

**An argument lost by both sides? The Parliamentary debate over the 2010
NHS White Paper**

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Abstract

This paper examines the rhetoric of government and opposition in the Parliamentary debate over the 2010 NHS White Paper 'Equity and Excellence'. It treats the debate as a process of deliberative argument in which Secretary of State Andrew Lansley justifies his reorganization, and explores the extent to which his policy argument was scrutinised by both the opposition and by members of his own coalition government .

The paper suggests that Lansley offered an unjustified reorganization based on market-based governance (although presented as 'social enterprise), and decentralised accountability, which would at the same time generate substantial savings in a time of financial austerity. This is contrasted with the often-fragmented arguments offered by voices in the opposition. The paper and asks questions about the extent to which Parliamentary debate is able to adequately scrutinise governmental proposals of the complexity of healthcare reorganization.

Introduction

This paper examines the 2010 coalition government's proposals to reorganize the National Health Service. This debate and policy discussion has been chosen because of

being so contentious - with the government putting in place a 'pause' in its passage through the legislature to address concerns from senior Liberal Democrats, medical representative groups and the general public. It is also the case that, despite the government struggling to get their legislation through Parliament, and perhaps losing the argument as to the necessity and form of their reorganisation, it was still implemented, albeit in a heavily-modified form.

The paper examines the Parliamentary debate around the reorganization's White Paper, examining the extent to which the reorganization was scrutinised, and suggesting that many of the problems the passing of legislation experienced came from the government's inability to present a coherent argument in their favour. It presents an argument-driven, rhetorical analysis of the debate.

It is commonplace within social policy writing to contrast 'rhetoric' with 'reality', with the former representing what policymakers say they are doing, and the latter what they actually are up to (Packwood, 2002). 'Rhetoric' has become associated with language designed to conceal, with falsity and, in political arenas, with the growth of 'spin' or even with 'political lying' (Osborne, 2005).

The language used by policymakers is certainly rhetorical, in that it will often be designed as much to persuade as to explain. But this does not mean that we should dismiss it as being unimportant. There are good reasons to redouble our efforts in scrutinising policy- not only to hold policymakers to account for what they say (which is an essential part of a democratic political process), but also because a close examination of the rhetoric of policy allows us to unpack the arguments policymakers present to us, and to scrutinise the basis on which policy arguments are being made.

The paper proceeds as follows: first it locates its approach within the field of critical policy studies, before presenting its methods in more detail, before explaining the context of the 2010 debate on NHS reorganization in more depth. It then analyses the Parliamentary debate around the government's White Paper 'Equity and Excellence', before presenting a discussion and conclusion.

Discourse in policy studies

The 'discursive turn' in policy studies attempts to move the focus of research away from rationalistic approaches that treat the definition, diagnosis and remedies to social problems as technical issues that are based law-like causes (Howarth & Griggs, 2012). Instead, taking a discursive approach suggests the importance of interpretation and critical evaluation in policy analysis. Discursively-based research adopts a range of positions, from being a supplement to more positivistic approach that treats them as 'frames' (Schon & Rein, 1995) or as conceptual frameworks for understanding the world (Dryzek, 1997), and which therefore treats discourses as variables that be subject to empirical testing (Torfing, 2005), through to those that argue that more of a radical break from rationalism is required (Fischer, 2003) in which discourse is not simply a measure of social relations, but it also constitutive of them (Gottweiss, 2006).

The approach taken here treats policy as an attempt to articulate practical action, but one which has to be expressed in language to be communicated, and with that language expressing more than policy-makers intend (Bacchi, 2009). It treats policy as constitutive of the world rather than descriptive, following insights of poststructuralist writers who regard human subjects, objects, social formations and symbolic formations not as fixed, but as constantly moving, changing and shifting. It uses a method that examines policy

rhetoric as argumentation (for practical action), based on scholarship from Fairclough and Fairclough (2012) and Bacchi (2009).

Political discourse analysis

The approach taken here links directly to the discussion above in that it is specifically geared to consider how political problems are conceptualised and argued in policy debates. Policy is treated as a set of proposals for practical action based on the partial representation of a particular problem. The diagnosis of social problems leads to problematisations that carry with them biases toward particular outcomes. For example a diagnosis of a service having a lack of responsiveness to public need has tended in recent years to lead to a market-based solution because of the assumption this will lead to that service becoming more dynamic as a result (Greener & Powell, 2009).

The language which is used to construct policy carries rhetorical effects that will often reveal a great deal about the assumptions that particular policies hold about the world. It is not an overstatement to claim that we live by our metaphors (Lakoff & Johnson, 2008), our representations of our own and others' subjectivities, and how we describe social problems and desirable outcomes.

The approach to political argument analysis closest to that described above is that of Fairclough and Fairclough (2012), who present a range of political debates using a framework that disaggregates political argumentation into a range of analytically linked categories; circumstances (the background and constructed problem being addressed); goal (what the proposal is meant to achieve); means-goal (how the mechanism proposed will achieve the goal specified); values (the values that underpin the diagnosis of circumstances, goal and mean-goal); and the over-riding claim for action (what the policymaker says must happen - usually the adoption of the policy proposal).

There may be several goals and several means-goal links made in a policy proposal, and at the same time those opposing or arguing against proposals often make counter-claims that question goals, means-goal linkages, the circumstances as defined by the policy proposals, and which question the underlying values of the policy being proposed. Those against a particular proposal may also point out negative consequences they envisage as likely to occur, and offer their own alternative counter proposals. Viewing policy proposals in this manner allow us to explore the elements of argumentation offered by policymakers in a clear framework that illuminates their proposals, whilst at the same time making clear the points of difference with opposition voices, and gives us a means of assessing the proposals likelihood of achieving their goals by assessing the strength of their arguments not only in rebutting opposition voices, but in relation to factual and evidence-based claims that they may be making in their proposals.

The Fairclough and Fairclough model presents us with a clear framework, but there are also some potential problems. For all its strengths, it does treat its 'circumstances' category fairly briefly, when it is often the case that the definition of a policy problem carries with it a clear steer as to the likely solution that will be proposed to deal with it - or in the terms suggested by Bacchi (2009), we must pay close attention to policy 'problematizations' - the way that policies construct problems so as to favour particular attempts at solutions or exclude others. It is therefore important to examine carefully the way that policy problems are represented and constructed in policy documents and debates to assess the extent to which those representations and constructions seem chosen to lead to favour particular policy solutions.

Incorporating insights from Bacchi in terms of problematization allows us to examine the debate concerning the introduction of the UK coalition government's NHS White Paper

'Liberating the NHS' in 2010 to explore why its proposals proved so contentious. The paper here examines the debate concerning the White Paper rather than the compromised Bill that ended up being voted into legislation later on. It does this to try and capture the values and ideas that the government wished to introduce, and the reaction to it and the counter-claims made by its opponents. It is the job of another paper to track the extent to which these objections and counter-claims were eventually addressed by legislation later on.

The NHS in 2010

By 2010, after increasing healthcare budgets considerably during the 2000s, the governing Labour party had both imposed central performance management of the NHS in England to an extent not seen before, and reinstated a market for care, allowing greater involvement from non-public providers more extensively than even Conservative 'internal market' of the 1990s (Greener, 2008).

In the 2010 election the Conservatives managed to outflank Labour in relation to healthcare by promising to protect the NHS budget if elected, a promise Labour did not feel it could match. This led to something of a stalemate in which Labour were reluctant to campaign around healthcare - despite the improvements that had been achieved during the 2000s, and the Conservatives appeared wary of discussing any plans they had formulated in relation to the service (Timmins, 2012). The NHS was largely conspicuous by its absence in the televised party leader debates.

After the election, and the formation of the coalition government, the NHS did not appear prominently in the published coalition agreement (HM Government, 2010). Six weeks later, however, a White Paper appeared putting far more radical change at its centre (Secretary of State for Health, 2010). The story how this dramatic change happened has

already been the subject of a short book by Timmins (2012), but briefly, a combination of Secretary of State Andrew Lansley being given a great deal of autonomy, the Prime Minister apparently not examining the proposals closely, and clinical representative groups also initially not grasping the significance of the proposals, meant that perhaps the most radical reorganisation of the NHS in its history began relatively quietly but then moved to a situation of antagonism between the government and its critics.

The 'Equity and Excellence' debate

The debate on the NHS White Paper 'Equity and Excellence: Liberating the NHS' was held in Parliament on the 12th July 2010 – mere weeks after the Coalition government had come to power, and was recorded in Hansard in columns 661-681.

What follows is not a description of the debate, which can be downloaded in full through Hansard. Instead, it is an analysis of that debate. First, however, it is worth giving a brief outline of it.

The debate began with the Secretary of State Andrew Lansley giving a statement 'on the future of the national health service' (c. 661) which outlined the government's commitment to the 'core principles of the NHS', but noted that the 'NHS today faces great challenges', also suggesting that 'For too long, processes have come before outcomes' and that the NHS needed to bring 'NHS resources and NHS decision making as close to the patient as possible' (c. 661).

Lansley went on claim that the reorganization would bring 'real, local democratic accountability to health care for the first time' and that it would 'liberate the NHS from the old command-and-control regime' and allow 'any willing provider to deliver services to the NHS' to create the 'largest social enterprise sector in the world' under the remit of

an 'efficient and effective' regulator and an 'independent and accountable NHS Commissioning Board' (c. 662)

The reorganization would simplify 'the NHS landscape', 'rebalance the NHS, reducing management costs by 45%...and abolishing quangos that do not need to exist' and 'phase out the top-down management hierarchy, including both strategic health authorities and primary care trusts' (c. 663).

Following Lansley's statement, Andy Burnham (the former Secretary of State for Health, leading the opposition in the debate) answered, followed by Lansley's responses, before the debate was opened to generally supportive comments from members from the coalition government, and hostile comments from the opposition.

The circumstances of the reorganization

The opening presentations in the debate, from Secretary of State Lansley and his Shadow, Burnham, present a picture of the government claiming significant change is necessary in terms of bureaucracy stifling staff from doing their jobs and holding them back from achieving the best health outcomes (a claim disputed by the opposition), and that the NHS faces considerable future challenges (not challenged by the opposition). In turn, the opposition suggest that the NHS is 'working well' and challenge the legitimacy of the reorganization because of it not being included in either the coalition agreement or election 'manifesto commitments' (c. 663).

In his opening statement, Lansley characterises the NHS as 'stifled by a culture of top-down bureaucracy which blocks its staff from achieving the best health outcomes' (c. 661), using the particularly memorable phrase that 'The current situation is akin to a shopping trolley being pushed to the checkout while the primary care trust is standing there with a credit card, bleating about whether things should be taken out of the trolley'

(c. 666). The result of this bureaucracy and ineffective purchasing of care was that survival rates are worse than our international neighbours with targets focused on processes not outcomes (c.661). Lansley acknowledged that the NHS has made some progress in the previous decade, but claimed that more must be done in giving local healthcare organisations greater 'freedom' (so the best can be built upon) (c.662) while at the same time the NHS was having to change to deal with the challenges of an ageing population, advances in medical technology and rising expectations' (c.661).

Burnham, speaking for the opposition in response, claimed that the NHS had made 'hard won' progress on objective measures and international rankings, and that the government's proposals represent a 'huge gamble with a national health service that is working well for patients' (c. 663). He suggested that the reorganization represents a 'U-turn of such epic proportions' and to have 'spectacularly ripped up' the coalition agreement with the 'spin operation' of the government' billing the reorganization as "the biggest revolution in the NHS since its foundation 60 years ago" even though the coalition agreement promised 'we will stop top-down reorganisations of the NHS' (c. 663).

This opening exchange is interesting in that it would normally be the government defending a public service, and the opposition demanding change. Coming soon after a general election, however, the argumentation positions have been reversed. This gives the opposition a problem in having to defend a service they are no longer responsible for (as it is the result of their own policy decisions), and the government good reasons to want to change things (so any improvements can be held up as being as a result of the changes they are proposing).

In terms of whether the structural reorganization Lansley proposes are necessary, one member of the opposition asks whether he has heard of the old adage, "If it ain't broke,

don't fix it"?. Lansley replies – ‘It is broke, and we are fixing it. We are fixing it because primary care trusts have not succeeded in delivering the outcomes that we are looking for, and they have consumed an enormous amount of money. ’ (c. 676). This presents Lansley’s problematisation of the present system as both a failure to deliver outcomes and of bureaucratic waste.

Finally, the issue of the extent of whether the health inequalities would be made worse by the reorganization was raised several times in the debate, and which led Lansley to present a final circumstantial factor which his reorganization was meant to address: ‘It would be a good idea if Labour Members at least acknowledged that over the last 13 years health inequalities have widened in this country... ’ (c. 681).

In all then, the problematisation presented by the government is that of a health service producing poor outcomes relative to comparable systems, stifled by wasteful bureaucracy and unable to deal with the challenges it now faces (including growing health inequalities). The opposition, in contrast, suggest that the NHS is working well, and emphasise how the proposals are a ‘gamble’ that risk losing ‘hard won’ progress that has been achieved, emphasising also the lack of democratic legitimacy the proposals hold having not been a central part of the government’s manifesto commitments in the recent election.

The reorganization’s goals

The coalition reorganization of the NHS was being presented by it as being radical, and so we might expect it to have ambitious goals. The goals specified in the White Paper and its debate are certainly wide-ranging. The opposition’s position, as outlined in their problematisation, was that the NHS is already working well, and so does not need reorganising again. Perhaps more significantly, however, some members of the

opposition appear to be suggesting that the goals offered by the government are not the 'real' ones - that the reorganization was really about the privatisation of care than improving healthcare.

Lansley presents the goals of his reorganization in a fragmented fashion, across several answers in the debate. In full, the wide-ranging aims are as follows

- To deliver 'health outcomes as good as any in the world' (c. 661)
- Respond to the demands of an increasingly an ageing population, advances in medical technology and rising expectations (c. 661)
- Create an outcomes framework setting out what the service should achieve, leaving the professionals to develop how (c. 661)
- Patients be assured that services are safe (c. 661)
- Decisions be made as close to the patient as possible ('no decision about me, without me') c. 661
- Patients given real choices, the right to choose their GP practice and greater access to health information including the right to control their patient record (c. 662)
- Introduce real, local democratic accountability by giving local authorities the power to agree local strategies to integrated care and control over local improvement budgets (c. 662)
- GPs lead commissioning to respond to the wishes and needs of their patients, informed by the NHS commissioning board guidelines and standards (c. 662)
- NHS trusts will be liberated from command and control regime and become Foundation Trusts, with power increasingly placed in the hands of their employees (c. 662)

- Management costs will be reduced by 45% in four years, un-necessary quangos abolished, £1bn moved from back office to front line, £20bn of efficiency savings made by 2014, all of which will be reinvested in patient care (c. 663).

The government is then promising not only to drive up quality (outcomes) at the same time as reducing costs, but also simultaneously changing a range of structures to give patients more choice, increase democratic accountability, give GPs more responsibilities and change the way NHS trusts work. Given this level of ambition the next section of the paper, which explores how the government believe means are linked to these goals, is extremely important.

This opposition, in response, present the case for change not occurring. They appear rather out-flanked, offering little in the way of an alternative plan other than the status quo - and so left in the odd situation of having to defend a public service they were no longer responsible for running.

Burham suggested that the NHS needs 'stability, not upheaval. All its energy must be focused on the financial challenge ahead' (c. 663), and that the opposition will support the government 'where sensible reductions' can be made to bureaucracy, 'but what he calls pointless bureaucracy, we call essential regulation' (c. 664).

Other members of the opposition also suggest that the 'real' goals of the reorganization are being concealed. Burnham suggests that they are 'removing public accountability and opening the door to unchecked privatisation' (c. 665), and 'the handing of the public budget to independent contractors' is 'tantamount to the privatisation of the commissioning function in the NHS' (c. 664). Later, another member of the opposition suggests that 'the real motive behind the reforms is to enable US multinational corporations....to parcel out health care to the private sector on a vast scale' (c. 673). To

the last point, Lansley simply answers ‘No, that is completely wrong on all counts’ (c. 673). This allegation of hidden privatisation is an important one to which we will return later in the paper.

Linking means and goals

Given the ambitious range of goals, and the dispute between government and opposition as to whether the NHS is ‘working well’ or not, a narrative about how the reorganization will meet the coalition government’s goals is clearly important - how would the reorganization meet the goals specified of it?

Lansley’s claim was that by removing bureaucratic barriers, and by putting place social enterprise and GP commissioning, the ambitious outcomes of the reorganization could be achieved. The opposition, in contrast, claimed that the proposed reorganization would undermine accountability (and even increase bureaucracy), ask GPs to take on commissioning roles they were not equipped to deal with, and pass public funds to GPs without adequate oversight of how that money will be spent.

The reorganization proposed two main means of achieving its goals. The first is to remove barriers, and the second to put in place ‘social enterprise’. The first strand links back to Lansley’s problematisation in relation to the NHS being stifled by top-down bureaucracy, and so to ‘remove unjustified targets and the bureaucracy that sustains them’ (c. 661). At the same time, however, targets would be replaced by an ‘outcomes framework’ to make sure standards are maintained (with a key difference being made between ‘targets’ and ‘outcomes’). Finally £20bn of efficiency savings would be generated by ‘dismantling’ bureaucracy (c. 663).

The second means was the creation of a ‘the largest ‘social enterprise sector in the world’, with improved regulation so it is not a ‘free for all’ , but within which, through a system

of 'any willing provider' and within GP-led commissioning (c. 662), payments would be a driver 'not just for activity, but also for quality, efficiency and integrated care' (c. 661). Lansley suggested that GP commissioning was about 'those who incur the expenditure – the general practitioners, on behalf of their patients – and who decide about the referral of patients are the same people who, through the commissioning process, determine the shape of service in their area. It is more accountable' (c. 665).

What Lansley is proposing therefore, appears to be a market-based programme of reorganization labelled as 'social enterprise' - perhaps as an attempt to avoid the charge of privatisation, in which GPs (as the doctors closest to patients), 'commission' (rather than purchase, again avoiding obviously market-based language), services on behalf of their patients.

The 'leap' Lansley's reorganization requires us to make, linking together the problematisation to the goals via the means described above, is that a reorganization that strengthens the role of market-based mechanisms in the NHS in England can both improve care and save money. He was trying to show that this reorganization is both a break from the past in expanding freedoms and social enterprise, and a continuity of the previous government's NHS where it appears to be showing progress.

The opposition, in turn, claim that rather than increasing accountability, the reorganization will decrease it - and even increase bureaucracy at the same time, that GPs are not ready to lead the commissioning of services (and so this will result in them passing on or even privatising their new duties), and that GPs might misuse their new budgets to pursue cheaper rather than better healthcare.

In terms of accountability, Burnham claims that the reorganization would lead to 'the wiping away of oversight and public accountability' (c. 664) while at the same time

creating the 'biggest quango in the world' (the new NHS commissioning board) but without explaining how it will be 'accountable to this House and to Members of Parliament'. Other opposition figures ask how GP practices will be 'watched over' in their spending, and claim that 'The Secretary of State has been asked about the accountability of the GPs, and he has not answered.' (c. 673).

The claim that GPs were not ready to lead the commissioning of services is made several times, with suggestions from Burnham that the reorganization represented 'the handing over of £80bn of public money to GPs, whether they are ready or not....only 5% of GPs are ready to take over commissioning....even the best GP practice-based commissioners are "only about a three" out of 10 in terms of the quality of their commissioning.' (c. 664). This claim is linked to the suggestion that the reorganisation is 'tantamount to the privatisation of the commissioning function in the NHS' (c. 664) and that it would 'cause significant problems with the progress' GP consortiums have already made under the previous government (c. 677).

Finally, there is an opposition claim that GPs would misuse their budgets. This is most clear in the question 'how will he guarantee that GPs will not look for cheaper medicine rather than better medicine' (c. 675).

In response to these concerns, Lansley appeared to grow increasingly impatient. After expressing the view that he has explained the accountability structure several times he says 'At the risk of repetition, let me say that GPs will be accountable to patients, who will exercise more control and choice. They will be accountable to the NHS commissioning board, which will hold their contracts, for financial control and for their performance, through the quality and outcomes framework. They will be accountable to their local

authority for their strategy and for the co-ordination of public health services and social care.’ (c. 673).

In response to concerns about whether GPs are ready or have the capacity to commission services Lansley claims ‘The hon. Lady and all her colleagues completely underestimate the capacity of general practitioners, who are responsible for the overwhelming majority of patient contact in the NHS, not only to take on the responsibility of deciding whether they should incur the expenditure for the referrals they make but to have a say in designing those services.’ (c. 681).

Finally, in response to concerns about GPs pursuing cheaper rather than better care, he suggests a further accountability measure (which he has already positioned himself as defending above) ‘Because patients will have increased choice-[Hon. Members: "How?"] Because patients will make their choices on the quality of service they receive, because the service will be free to them.’ (c. 675)

Lansley’s claim, then, is that the accountability structures avoid the problems the opposition claim they will create, but in answering those structures appear rather complex. Lansley also does not give a clear answer to the concerns raised about privatisation by the opposition.

The government presented their reorganization as an extension of values often presented in NHS White papers including free, comprehensive and equitable care, but extended to include decisions being made jointly, and the right to choice. The opposition instead propose supporting that ‘loyal public servants’ be treated more respectfully, suggesting that the proposals are about privatising healthcare, and will lead to chaos rather than order as they abolish ‘essential regulation’ rather than ‘pointless bureaucracy’.

Values

In terms of values, the government's proposals faced a difficult balancing act, both attempting to show they are supportive of the NHS (in terms of its 'core values'), but at the same time also showing their proposals are different from what has gone before. To try and achieve this, Lansley proposes 'A comprehensive service for all, free at the point of use, based on need, not ability to pay. The principle of equity will be maintained, but we need the NHS also consistently to provide excellent care' (c. 661). This is a particular definition of equity, based on providing equity of access to excellent care (through choice and social enterprise), rather than the same care for all.

In addition to linking to values invoked by previous governments, new values are also proposed by Lansley, including 'No decision about me, without me' (c. 661) and the 'right to choose' (c. 662) for patients. Despite the title of the White Paper ('Liberating the NHS') neither liberty nor freedom are mentioned extensively in the debate, with a slightly stronger emphasis on democratic accountability, which is mentioned three times.

The opposition stressed instead values of stability and the respectful treatment of 'loyal public servants' (c. 664), expressing concerns about the privatisation of healthcare (c. 664), and that the proposed reorganization would lead to 'chaos' not 'order' (c.665) leading to services that will 'vary from street to street' (c. 665). Burham counter poses 'essential regulation' with the 'pointless bureaucracy' suggested by the government (c. 664).

Government and opposition claims

In sum then, the governments' main claim is that NHS bureaucracy is stifling creative and should be abolished with commissioning being made GP-led using a payment system that is a driver for activity, quality, efficiency and integrated care by bringing the management of resources and the management of care together. Care providers should be made free

NHS trusts from bureaucratic control through a social enterprise model based on 'any willing provider', care be outcome-focused, and commissioners be rewarded for delivering care in line with quality standards in a regulatory regime designed to assure patients that services are safe and the social enterprise sector regulated to ensure efficiency, effectiveness and comprehensiveness. Patients will be given more choices and decisions made as closely as possible to them, with Healthwatch championing their needs. Democratic accountability will be increased by giving local authorities the power to bring NHS, public health and social care together by giving them control over local improvement budgets and strategies.

The counterclaim offered by the opposition is that the NHS is working well having made 'hard won' progress and needs stability to meet the 'financial challenge ahead' as NHS reorganizations 'cost money and divert resources'. The opposition argue that the proposed reorganization will demoralise staff and redundancies and the abolition of national pay bargaining are a poor 'way to treat loyal public servants', with commissioning being privatised, and market forces being allowed to create 'chaos' in a system where there will be less public or parliamentary accountability than the present system. Finally there is the claim that the reorganization will not reduce bureaucracy but increase it as the NHS commissioning board will create biggest quango in the world, as well as creating inequity as the reorganization will make services vary from street to street.

The overarching narrative of the reorganization

Lansley portrays the NHS as a moribund, stifling organization which the reorganization will free staff from. How will the NHS be organized instead in the future? Through 'the largest social enterprise sector in the world', but 'not a free-for-all' (c. 662).

Lansley then is claiming to capture the dynamism of the market without using the term 'market' - instead preferring 'social enterprise', mindful of allegations of him privatising the NHS. At the same time as this, he is attempting to harness market-based dynamism with control through effective regulation - but without that regulation being bureaucratic (which is associated with stifling staff), and making sure services are 'efficient and effective' as well as 'comprehensive'.

If freedom from bureaucracy and 'social enterprise' are the first two elements of the reorganization, the third is Lansley's claim to be putting in place 'a long-term vision for an NHS that is led by patients and professionals' by claiming he 'will bring NHS resources and NHS decision making as close to the patient as possible' by introducing 'real, local democratic accountability to health care for the first time in almost 40 years by giving local authorities the power to agree local strategies to bring the NHS, public health and social care together.'

The appeal of Lansley's narrative for the public comes in giving them the 'right to choose', presenting healthcare as another consumer choice, and at the same driving up clinical standards as a result. Intuitively, who does not want more choice? And if such choices will actually make the NHS better as a result, what grounds could there be for not wanting to agree with the reorganization?

Lansley's narrative is an attempt to explain how it will both abolish bureaucracy, but ensure there is proper regulation and democratic accountability; it will put control of the NHS in the hands of patients and professionals, even while it is itself is designed by politicians; it will drive dynamism through 'social enterprise', but at the same time legislate for a 'stronger economic regulator'. The narrative therefore attempts to conceal or gloss-over the multiple, long-standing problems the reorganization was attempting to

overcome, misrepresenting an oligopolistic market structure as having the dynamism of perfect competition through the label 'social enterprise' with no clear strategy for dealing with the financial failure of healthcare providers; of there being no means through which patients are meant to make choices between different healthcare providers; of GPs lacking time or ability to make commissioning decisions; and of the problem of putting the NHS through significant reorganization at a time when large budgetary savings are required.

Lansley's narrative locates GPs as the doctors closest to patients as shoppers for care on behalf of patients (using a supermarket metaphor), but conceals the rationing for care that will result. 'Social enterprise' in turn conceals the antagonism of public and non-public providers attempting to compete within scarce resource limits for care contracts, but without any real scope to allow large public care providers to financially fail (because of their size and importance to the care 'market', and because they are needed to guarantee continuity of care provision should non-public providers exit or financially fail – which they certainly subsequently did).

The picture presented by the opposition represents an alternative, but equally unviable narrative, that of the present organisational form working 'well' at a time when health services across the world face significant challenges, and so that no reorganization is necessary. Burnham appears to be suggesting that the more limited use of the market that the previous government put in place has ameliorated the fundamental tensions in healthcare explored above, but which still have not addressed the antagonisms between resources and need. The narrative offered here is based on stability and continuity - both of which are undoubtedly virtues, but hardly offering an inspiring alternative imaginary

for the future of the National Health Service where the basic antagonisms underpinning healthcare remain unaddressed.

Discussion and conclusion

Did the debate hold the proposals adequately to account?

The debate itself offers significant issues that ended up serving neither the government nor opposition well.

On the government side, the proposals seemed to have been subject to little detailed scrutiny, with Lansley not able to respond to criticisms about the privatisation of healthcare and lack of accountability in his proposed structures with little effort. This meant that suspicions from clinical representative groups and the public more generally were not allayed or responded to in detail. Discussion in the debate was often personalised and even rude.

This suggests serious problems in the Parliamentary accountability process in that it left issues about privatisation and accountability in the Bill unexplored in depth. By not opening these issues to scrutiny, the end result is that health service reorganization, regardless of whether it is needed or not, has become such a difficult and even politically toxic issue that no political party is likely to attempt it again soon (Timmins, 2012).

In sum, too little time was spent on considering the problematisation of the debate and there is a lack of a narrative linking the reorganisations aims and means with no clear sense of main problem the reorganization is meant to achieve, leading to ample space for conspiracy theories about privatisation to be made by the opposition.

The voice of the opposition was remarkably muted - perhaps because the main opposition party has been in government too recently to criticise the service being

offered, or to offer an alternative vision to that of the government. This suggests a significant problem for opposition to a new government making radical proposals - how is the opposition to counter?

The combination of government without a reorganization narrative and an opposition unable or unwilling to offer an alternative led to a process in which proposals were debated, but not tested as fully. If politics is meant to lead to practical action, then the politics of the debate was not a success.

What was the reorganization for?

If we examine the debate, then the explanation that the reorganization is ideological appears a strong candidate to be the most powerful one. In the debate (in contrast to the White Paper itself) the government gives a range of problems the reorganization was meant to address, but fails to answer the charges against it around stealth privatisation and so it is hard to refute the alternative explanations that link Conservative business interests to private healthcare providers and their roles in lobbying for market-based healthcare reorganization.

The government's articulation of the reorganization failed to explain how the means it proposed would deal with the ambitious goals it specified. Equally, the failure of the Parliamentary process, the closeness to the election meaning the opposition do not scrutinise the proposals or offer a coherent alternative, do not offer an encouraging picture of Parliamentary debate or White Paper presentation.

The NHS Bill, eventually passed in 2012 after over 2000 amendments, appeared to satisfy no-one in that the market-based solution was blunted in the face of Liberal Democrat concerns about accountability, an online petition supported by the public sufficiently forcing an extra debate in Parliament and increasingly widespread clinical opposition. At

the same time, opposition concerns about privatisation appear not to have been fully alleviated in that the non-public entry of healthcare providers the government appeared so keen to encourage still occurred.

A final question which comes from the analysis above is to ask why it is that the marketization of care in one form or another was so accepted by both government and opposition. Why was no alternative being proposed?

One possible answer is that a consensus between both main political parties about market-based healthcare reorganization appears to have been reached, with the only dispute being the extent of the privatisation associated with it. The market-based logic had dominated public reform in the US and UK since the 1980s, with the NHS initially appearing as a laggard (Klein, 1986), but as barriers to change such as the institutional power of the medical profession in blocking reorganization and Conservative concerns about appearing to privatise care eroded (the latter not least as Labour appeared so keen to introduce non-public provision in the 2000s), then the use of market-based solutions appeared to be the only ones being actively considered by consecutive governments. Combined with the easy appeal of presenting such proposals to the public as extending their choices, the proposals offer a narrative of harnessing the intrinsic antagonisms present in healthcare to creative ends through market-based solutions while extending patient choice at the same time. This narrative, however, fails to get to grips with the intrinsic tensions present in providing healthcare, and so is somewhat chimerical.

In conclusion, it appeared then that government's presentation of their reorganization, both in the White Paper and in Parliament, contributed substantially to the problems they experienced in taking their Bill through the legislature, with their problematisation failing to adequately justify the reorganization, and leaving the government open to a

justifiable counter-claim that the reorganization was ideologically grounded in expanding the use of market mechanisms into healthcare rather. The lack of alternatives imaginaries to this market-based model in the debate, however, suggests a failure of the opposition to articulate a genuine alternative to the reorganization. Without such a counter-narrative, the ability to mobilise opposition to the extent of blocking the Bill was always blunted. If the coalition government were guilty of pushing through badly-through-out and argued legislation, the opposition were guilty of failing to organise to prevent it.

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