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Title: An Adornian Ideology Critique of Neo-Liberal Reforms to the English NHS.

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Abstract

In this article, I undertake an ideology critique of reforms to the English NHS within the neo-liberal era. The critique draws primarily on the writings of the Frankfurt School philosopher Theodor Adorno. I use the method of ideology critique to explain the influences on and reasons for the reforms, the contradictions in government discourse and policy and the potential reifying effects of the reforms. I also use the method as a basis for conceiving alternatives. Adorno thought that ideology was becoming more positivistic, thereby rendering critique more difficult. I identify both liberal and positivistic elements within the discourse of successive governments pertaining to healthcare. Liberal norms (such as freedom and equality) within government discourse, and the law, concerning healthcare, continue to enable the critique of ideology and are a basis for conceiving alternatives to current neo-liberal policies, which have the potential to reify healthcare and undermine the solidarity underpinning the NHS.

Introduction

I undertake an ideology critique of market reforms to the English NHS, within this article, which draws on the writings of the Frankfurt School philosopher Theodor Adorno, to explain

such reforms (and their potential reifying effects), highlight contradictions and conceive alternatives. I identify the presence of contradictory norms in government discourse concerning healthcare, many of which have been translated into law. Adorno distinguished between liberal ideology and positivist ideology.[1] According to Adorno, the emphatic concepts of the former, such as freedom and equality, were not realised within contemporary Western societies.[2] Consequently, Adorno argued that such concepts can be used to critique such societies and as a basis for thinking of alternatives. However, Adorno believed that ideology was becoming more positivistic as justifications for social conditions were beginning to say nothing more than that things are the way they are.[3] Similarly, Wendy Brown argues that, in the current neo-liberal era, the emphatic concepts of liberal ideology have been expunged from government discourse thereby sealing any gap which could allow for ideology critique.[4] Government discourse concerning healthcare within England contains contradictory norms. I identify the enduring presence of liberal norms within such discourse, some of which have been translated into law, which enable the continued critique of ideology and the formulation of alternatives to potentially reifying neo-liberal policies. My analysis pertains solely to healthcare. Government discourse concerning other policy areas may be more, or less, positivistic.

Theodor Adorno

In recent decades, government reforms to the English NHS[5] have marketized the service and facilitated increasing privatisation. Although the concept of privatisation is contested, I utilise the following definition from the World Health Organisation (WHO): 'a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services'.[6] The reforms to the English NHS have been described as ideological by

numerous academics.[7] However, such academics have rarely explored the meaning of the concept of ideology. The use of the concept of ideology requires explanation as 'no single conception of ideology…has commanded universal assent'.[8] My examination of NHS reforms seeks to address this lacuna by more thoroughly engaging with the concept of ideology and its capacity to illuminate the reasons for the reforms, contradictions within government discourse and alternatives. I primarily draw on Adorno's ideas concerning the concept of ideology. Adorno's ideas are particularly useful in highlighting the contradictions within dominant discourses and in elucidating emancipatory possibilities. In contrast, Louis Althusser's ideas concerning ideological interpellation are too monistic[9] and Slavoj Zizek's self-referential Hegelian ontology prevents any prospect of imaging alternatives.[10] As evidence suggests that recent reforms are a source of public dissatisfaction with the NHS[11] and it appears that the market fetishism that has characterised government healthcare policy for the last few decades is dwindling (evident in the recent emphasis on integration in government discourse), it is an opportune time for conceiving alternatives.

Adorno was critical of the extension of the exchange principle in modern societies, which he viewed as a source of reification (the mystification of social relations). Adorno's exchange principle concept is derived from Karl Marx's distinction (following Aristotle and Adam Smith) between the two aspects of a commodity: use value ('the usefulness of a thing'[12]) and exchange value ('a mutual relation between various kinds of labour of individuals regarded as equal and universal labour'[13]). In Adorno's view, the exchange principle rendered unlike things alike[14] and had come to universally dominate mankind.[15] Adorno averred that the same principle was also evident in law, which treats people alike, thereby neglecting differences.[16] There are several modalities of reification in Adorno's writings: philosophical, social and aesthetic.[17] I utilise the former two within this article. The exchange principle is an example of philosophical

reification, which refers to a type of identity thinking in which the contingent nature of human experience is foreclosed as phenomena are treated as fixed.[18] Social reification refers to instrumental rationality (means becoming ends in themselves).[19] Both modes of reification are evident in Adorno's diagnosis of the increased subjectivization ('the dissolving of the world into the activity of the subject') and objectification of the world ('as something contrasted with the subject'),[20] which consumerism exemplifies. This generates coldness, and in turn disenchantment, which Adorno regarded as the fundamental principle of bourgeois subjectivity.[21]

The NHS was created via the National Health Service (NHS) Act (1946). The NHS' founding principles were that it was to be free at the point of access (with equality of access based on need), universal, comprehensive and funded from general taxation. Adorno may seem an odd choice on whom to base a critique of reforms to the English NHS, as he was critical of both welfare states and law. Adorno contended that the intervention of Western states in creating welfare states was intended to preserve capitalist social relations. He described welfare states as 'the embodiment of self-defence' to 'damper and police the antagonisms...lest society...disintegrate'.[22] In ameliorating social life under capitalism, welfare states, Adorno argued, secured 'for slaves their existence within slavery'.[23] Adorno emphasised the repressive aspects of law.[24] Espen Hammer contends that Adorno threw 'the baby out with the bathwater' in this regard.[25] In contrast to Adorno, other dialectical scholars have noted the emancipatory potential of law.[26] I aver that welfare states, and the laws which created them, can be viewed positively in Adornian terms. The NHS Act (1946) was emancipatory in decommodifying healthcare. In contrast, in the United States (US), where health care access is primarily through private health insurance, many are uninsured or underinsured and medical bills cause nearly half of all personal bankruptcies.[27] Nonetheless, recent reforms (including legal reforms) have

meant that the exchange principle has been extended within the healthcare domain within England and the NHS is being increasingly objectified. Adorno viewed solidarity as a means of resistance to capitalism.[28] Rahel Jaeggi defines solidarity as 'standing up for each other because one recognises one's own fate in the fate of the other'.[29] The NHS institutionalised solidarity in respect of healthcare.[30] The reifying modes identified by Adorno could potentially erode this solidarity by generating estrangement.[31]

Adorno has been criticised for emphasising theory over practice. In this respect, Gyorgy Lukacs famously accused him of having 'taken up residence in the Grand Hotel Abyss'.[32] Adorno asserted that 'thinking is actually and above all the force of resistance'.[33] I demonstrate that what citizens think about the NHS is important, that patients are resistant to neo-liberal norms (thereby inhibiting their translation into practice) and that increased awareness of the divergence between government discourse and actuality could potentially inform praxis. Adorno's ideas are useful in conceiving alternative healthcare policies. One problem with the NHS is that as it was instituted as a medical enclosure[34] dominated by medical professionals, it has not empowered patients. In the neo-liberal era, markets have been viewed as the best means of empowering patients. However, markets extend the reifying effects identified by Adorno. Adorno believed that a free society was only possible under certain objective conditions (social conditions of unfettered plenty) and collective control of those conditions.[35] Without such collective control, which markets disperse, the domain of healthcare will remain opaque to citizens. While the NHS has met most health care needs within England, public control through ministerial accountability to Parliament is an inadequate means of empowering patients. I use Adorno's ideas to demonstrate that improved voice mechanisms are a more adequate means, than markets, of empowering patients.

Ideology Critique

The method of ideology critique involves studying the way 'in which meaning (or signification) serves to [establish and] sustain relations of domination'.[36] The method is avoided by many contemporary scholars,[37] but alternative methods have been criticised for taking political ideologies, such as neo-liberalism, at face value, rather than confronting their claims with actuality.[38] In contrast, scholars using the method of ideology critique evaluate whether the norms articulated within discourse correspond to reality.[39] Michael Freeden contends that ideologists seek to cement 'the relationship between words and concepts', attaching 'a single meaning to a...term'.[40] In this regard, Adorno contended that language was unable to perfectly subsume the objects that it sought to describe. Adorno described this phenomenon as identity thinking. Adorno argued that 'philosophy must involve a constant self-correction of language, so that the significance with which the world reveals itself to the subject can find its way to expression'.[41] Identity thinking masks heterogeneity and may repress the contradictions that exist within societies. Adorno conceived ideology as a type of identity thinking in which the meaning attached to concepts helps to perpetuate the domination of particular social groups.[42] In capitalist societies, the bourgeoisie is the dominant social class. Reforms (including legal reforms) to public services which furnish private companies with new opportunities extend the domination of the capitalist class. Language may be used to attempt to justify, obscure or deny such domination.

Although some argue that Adorno favoured non-identity thinking (abandoning conceptual mediation),[43] Deborah Cook notes that he thought that conceptual mediation was necessary for thinking.[44] For example, Adorno stated that:

> 'Thought that is absolutely without reference-the complete opposite of the philosophy of identity-thought that removes all participation on the subject's part and all anthropomorphism from the object, is the consciousness of the schizophrenic'.[45]

Adorno was against compartmentalized thinking where everything is 'neat and tidy'.[46] Rather, Adorno favoured rational identity thinking which endeavours to ensure that concepts do justice to the reality that they describe.[47] According to Adorno:

> 'our aim is not to juggle concepts, arranging and rearranging them as neatly as possible like a stamp collection, but to deploy concepts in order to bring the subject, whatever it may be, to life'.[48]

Rational identity thinking would involve a closer approximation between conceptualisations of society and existing conditions. The way that Adorno suggested to do this was through 'constellations [which] represent from without, what the concept has cut away from within'.[49] Nonetheless, the prefix, rational, only implies a closer, rather than a complete, approximation between concept and object. Adorno's critique of rationality was that it was often predicated on the latter. While concepts which are used in dominant discourse often exclude the

experiences of those who are dominated, scholars can critique such concepts and develop new conceptualisations to more adequately represent experience.

Adorno favoured immanent critique, which avails itself of norms which the society being critiqued would recognise as its own.[50] This is because Adorno recognised that a problem with transcendent critique is that utopian ideas are easily characterised as arbitrary.[51] Similarly, Jaeggi describes the method of ideology critique as parasitic, as it depends on norms that it does not generate by itself.[52] Adorno averred that ideology critique 'is only possible insofar as the ideology contains a rational element with which the critique can deal'.[53] According to Adorno, 'ideologies...become false only by their relationship to the existing reality'.[54] Adorno wrote that Marx's concept of ideology 'was supposed to reveal how little the concept which capitalist society had of itself had to do with reality'.[55] The problem is that distinguishing between conceptions and reality is difficult because ideological fantasy is part of our reality.[56] For example, Zizek states that people know that there is no magic behind money but nevertheless 'treat it as an embodiment of wealth'.[57] Adorno thought that words could never be identical with the objects that they describe, hence his aphorism that 'the whole is the untrue'.[58] However, he described the notion of constitutive subjectivity as a fallacy[59] and emphasised the 'preponderance of the object'.[60] Thus while Adorno stressed that the object could never be perfectly known through concepts, he was opposed to relativism. Although objects can never be perfectly known, some statements about them can still be favoured over others. As Terry Eagleton notes, if a person states that there is a tiger in a bathroom and another person denies this, 'one…has to be wrong'.[61]

Fabian Freyenhagen contends that Adorno's critique is not solely immanent as firstly, such a critique 'could only demonstrate the cost of holding on to a value or ideal'.[62] Secondly, Freyenhagen notes that an immanent critique could be used to criticise a thought system internally, such as Nazism, but that we may not want to achieve its aims.[63] Consequently, Stuart Walton argues that Adorno's critique seeks to illuminate the internal contradictions in dominant discourses.[64] I highlight the contradictions in government discourse regarding the NHS. Raymond Williams argued that dominant norms compete with residual and emergent norms.[65] I demonstrate that the discourse of successive governments, pertaining to healthcare within England, is contradictory as it contains all of these competing norms. However, Adorno's critique is not merely designed to reveal contradictions. Rather it also contains a transcendent element. Adorno notes that emphatic concepts, such as freedom and equality, are both descriptive (is) and prescriptive (ought).[66] Adorno averred that 'from an early period onward the bourgeoisie must have feared that the logic of its own principles could lead beyond its own sphere of interests'.[67] Consequently, Adorno stated that the bourgeois period has involved a contradiction between the simultaneous emancipation and dampening of critical spirit.[68] Emphatic concepts may be used to describe existing conditions by those contending that they have already been realised to attempt to dampen critique. However, as such concepts also have a normative dimension, they can be used to critique existing conditions as they augur going beyond them. Adorno distinguished between liberal and positivist ideology.[69] While the former is characterised by emphatic concepts, the latter typifies identity thinking as it fuses the theoretical and the actual. Adorno stated that as liberal society was not identical with the emphatic concepts of liberal ideology, such concepts tacitly denounce existing conditions.[70] For example, regarding freedom, Adorno argued that:

> ‘in the modern world the idea of the freedom of all has not become literally true, because in the meantime the critical analysis of society has demonstrated in countless ways that the formal liberty of all individuals in bourgeois society must be contrasted with their actual unfreedom in reality’.[71]

Consequently, Adorno believed that liberal society had not realized its own ideals. The method of ideology critique enables both an immanent critique, involving scholars assessing the justifications employed within discourse, to legitimise existing social relations or changes to such relations, but also contains a transcendental element, in revealing the disparity between concept and actuality, which is a potential basis for conceiving alternatives. However, as Susan Marks notes, Adorno believed that alternatives had ‘no emancipatory guarantees’.[72]

Adorno theorised that reality and ideology were converging and that liberal ideology was losing, or had already lost, the critical moment that it possessed.[73] This convergence resulted in positivist ideology, which ‘hardly says more than that things are the way they are’.[74] Adorno diagnosed this convergence in the totally administered society of late capitalism.[75] It is also evident in the ‘there is no alternative’ (TINA) mantra of Margaret Thatcher (UK Prime Minister between 1979 and 1990). Thatcher was the first of successive Prime Minister’s maturing the neo-liberal project.[76] Thatcher used the TINA mantra in an effort to justify her policies, such as privatisation and deregulation. The increasing prominence of positivist ideology was, in Adorno’s view, undermining the possibility of critique. Adorno lamented that there is not ‘a crevice in the cliff of the established order into which an ironist might hook a fingernail’.[77] Nevertheless, Cook avers that Adorno erred in some passages of his work by denying ‘the important motivational role that [liberal] ideas like freedom and equality continue to play in

contemporary consciousness'.[78] Cook views Adorno's negative dialectics (a dialectics of non-identity[79]) as 'an attempt to find a finger-hold in the cliff of the established order'.[80] Brown has also argued that the gap between ideals and lived realities has been sealed in contemporary neo-liberal societies thereby precluding ideology critique.[81] In contrast, this article supports Cook's notion of the continued importance of the liberal ideas of freedom and equality by highlighting their continued invocation in government discourse pertaining to healthcare within England.

Freedom

The NHS' founding principles can be characterised as residual norms to distinguish them from the dominant neo-liberal norms of the contemporary era.[82] Neo-liberal norms include competition, choice and inequality. Neo-liberalism became the dominant ideology after the social democratic consensus disintegrated following economic crises in the 1970s. Neo-liberals, such as Friedrich Hayek and Milton Friedman, criticised the welfare states that had developed in Western states for eroding freedom by substituting individual market choices with state planning decisions. There was a consonance between neo-liberal critiques and left-wing critiques of welfare states.[83] For example, Jurgen Habermas argued that welfare states had reifying effects by treating people as objects.[84] Roberto Unger identified an emerging consciousness which arose due to the perceived problems with welfare states.[85] The norms that arose due to the awareness of the problems of welfare states, such as the need to reduce class inequalities in health (which persisted despite the creation of the NHS) and the aforementioned need to empower patients, can be characterised as emergent norms.[86]

The NHS was designed to be accountable to the public through ministerial answerability to parliament. However, such accountability was deemed to be a 'constitutional fiction'.[87] Both voice and choice mechanisms are considered potential means of empowering patients.[88] In the early 1970s, Community Health Councils (CHCs) were established to represent patient's voices.[89] In contrast, in the neo-liberal era the emphasis has been empowering patients through market reforms to provide them with more choices. The appeals to patient choice in the discourse of successive governments have drawn on neo-liberal ideology, in which the concept of freedom is attached to the ability of consumers, as buyers, to make choices in a market (thereby engendering competition among providers). The increase in audit in the NHS, beginning in the 1980s, to facilitate comparisons between different entities, was informed by a similar competitive logic. The neo-liberal conception of freedom has influenced successive governments, but, in practice, increased choices have not always resulted from their market reforms. Even if patient choice had been successfully extended, this is an inadequate means of empowering patients. Enervated voice mechanisms have been retained alongside choice mechanisms. Enhanced voice mechanisms could facilitate collective control in the domain of healthcare, which Adorno theorised was necessary for freedom.

Many significant NHS reforms were undertaken during Thatcher's premiership, such as the introduction of general management, the reduction of the NHS' comprehensiveness (for example, some services, such as long-stay nursing care, were transferred to local authorities which can charge for care,[90] thereby extending the exchange principle), the contracting out of non-clinical services, the expansion of audit and the introduction of an internal market (via the National Health Service and Community Care Act (1990)), which was implemented during John Major's premiership (1990-1997). The internal market sought to introduce competition into the NHS by splitting purchasers (District Health Authorities and some GP fundholders)

and providers (such as hospitals). Contracts were intended to replace the hierarchical relationships within NHS governance. However, the adopted contracts were not legally enforceable and hierarchical relationships remained intact.[91] The justifications for the reform, within government discourse, included the notion that it would enhance choice.[92] The internal market can be critiqued by assessing whether it instantiated this principle. Contrary to scholars, such as John Spiers,[93] who desire patients to make financially empowered choices, the internal market involved the aforementioned purchasers acting on their behalf. According to Anne Davies, purchasers decisions were heavily influenced by central guidance.[94] Calum Paton contends that clinical objectives were given priority over the internal market soon after its implementation.[95] In his view, the internal market and subsequent market reforms have 'come in with a bang and gone out with a whimper'.[96] Some evidence suggests that the internal market reforms actually reduced choice.[97] Consequently, even if it was accepted that enhanced choice leads to enhanced freedom, this was not achieved by the internal market reforms.

The Labour governments between 1997 and 2010 differed from their Conservative predecessors in pledging and implementing spending increases in healthcare designed to elevate the UK to the average proportion of GDP spent on healthcare in other European Union (EU) countries. Nonetheless, Labour emulated their Conservative predecessors in continuing to transfer services from the NHS to local authorities (thereby extending the exchange principle).[98] In addition, despite having opposed the internal market, Labour retained the purchaser-provider split. Labour instigated performance management in the NHS through the use of targets.[99] The '*NHS Plan*' contained numerous targets, such as reducing waits for outpatient and inpatient appointments[100] and ending long waits (over four hours) in accident and emergency (A&E).[101] The performance of providers in relation to targets determined the amount of autonomy that they were afforded. For example, initially only providers that

performed well in the star rating system (introduced in 2001 and abolished in 2006) could apply to become foundation trusts (FTs). However, the reliability of such measurements has been questioned. For example, the House of Commons Health Committee noted the instability in the results of the star rating system.[102] Michael Mandelstam described targets as a type of 'misleading metonymy' as they cannot accurately capture the complexity of the performance of providers.[103] Targets are thus a perfect example of identity thinking. Targets were gamed[104] and had other unintended consequences. For example, Mandelstam notes that the four-hour A&E target detrimentally affected the performance of other hospital departments. [105] Consequently, a means (targets), to achieve ends (enhancing services), appears to have often impeded such ends.

From its second term (2001-2005) onwards, Labour gradually began reintroducing market-mechanisms into the NHS. [106] Such reforms included demand side reforms (such as progressively furnishing patients with more choices, ultimately of any willing provider for some services), supply side reforms (for example, through creating Independent Sector Treatment Centres and FTs[107]) and transactional reforms (such as introducing payment by results to finance many treatments).[108] Labour's reforms meant that the amount of the NHS budget spent on commissioning private providers rose from 2.8% in 2006/07 to 4.4% in 2009/10.[109] Private healthcare companies influenced the reforms that they benefited from. For example, both Tony Blair (UK Prime Minister between 1997 and 2007)[110] and Gordon Brown (UK Prime Minister between 2007 and 2010)[111] have alluded to their discussions with agents of such companies about extending opportunities for them. The agents of private healthcare companies, such as Ian Smith (General Healthcare Group Chief Executive between 2004 and 2006), have also alluded to the influence that they exerted on Labour's reforms.[112]

Similarly to their Conservative predecessors, one of the justifications for Labour's market reforms was that they would empower patients through furnishing them with more choices. For example, Labour's manifesto for the 2001 general election promised to 'give patients more choice'.[113] Labour sought to justify affording patients with more choices on the basis that this could also assist in reducing health inequalities.[114] Labour received academic support from Julian Le Grand, who was also a Health Adviser to Blair between 2003 and 2005. Le Grand contended that the models favoured by social democrats (trust and voice) would not generally deliver high quality, responsive, efficient or equitable services, but that 'properly designed' choice and competition policies could.[115] In contrast, critics, such as Paul Dorfman, argued that by enabling the flight of choosers, patient choice policies could exacerbate inequalities for those unable or unwilling to travel.[116]

The word consumer appeared more in Labour's policy documents for health than for other policy areas,[117] indicating that Labour politicians, like their Conservative predecessors, subscribed to the neo-liberal notion that consumer choice and freedom were synonymous. Adorno argued that the very question of freedom arose with the emancipation of the bourgeoisie from feudal society.[118] According to Adorno, the bourgeois progressive principle spelled the end of feudal privileges.[119] The progressive element of this principle was that in reducing human beings 'to the abstract definition of 'human being', to the exclusion of their specific characteristics' it provided people 'a measure of protection and justice'.[120] However, Adorno argued that bourgeois legal and moral systems 'cut away everything specific to living human beings and treat them as if they were merely impersonal parties to contracts'.[121] In Adorno's view, 'every category conceived in isolation inevitably leads to violence and

injustice'.[122] Adorno's analysis of bourgeois conceptions of freedom, and the repressive potential of law, chimes with criticisms of the patient choice policies within the NHS. For example, Marianna Fotaki argued that in furnishing choices to patients, Labour's policymaking was based on the notion of an abstract consumer able to make rational decisions, and failed to account for the existing inequalities in geography or socio-economics which affect access to health services[123] or the theoretical developments and empirical evidence challenging the notion that the exercise of choice was a highly rational process.[124]

A positivistic element within Labour's discourse concerning healthcare was the naturalisation of the relationship between patients and health services as a consumerist one. This is evident in the '*NHS Plan*' which stated that 'we live in a consumer age' and that 'today, successful services thrive on their ability to respond to the individual needs of their customers'.[125] It is also evident in Alan Milburn's (Secretary of State for Health between 1999 and 2003) speech at the second reading of the FT legislation, in which he stated that 'whether we like it or not, this is a consumer age' in which 'people demand services that are tailored to their individual needs'.[126] However, efforts to interpellate patients as consumers were resisted. Critics argued that insufficient information was available to assist patients in making informed choices.[127] A study, in 2007, revealed that many patients did not recall being offered choices.[128] Where patients were aware of the ability to choose, they often continued to rely on GP advice rather than making their own decisions.[129] Where patients did make their own decisions, many opted for their local provider.[130] John Clarke notes that patients passively dissented to their interpellation as consumers and that they observed of their relationships to public services that 'it's not like shopping'.[131] Angela Coulter argued that Labour was 'more interested in fostering consumerism than in strengthening civil society'.[132] Nonetheless, voice mechanisms were also retained as a purported means of empowering patients. However, Peter Vincent-Jones notes

that patient voice was 'narrowly conceived and restricted in scope'.[133] Labour abolished CHCs[134] and replaced them with various weaker successor mechanisms. The failure of such mechanisms to effectively represent patient voices is exemplified by the critical appraisal of them in the Francis Report (published following the public inquiry into the poor care and high mortality rates at Mid Staffordshire NHS FT).[135] Labour established a dual governance structure for FTs, consisting of a Board of Directors and a Board of Governors. The latter are elected, but participation in such elections is low.[136] Studies indicate that some members of Boards of Governors have been captured by the management culture of FTs[137] and require further training.[138]

The Conservative and Liberal Democrat parties formed a coalition government after the general election in 2010 resulted in a hung parliament. There was a resonance between the liberal conservatism of the Conservative party, under the leadership of David Cameron (Prime Minister between 2010 and 2016), and the economic liberalism of the Liberal Democrats, under the leadership of Nick Clegg (Deputy Prime Minister between 2010 and 2015).[139] The coalition contained ministers who were 'saturated in neoliberal ideas and determined to give them legislative effect'.[140] Andrew Lansley (Secretary of State for Health between 2010 and 2012) had been a civil servant involved in utility privatisations in the 1980s and had similar plans for the NHS,[141] which he had developed in opposition.[142] Some Liberal Democrat cabinet members had also advocated NHS reform.[143] Like their Labour predecessors, the coalition's reforms were influenced by the agents of private healthcare companies which benefited from them. Such influence included lobbying, financial links with politicians[144] and direct advice (some of the proposals in the bill which became the Health and Social Care (HSC) Act (2012) were drafted by McKinsey, many of whose clients benefited from the reforms[145]). Anthony Seldon argues that Cameron afforded Lansley too much leeway and did not precisely

understand his plans.[146] The Liberal Democrats rejected the HSC Bill at their spring conference in 2011. In response, a legislative pause was announced to enable the government to undertake a listening exercise. After the listening exercise, Lansley was clear that no real ground had been conceded.[147] In furnishing private companies with more opportunities and undermining the NHS' founding principles (considered further below), the HSC Act (2012) illustrates the repressive aspects of law noted by Adorno. It instituted a new market within the NHS. Similarly to the previous markets, the new market was justified on the basis of empowering patients, through patient choice, and empowering GPs, by enabling them to purchase secondary care services on their patients behalf by collaborating within Clinical Commissioning Groups (CCGs).[148] Both CCGs and NHS England (a non-departmental body which oversees the day-to-day operation of the NHS in England and commissions primary care and specialist services) have statutory duties to act with a view to enabling patients to make choices.[149] However, the patient choice policy has taken a backseat.[150]

In contrast to their Labour predecessors, coalition politicians indicated that they desired to move away from the use of targets. However, they were retained due to political pressures[151] and because holding providers to account through other means proved difficult.[152] Although patient choice has currently taken a backseat, Conservative-led governments since 2010 have facilitated the production of new information within the NHS, which is designed partly to assist patients, conceived as consumers, in making choices. This is symptomatic of the increased objectification which Adorno considered was a source of reification in modern societies. The coalition furnished patients with the legal right to choose the consultant specialist at their first outpatient appointment.[153] From 2013 onwards, consultant level quality and outcomes have been published for ten key specialities, to assist patient choice.[154] Critics have argued that the publication of surgeon specific mortality data (SSMD) misrepresents surgeons as wholly

responsible for patient outcomes by failing to account for the impact of resources and the wider hospital team.[155] The publication of such data has disenchanted some surgeons who are avoiding risky operations.[156] Consequently, another means (publishing data), to achieve ends (enabling patients to get the best treatment), appears to be impeding such ends in some cases.

From 2013 onwards, patients have been able to provide feedback through friends and family test scores (available on the MyNHS website). Such scores reduce quality (people's experiences during their treatment) into quantity (a number) which, as Adorno argued, is a process of abstraction which 'distances itself from the objects'.[157] Adorno stated that the 'knowledge being sought in negative dialectics is qualitative'.[158] Quantitative information is insufficient to adequately capture the complexity and diversity of patient experiences and is thus unlikely to illuminate choices for patients. Rather it will occlude some patient experiences from being adequately expressed. In contrast, voice mechanisms could allow such complexity to be expressed and registered to influence service improvements. Although similarly to their Labour predecessors, the coalition focussed on patient empowerment through choice, it also instituted new voice mechanisms within the NHS. It created a statutory body, Healthwatch[159] (a national organisation which is part of the Care Quality Commission (CQC)), and non-statutory bodies, Local Healthwatch (LHW), to represent patient voices. However, Healthwatch's lack of independence has, in the view of Jacky Davis et al, rendered it toothless.[160] Sally Ruane argues that LHWs suffer from insufficient resources and role confusion.[161] Consequently, neither the current choice or voice mechanisms are able to adequately empower patients.

A positivistic element within the coalition's discourse was its naturalisation of diversity of provision, which is evident in the claim that it was the only way 'to meet…needs and increasing expectations or ensure that services are appropriately tailored to meet the gap between the rich and the poor'.[162] As patient choice policies have taken a backseat, the current NHS market is primarily characterised by providers competing for tenders from CCGs rather than competing for patients (where services are opened up to patient choice). In tendering, commissioners are required to comply with the regulations passed pursuant to HSC Act (2012), S.75,[163] and EU public procurement law. The threat of potential legal challenges appears to have led some commissioners to put services out to tender even where it has not been deemed to be in the interests of patients.[164] The market has thus become an end in itself, symptomatic of social reification. The amount of the NHS budget going to private providers was calculated, in 2017, as totalling £12.7 billion.[165] Since the publication of NHS England's '*Five Year Forward View*',[166] in 2014, the emphasis has been on integration rather than competition. England was divided into forty-four regions. Sustainability and Transformation Plans (STPs) have been developed in each region and are viewed as a shift from competition to planning.[167] In 2017, Simon Stevens (Chief Executive of NHS England from 2014 onwards) stated that some STPs may develop into accountable care organisations (ACOs).[168] There are fears that ACOs, which have been renamed Integrated Care Partnerships (ICPs), could provide more opportunities for the private sector.[169] The government is currently consulting on introducing ICP contracts[170] following legal challenges.[171] Despite the recent emphasis on integration, there continues to be a large amount of activity within the NHS market.[172]

Equality

As mentioned above, inequality is a neo-liberal norm. Adorno was critical of the concept of equality as it could lead to differences being neglected. However, Adorno's criticism does not apply to the residual norm of equality of access, which was necessarily attuned to the different needs of patients accessing NHS services. Nor does it apply to the emergent norm of reducing health inequalities, which is concerned with differences in morbidity and mortality influenced by the capitalist system which Adorno critiqued. The Thatcher government did not enact reforms affecting the residual norm of equality of access to NHS services, as this was deemed to be electorally unviable given the strong public support for the NHS. In the early 1980s, Thatcher was forced to state that the NHS was safe with the Conservatives following a leak that her government was considering various options to privatise it.[173] Nonetheless, Thatcher's government did implement policies designed to encourage private sector growth.[174] In Thatcher's view, it was 'disgraceful that those who could afford it relied on the taxpayer'.[175] If employed in government discourse, this argument could generate estrangement by dividing patients into those who can and cannot afford private provision. If more affluent patients were treated privately, the risk pooling and cross subsidy underpinning the NHS would be undermined. However, this argument has not been employed in the discourse of any of the governments maturing the neo-liberal project.

In respect of the emergent norm of reducing health inequalities, the Thatcher government attempted to bury the Black Report[176] on health inequalities which had been commissioned by David Ennals (Secretary of State for Social Services between 1976 and 1979) in 1977, during James Callaghan's premiership (1976-1979), and was published in 1980. Although the topic of health inequalities was excluded from the political agenda until Labour's election in 1997, the Black Report significantly influenced the research community.[177] The Thatcher government's policies increased class inequalities in health.[178] As the Thatcher governments

did not aim to reduce such inequalities, Gareth Williams notes that they assiduously avoided the term inequality.[179] Rather, as Clare Bambra notes, the Thatcher government used the positivist term 'health variations', which implied that health differences were natural and not the responsibility of politicians.[180] In contrast, the subsequent governments maturing the neo-liberal project have explicitly adopted the goal of reducing such inequalities. Consequently, although inequality is a neo-liberal norm, the Thatcher government did not challenge the residual norm of equality of access or mention the emergent norm of reducing health inequalities.

While the Labour governments between 1997 and 2010 narrativised the NHS as outmoded in respect of its organisation, the founding principles, such as equality of access, were described as correct within its discourse. This is exemplified by Milburn's speech at the second reading of the FT legislation, in which he stated that the NHS' principles were right,[181] but that it needed to change 'how it works in practice'.[182] Nonetheless, as mentioned above, such principles were undermined during Labour's period in office. While Labour's Conservative predecessors avoided the use of the term inequality, Labour established an independent inquiry into health inequalities, headed by Donald Acheson,[183] and subsequently adopted the goal of reducing such inequalities.[184] Labour's discourse linked the extension of patient choice with the goal of reducing health inequalities. Other policies adopted to achieve this goal included schemes, such as Sure Start (centres offering families support), and the allocation of extra resources to deprived areas.[185] Although initial analyses indicated that health inequalities continued to worsen, a study based on more recent data suggests that Labour's strategies reduced geographical health inequalities in life expectancy.[186] However, the high correlation between wealth inequalities and health inequalities[187] indicates that more concerted action regarding the former is necessary to reduce the latter. The former became a non-issue for

Labour,[188] which as Peter Mandelson famously stated, in 1999, was 'intensely relaxed about people getting filthy rich'. [189] Bambra notes that while successive reviews into health inequalities have recommended the redistribution of wealth, the policy effects of such reviews have been minimal.[190]

Similarly to their Labour predecessors, the coalition (which remained in office until the 2015 general election, after which the Conservative party has governed alone) claimed to support the NHS' founding principles. The coalition's discourse contained residual and emergent norms. For example, Cameron and Clegg asserted that 'the promise of care based on need and not ability to pay is inviolable'[191] and that 'inequalities in access to…decent healthcare…leaves our society less free, less fair and less united'.[192] Similarly, the Conservative's manifesto for the 2017 general election stated that the party continued to believe 'in the founding principles of the NHS'. [193] However, such avowed belief is belied by the HSC Act (2012) which undermines such principles. Equality of access has been undermined as FTs are now able to derive 49% of their income from fee paying patients.[194] Many FTs have seen large increases in the proportion of their income attributable to fee paying patients while standards for NHS patients have deteriorated.[195] Such deteriorating standards are attributable to the decline in the proportion of GDP spent on health during the 2010s. Consequently, the exchange principle has been extended and the profits of many private companies have swelled, as many patients have decided to pay for private treatment rather than wait longer for free NHS treatment.[196]

The coalition also reduced the NHS' comprehensiveness by replacing PCTs with CCGs, which are not required to provide all of the same services (for example, while PCTs were required to provide services concerning drug and alcohol misuse,[197] CCGs are not[198]). In addition, the

Secretary of State for Health is no longer required to provide (only to promote) a comprehensive health service.[199] Some of their powers, including the power to impose charges,[200] were bestowed to commissioners,[201] further threatening comprehensive provision. There is concern that the change to the duty will lead to changes in how the NHS is financed.[202] In this respect, it is feared that personal health budgets (PHBs), which were piloted under Labour and have been extended to around 23,000 patients, will enable insurance for top-ups.[203] The government has recently consulted on extending PHBs to around 350,000 patients.[204] PHBs would furnish patients with the financially empowered choice that Spiers advocates, but negatively affect equity and solidarity. The principle of universality has been undermined as the HSC Act (2012)[205] introduces eligibility criteria into the NHS, enabling providers to choose patients. The coalition was akin to their Labour predecessors, and unlike the Thatcher and Major governments, in that it endorsed the aim of reducing health inequalities. The coalition accepted most of the recommendations of Michael Marmot's review into health inequalities (commissioned by Labour in 2008)[206] and subsequently created numerous statutory duties.[207] However, such duties have not been implemented effectively[208] and the coalition's (and subsequent government's) austerity policies are likely to exacerbate such inequalities.[209] The gap in life expectancy between the rich and the poor has widened between 2001 and 2015.[210] Thus with respect to the principle of equality, the contradiction is that government policies (such as austerity) undermine it, while government discourse continues to validate it.

Alternatives

After analysing whether norms are realised in practice, scholars using the ideology critique method can construct alternatives. Formulating alternatives is important in avoiding positivistic

thinking and challenging dominant discourses and policies. Although there were positivistic elements within the discourse of successive governments (such as Labour's claim that there is no alternative to consumerism and the coalition's similar claims regarding diversity of provision) concerning healthcare, there were also liberal elements, and residual and emergent norms, derived from, or directly appealing to, the concepts of freedom and equality. Such liberal concepts and norms provide a basis for hooking a fingernail into the cliff of government discourse pertaining to healthcare. Nonetheless, government discourse concerning other policy areas may be more positivistic, which may render critique more difficult.

The adoption of patient choice policies within England can be criticised on the basis that the marketization of the NHS has not always furnished patients with such choices (rather choices have tended to be made on their behalf by others, such as GP fundholders and CCGs). Market reforms were also justified on the basis of increasing efficiency, but actually render healthcare 'more bureaucratic and more expensive to administer'.[211] Even if the reforms had wholly succeeded in extending choice, this would not empower patients as the conception of freedom informing such policies treats patients as abstract entities divorcing them from the realities affecting their capacity to make choices. Additionally, the information that is being produced to facilitate such choices is superficial. Fredric Jameson argues 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'.[212] Choice mechanisms prevent patient experiences from being adequately articulated and registered. Voice mechanisms are a more effective way for the constellation of patient experiences to be expressed and comprehended. The NHS (Reinstatement) Bill proposes re-establishing CHCs to represent patient voices.[213] However, although CHCs compare favourably to their maligned successors, they were criticised for being unrepresentative[214] and for their inability to effect

changes at a wide level[215] hence other mechanisms, such as elections to healthcare bodies, may also be required to enhance patient voice. Increased democratic deliberation within the NHS may enhance social learning[216] and, in turn, improve services. If stronger voice mechanisms are adopted, efforts should be made to ensure that the mechanisms are properly resourced, representative, independent and afforded sufficient power.

Although inequality is a neo-liberal norm, the governments maturing the neo-liberal project within England have not challenged the residual norm of equality of access to healthcare, while the Labour governments between 1997 and 2010 and Conservative-led governments from 2010 onwards explicitly adopted the goal of reducing health inequalities. However, such residual and emergent norms regarding equality have been undermined in practice. While successive governments continue to validate such norms, a gap will persist between government discourse and existing conditions, as experienced by patients, rendering the former amenable to the very ideology critique that Adorno feared was becoming more difficult. If government discourse and patient experience continue to diverge, a legitimation crisis could result as patients become increasingly aware of this gap.[217] An alternative is the aforementioned NHS (Reinstatement) Bill, which is supported by many parliamentarians and celebrities, which would amend legislation that has undermined the NHS' founding principles. The reduction of health inequalities will require alternative economic policies to austerity, which has widened the life expectancy gap.

Conclusion

I have used the method of ideology critique, within this article, to explain and examine market reforms to the English NHS and conceive alternatives. While Adorno feared that ideology was

becoming more positivistic, I identified both liberal and positivistic elements in government discourse concerning healthcare. I demonstrated that government discourse contains contradictory norms. Residual and emergent norms (which draw on liberal concepts) appear alongside dominant neo-liberal norms, within such discourse, as governments have deemed it to be politically unviable to challenge them. Such norms have been undermined in practice but can be used to critique government policy and conceive alternatives. Legislative amendments could prevent both residual norms from being undermined and the potentially reifying effects of neo-liberal policies. While successive governments claimed to desire health inequality reductions, this goal is undermined by neo-liberal economic policies. Neo-liberals proposed market reforms, to empower patients, which governments have implemented (although enervated voice mechanisms were also retained). Markets are an inadequate means of empowering patients. Enhanced voice mechanisms could more effectively capture patient experiences and lead to improvements in services.

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