status within a national health service. Noteworthy in this context is the “Save Lewisham” Campaign which launched a judicial review against plans by a special trust administrator and Jeremy Hunt to close down the A&E department at Lewisham Hospital. The judgement was in favour of the campaign¹³ and now it remains to be seen whether the appeal court will overturn the judgement. In any case, this example shows that political action based on a broad community base may lead to opposition to marketisation plans. Despite the overall decline in voice through industrial action, voice through campaigning has increased and broadened in its constituent structure,

¹³ The judgement is available under: http://www.judiciary.gov.uk/Resources/JCO/Documents/Judgments/Lewisham-v-SSH310713.pdf (last seen 05.09.13).
now encompassing community organisations. However, it may be argued that this change in the quality of voice is detrimental, since campaign may be less effective than industrial action. All in all, a decrease in voice can be attested in parallel to the increase in marketisation within the NHS, particularly across the dimensions of consumerism, pay determination, professional voice and industrial action. This decrease has not, however, constituted a linear process, as the impact of equality and diversity measures, heightened consumerism, union voice (especially in the Two-Tier Code), professional resistance and the recent upsurge in broad-based campaigning and organising has demonstrated.

6. The Effects of Marketisation on Extraction: Accelerating the Ability To Marketise

Within marketisation theory, the second major effect of marketisation is conceptualised as an increase in extraction. This move from productive to extractive economic activity means that profits are made while previous investment by the profit-making firm is minimised. In this sense, there have been three major dimensions of extraction in the NHS: the contracting out of services, extraction through the Private Finance Initiative (PFI) and other forms including increased management consulting.

Both contracting out and PFI constitute segments of the public services industry, which is characterised by providing “services to the public on behalf of government or to the government itself” (Julius 2008: 5). The health sector has been the largest public service industry segment exhibiting 30% of the total market or around £24.2 billion in 2008 (ibid.: 16).

As mentioned above, the contracting out of ancillary service was mandated in 1983 by the DHSS in relation to all ancillary services in health authorities. It enabled large efficiency gains through personnel reductions (Seifert 1992: 38). It is estimated that ancillary staff has been reduced from 260,000 in 1981 to 120,000 in 1994 (Leys/Player 2011: 27), though getting data on ancillary staff is difficult, since it is fragmented due to the regular change of employer (Grimshaw 2009: 444).

From case study evidence, however, it is clear that work in contracted out firms is highly precarious suffering from poor working conditions and boasting a high percentage of women and people from ethnic minorities. In this sense, 60% of hospital cleaning work in 2005 could be categorised as low-wage (ibid.) and 80% took the form of part-time work (ibid.: 445). In Wills’ case study, 96.7% of ancillary workers at the Royal Hospital London were born outside of the UK (2009: 457, fn. 5). At the Queen Mary Hospital there were 120 cleaners on national
minimum wage without sick pay, with only 10 days paid holiday, and most staff was employed for just 2 hours per day (ibid.: 450). It is clear that contracts are often won in tendering processes by ensuring a lower cost of service provision which in turn entails work intensification, a deterioration of working conditions and precarious work for those employed by the contractor firm.

Contracting out also refers to agencies for temporary working. These are especially focussed on providing professionals. Again, the working conditions for temporary workers are precarious and involve a high proportion of immigrant labour (Tailby 2005: 386). Furthermore, nurses have reported working on weekends to attain higher pay due to unsocial hours which also conflicts with domestic responsibilities and home life (ibid.: 379).

Expenditure for bank\(^\text{14}\) and agency nursing rose from £216 million in 1997/98 to £370 million in 2004/05 with a special NHS agency created in 2004 to curtail agency spending (NHS Professionals) (Hoque et al. 2008: 394). In the financial year of 2012/2013, the NHS may spend as much as 20% more on bank and agency staffing coming up to £450 million (Moore 2013). With regard to the medical profession, expenditure on surgeons working via agencies rose from £214 million in 1996/1997 to £750 million in 2009/2010 (Bach/Kessler 2012: 79).

Due to this high expenditure, the agency worker market overall has moved from relatively unregulated commissioning to a managed market structure (Hoque et al. 2008: 399) resulting in an increase in master vendor deals (which occur when one vendor is contracted as the sole vendor for all temporary staff). The effects of this type of deal have been a deskilling of recruitment consultants when agencies move to outsource customer interaction in callcenters, (ibid.: 404), increased pressure on the master vendors to place their own temporary staff (rather than choosing to subcontract), since master vendor deals are won by lower promised costs, in turn achieved by lowering profit margins (ibid.: 403); and this increased pressure to place has led to a deterioration of choice for agency workers as well as their overall satisfaction (ibid.: 405). However, with the Coalition Government cutting posts and choosing not to increase spending on the NHS in real terms, the resulting overstretching of staff will have to be met by agency workers, which in turns accounts for the recent upsurge in agency spending.

A final dimension of extraction via agency working is highlighted by considering the role of overseas nurses brought to work in the English NHS. Around 30,000 overseas nurses were registered from 2001-2003 (UNISON 2004: 6) with the largest part being from the Philippines (roughly 48%) (ibid.: 7). Often, international recruitment agencies, which illegally

\(^{14}\) Bank nursing refers to an internal NHS system within which nurses can sign up (voluntarily) for extra shifts.
charge nurses placement fees, will be used when trying to attain overseas nurses (ibid.: 10). Furthermore, there have been many cases of overseas nursing being placed below their knowledge levels and even being bullied by employers who withhold their passports (ibid.: 21). As mentioned above, the need for agency work has come from a general nurse shortage. This shortage has arisen, since the number of qualified nurses working for the NHS has declined from 67% in 1996 to 63% in 2006 (Curtis et al. 2009: 847) despite significant growth in the overall number of qualified nurses (ibid.: 848). This indicates that the general deterioration in working conditions due to increased marketisation constitutes an important direct factor for the nursing shortage; which in turn is exacerbated by the Coalition Government’s financing and pay freeze.

Apart from extraction via the contracting out of ancillary services and agency working, the second major, and arguably far more profitable, form of extraction in the NHS has been the PFI. Though the Conservatives introduced PFI schemes in 1992 as a way of bypassing requirements for public sector borrowing (Edwards 2009a: 17), by 1997 there had been no PFI scheme approved or completed in the health sector (ibid.: 18). It was New Labour that started to approve PFI schemes due to Gordon Brown’s golden rule (non-capital spending should be financed by government revenue) and his sustainable investment rule (debt should be kept below 40% of GDP, significantly lower than the European Stability and Growth Pact’s 60%) (ibid.: 20). From 1997 to 2009 101 of 135 new hospitals were built via PFI-financing (Pollock/Price 2011: 298).

The definitive characteristic of PFI schemes is that the private sector not only designs, builds and operates facilities on behalf of the public sector, but also finds the financing for the construction and subsequently owns the facilities (Edwards 2009b: 1). This means that the public sector then rents the facilities within contracts lasting between 30 and 40 years, and the government benefits in so far as the construction costs do not show up in the public budget. However, the taxpayer still pays for the construction via rental payments without owning the facilities in the end. In this sense, PFI’s constitute not only a marketisation of hospital construction (via the tendering process for this construction), but also a privatisation of hospital assets (due to ownership belonging to the private sector).

Except for these problems, numerous other problems have been reported by state enquiries. A general lack of transparency due to commercial confidentiality has been lamented (House of Commons Committee of Public Accounts 2011: 5), as well as the fact that many investors move their tax base offshore resulting in a loss of tax revenue (ibid.). Furthermore, the public sector has not made use of its power in terms of “bulk buying” (ibid.: 6) and therefore,
showed poor commercial and bargaining skills. In addition, 20% of NHS Trusts were dissatisfied with maintenance services which were not subject to reviews during the contract period (as opposed to cleaning and catering) (NAO 2011: 28). Lastly, the risk of construction is transferred from the private equity consortium providing the financing to the facility management and construction companies, resulting in a disregard for overrunning construction costs which in turn are generally picked up by the government (Pollock 2004: 56f.)

The biggest problem, however, is that using PFIs in hospital construction is by no means a mechanism for providing value for money for the public sector. Edwards (2009b: 4) estimates that the public sector would save around £2.6 billion per year if it had built all PFI-constructed hospitals. The reason is that the public sector has less than half of the amount of interest in borrowing than the private sector (4.3% versus 10%; ibid.: 1) which cannot be recovered in faster construction or by reducing transaction costs (Edwards 2009a: 25). This dynamic has resulted in return on investments achieved for the private sector within the first 5 years after construction meaning that the remaining (often 25+ years) constitute pure profit.

In the case of the Norfolk and Norwich University Hospital trust, this has resulted in building costs between £159 and £229 million while the rental payments from 2001 to 2008 were £197 million and they are likely to be around £823 million from 2009 to 2037 (Edwards 2009b: 5). Edwards (2009a: 73) also names the examples of Innisfree Limited which received a real annual rate of return of 200% between 1998 and 2008 through PFI investments, and of Serco Investments Limited which achieved a 39% annual return on shareholder funds between 1998 and 2007. Profits can go up to as high as 1100% rate of return (ibid.: 74).

Though this form of extraction is highly lucrative for the private sector, there is a further detrimental dimension to PFIs for the public sector. In effect, PFIs cause most NHS trusts (and presumably also Foundation Trusts) to have a structural deficit, since the system of Payment by Results introduced by New Labour reimburses treatments lower than the required payments for capital costs (Hellowell/Pollock 2007: 6). At the proportion of 5.8%, the reimbursements are lower than the required proportion ranging between 8.3% and 10.2% (ibid.). In the instance of the County Durham & Darlington Priority Services NHS trust, the proportion of income as capital cost stood at 35% due to having 3 large PFI contracts (ibid.: 21). The effect on neighbouring trusts is also detrimental, since, apart from implementing service and cost reductions, a common policy measure is to sell off profitable assets from financially stable trusts to free up money for the trusts in deficit from PFI payments (ibid.: 24). This is what had happened with Lewisham Hospital when the South London Healthcare
Trust, which has now been dissolved\textsuperscript{15}, was in such a high deficit that the trust special administrator mandated closing down Lewisham’s A&E department, which had recently been refurbished for £12 million (BBC News 2013b).

Since it was New Labour that approved many of the PFI deals in the hospital sector (mostly in the mid-2000s), the full impact of PFI deals with their long contracts and high rental payments has not yet reached the NHS. It is, however, clear that in conjunction with the Coalition Government’s pay and financing squeeze, PFI financing will structurally drive trusts into deficit, which will provoke further selling off of assets, cost and service reductions, as well as a potential increase in private takeovers of hospitals deemed to be underperforming, as the Hinchingbrooke Hospital takeover has exemplified. In this sense, marketisation is a self-fulfilling prophecy, since, once introduced, it tends to create the conditions for its own realisation.

Apart from PFI, another way of extracting profits is through large NHS IT programmes, the most prominent of which being “Connecting for Health” which up until 2011 has cost £20 billion without being operative (Leys/Player 2011: 91). What is more, as mentioned above, setting up an ISTC requires the transfer of large amounts of NHS staff meaning that large amounts of the NHS’s resource pool is directly being transferred without recruitment or training costs. A further example of extraction has been the growing use of management consulting services since 2000, which grew to £600 million in 2005/06 (House of Commons Health Committee 2009: 3). This form of extraction is also highly problematic, since there is a large crossover between the private sector and public sector in healthcare, resulting in great potentials for conflicts of interest. One example is Mark Britnell, who worked in senior managing roles in the NHS for 20 years and has been working as the global director for KPMG Health since 2009 (Coombes 2012). Furthermore, McKinsey has been highly influential in driving the marketisation of the NHS with many examples of overlap between its staff and the NHS (Davies 2012). This area of extraction has been relatively under-researched and therefore, a lot of evidence for the extraction via management consulting remains anecdotal. However, the reduction in management consultants and expert policy advisers by the Coalition Government (DoH 2010: 44; Klein 2013: 240) suggests that it may have only been the New Labour government that predominantly practiced extraction via management consulting.

All in all, there has also been an increase in extractive economic activity following the introduction of marketisation pressures into the NHS, particularly in the areas of contracting

out services and hospital construction via PFI. Interestingly, though, extraction has come in with a delayed effect, generally gaining salience only with New Labour, but being indirectly intensified via the Coalition Government’s spending policy in the NHS.

7. Conclusion

This review of the history of marketisation in the NHS has shown that marketisation pressures were first introduced by the Conservative Governments from 1983 to 1997 with these first steps being relatively ineffective. New Labour then took on the role of accelerating the marketisation process by introducing entry points for private provision in both primary and secondary care. The Coalition Government has further built on the measures taken by New Labour, but its major restructuring of purchasing and of the hospital sector in the Health and Social Care Act 2012 has generally been a political fiasco (Klein 2013). With these three phases of marketisation, however, the conditions for a private healthcare market in the England have been established and it remains to be seen whether private actors engage in this restructured economic sector.

The effect on voice has also been a general decrease, though with some notable exceptions, such as the Two-Tier Code, which was a sedimentation of union voice under New Labour (now abolished by the Coalition Government) and the increase in professional voice for GPs in their new purchasing function.

An increase has also been demonstrated with regard to extractive economic activity, particularly in terms of contracting out services and PFI hospital construction. These measures have been highly problematic and can be said to have established a system of deficit creation which may further intensify the marketisation of the NHS.

Interestingly, the effects on voice and extraction have not been linear or proportional to the intensity of marketisation pressures: after evidencing a strong increase of voice in terms of unionisation and industrial action, institutions were put in place to stifle this form of worker voice; and following the introduction of PFI by the Conservatives, it was only New Labour that rapidly increased hospital construction via PFI, though the Conservatives had radically mandated the contracting out of all ancillary services early in the 1980s.

Moreover, the review has made clear that despite the theoretical and empirical impossibility of providing healthcare efficiently via market mechanisms (Allen 2013), the past 30 years of UK public health policy have been structured around marketisation pressures. This lends weight to the concern that the UK, which is still the opposite of the USA in terms of its
healthcare policy, has incrementally been experiencing an approach to the US-American style of private provision in healthcare. Moving closer to private provision is one of the effects of neoliberalism on healthcare (Navarro 2009: 425) and in the USA, this structure of healthcare provision has led to private bankruptcy and preventable deaths of up to 100,000 per year (ibid.: 429). Overall, then, at least in terms of public health, this approach can be deemed to have highly detrimental effects.

References


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Edwards, Chris (2009a): Private Gain and Public Loss; the Private Finance Initiative (PFI) and the Norfolk and Norwich University Hospital (NNUH); a Case Study. Available online under: http://www.uca.ac.uk/polopoly_fs/1.116274!Private%20Gain%20and%20Public%20Loss%20-%20June%202009.pdf (last seen 05.09.13).


Appendix 1: Public Satisfaction with the NHS

Figure 1: Trends in satisfaction with the NHS since 1983

- Very + quite satisfied
- Neither
- Very + quite dissatisfied

"Question asked: 'All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service is run nowadays?'


Figure 2: Net satisfaction with the NHS overall

*Net satisfaction = very + quite satisfied minus very + quite dissatisfied
**Question not asked in 1995, 1998 and 1992

Figures 1 and 2 taken from the King’s Fund and available online under: http://www.kingsfund.org.uk/projects/bsa-survey-2012 (last seen 05.09.13).
## Appendix 2: Summary of Marketisation Phases

### Table 1: Conservative Governments’ Marketisation Measures 1970-1974 and 1979-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Plan and/or Measure</th>
<th>Marketisation Effect/s</th>
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</thead>
<tbody>
<tr>
<td>1974</td>
<td>NHS Reorganisation: introduction of Community Health Councils</td>
<td>Increased consumerism</td>
</tr>
<tr>
<td>1983</td>
<td>DHSS directive: All ancillary services of health authorities contracted out</td>
<td>Competitive tendering, service standardisation</td>
</tr>
<tr>
<td>1991</td>
<td>National Health Service and Community Care Act: Purchaser/Provider split, option of fundholding for GPs, self-governing hospital trusts</td>
<td>Competition introduced in purchasing, contractualisation as coordination mechanism</td>
</tr>
<tr>
<td>1991</td>
<td>Patient’s Charter: introduction of performance guides, definition of patient rights</td>
<td>Increased consumerism, performance management introduced</td>
</tr>
<tr>
<td>1993</td>
<td>NHS Reorganisation: Replacement of District Health Authorities for regional offices of NHS Management Executive</td>
<td>Cutting personnel through centralisation, merger of institutions legalised</td>
</tr>
</tbody>
</table>

### Table 2: Labour Governments’ Marketisation Measures 1997-2010

<table>
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<tr>
<th>Year</th>
<th>Plan and/or Measure</th>
<th>Marketisation Effect/s</th>
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<tbody>
<tr>
<td>1997</td>
<td>New NHS: Purchaser/Provider split retained, introduction of Primary Care Groups/Trusts</td>
<td>Retention of internal market, universalisation of fundholding, increased target-setting through Public Service Agreements with contracting out of failing services</td>
</tr>
<tr>
<td>2000</td>
<td>NHS Plan: GP contracts with PCTs (instead of with State Secretary), productivity as criterion for merit awards,</td>
<td>Increased contractualisation, increased managerialism</td>
</tr>
<tr>
<td>2002</td>
<td>Growing Capacity: Independent Sector Treatment Centers</td>
<td>Push for growth of private sector secondary care</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
<td>Description</td>
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<td>------</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>2003</td>
<td>Health and Social Care (Community Health Standards Act) 2003:</td>
<td>Establishment of foundation trusts, payment by results</td>
</tr>
<tr>
<td></td>
<td>Health and Social Care (Community Health Standards Act) 2003:</td>
<td>Establish ment of trusts with more autonomy in terms of commercial contracting, staff renumeration and regulation (by Monitor), payment by treatment (rather than in lump sums)</td>
</tr>
<tr>
<td>2004</td>
<td>New GP contract: Ability to opt-out of out-of-hours care, increase in income, regulation via Quality and Outcomes Framework</td>
<td>Loss of GP monopoly on primary care provision/entry point secured for private providers</td>
</tr>
<tr>
<td>2005</td>
<td>Health Reform in England: Emphasis on supply-side diversity, patient choice of 5 providers (1 of which is ISTC)</td>
<td>Push for private provision of primary care</td>
</tr>
<tr>
<td>2005</td>
<td>DoH directive: All PCTs were to contract out community health services by 2008</td>
<td>Attempt to contract out community health services blocked by unions</td>
</tr>
<tr>
<td>2006</td>
<td>Hinchingbrooke Next Steps: competitive tendering process for takeover of Hinchingbrooke Hospital by private providers due to underperformance</td>
<td>Contract awarded to Circle in 2010, first hospital to be operated by private company from February 2012 onwards</td>
</tr>
<tr>
<td>2007</td>
<td>Healthcare for London: Plans to create polyclinics, based on APMS contracts with national extension of scheme in 2008</td>
<td>Further entry point for commercial providers or GP consortia</td>
</tr>
<tr>
<td>2009</td>
<td>Necessity – Not Nicety: creation of Co-operation and Competition Panel, formal plan to contract out community health services</td>
<td>Institution with responsibility to promote competition created, ability to contract out community health services after 2 incidents underperformance</td>
</tr>
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</table>
Table 3: Coalition Government’s Marketisation Reforms 2010-present

<table>
<thead>
<tr>
<th>Year</th>
<th>Plan and/or Measure</th>
<th>Marketisation Effect/s</th>
</tr>
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<tbody>
<tr>
<td>2010</td>
<td>DoH Directive: Community health services to be contracted out</td>
<td>Contracting out of community health services</td>
</tr>
<tr>
<td>2010</td>
<td>Two-Tier Code replaced by Principles of Good Employment Practice</td>
<td>Flexibilisation of employment terms and working conditions for staff hired by contractors</td>
</tr>
<tr>
<td>2012</td>
<td>Health and Social Care Act: Creation of Clinical Commissioning Groups, creation of NHS Commissioning Board, universalisation of foundation trusts, changed resource allocation calculation formula, termination of borrowing from state</td>
<td>Completion of contractualisation, completion of purchaser autonomy, regulation by small agencies (Monitor and Care Quality Commission) rather than State Secretary, entry point for private lenders, flexibilisation of determination of service provision</td>
</tr>
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</table>