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**Article:**

Benbow, D.I. [orcid.org/0000-0002-2266-0611](https://orcid.org/0000-0002-2266-0611) (2019) *Juridification, new constitutionalism and market reforms to the English NHS*. *Capital and Class*, 43 (2). pp. 293-313. ISSN 0309-8168

<https://doi.org/10.1177/0309816818780647>

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## Introduction

Successive UK governments, in the neo-liberal era, have instituted market mechanisms within the NHS and increasingly afforded private healthcare companies with opportunities to deliver clinical services. Such reforms divert resources away from patient needs to bureaucracies (required to administer the quasi-markets that have been instituted within the NHS) and the coffers of private companies. In fragmenting provision, they also undermine risk pooling and cross subsidy within the NHS. Such governments have sought to naturalise their reforms by adopting many of the strategies of depoliticisation delineated by Bob Jessop (2015). The strategies of juridification (the increase of formal law) and new constitutionalism (transnational legal rules which restrict national policymaking to the model of liberal democratic capitalism) are examined within this article. While the NHS has become increasingly juridified (laws increasingly regulate the behaviour of NHS actors and are increasingly resolving disputes), it also appears to have been increasingly politicised as is indicated by the activities of campaign groups, such as the largest rally in NHS history (against cuts and privatisation) in London in March 2017. In addition, search results of the newspaper database Proquest European Newsstream and Hansard (transcripts of parliamentary debates) suggest a heightened awareness of the potential for transnational laws to constrain NHS policymaking. In chronicling the frustrated efforts of the strategies of juridification and new constitutionalism to naturalise market reforms to the English NHS, this article reveals that the solidarity that was important in the creation of the NHS endures (although the institutions discharging this principle are being undermined through inadequate funding and privatisation) and limits to neo-liberal hegemony.

## Depoliticisation

There are many ways of conceiving neo-liberalism. Marxists regard neo-liberalism as the current hegemonic ideology and a class project to “restore and consolidate capitalist class power” (Harvey 2010: 10). Foucauldian scholars regard neo-liberalism as a political rationality which seeks to extend the model of *homo-economicus* (the man of exchange) “to every social actor in general” (Foucault 2008: 270). The ideology, or political rationality, of neo-liberalism became dominant after the post Second World War social democratic consensus disintegrated, due to economic crises, in the 1970s. Neo-liberals idealise markets as the best means of allocating resources and ensuring individual freedom (Turner 2008: 4). This idealisation of markets explains the market reforms to public services, such as the NHS, within the neo-liberal era. In addition, private companies have pressurised governments to marketise and privatise healthcare, which is attractive to them as demand appears to be insatiable and the state is a guarantor of profit (McKinley 1984: 5). However, as Alan Hunt and Gary Wickham (1994: 102) note, the translation of political rationalities, such as neo-liberalism, into practice, involves attempt, incompleteness and resistance.

Governments within the neo-liberal era have attempted to naturalise their reforms by endeavouring to remove them from political contestation. Anita Chari (2015) argues that, at the most basic level, “neo-liberal domination is...a form of depoliticisation” (p. 22). Bob Jessop (2015) has identified several depoliticising strategies on the levels of

polity, politics and policy. The strategies considered within this article are juridification, which Jessop states is a means of redrawing the boundary between the political and the non-political (depoliticization) (p. 101), and new constitutionalism (a means of depoliticization) (p. 104). Such concepts are clarified in the following paragraphs and utilised within the rest of the article to assess whether efforts to depoliticise market reforms to the English NHS have succeeded. In demonstrating the apparent failure of such strategies to naturalize market reforms to English healthcare, this article reveals limits to neo-liberal hegemony and the endurance of solidarity concerning healthcare.

### Juridification

The concept of juridification was popularised by Jurgen Habermas. Habermas (2006) used the concept to refer to the general tendency “toward an increase in formal (or positive, written) law that can be observed in modern society” (p. 357). Juridification was viewed as a legal problem by Habermas, but many other scholars regard it as a political problem (Veitch et al 2012: 260). For example, the concept was first used by Otto Kirchheimer (1969) to describe labour disputes that had been “formalized juridically and thereby neutralized” (p. 7). Similarly, Boaventura de Sousa Santos (2005) contends that juridification involves the receding of politics as “the protection of more and more social interests became a function of technically minded legal experts rather than of political mobilization and political leverage” (p. 37). Habermas (2006) identified “four epochal juridification processes” (p. 357). The first led to the bourgeois state, in which the state and the economy were differentiated and the concept of the legal person was created (pp. 357-358). The second led to the

constitutional state” (p. 357), in which the state was constitutionalised through the rule of law (p. 359). The third led to the democratic constitutional state (p. 357), in which “constitutionalized state power was democratized” (p. 360). The fourth wave led to the “democratic welfare state” (p. 357). Habermas contended that welfare states had reifying effects as they “treated [people] as objects” (p. 370). In the neo-liberal era, governments have instituted markets within public services with the stated intention of making them more responsive to users. According to Scott Veitch et al (2012), the marketization of public services, together with the re-embedding of private law mechanisms (particularly contract and property law) within them, signifies a fifth epoch of juridification (p. 262).

The five dimensions of juridification delineated by Lars Blichner and Anders Molander (2008: 38) are used, in this article, to examine recent NHS reforms. The first dimension is constitutive juridification, whereby the legal system accrues competences by establishing or altering the constitutive norms of a political order (p. 38). The second dimension refers to a process through which law comes to regulate an increasing number of different activities (pp. 38-39). This article describes how laws, such as contract law and EU public procurement and competition laws, have increasingly come to regulate the NHS. The third dimension refers to a process through which conflicts are increasingly solved by, or with, reference to law (p. 39). This article demonstrates that conflicts regarding NHS procurement are increasingly being resolved with reference to, or by, law. The fourth dimension refers to a process through which the legal system and profession acquire more power as contrasted with formal authority (p. 39). The increase in litigation noted in this article suggests that the legal system has acquired more power over the NHS. The fifth dimension is legal framing, a process

by which people increasingly perceive themselves, and others, as legal subjects (p. 39). In this regard, new legal statuses have affected the behaviour of NHS entities.

### New Constitutionalism

Juridification may be driven by external constitutional constraints. Stephen Gill (1995) has identified the political project of new constitutionalism, which attempts “to make transnational liberalism, and if possible liberal democratic capitalism, the sole model for future development” (p. 412). Gill (2008) states that this may involve alterations to the “supreme laws and governing frameworks of nations” and the extension of ‘pre-commitment’ mechanisms “designed to ‘lock in’ commitments to disciplinary neo-liberalism” and prevent alternatives, such as socialism, by making its means, such as nationalisation, illegal (p. 79). This logic is evident in the EU, which the UK joined in 1973. Bastiaan van Apeldoorn (2013: 189) states that the EU subordinates the democratic governance of member states to the dictates of the single market. EU law affects the English NHS in numerous ways. Both John Harrington (2007) and Kenneth Veitch (2012) have analysed juridification in respect of patient mobility case law. This article concentrates on EU public procurement and competition law. The former is designed to prevent discrimination on the grounds of nationality (Collins 2015: 2). The latter is designed to ensure that competition, where it exists, benefits consumers (Ibid). Scott Greer (2008: 224) states that such laws apply to the healthcare systems of EU member states due to decisions of the Court of Justice of the European Union (CJEU). EU member states are able to deliver public services through the public sector but, as Ben Collins (2015: 3) notes, EU public procurement law and competition law become

applicable when markets are used. It has been argued, for example by Kyriaki-Korina Raptopoulou (2015a: 116) and Tamara Hervey and Jean McHale (2015: 545), that once an EU member state privatises health services, it cannot return them to public ownership. Consequently, once EU laws are engaged following privatisation, they may lock out alternatives to the market. The impact of successive reforms on the applicability of EU laws to the NHS is considered below.

## NHS

The UK NHS was established, in the era of the social democratic consensus, via the National Health Service Act (1946), and became operational in 1948. The NHS' founding principles were that it was to be free (at the point of access), comprehensive, universal and funded from general taxation. Rahel Jaeggi (2001) argues that healthcare systems, such as the NHS, institutionalised solidarity, which involves "standing up for each other because one recognises one's own fate in the fate of the other" (p. 291). According to John Torrance (1977), reification (of which depoliticization is a mode) may undermine solidarity (p. 105) and generate estrangement (p. xiii). Historically, the internal regulation of the NHS was commonly achieved through circulars, often issued as per the Secretary of State for Health's power to give directions (National Health Service (NHS) Act (1977), S.17) and various other Department of Health policy statements (Newdick 2005: 75). In the current neo-liberal era, politicians have regarded markets as the answer to the reifying effects of welfare states identified by Habermas. As successive governments in the neo-liberal era have viewed full marketization of healthcare as being electorally unviable, they

have instituted quasi-markets within the NHS. This article focuses on secondary care, although primary care has not been immune from reform. The three episodes of market reform examined within this article are the internal market introduced by the Conservatives in the 1990s, the mimic-market created by Labour's reforms in the 2000s and the current market instituted by the Conservative-Liberal Democrat coalition government's Health and Social Care (HSC) Act (2012).

### The Internal Market

The Conservative party was in government for eighteen years between 1979 and 1997. It introduced an internal market into the NHS, via the National Health Service and Community Care (NHSCC) Act (1990). This split purchasers (District Health Authorities and some fundholding GPs) and providers. The reforms ended the advantages of cost-sharing and integrated care (Pollock et al 2005: 47) thereby increasing bureaucracy and overhead costs (Lister 2007: xi). Providers could apply to become trusts (which differ from other trusts in English law). The new legal status of trust meant that management and financial functions became dominant in hospitals (Jenkins 1995: 78). The NHSCC Act (1990), S.4(3), provided that agreements between health service bodies did not give rise to contractual rights or responsibilities. It was intended that disputes would be resolved by internal regimes of conciliation and arbitration (Hughes et al 1997: 73). In practice, parties to disputes were encouraged to resolve them between themselves or through informal conciliation (Hughes et al 1997: 73-74). Thus although the NHS had been marketized, disputes were still resolved internally rather than with reference to legal rules.

EU competition law may have become applicable following the introduction of the internal market (Lear et al 2010: 345). However, this is uncertain as it was never assessed by the courts (Lear et al 2010: 345). Another transnational legal regime with the ability to constrain NHS policymaking is the General Agreement on Trade in Services (GATS), overseen by the World Trade Organisation (WTO). GATS entered into force in 1995 and brought services under the domain of multilateral trade rules for the first time (Sinclair 2015: 112). The UK government (unlike many other governments) agreed to liberalise hospital services (Pollock and Price 2002). As the role of non-NHS providers increases, it becomes more likely that parts of the NHS may fall under GATS rules (Vincent-Jones 2006: 64) which may entrench privatisation (Sexton 2003: 100). Although the potential constraining effect of GATS on NHS policymaking was noted by many academics, it did not inform public debate. The following keyword searches were conducted on the Historic Hansard website: 'NHS WTO', 'NHS GATS', 'NHS World Trade Organisation' and 'NHS General Agreement on Trade in Services'. There were no results for the first two search terms within the 1990s. There were sixty-one results and six results for the latter two search terms respectively, but none of the generated results concerned parliamentary discussion regarding the potentially constraining effect of GATS on NHS policymaking within the 1990s. The same keyword searches were conducted on Proquest. There were no results for the second search term, although the first, third and fourth search terms generated fourteen, 267 and sixty-five results respectively. Of such results, only one article, by Will Hutton (1999), concerned the potential applicability of GATS to the NHS.

Although the internal market was criticised by the Labour party and was opposed by the British Medical Association (BMA), many citizens were unaware of the reforms. For example, about half of the participants in Marianna Fotaki's (1999: 1423) case study of cataract surgery in Outer London were unaware of the reforms. Thus the market reforms of the 1990s were not highly politicised and the potential external constitutional restrictions on NHS policymaking seem not to have generated much comment (outside of academia) in that decade. This may be because the internal market was less controversial than subsequent reforms, as it did not furnish private companies with new opportunities (as it involved competition between NHS providers), and disputes were resolved internally (hence the courts were unable to adjudicate on the applicability of transnational laws).

### Labour's Mimic-Market

Despite having opposed the internal market, once elected in 1997 (the first of three electoral victories) Labour retained the split between purchasers and providers, which was "renamed commissioning" (Timmins 2012: 21). In contrast, the split was removed in Scotland and Wales by newly devolved governments, which were enabled to determine health policy for their respective countries. In England, Primary Care Groups (PCGs), which evolved into Primary Care Trusts (PCTs) (Paton 2002: 128), were given responsibility for commissioning. Following its re-election in 2001, Labour gradually started introducing market-like mechanisms into the NHS (Mays et al 2011: 6). This involved demand side reforms, supply side reforms, transactional reforms and system management reforms (Department of Health 2007a: 3). The supply side

reforms included increasing provider diversity. For example, New Labour created foundation trusts (FTs) (via the Health and Social Care (Community Health and Standards) (HSC) Act (2003)) which were afforded greater freedoms than NHS trusts. Such freedoms included independence from the Department of Health (rather they are regulated by Monitor) and powers to borrow and invest money. Pauline Allen et al's (2011) case study indicated that trusts became "more business focused" once elevated to FT status (p. 3). New Labour also enabled private companies to increasingly deliver NHS services by creating independent sector treatment centres (ISTCs), which provided NHS elective and diagnostic procedures. NHS patients were also enabled, in some circumstances, to choose private providers. Consequently, an increasing proportion of the NHS budget was channelled to private providers. The transactional reforms included introducing payment by results (PBR) for reimbursing secondary care providers for many treatments. As already alluded to, the demand side reforms included furnishing patients with more choice (ultimately of any willing provider for some treatments) and developments in commissioning, such as commissioners being encouraged to use external support from private companies.

The activities of commissioners became increasingly regulated by law. Labour encouraged commissioners to utilise external commissioning support from private companies. Commissioners that did so were required to comply with EU public procurement law. The Public Contract Regulations (PCR) (2006) implemented a 2004 EU public procurement directive into UK law. The directive distinguished between part A services (including management and procurement consultancy services) and part B services (including health and social care services). The former were subject to the provisions of the directive. In contrast, contracts relating to the latter were only subject

to Article 23 (concerning technical specifications) and Article 35(4) (concerning notices) of the directive (as per Article 21). Thus commissioners using competition in procuring health and social care services were not required to comply with all of the provisions of the directive. Nonetheless, they were still required to adhere to the principles of the EU treaties.

Although Labour encouraged both external commissioning support and provider diversity, commissioners could avoid the public procurement rules if they provided services in-house, or, as per the *Teckal* case, they exercised control over the provider (which undertook the essential part of its activities with the commissioner) similar to their control over their own internal departments (Collins 2015: 5/ Hancher and Sauter 2012: 147-148). Consequently, NHS contracts between PCTs and NHS Trusts were exempt, but contracts between PCTs and FTs were not (Brown 2013). Nonetheless, Labour's championing of diversity of provision meant that care increasingly began to be bought through legally binding contracts. Consequently, EU public procurement law became more applicable (Timmins 2008). Scott Greer and Simone Rauscher (2011: 812) state that Labour deliberately opted to force EU public procurement law into health services as it was a logical consequence of, and a way to lock in, a market for clinical services. The '*Principles and Rules for Co-operation and Competition*' ('*PRCC*'), published by the Department of Health in 2007 (2007b), contained EU legal positions (Owen 2015). Conflicts were increasingly resolved with reference to the '*PRCC*', adjudicated on by the Co-operation and Competition Panel (CCP) established in 2009.

The increased competition within the NHS, occasioned by Labour's reforms, meant that EU competition law was also engaged. EU competition law applies if a service is economic and a service provider is an undertaking (Greer et al 2014: 101). Okeoghene Odudu (2011: 233) states that activities are considered economic firstly, if an entity supplies goods or services to the market. Secondly, as per the *Bettercare Group Limited* case, absent legislative intervention, there must be the potential to make a profit (p. 233). Odudu states that this is a technical question concerning whether a service could merely be provided to fee-payers (p. 236). The EU treaties do not define what constitutes an undertaking (p. 232). Odudu states that an entity may be deemed to be an undertaking in relation to some activities, but not others, even if it is not for profit (p. 232). Odudu concluded that although NHS hospitals in England are state owned and funded and operate to provide universal coverage, free at the point of delivery, they "fall within the scope of EU competition law" (p. 238). However, EU competition law may not have applied to the entire English NHS. As Simon Taylor (2015: 6) argues, it could be credibly argued that NHS providers are only economic operators concerning activities which have been exposed to competition, such as diagnostic and elective secondary care services.

As with public procurement law, there are exemptions to competition law. For example, it may not apply if a service is designated as a service of general economic interest (SGEI) (as per TFEU, Article 106(2)), a service of general interest (SGI) (which is not part of any binding legal text), a social service of general interest (SSGI) or a non-economic service of general interest (NESGI) (as per the Treaty of Lisbon, Protocol 26) (Neergaard 2013: 207-210). However, such concepts are not integrated into the law, or vocabularies, of member states (Bauby 2013: 36), hence their applicability is

ambiguous. Ulla Neergaard (2011: 48-49) notes that the concept of solidarity (internal to member states) has also become increasingly significant in EU law, but that the degree of immunity it affords is unclear. Consequently, although scope existed for exceptions, in increasing competition within the NHS, Labour's reforms meant that EU competition law became increasingly applicable.

As its reforms afforded increasing opportunities for private companies within the NHS, Labour faced increasing criticism from its own backbenchers, trade unions and academics who were concerned about the impact on the NHS. In addition, Sally Ruane (2016) notes that "one of the consequences of marketization and growing privatisation was the emergence of groups of citizens organising to resist further developments" (p. 280). For example, Keep Our NHS Public (KONP) was formed in 2005 and organised national protests and local campaigns. While privatisation became increasingly contested, the potential for EU law to render it irreversible does not appear to have attracted much attention outside of academia. Keyword searches of 'NHS EU public procurement' and 'NHS EU competition law' were conducted on the Historic Hansard website. The search terms generated three and four results, within the 2000s, respectively. None of the results showed parliamentary acknowledgement of the potential constraining effect of EU law on NHS policymaking. Nonetheless, some politicians were aware of this potential constraint. For example, Frank Dobson (Secretary of State for Health between 1997 and 1999) advised Tony Blair (UK Prime Minister between 1997 and 2007) to seek an exemption for the NHS within the Lisbon Treaty (Dobson 2013: 41). This did not materialise. The same searches were conducted on Proquest and generated 159 and 204 results respectively. Although many of the generated results were not relevant, such searches indicate that some

journalists, such as Nicholas Timmins, recognised such constraints. Labour's reforms thus meant that the NHS became increasingly subject to contract law and EU public procurement and competition law. Although the privatisation that such reforms facilitated was contested, there is an apparent lack of awareness among politicians, and many journalists, of the potential for EU law to restrict NHS policymaking. This may be because of the aforementioned exceptions and because private companies tended to refer contested issues to CCP rather than the courts.

### The Health and Social Care Act (2012)

The HSC Act (2012) instituted the current market in the English NHS. The amount of the NHS budget going to private providers has increased. It was recently calculated as totalling £12.7 billion (Lafond et al 2017: 3). Additionally, the NHS is not currently being adequately funded. Between 2009/10 and 2014/15, increases in public spending on health averaged 1.1% a year, the lowest five-year growth rate since the 1950s (Luchinskaya et al 2017: 141). This contrasts with the spending increases above inflation of three to four percent per annum that the NHS requires to maintain performance and grow services (Davis et al 2015: 12). Such inadequate funding has meant that NHS performance has deteriorated leading to increasing private activity outside of the NHS. As a result, the profits of some private providers have doubled (Price 2016). The use of market mechanisms, requiring expensive tendering processes and potential legal challenges, also represents a large opportunity cost for the NHS. Calum Paton (2016: 165) estimates that the recurring annual costs of the

current market are approximately £4 billion. This amount would be better spent on patient care.

The HSC Act (2012) abolished Strategic Health Authorities and PCTs. It created NHS England, to commission primary care and specialist services, and Clinical Commissioning Groups (CCGs), to commission secondary care services. Monitor (now known as NHS Improvement following its merger with the NHS Trust Development Authority in 2016) was empowered as a sector regulator to prevent anti-competitive behaviour. It's Co-operation and Competition Directorate took over CCP's role in 2013. Commissioners are required to comply with the regulations passed pursuant to the HSC Act (2012), S.75, and PCR (2006), for procurements before the 18<sup>th</sup> of April 2016, or the Public Contract Regulations (PCR) (2015), for procurements after that date. PCR (2015) implemented the 2014 EU directive on public procurement into UK law. This removed the aforementioned distinction between part A and part B services. Consequently, commissioners must advertise all invitations to tender for health service contracts above specified thresholds in the Official Journal of the EU (OJEU) and follow a specified procurement process (Collins 2015: 3). Nonetheless, as with PCR (2006), there are exemptions to PCR (2015), such as the sole supplier exemption. The government has not issued guidance on how the S.75 regulations and PCR (2015) interrelate (Procurement Lawyers Association (PLA) 2016: 13). PLA (2016: 25) surmise that inconsistencies are likely to be resolved in favour of EU law because of its supremacy.

Anne Davies (2013) argues that the HSC Act (2012) exemplifies the second (law regulating an increasing number of activities) and fourth (the legal system acquiring more power) dimensions of juridification, identified by Blichner and Molander, as it “involves much greater use of law to structure and regulate the NHS, in place of traditional mechanisms like ministerial direction” (p. 567). Davies avers that the reforms are also indicative of another sense of juridification, identified by Veitch et al, in which decisions that were previously a matter for government policy become shaped and governed by legal rules (p. 567). For example, Davies notes that the use of private firms within the NHS has become a technical legal matter (p. 567). Davies examined three areas of juridification: “mergers between providers, other competition law requirements for providers [abuse of a dominant position and agreements to restrict competition], and the rules applicable to commissioners” (p. 581). These areas are examined in the following paragraphs.

Davies (2013) states that, before the HSC Act (2012), mergers, abuse of a dominant position and agreements to restrict competition were dealt with via the ‘*PRCC*’ (pp. 581-582). Davies states that the HSC Act (2012) altered the situation, regarding abuse of a dominant position and agreements to restrict competition, by: implicitly accepting that competition law applied to at least some aspects of NHS activity; empowering Monitor as the sector regulator; and, requiring licence-holders to refrain from anti-competitive behaviour (p. 582). As such law already applied (although scope existed for exceptions), the altered situation was government acknowledgement of its applicability rather than a legal change. Davies states that CCP had determined whether to approve proposed mergers through a cost-benefit analysis (p. 581). The HSC Act (2012) subjects mergers involving FTs to the Enterprise Act (2002), enforced

by the Competition and Markets Authority (CMA) (created following the merger of the Office of Fair Trading and the Competition Commission in 2014). Davies stated that the change meant that there could be serious consequences if a merger breached the rules (p. 581). This was evidenced by a proposed merger, between Royal Bournemouth and Christchurch Hospitals and Poole Hospital Trusts, failing, in 2013, as it was deemed that it would reduce competition in Dorset. The *Guardian* columnist Polly Toynbee (2013) noted that the applicability of EU competition law deterred other potential mergers which may have benefited patients. Nonetheless, Marie Sanderson et al (2016: 16) state that following the decision, the NHS has avoided entanglement with competition law. Instead sector regulators have relied on sectoral rules (Sanderson et al 2016: 16/ Calkin 2014).

Davies (2013: 583) notes that competition and public procurement law are mutually exclusive hence a body cannot be subject to both. However, Davies states that this distinction was blurred by both the '*PRCC*' and the HSC Act (2012) (p. 583). For example, R.10 of the S.75 regulations forbids commissioners from engaging in anti-competitive behaviour. The PLA (2016: 73-74) argue that NHS commissioners may be deemed to be undertakings in certain circumstances, for example, if they sell on their purchased services (although they conclude that this is unlikely). PLA (2016: 13) contend that the S.75 regulations arguably conflict with each other. Consequently, the amount of discretion afforded to commissioners regarding tendering is contested. David Lock QC (2013) argues that the narrow test in R.5 of the S.75 regulations (which states that commissioners may award new contracts to a single provider where they are satisfied that only that provider is capable of providing the contracted services) emasculates R.2 (which states that commissioners must act to secure service-user's

needs and improve service quality and efficiency) and R.10 (which permits commissioners to engage in anti-competitive behaviour if it is in patient's interests for services to be provided in an integrated way or for co-operation between providers to improve quality). Lock (2013) states that if a contract can be provided by more than one provider, commissioners must hold a competitive tender, even if it is not in patient's interests. However, PLA (2016: 21) state that Monitor's guidance suggests that the starting point for commissioners, in determining whether to use competition, is R.2 and R.3 (which states that commissioners must procure services from one or more providers that are most capable of delivering the objectives outlined in R.2 and provide the best value for money in doing so) rather than R.5.

Although the discretion afforded to commissioners, regarding the use of competition, is contested, many commissioners have acted as though such discretion was curtailed. A *Health Services Journal (HSJ)* poll found that forty-six percent of respondents (103 respondents across ninety-three CCGs) stated that CCGs had not been able to change services as desired due to the regulations, or concerns about them, and twenty-nine percent stated that they had invited competition for services where they would not have done if not for the rules (West 2014). Thus commissioners may opt to conduct expensive tendering processes due to fear of potential legal challenges. A fifth of respondents to *HSJ's* poll stated that their CCG's decisions had been legally challenged (West 2014). Providers dissatisfied with tendering processes may complain to NHS Improvement, the European Commission (which can refer issues to CJEU) or the courts via judicial review (if public law principles are contravened) (PLA 2016: 50-57). Sanderson et al (2016) argued that the small number of cases suggests a long-standing practice to settle matters informally, even avoiding

NHS Improvement's sector specific regulation. However, as the NHS Support Federation (NSF) (2017: 38) note, some providers, such as Virgin, have become increasingly litigious. For example, in 2017 Virgin was paid an undisclosed fee to settle a legal case regarding its challenge to the decision of CCGs in Surrey not to award it a contract to provide children's health services (NSF 2017: 38). It was speculated that the fee was approximately £2 million (Embury-Dennis 2017). This payment generated controversy and thousands have signed a petition demanding that Virgin return the money to the NHS (Embury-Dennis 2017). Thus conflicts are increasingly being solved with reference to law (for example, by CCP or NHS Improvement) and by law itself (within the courts) and the legal system is acquiring more authority through litigation.

There are countervailing forces to competition, such as resource constraints, which prevent commissioners from undertaking numerous tenders (Osipovic et al 2016: 834), and the squeeze on prices due to austerity and limited budgets (Krachler and Greer 2015: 216-217). In addition, campaigners have influenced commissioner's decisions. For example, campaigners prevented Virgin taking over children's health services in Bristol (Molloy 2016). Nick Krachler and Ian Greer (2015) state that the vigorous defence of the NHS by campaigners, such as KONP, has "kept healthcare policy highly politicised" (p. 222). Although privatization has become a technical legal matter, the proliferation of local KONP groups, which have more than doubled since 2010, suggests that there is increased awareness of, and resistance to, it. KONP collaborated with other groups to create Health Campaigns Together (HCT), which organised the largest rally in NHS history, against cuts and privatisation, in London, in March 2017. This indicates that public solidarity, which was important in the creation of the NHS, endures in respect of healthcare.

In addition, there has been an increased focus on integration, rather than competition, which is evident in NHS England's '*Five Year Forward View*' ('*FYFV*'). Commissioners in Allen et al's (2017: 7) case study believed that '*FYFV*' afforded them greater latitude in deciding whether to tender services. '*FYFV*' outlined a number of new models of integrating care. Numerous vanguards have been established in this regard. In order to implement '*FYFV*', England was divided (without legislation) into forty-four areas and Sustainability and Transformation Plans (STPs) were composed for each one. STPs have proposed reconfigurations to services, in an effort to resolve the problems caused by inadequate funding (Leys 2016: 7). For example, in Dorset, proposals to reconfigure Poole hospital, including closing its accident and emergency (Our Dorset 2016: 31) were recently approved by Dorset CCG, but are opposed by the pressure group, Defend Dorset NHS, which has launched a judicial review (BBC 2018). STPs are viewed as a shift from competition to place-based planning (Alderwick et al 2016: 7). Simon Stevens (NHS England Chief Executive since 2014) states that some STPs may develop into accountable care organisations (ACOs) which can move beyond the purchaser/provider split (Committee of Public Accounts 2017: Q90).

Kailash Chand (2017) argues that developments, such as devolution of health service functions to some areas, such as Manchester, Liverpool and London (facilitated by the Cities and Local Government Devolution Act (2016), S.18), and the development of ACOs, signal the demise of CCGs. Without legal changes, integration may be challenged. Nevertheless, NSF (2017: 35) note that NHS organisations are finding ways of avoiding tendering. For example, health leaders in Manchester game-played

the rules in advertising a £6 billion contract to run a local care organisation (part of a new integrated care model) in the city by not dividing the large contract into lots (as is common practice) and through the very short time frame (six weeks) for bids (NSF 2017: 35/ Sanchez-Graells 2017). The Department of Health (2017) has conducted a technical consultation on proposed regulatory changes to facilitate ACO contracts. As there has not been a public consultation, or parliamentary scrutiny, a group of academics, including Allyson Pollock and the late Stephen Hawking, have challenged such proposed changes through a judicial review. There are fears that ACOs will provide private companies with new opportunities within the NHS. Despite the seeming shift away from competition, NSF (2017: 3) note that market activity for NHS contracts continues apace, as £7.1 billion worth of NHS clinical contracts were awarded through tendering between April 2016 and April 2017.

The potentially constraining effect of EU law on the NHS became a contested issue during the coalition's period in government. For example, Ed Miliband (Labour party leader from 2010 to 2015) asked David Cameron (UK Prime Minister between 2010 and 2016) at a session of Prime Ministers Questions to confirm whether the bill which became the HSC Act (2012) would make "health care subject to EU competition law for the first time in history?" (H.C. Deb. 16 March 2011). As outlined above, such law already partly applied to the NHS prior to the HSC Act (2012). Miliband's belief that the legislation would initiate the applicability of EU competition law demonstrates a lack of awareness of the impact of Labour's reforms. Nonetheless, some parliamentarians, such as Lord Clement Jones, were aware that EU competition law had applied to the NHS "for some years" (Health and Social Care Bill Deb. 13 December 2011).

Hansard searches of 'NHS EU public procurement' and 'NHS EU competition law', from 2010 onwards, generated forty-three and seventy-seven spoken references respectively. The same searches were conducted on Proquest and generated 285 and 691 results, from 2010 onwards, respectively. Such search results suggest increased parliamentary and journalistic awareness of the applicability of EU law to the NHS. Andrew Lansley (Secretary of State for Health between 2010 and 2012) argued that the HSC Bill was not extending either EU or domestic competition law (Health Committee 2011: Ev.92). He stated that "literally, our legislation cannot affect the extent of EU competition law" (Health Committee 2011: Ev.94). In contrast, Simon Burns (Minister of State for Health Services between 2010 and 2012) stated that "as NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition laws will increasingly become applicable" (Health and Social Care Bill Deb. 15 March 2011). Thus Lansley's claim that UK legislation could not affect the extent of EU competition law was misleading, as the UK government could enact legislation that would increase competition within the NHS, and this would, in turn, extend the application of EU competition law to the NHS.

The coalition's HSC Act (2012) has led to increased private provision and the increased applicability of EU laws. The strategy of juridification appears to have failed to depoliticise such changes, which have been contested. Similarly, the strategy of new constitutionalism appears to have failed as the exact nature of the applicability of EU public procurement and competition laws became politically contested during the

coalition's period in government. In 2015, Andy Burnham (Shadow Secretary of State for Health between 2011 and 2015) stated that Labour would fully exempt the NHS from EU public procurement and competition law (Collins 2015: 1). According to Burnham, the European Commission had confirmed that this was possible (Campbell 2015). However, as mentioned above, EU law may constrain the policymaking abilities of national governments regarding services which are already subject to competition.

### The Brexit Referendum and Afterwards

The Conservatives won a majority in the House of Commons in the 2015 general election and thus were able to govern without the Liberal Democrats. In June 2016, the UK electorate voted to leave the EU, in a referendum. Cameron resigned as Prime Minister and was succeeded by Theresa May. The Conservatives lost their majority in the 2017 general election, but continue to govern with the support of Northern Ireland's Democratic Unionist Party (DUP). During the referendum campaign, the potential of EU laws to constrain NHS policymaking was raised by some pro-Brexit organisations and campaigners, such as Labour Leave (a pro-Brexit campaign group within the Labour party) and David Owen (2016: 139), former leader of the Social Democratic Party between 1983 and 1987 (before its merger with the Liberal party to create the Liberal Democrats) and a member of the Campaign Committee (the governing body) of Vote Leave (which the Electoral Commission designated as the official campaign in favour of leaving the EU). Searches of newspapers and other sources indicate that there were concerns prior to, and during the referendum campaign, that a potential trade deal between the US and the EU, known as the trans-Atlantic trade and

investment partnership (TTIP), could restrict policymaking concerning the NHS. The UK government's decision to expose public ambulance services and all secondary care services to the liberalising effect of a trade agreement between Canada and the EU, the Comprehensive Economic and Trade Agreement (CETA), was viewed as a worrying precedent for TTIP (Raptopoulou 2015b: 2).

A Proquest search of 'NHS TTIP', from 2013 (when the TTIP negotiations began) onwards, generated 1,038 results. The potential impact of TTIP was raised in numerous articles within the *Guardian* (Quinn 2016/ Mason 2016) and the *Independent* (Williams 2015/ Sheffield 2016). The same search was conducted on Hansard and generated 147 spoken references. For example, the impact of the prospective deal on the NHS was considered within a House of Commons debate dedicated to TTIP on the 10<sup>th</sup> of December 2015 (H.C. Deb. 10 December 2015). TTIP also provoked reactions from trade unions, such as Unite the Union, which sought and published legal advice from Raptopoulou (2015b) and Michael Bowsher QC and Azeem Suterwalla (2016), regarding the legal implications for the NHS. 38 Degrees (a not for profit political activism organisation) organised a petition to prevent TTIP (which received thousands of signatures), orchestrated the sending of emails to politicians and disseminated its message via advertisements and leaflets (Whalley 2016).

Owen Worth (2017: 351-354) argues that although many left-wing Brexit supporters hoped it would free the UK from the EU's neo-liberal structures, it has succoured the far-right, conservatives and hyper-liberals and may diminish the prospects for socialist renewal. Worth's pessimistic analysis was partly influenced by Labour's poor opinion

poll ratings in early 2017 (p. 354), which were subsequently belied by Labour's performance in the 2017 general election. As the above analysis demonstrates, legal constraints on NHS policymaking result from political choices. Some of the potentially available political choices pertaining to Brexit may threaten national policymaking concerning the NHS. As both May and Jeremy Corbyn (Labour Leader since 2015) favour leaving the EU single market, the constraints of EU laws on NHS policymaking may cease to apply after Brexit, depending on the terms of any future trading agreement between the UK and the EU (McKenna 2016).

Given the current government's commitment to free trade, Mark Dayan (2017: 14) argues that Brexit may simply mean replacing the backstops of EU single market law with new ones. If the UK leaves the customs union (as May wishes, but Corbyn now opposes), it could enter into trade agreements that restrict parliament's ability to legislate regarding the NHS. Concern about this has been expressed by journalists, such as George Monbiot (2016), trade union leaders, such as Dave Prentis (General Secretary of UNISON since 2001), politicians, such as Jonathan Ashworth (Shadow Secretary of State for Health from 2016 onwards) (Edwards 2017) and numerous doctors, many of whom signed a letter, printed in the *Guardian*, demanding protection for the NHS "from a [Donald] Trump [US President from 2017 onwards]-style corporate takeover" (Macklin-Doherty et al 2017). In addition, thousands of people have signed an open letter to Liam Fox (Secretary of State for International Trade from 2016 onwards), written by 38 Degrees, which states that any new trade deals must protect the NHS (38 Degrees 2017).

## Discussion

The English NHS has been increasingly juridified, in the neo-liberal era, as laws (such as contract law and EU public procurement and competition laws) have come to increasingly regulate the activities of NHS actors (and new legal statuses have altered the behaviour of such actors). In addition, conflicts within the NHS have been increasingly solved with reference to (for example, by CCP and NHS Improvement), and by (as private providers have become more litigious), law, hence the legal system has accrued more power as contrasted with formal authority. Although privatisation has become a technical legal matter, the NHS seems increasingly politicised, as is evident in the activities of groups such as KONP and HCT. Recent surveys reveal a decline in respondents agreeing with the notion that the provider of health services is immaterial, as long as they are free (Ipsos MORI 2013/ Appleby et al 2015: 115). This may indicate increased public awareness of the detrimental effect of the expanding private sector on the NHS. It could translate into increased clamour for neo-liberal reforms to be reversed, as the NHS (Reinstatement) Bill proposes, given continued public support for the NHS' founding principles (Gershlick et al 2015: 11).

The evident concerns regarding the potential of TTIP and post-Brexit trade deals to constrain NHS policymaking suggest a heightened awareness of potential external constitutional constraints, in respect of healthcare, given the contrast in parliamentary and journalistic comment on such constraints, over time, detected within this article. The search results, from Hansard and Proquest, revealed that there was no parliamentary and little journalistic acknowledgement of the potential constraints on

NHS policymaking imposed by GATS in the 1990s. Similarly, there was no acknowledgement, in parliamentary debates, of the potential constraints imposed by EU law in the 2000s, although some journalists acknowledged this. In contrast, the aforementioned search results indicate that many parliamentarians and journalists have acknowledged such potential constraints since 2010. Similarly, many parliamentarians, journalists and campaigners have acknowledged the potential constraints of TTIP and post-Brexit trade deals on NHS policymaking. The internet, in particular social media, may have been important in heightening awareness as it enables campaigners to easily disseminate their messages widely. Campaigns against privatisation and the seeming heightened awareness of the potential constraints of transnational laws indicate that the strategies of juridification and new constitutionalism have not succeeded in naturalising market reforms to the NHS or weakened public solidarity concerning healthcare (although the institutions executing this principle are being undermined through underfunding and privatisation), thereby revealing limits to neo-liberal hegemony.

## Conclusion

Markets have been idealised by successive governments in the neo-liberal era which have marketized and privatised the English NHS, thereby diverting money away from patient needs and undermining risk pooling and cross subsidy within the NHS. Such governments have employed strategies to attempt to naturalise their reforms. The NHS has been juridified as law, for example, contract law and EU public procurement and competition law, increasingly regulates NHS activity and resolves conflicts.

However, the activities of campaign groups indicate that although privatisation has become a technical legal matter, it is highly politicised, and differences in journalistic, parliamentary and public responses to potential external constitutional constraints, over time, suggest a heightened awareness of such restrictions. Consequently, the strategies of juridification and new constitutionalism appear to have failed to naturalise market reforms to the NHS, revealing limits to the hegemony of neo-liberalism and the endurance of public solidarity concerning healthcare.

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