# Ideological Closure, Austerity and National Health Service Reforms: How do UK healthcare bureaucrats close down the political space available for ethical debate of budgets, reforms and their consequences?

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For my PhD research, I spent a year doing ethnographic fieldwork in Greater Manchester, with political activists campaigning against cuts and privatisation in the National Health Service (NHS), the UK's public healthcare system. In this blog I focus on what I learnt from interviewing the managers and politicians who were pushing through the reforms to which activists objected.[1]

Previous research (Russell, Greenhalgh 2012) has found that affordability and efficiency infiltrated and became part of the way these "decision-makers" talked about their own ethics, complementing the purported original NHS principles of universality, comprehensiveness, and being free at the point of use.

While my findings do not contradict those earlier findings, what I found was a bit different. The managers and politicians that I spoke to circumvented ethical debate by placing constraints around what could be debated *as* ethics.[2] The key focus of activist ire – fiscal austerity – was something that managers and politicians accepted as simply "the reality". Moreover, it was a reality over which they had little control, and within which they still had to act to realise the same ethical principles that were put forward by NHS activists: of protecting and maintaining health services that were universal, free and comprehensive.

I won't go into too much detail here on local or national healthcare policy or reforms. (Those interested in NHS reforms can see my paper here (Pushkar 2018), or more recent articles from thinktanks such as CHPI, King's Fund and Nuffield Trust). In summary, since 2010, Tory governments have severely limited public investment in the NHS.[3] Managers and local government politicians have responded by identifying three key problems facing the NHS: "financial pressures" as a result of the cuts, a shortage of clinical and non-clinical staff, and increasing need for healthcare amongst an ageing UK population. Since 2014, bureaucrats have generally attempted to solve these problems through instituting "new care models". These models focus on integration and partnership, both within the NHS, but also between NHS organisations and other state institutions, especially local government and social care. One commonality between many of the new care models being proposed nationally is to move care out of hospital, into the community, where care can be provided that is supposedly not only better for the patient, but also cheaper for the state. A major sticking point is that the plans often propose that the creation of such new care models will facilitate the closure of pre-existing hospitals. To simplify a little, activists argue that they have no problem with integration itself, but they do oppose integration if it is a Trojan Horse for cuts and privatisation, manifesting as public

hospital closures or degradations, creating space for “partnerships” with – or wholesale takeovers by – non-state organisations.

One of my friends in Greater Manchester, an activist that I will call Luther (all names in this blog have been changed), summarised the activist argument in a speech that he gave to his local Labour Party branch:

> The claim of [current NHS reforms] is that better community-based services will improve the health of some chronically sick and frail people. Supposedly they will therefore have less need for hospital emergency and outpatient services, thereby saving heaps of money … The underfunding gap is to be closed by cutting hospital services and particularly emergency hospital beds. This is at a time of rising need for those beds. Already one in ten beds has been lost in the last six years. The UK has the second lowest beds per head in Europe.

The worry being elucidated by Luther was that people would not be able to access hospital care, because the beds required to provide that care would be lost according to the plans for reform. The NHS would no longer be universal or comprehensive.

NHS
STOP THE SELL-OFF
Keep our NHS Public!

Protestors with placards, Dunning Hospital. May 2018. Copyright: P. Pushkar

The activists with whom I spent time met with MPs, councillors and senior managers, as well as attending council, hospital and other NHS organisational board meetings. They did research, read papers, asked questions and raised the concerns elaborated by Luther. But when they challenged managers and politicians, they felt that they were not listened to, that the manager or politician in question would either deflect their questions, avoid them, or actively attempt to silence the whole group.

One of the key frustrations that they voiced to me and to each other at protests, meetings and interviews was how the proponents of these reforms presented them as risk-free, blithely stating that they would both improve the health of the residents of Greater Manchester *and* save money. Campaigners worried that it could only do the latter by placing the healthcare – and therefore the health – of Manchester's residents at great risk, by reducing services, by reducing bed capacity, by having fewer or less-skilled staff, etc. To be more precise, the NHS's core services were being reduced in order to save money. Activists pointed out how the plans being promoted to the wider public were not being honest about this underlying principle of frugality trumping need, and its associated risks, which ran counter to the NHS's principles of providing universal, free, comprehensive services.

Managers confirmed to me that activists were correct that fiscal austerity was impacting patient care. When I interviewed one senior manager at a hospital trust, Betty, she apologised for starting late after a flustered phone call dealing with an emergency related to the huge inflow of patients to the emergency department. Then she told me,

> The big thing at the moment that we're dealing with is the huge pressures that we're facing because of winter, with the number of patients needing to come into hospital, with the beds all being full … We're also … dealing with the fact that we have huge financial problems. We're almost going bankrupt, we are having massive deficits and the political and the strategic consequences of that. We're dealing at the moment with big, big changes that are happening in [a town in Greater Manchester] where we're trying to do more out of hospital care because we cannot carry on the way we are. So we're getting this big impact on patients and staff.

Betty confirmed activists' fear that financial constraints were impacting patient services. Activists also had concerns regarding the honesty of managers. Again, Betty confirmed to me that activists were right to harbour these concerns. First, she explained the reasons why current reconfigurations might benefit patients, namely that integration of healthcare and social care

could reduce separation between services, thus allowing them to run together with fewer disruptions. Then she explained the problems:

> I think there is a dishonesty about how it's being presented to the public because we're not also talking enough about the fact that this is because we haven't got enough money to continue as we are. So I think what we're trying to do is good, but I don't know how honest the conversation is because we're not talking about the fact that we haven't got enough money and that's part of the reason for wanting to do this. And we also have this recruitment crisis. So, we're only talking about the bit we want to talk about, packaging it up in a really positive way. And therefore, understandably, it's leading to cynicism from these protest groups, because we're not explaining it clearly and openly and as honestly as we should, in my view.

Moreover, she agreed that managers at board level in the hospital trust and the other NHS organisations in her district had "ignored [NHS activists], kept them at arm's length, patronised them, criticised them and tried to stifle and stem discussion with them". So why did managers and politicians follow the path they did, while claiming to hold the same values as NHS activists?

When I asked them if they considered affordability or efficiency as *ethical* principles, they generally shook their heads. Instead they described a requirement to spend within one's means as "the reality". A senior councillor in central Manchester put it to me that efficiency was not in itself an ethical principle that she held to, but that she did seek to do the best for the NHS with what was "within our gift". In reference to the £6bn allocated to all of Greater Manchester for the NHS, a senior councillor in another part of Greater Manchester said to me, "No, it's not enough in a sense, but it's what we've got. That's the thing … so we need to find ways of making sure that money is well used, better used, more effectively addressing the needs of populations rather than simply providing ill-health care."

I am not trying to say that efficiency had not crept into their ethics. Indeed, other statements regarding a responsibility to be careful with "taxpayers' money" did suggest that they did understand economic prudence to be one of the duties of "decision makers with budgetary responsibility working in the public sector" (this quotation is the byline of a magazine that I found lying on the table while I waited to interview one manager). Regardless, ethics can be *debated*. The point I am arguing here is that managers and politicians did not regard the finitude of their resources as something they could debate. It was simply a reality that formed the constraints within which they had to act. Any values they had could only be realised as far as was possible within those constraints. There is no magic money tree. Get used to it. Put otherwise, once councillors and managers have accepted that the money they are given is what they have got, parsimony becomes unavoidable. There is no debate.

In the eyes of managers and politicians, they had formed a plan to do the best they could with “what we’ve got”. Since NHS activists were seeking to stop the council from taking these actions, councillors began to see them as adversaries. Thus it was NHS activists that were stopping councillors from realizing the values of the NHS as they understood them. In opposing NHS reforms, councillors felt that the activists were trouble-makers, advocating a “do-nothing scenario” that would ultimately lead to the collapse of the NHS. I saw councillors become visibly angry when discussing the group of campaigners that Luther came from. One councillor banged his hand on the table in the middle of an interview with me, another shouted at them aggressively during a public engagement event that I had organised. These councillors justified their actions to evade or shut down negotiation with NHS activists on the basis that it was the activists that were getting in the way of managers and politicians realising the values of the NHS *as far as was possible*.

On the other hand, activists attempted to point out that the constraints within which managers and politicians imagined what was possible were not natural, not rigid. These constraints were set by decisions made by people, and thus were amenable to change. Activists understood budgetary restrictions as choices, open to moral critique and debate. They undertook this task of moral critique through an exposition of the consequences of those decisions. In other words, they understood economy as both moral and political.

By placing discussion of finances outwith the realm of ethical debate, managers closed down the space for political contestation. Put otherwise, I have described a case of ideological closure. Managers and politicians narrowed the space within which the politics of negotiation could take place, by placing certain areas outwith the realm of ethics. Frugality was required because restricted budgets were simply the reality. They accepted a limit to what they could achieve because they felt they had to, in order to get on with realising their aspirations, however limited they were. But as Bear and Mathur (2015) have described recently with regard to bureaucrats in India, this act of closure, the effective acceptance of fiscal austerity, did not mean that they completely gave up on utopic aspirations. The managers and politicians that I spoke to seemed to genuinely hold to the founding NHS values of universality, comprehensiveness and being free at the point of use, but *only as far as was possible* with “what we’ve got”. Activists, frustrated by the naturalisation of austerity, sought to prise open this ideological closure, expose the human decisions and social relations behind it and thus open NHS reforms to ethical debate.

[1] This post is a slightly changed version of a text published on https://boasblogs.org/endofnegotiations/ideological-closure-austerity-and-national-health-service-reforms/

[2] By ethical or moral, I mean to refer to how actors evaluate their actions and aspirations with regard to how things ought to be or ought not to be, often using language that makes reference to what is good, bad, right or wrong. By political, I mean to refer to debate, argument and conflict regarding how societal structures are or should be organized.

[3] Despite having a Tory national government, most parts of Greater Manchester have a

Labour-led council. All of the politicians quoted in this blog are Labour Party members.

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