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‘‘With great power comes great responsibility’’.

Introduction

In this article, I evaluate democracy, ministerial power and responsibility and institutional depoliticisation within the English NHS. A democratic deficit has existed within the NHS since its inception. The NHS’ administrative structure was designed to be accountable upwards to ministers (answerable to parliament) affording them a semblance of control over what was a professionally dominated service. Numerous reorganisations and management and market reforms, in the neo-liberal era (**from the late 1970s onwards**), sought to increase political control over the NHS. While successive governments claimed that they desired to empower patients (primarily through patient choice) and decentralise power, central control over the service has increased. Nonetheless, politicians sought to insulate themselves from responsibility through institutional depoliticisation, to shift blame, facilitated through legal changes. This strategy is evident in the creation of the National Institute for Clinical Excellence (NICE), Monitor and NHS England.

While NICE and Monitor were created, **by New Labour**, in an effort to reduce government culpability for health technology regulation and the operation of foundation trusts (FTs), respectively, NHS England was established, **by the Health and Social Care (HSC) Act (2012),** in an effort to reduce government culpability for healthcare generally. NHS England **was designed to enable** governments to try to shift blame for NHS problems. This is significant as the English NHS is currently being undermined through inadequate funding (spending increases **from 2010 onwards** are the lowest in decades) and privatisation **(many services are being outsourced to**

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private contractors paid from NHS budgets). While NHS England can potentially both politicise issues and remove them from political contestation, government strategies of blame shifting are unlikely to succeed as it retains important powers (such as determining NHS funding) and the public has not shifted from blaming the government to blaming NHS England. This demonstrates limits to the capacity of law to legitimise changes to social relations. Patient choice policies **were justified on the basis of empowering patients but in fact enabled the creation of markets**. **I argue that addressing the NHS' democratic deficit is crucial to empowering patients.**

Depoliticisation

Colin Hay defines politics as ‘‘the capacity for agency and deliberation in situations of genuine collective or social choice’’. [1] If such capacity is undermined, this constitutes depoliticisation, which is a mode of reification. Once an issue is removed from agency and deliberation it becomes naturalised rather than contested. Neo-liberalism has been the dominant ideology in the UK since the disintegration of the post Second World War social democratic consensus in the 1970s. Successive governments have renewed the neo-liberal project [2] which David Harvey describes as a class project ‘‘to restore and consolidate capitalist class power’’. [3] Depoliticisation is a strategy of neo-liberal governance. [4] The potential depoliticisation of neo-liberal reforms is significant because such reforms benefit the dominant class. For example, market reforms seek to redistribute wealth to the affluent [5] by facilitating the possibility of profit-making for private companies (which have influenced government policy) from services which are funded publicly. [6] Law may facilitate depoliticisation because, as Karl Klare argued, it

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might induce ‘‘the belief that our evolving social arrangements and institutions are just and rational or at least inevitable and therefore legitimate’’. [7] Nonetheless, a tension exists between the capacity of law to legitimise changes to social relations and traditional views of what is legitimate. Bob Jessop contends that depoliticisation may occur on the levels of polity, politics and policy. [8] Governments have employed strategies on each level in their attempts to depoliticise healthcare.

I concentrate on institutional depoliticization, [9] a polity level strategy involving a re-organisation of the political division of labour in an effort to pass the buck. [8] The literature regarding depoliticisation has been criticised for overemphasising the novelty of the phenomenon. [10] I emphasise that the NHS has had a democratic deficit since **1948 because** politics is missing from its structure. [11] Democratic control was to be through ministerial accountability to parliament, which gave the Department of Health a semblance of control. Central control has increased, but ministers have utilised institutional depoliticisation in an attempt to reduce their accountability. Patrick Diamond argued, in relation to his research regarding New Labour, that there was a dialectical relationship between politicisation and depoliticisation as policymakers adopted a hybrid mix, accruing power to ‘take credit’ and giving it away (‘blame shifting’). [12] I assess whether the efforts of successive governments to shift blame regarding healthcare have been successful. This is increasingly significant as the NHS is currently being undermined by inadequate funding and privatisation. In respect of the former, recent spending increases **from 2010 onwards** are the lowest since the 1950s, despite population growth of over four million and an increase in the elderly proportion of the population (with greater average costs). The NHS has not been

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furnished with the spending increases above inflation of three to four percent per annum that it requires to maintain performance and grow services. [13]

Power and Responsibility

Before the NHS, there were voluntary and municipal hospitals (administered by local authorities) within the UK. The National Health Service (NHS) Act (1946), passed by the first majority Labour government (1945-1951), created the UK NHS, which became operational in 1948. The statute nationalised hospitals, although many voluntary hospitals were disclaimed from its provisions. [14] The NHS’ founding principles were that it was to be free (at the point of access), universal, comprehensive and funded from general taxation. As public support for such principles endures, they can be viewed as part of what E.P. Thompson conceptualised as a moral economy, a ‘‘popular consensus as to…legitimate and…illegitimate practices’’ based on a ‘‘traditional view of social norms and obligations’’. [15] The NHS originally had a tripartite structure. Hospitals were administered by Regional Hospital Boards (RHBs), Hospital Management Committees (HMCs) and Boards of Governors (which administered teaching hospitals), Executive Councils administered GPs and dentists, and local authorities had responsibility for many personal and environmental health services. 16

The NHS Act (1946) gave the Minister of Health both great power and great responsibility. William Mackenzie defined power as ‘‘the capability to affect people’’. 17 The NHS Act (1946), S.1(1) required the Minister of Health to provide a

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comprehensive health service. Mackenzie described the Minister of Health (now known as the Secretary of State for Health) as ‘‘without limit or qualification sovereign of the service’’. [17] The Minister appointed RHBs and historically, the NHS was regulated through circulars (often issued in line with the Minister’s power to give directions [18]) and other Ministry of Health (now known as the Department of Health) policy statements. [19] The centre could not simply dictate as entrepreneurial, judgmental and professional knowledge, which was ‘‘too complex to be caught in crude statistics’’, lay with the periphery. [20] Such professional dominance led Peter Miller and Nikolas Rose to describe the NHS as a medical enclosure. [21] Thus, although sovereign in theory, the Minister of Health’s power was circumscribed in practice.

Mackenzie defined responsibility as being answerable. [17] Democratic control over the service was to be through the Minister of Health’s accountability (the requirement to report and explain) [22] to parliament. The transfer of control over hospitals from democratically elected local authorities to unelected bodies was opposed, in cabinet, by Herbert Morrison (Deputy Prime Minister between 1945 and 1951). Ultimately, the plan of Aneurin Bevan (Minister of Health between 1945 and 1951) to nationalise such hospitals prevailed. Bevan feared that if local authorities were responsible for hospitals a second best service would have resulted. [23] Bevan hoped that future local government reform would enable the service to be democratised. [23] Accountability was designed to be through management upwards to the Minister of Health. [24]

Bevan famously stated that ‘‘if a bedpan lands on the floor in the hospital in Tredegar it should be clanging in Whitehall’’. [25] Brian Edwards notes that this quip haunted

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Bevan’s successors, who complained that ‘‘the balance at the centre was not right’’. [26] For example, David Owen (Minister of State for Health and Social Security between 1974 and 1976) stated that the Department of Health had become ‘‘bogged down in detailed administration covering day-to-day management that has been sucked in by the parliamentary process’’. [27] In Owen’s view, the answerability of ministers to parliament gave the semblance of control, but in practice, there had been ‘‘little central direction or control’’ regarding some major aspects of healthcare. [27] The absence of politics within the NHS necessarily meant that the parliamentary process was the only way citizens could have their grievances, concerning healthcare, redressed. A Royal Commission determined that ‘‘detailed ministerial accountability for the NHS is largely a constitutional fiction’’. [28] This myth of ministerial accountability was deemed by an Association of Community Health Councils for England and Wales (ACHCEW) commission, chaired by Will Hutton, in 1999, to have ‘‘disguised a wider absence of accountability and transparency of decision making within NHS structures’’. [29]

Centralisation

Successive reforms sought to increase central control. For example, in the early 1970s, Keith Joseph (Secretary of State for Health and Social Services between 1970 and 1974) devised an NHS reorganisation to unify its structure and strengthen accountability to the centre. [30] The National Health Service Reorganisation (NHSR) Act (1973) replaced RHBs and HMCs with Regional Health Authorities (RHAs), Area Health Authorities (AHAs) and District Management Teams (DMTs). The democratic deficit was unaddressed as the authorities were unelected. The NHSR Act (1973) also

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required AHAs to appoint Family Practitioner Committees (FPCs), which replaced Executive Councils. FPCs were subsequently renamed Family Health Service Authorities (FHSAs). AHAs were abolished in 1982 and District Health Authorities (DHAs) replaced DMTs. In 1996 RHAs, DHAs and FHSAs were abolished and 100 Health Authorities were established.[31] The NHSR Act (1973) also created Community Health Councils (CHCs) to represent patient voices. CHCs changed attitudes towards users, helped to politicise issues[32] and could halt contested service changes and refer them to the Secretary of State. However, Christine Hogg argued that they were ‘‘never intended as democratic control or accountability’’.[33] They were abolished (in England) in 2003 and replaced by a succession of weaker patient and public involvement mechanisms.

The NHS had been dominated by professionals, but during Margaret Thatcher’s premiership (between 1979 and 1990), there was a shift ‘‘to a management/commercial logic’’.[34] In 1983, Roy Griffiths’ report recommended introducing general management.[35] Nicholas Timmins states that the NHS subsequently moved from an administered to a managed system.[36] General management was, according to John Mohan, ‘‘a means of imposing central government targets on the service’’.[37] Targets are based on indicators, which Sally Engle Merry describes as, ‘‘statistical measures that are used to consolidate complex data into a single number or rank that is meaningful to policymakers and the public’’.[38] Such indicators evince a preference for superficial but standardized knowledge.[38] The Griffiths report also led to the creation of a Supervisory Board (subsequently replaced by a Policy Board, which was abolished in 1995), to make strategic decisions, and a Management Board (subsequently renamed the NHS Management Executive

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and then the NHS Executive and abolished in 2000), to plan policy implementation, within the Department of Health. The latter was moved to Leeds, but power and day-to-day decision making remained with ministers in London. [39] Patricia Day and Rudolf Klein stated that the evolution of such bodies demonstrated the difficulty in separating policy from management. [40]

Simon Jenkins argues that general management did not relieve Thatcher’s government from political pressure. [41] Consequently, a review in the late 1980s led to the introduction of an internal market, **which was implemented during John Major’s premiership (1990-1997)**. **The internal market** split purchasers and providers. **The purchasers included DHAs and GPs (who could apply to become fundholders, thereby fragmenting the local power of DHAs and FHSAs). Providers were enabled to become NHS trusts with greater autonomy from DHAs. Both NHS trusts** [42] **and health authorities** [43] **were given private sector-style boards which increased the democratic deficit, as even less attention was paid to notions of representativeness.** [44] The reforms were regarded as replacing a management hierarchy with contracting between purchasers and providers. [45] However, hierarchical relationships remained largely intact [46] and central guidance strongly influenced purchasers. [44] Although market reforms are often justified on the basis of increasing efficiency, John Lister notes that they make healthcare ‘‘more bureaucratic and more expensive to administer’’. [47] For example, the internal market increased bureaucracy and overhead costs [48] by ending the advantages of cost-sharing and integrated care. [49] The centralising effect of the reforms led Jenkins to argue that, by 1997, ‘‘Bevan’s desire to hear the clatter of every bedpan in the corridors of Westminster had been

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realized’’ as the NHS became ‘‘micro-managed from the centre to meet the needs of short-term, media-led politics’’. [50]

New Labour

The Labour party was rebranded as New Labour under Tony Blair’s leadership (1994-2007) and won three successive general elections (in 1997, 2001 and 2005). Labour devolved powers to Scotland, Wales and Northern Ireland, hence the Secretary of State for Health is now only responsible for the English NHS. New Labour had pledged to abolish the internal market, but although it abolished GP fundholding, [51] it retained the purchaser/provider split, which was renamed commissioning. [52] Commissioning was given to 481 Primary Care Groups (PCGs), **which were GP-led bodies**. PCGs subsequently evolved into 303 PCTs [53] (reduced to 152 in 2006). Health Authorities were **consolidated** into twenty-eight Strategic Health Authorities (SHAs). [54] SHAs were public bodies which published board papers and met in public until forced mergers reduced their number to ten in 2006. PCTs were **not directly accountable to the public and** were principally held to account through top-down management from SHAs. [22] Labour’s governance was described as ‘‘targets and terror’’. [55] It introduced numerous targets, such as reducing waits for outpatient and inpatient appointments and ending long waits (over four hours) in accident and emergency (A&E). [56] The amount of autonomy afforded to providers was determined by their performance in relation to targets. [55] Anna Dixon and Arturo Alvarez-Rosete describe targets as the epitome of micro-management, direct **ministerial** interference in the day-to-day running of the NHS. [57] New Labour also created a market in secondary

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care, **evident in supply-side reforms, such as the creation of FTs and independent sector treatment centres (privately run centres which undertook NHS elective and diagnostic procedures and were paid approximately eleven percent more than NHS providers), and demand-side reforms, such as furnishing** patients a choice of any willing provider (AWP) for some services. **Andy Burnham (Secretary of State for Health between 2009 and 2010) appeared to change the AWP policy, in 2009, by announcing that the NHS was the preferred provider, but subsequent procurement guidance clarified that procurement should not favour any particular provider.** [58] Although both New Labour and the subsequent coalition stated that they wanted to decentralise power within the NHS, Scott Greer and Margitta Matzke state that their reforms centralised power among strong nationwide regulators accountable to ministers. [59]

New Labour’s reforms led to ‘‘numerous functions traditionally overseen by health ministers’’ being ‘‘undertaken at arm’s length from the Department of Health’’. [60] NICE was created (it was a special health authority, [61] but is now an executive non-departmental body [62]) in an effort to reduce ministerial culpability regarding health technology regulation. According to Matthew Wood, NICE **succeeded** in reducing ministerial culpability, as it was supported by a structure of formal institutional rules and informal norms which meant that ministers did not seek to intervene in its decision making processes [63] (despite pharmaceutical companies and right wing newspapers pressuring ministers to make new drugs available). The Commission for Healthcare Audit and Inspection (CHAI), also known as the Healthcare Commission, was created to inspect NHS providers. [64] It was subsequently dissolved, along with the Commission for Social Care and Inspection and the Mental Health Act Commission and they were

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replaced with the Care Quality Commission (CQC). [65] Despite the creation of such bodies, healthcare quality remains a contested issue.

Monitor was created as the independent regulator of FTs. [64] **FTs were created despite parliamentary opposition from Labour backbenchers. FTs can borrow money, generate surpluses and form subsidiaries and joint ventures with private companies, which can accumulate profits.** Unlike other hospitals, with a line of accountability to the Department of Health, FTs were to be accountable to Monitor, their members (who are not required to be representative of, or answerable to, the local population [66]), elected governors (FTs have a dual governance structure consisting of a board of governors and a board of directors), PCTs and CHAI. [67] John Reid (Secretary of State for Health between 2003 and 2005) confirmed that FTs ‘‘are independent of the department, and directly accountable to their local populations and to parliament’’. [68] Richard Lewis noted that this meant, in theory, no minister would have to defend healthcare professionals and managers in parliament. [69] Monitor was somewhat successful in reducing ministerial culpability because, as William Moyes (Executive Chairman of Monitor between 2004 and 2010) et al noted, frequently cases of failure or potential failure of FTs ‘‘were managed without ministerial intervention or formal parliamentary interest’’. [70]

However, Moyes et al state that major policy failures often lead to top-down accountability returning. [70] For example, they argue that the Mid Staffordshire NHS FT (**Mid Staffs**) case shows that a Secretary of State may consider themselves accountable and intervene, irrespective of the legal position, where a failing body

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threatens patient health or safety. [70] The **Mid Staffs** scandal arose due to the poor care and high mortality rates at the hospital, which in its efforts to secure FT status, cut staffing levels to reduce a deficit. A public inquiry, chaired by Sir Robert Francis Q.C., was established in June 2010 to investigate the hospital. Moyes had informed Alan Johnson (Secretary of State for Health between 2007 and 2009) that he was not responsible for handling the scandal. [71] In response, Johnson told Moyes to ‘‘piss off’’ as he was ‘‘dealing with this’’. [71] The law may therefore be used to consolidate changes to public services, such as diminishing ministerial responsibility, but, in practice, ministers may still intervene. As Timmins avers, legislation is trumped by the behaviour of the minister. [36] This indicates that law may not legitimise changes to norms concerning ministerial behaviour where the public and politicians consider that ministers could or should intervene. Many NHS Chief Executives have complained about increased regulation and information demands since the **Mid Staffs** scandal and that FT freedoms have dwindled as funding has contracted. [72]

Developments since 2010

The 2010 general election resulted in a hung parliament, following which the Conservative and Liberal Democrat parties formed a coalition government. The coalition’s central policy of austerity, which it justified on the basis of reducing the UK’s national deficit, which rose following the Great Recession (2008-2009), involved public spending cuts and public service restructuring. [73] However, Mark Blyth notes that austerity policies have not succeeded historically in promoting growth or reducing debts. [74] The coalition lasted until the 2015 general election, in which the

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Conservatives won a majority of twelve in the House of Commons and were thus able to govern alone. David Cameron (Prime Minister between 2010 and 2016) resigned following the UK electorate’s vote to leave the European Union (EU) in a referendum in June 2016, and was succeeded by Theresa May. The Conservatives lost their majority in the 2017 general election, but continued to govern with the support of Northern Ireland’s Democratic Unionist Party (DUP). The policy of austerity has persisted since 2015 and has detrimentally affected public services. Although the coalition stated that it wanted to move away from process targets, their use has continued since 2010. [75] In addition, more indicators concerning outcomes, such as friends and family test scores (**which convert patient experiences into a percentage of patients who would recommend a service to their family and friends**), are being produced, partly to inform patient choice. Such indicators reduce quality to quantity which, Theodor Adorno argued, is a process of abstraction that ‘‘distances itself from the objects’’. [76] I contend that enhancing patient voice is a preferable means of empowering patients.

The HSC Act (2012) facilitates the current secondary care market. The legislation was passed despite much opposition, which led to an unprecedented pause as it proceeded through the legislative stages in parliament. The HSC Act (2012) abolished SHAs and PCTs and created NHS England and Clinical Commissioning Groups (CCGs), neither of which are directly accountable to the public. NHS England commissions primary care and specialist services, while CCGs commission secondary care services. Since April 2015, CCGs have been able to apply for joint or delegated responsibility for some primary care commissioning. [77] Regulations [78] passed pursuant to the HSC Act (2012), require commissioners to put many services out to tender.

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Contracts may be awarded to a single provider or services may be opened up to patient choice of any qualified provider (AQP). Monitor was empowered as the sector regulator. CCGs are regulated as market actors by NHS Improvement (created following the merger of Monitor and the NHS Trust Development Authority in 2016), through a performance management regime run by NHS England [79] and also respond to their co-located local authority. [80] Calum Paton estimates that the recurring annual costs of the current market are approximately £4 billion. [81]

In 2014, John Appleby calculated that, accounting for inflation, NHS spending had increased by an average of 0.7 percent per year for six years, the lowest increase since the 1950s. [82] Lister states that the coalition aimed ‘‘to scale down public providers, downgrade and discredit public services and strengthen the position of private companies such as Serco and Virgin’’. [83] The competition provisions of the HSC Act (2012) have increased the proportion of the NHS budget going to private providers (the total amount was recently calculated as £12.7 billion [84]), while inadequate funding has also facilitated increasing private activity outside the NHS. [85] Nonetheless, private companies profits have been affected by austerity, campaign groups (such as Keep Our NHS Public) have kept privatisation highly politicised [86] and NHS England emphasised integration (rather than competition) in ‘*Five Year Forward View*’. [87] The coalition, and subsequent Conservative governments (which have also inadequately funded the NHS), have sought to shift the blame for the consequences of such policies. The HSC Act (2012), S.1 amended the NHS Act (2006), S.1(1), hence the Secretary of State for Health is no longer required to provide (as the earlier statute originally stated), only to promote, a comprehensive health service. Allyson Pollock states that the reason for the change is that alternative funding (from private health

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insurance, charges or co-payments) will become necessary. [88] The Secretary of State retains ministerial responsibility to parliament for health service provision in England. Nonetheless, as Grahame Morris (Labour MP for Easington) noted, many of their functions have been given to other bodies. [89] Pollock and Price note that ‘‘ministers cannot be responsible to parliament for the exercise of functions that are not theirs’’. [90] Consequently, they argue that parliament will ‘‘not be able to hold the Secretary of State to account for failures in the provision of health services’’. [90]

NHS England

Matthew Flinders and Wood note that NHS England was established ‘‘on the basis of explicit arguments concerning the need to depoliticise healthcare policy’’. [91] The notion of creating an independent board to run the NHS had been suggested and rejected prior to NHS England’s creation. For example, Gordon Brown (Prime Minister between 2007 and 2010) considered it before succeeding Blair. [92] NHS England is one of several national NHS organisations along with NICE, Public Health England, the CQC and NHS Improvement. Greer et al state that the old Department of Health was spun off into new organisations, creating the ‘‘potential for incoherence, duplication and turf wars at the centre’’. [93] In September 2016, Baroness Walmsley (a Liberal Democrat peer), contended that it was still ‘‘unclear how the five national bodies [NICE, CQC, PHE, NHS England and NHS Improvement] interact with each other, and where the Secretary of State comes into the picture’’. [94] Greer et al state that despite staff reductions within the Department of Health, ministers maintained a grip on policy through levers, such as the power of patronage, the power to set budgets and the

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ability to legislate to achieve ministerial priorities. [95] Stephen Peckham expressed uncertainty regarding whether NHS England responds to political pressure from the public, the Department of Health and Parliament. [80] Much of its activity flows through its local area teams, which are accountable only upwards. [13] The Public Administration Select Committee determined, in 2014, that the relationship between the Secretary of State and NHS England was ‘‘still evolving’’. [96]

NHS England is a non-departmental body, outside of the formal structure of the civil service. [93] The Secretary of State is required to publish a mandate setting out objectives for NHS England and to review its effectiveness. [62] Although the coalition stated that NHS England would be independent, it appears to have responded to government pressure. In response to the announcement that responsibility for safe staffing ratios would be transferred from NICE to NHS England, Sir Robert Francis stated that ‘‘NICE…has an advantage not enjoyed by NHS England of being independent’’. [97] In 2014, Simon Stevens was appointed as NHS England’s Chief Executive. Stevens worked as a healthcare manager after leaving university and became a policy adviser to New Labour between 1997 and 2004. [98] Subsequently, he was employed as a Senior Executive by United Health, one of the largest private insurers in the United States (US). He became President of its Global Health division in 2009. In 2010, Stevens authored an article supporting the coalition’s then planned NHS reforms. [99] His employment history meant that his appointment was questioned. [100] Solomon Hughes noted that whilst Stevens was at United Health, he campaigned against the proposed public option of Obamacare [101] and was a founder member of the Alliance for Healthcare Competitiveness (AHC), which sought to force NHS

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privatisation through via a proposed trade deal between the US and the EU, known as the Trans-Atlantic Trade and Investment Partnership (TTIP). [102]

The *Guardian* columnist, Polly Toynbee, argued that Stevens’ independence enabled him to ‘‘write a report demanding money from the Treasury’’, which ‘‘no one in the old Department of Health could do’’. [98] Paton contends that Stevens **successfully persuaded** the government, prior to the 2015 general election, that £8 billion was required, although he argued that his ‘‘overambitious statement on efficiency savings of £22 billion…let the government off the hook somewhat’’. [81] However, David Laws (a Liberal Democrat who served in the coalition cabinet) contends that Stevens originally requested an extra £15-16 billion extra but was told to reduce the amount requested ‘‘to a more deliverable sum’’. [103] This casts doubt on NHS England’s independence and Stevens’ persuasive capabilities. The articulation of the £8 billion figure served to remove the resources that the NHS required from political contestation, as it was widely accepted. However, recent controversy regarding NHS funding demonstrates that it has become recontested. The House of Commons Health Committee deemed the £8 billion figure to be misleading as total health spending will increase by £4.5 billion in real terms by 2021. [104] **Once NHS-specific inflation (staff, technology, drugs) is factored in, the figure shrinks to £800 million.** [105] Thus the NHS is not being furnished with the reduced figure that Stevens was pressured to request.

After she succeeded Cameron, May informed Stevens that the NHS should focus on efficiencies and could learn from the cuts implemented by the Home Office and the Ministry of Defence whilst she (May was Home Secretary between 2010 and 2016)

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and Philip Hammond (who was Secretary of State for Defence between 2011 and 2014 and who May appointed Chancellor of the Exchequer in 2016) were at those respective departments. [106] Efforts to secure efficiencies in the NHS through reductions in tariff payments to NHS providers have left many hospitals with deficits as their costs are outstripping their incomes. [107] Stevens challenged May’s narrative, that the NHS had received the amount that it had asked for, at a Committee of Public Accounts (CPA) hearing in January 2017, describing it as ‘‘stretching it’’. [108] Subsequently, May’s aides briefed against him. [109] The CPA criticised the key players running the NHS for ‘‘bickering in public’’. [110] In November 2017, Stevens warned that faith in democratic politics would be eroded if extra money for the NHS, which had been promised in the 2016 Brexit referendum by some current cabinet ministers, such as Boris Johnson (Foreign Secretary since 2016), is not delivered. [111] Stevens requested that the NHS be afforded an extra £4 billion for 2018/19, but Hammond rejected this [112] and allocated less than half of this amount in his Autumn budget.

Edwards argued, in 2007, that the creation of a Chief Executive of an independent NHS board would establish ‘‘for the first time a role for a powerful non-political leader of the NHS’’. [113] Similarly, I contend that NHS England’s Chief Executive has the potential to be a prominent national figure able to speak on the NHS’ behalf. Past NHS Chief Executives, who were part of the Department of Health, only appeared on television during minor crises. [39] In contrast, Stevens has been interviewed twice on the BBC’s prominent Sunday morning current events programme, ‘*The Andrew Marr Show*’. Such authority to speak on the NHS’ behalf can be viewed as a double-edged-sword, as it may facilitate the removal of issues from political contestation (as is evidenced by the wide acceptance of the £8 billion figure) but may also politicise issues

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(evidenced by the aforementioned bickering). The resignation of the NHS Chief Executive could also damage a government. Toynbee argued, in January 2017, that the resignations of Stevens and Jim Mackey (Chief Executive of NHS Improvement), on the grounds that insufficient funding was threatening patient safety, could have been an act of self–sacrifice to rescue the health service. [114] Stevens’ decision to stay indicates that, despite the bickering, there is agreement between NHS England and the government regarding NHS reform.

Timmins contends that Stevens attracted much of the heat in the current funding crisis and that blame shifting has succeeded to the extent that Jeremy Hunt (Secretary of State for Health from 2012 onwards) ‘‘is apparently not responsible for what is happening on his watch’’. [115] Timmins avers that Hunt was able to appear on the radio and declare elements of NHS performance unacceptable, despite his involvement in its running (such as demanding performance updates and grilling representatives from various national bodies), and ‘‘emerge apparently unscathed’’. [115] NHS England’s existence may enable politicians the opportunity to engage in blame shifting, but I disagree with Timmins regarding the success of this strategy. Although legal changes enable Hunt to criticise the NHS, Toynbee and David Walker note that Hunt was told to muzzle such criticism, prior to the general election in 2015, after polling data indicated that it was rebounding on the government. [116] The Conservatives failure to retain their majority in the 2017 general election may be attributable to public dissatisfaction with austerity policies which have impacted public services. Insufficient NHS funding has led to many cuts being proposed by Sustainability and Transformation Plans (STPs) which have been composed throughout England, which has been divided into forty-four STP areas. STPs are viewed as a move away from

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competition to place based planning. [117] STPs comprise a top-down and secretive re-organisation which has developed outside of the current legal framework. STPs are unaccountable, as they are not public bodies and are not within the ambit of the NHS Constitution or the Freedom of Information Act (2000). Stevens states that accountable care organisations (ACOs) will be developed in between six and ten STP areas ‘‘effectively ending the purchaser/provider split’’. [118] Without legislative changes, ACOs may be challenged for evading competitive tendering processes. [119] ACOs may present private companies with more opportunities and may be inimical to equity, as similar managed care organisations in the US have sought to exclude unprofitable patients. [120] STPs have generated opposition from the public and local councillors. [121]

In March 2017, an estimated 250,000 people participated in the biggest NHS rally in history (organised by Health Campaigns Together), marching in London in protest against cuts (whether or not proposed by STPs) and privatisation. [122] Many of the demonstrator’s placards criticised Hunt, while Stevens’ name was notably absent. This may be because Hunt has been a controversial Secretary of State. **For example, he was involved** in an acrimonious dispute regarding new contracts for junior doctors (who resorted to strike action in 2016). Insufficient funding means that the NHS is anticipating a difficult winter. May has reportedly told Stevens that he will be responsible for the NHS’ winter performance. [123] Nonetheless, while the government may try to shift blame, the public do not appear to have shifted from blaming the government to blaming NHS England. The traditional view of norms and obligations in England is that the government is responsible for healthcare. The government’s efforts to shift blame are impeded by the fact that it retains important powers, such as determining NHS funding. Frank Dobson (Secretary of State for Health between 1997

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and 1999) states that although, in law, the minister does not have direct responsibility ‘‘nobody believes it really, and he [Hunt] is clearly interfering all the time’’. [124] Consequently, as Jarman argues, ‘‘the new structure of the NHS does not change the fact that the public and media will continue to attribute the success or failure of health policy to the government’’. [125] This indicates that there are limits to the legitimising capacity of law. Consequently, government failure to adequately fund the NHS may become increasingly difficult politically. [126]

Addressing the Democratic Deficit

Market reforms were justified on the basis of empowering patients through furnishing them with choices. However, as Alex Mold notes, ‘‘choice was an attractive way to package NHS reform: it was not always about giving the patient more to choose from’’. [127] For example, the AQP policy (which was itself a compromise replacing AWP) has taken a backseat. [128] In any event, as mentioned above, such choices rely on superficial indicators. I argue that voice is a preferable means of empowering patients. Fredric Jameson noted that freedom of choice is exaggerated and ‘‘is scarcely the same thing as the freedom of human beings to control their own destinies and to play an active part in shaping their collective life’’. [129] The national political process is too remote to enable citizens to meaningfully control and shape health policy. The Cities and Local Government Devolution Act (2016) has facilitated the devolution of health service functions to some English regions (such as Greater Manchester, London and Liverpool). Some argue that devolution has been adopted as another means of shifting blame. [130] Lisa Nandy (Labour MP for Wigan) notes that, so far, devolution has not

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involved the public controlling and shaping health policy in Greater Manchester. [131] The public across England have also not been involved in shaping STPs. I agree with the aforementioned ACHCEW commission which recommended that the public be directly involved in running the NHS or in electing its decision makers. [29] Bevan stated that ‘‘the purpose of getting power is to be able to give it away’’. [23] Politicians should give power away not to shift blame, but to empower citizens.

Conclusion

The NHS Act (1946) made the Minister of Health sovereign in theory, but their power was curtailed in practice. Although democratic control over the NHS was to be through their accountability to parliament, this was deemed to be a myth. Management and market reforms centralised control within the NHS. Successive governments have employed the strategy of institutional depoliticisation in an effort to reduce their culpability for healthcare. New Labour’s creation of NICE and Monitor were somewhat successful in this regard. The coalition created NHS England to try to pass the buck for healthcare in general, which is significant as the NHS is currently being undermined by inadequate funding and privatisation. NHS England has the potential both to politicise issues and to remove them from political contestation. While NHS England’s existence enables governments to try to shift blame, this strategy is unlikely to be entirely successful as the government retains important powers over the NHS and the public still regard it as responsible. I argued that addressing the democratic deficit within the NHS is a preferable means of empowering patients than market reforms.

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