

# **Opening up the NHS to market: Using multimodal critical discourse analysis to examine the ongoing corporatisation of health care**

Gavin Brookes and Kevin Harvey

The University of Nottingham

## **Abstract**

Since its implementation, the British Government's controversial 2013 Health and Social Care Act has had far-reaching effects on English health care provision, not least the creation of 212 regional practitioner-led clinical commissioning groups (CCGs) which are now responsible for much of the service provision across the country. Taking as an example the website of one of these new commissioning groups, this study shows that multimodal critical discourse analysis (MCDA) can reveal how health and social care matters are being increasingly framed within a corporate and neoliberal set of ideas, values, identities and social relations. Despite government assurances that the Act preserves the (non-commercial) founding values of the NHS, our MCDA provides textual evidence of the influence of neoliberal and commercial discourses operating across CCG websites, which appear to prioritise corporate rather than the practical, day-to-day concerns of patients.

## **Keywords**

Clinical commissioning groups, NHS, commercialisation, neoliberalism, privatisation, marketisation, multimodal critical discourse analysis

## **1. Introduction**

This study critically examines some of the ongoing semiotic changes in contemporary health care communication brought about by the continuing privatisation of the British National Health Service (NHS). It focuses on the discourse of clinical commissioning groups (CCGs), new clinical bodies which came into being as a result of recent structural changes made to the NHS. This study demonstrates how a close multimodal critical discourse analysis is able to expose a set of neo-liberal values that have become increasingly widespread since the advent of the 2012 Health and Social Care Act (hereafter ‘the Act’). In light of this controversial legislation, which introduced compulsory competition in the accessing and commissioning of health care services, we argue that contemporary health discourse requires greater critical attention – not just from medical professional bodies and health policy experts – but also from analysts able to critically examine health information and policy discourse, much of which is subtly Daedalian and reality-obscuring, and has so far received, from a discourse analysis perspective at least, very little critical scrutiny. Indeed, critical discourse studies of the privatisation of public institutions have tended to focus on the rhetoric of higher education, in particular the marketisation of the discursive practices of universities (e.g. Fairclough, 1995; Mautner 2010a, 72-98; Morrish and Sauntson 2013).

## **2. The 2012 Health and Social Care Act and the (on-going) privatisation of public health provision**

The marketization of contemporary British health care provision is by no means a new phenomenon. In 2003, for example, the New Labour government opened up segments of the NHS to private companies and decoupled its hospitals from public-service constraints, allowing various NHS establishments to operate like autonomous businesses (Player 2013). Although New Labour denied that these moves amounted to privatisation, selling them instead as ends towards community empowerment and the democratisation of health provision (Player 2013: 44), the reality was that the independent sector was now being contracted to carry out significant amounts of elective procedures and hence had become very much an integral part of the NHS.

The 2012 Health and Social Care Act, however, accelerated this privatisation process to the point that many public health commentators claimed that the passing of the legislation marked ‘the end of the NHS in England’ altogether (Pollock and Roderick 2015, 2257). The market mechanisms at the heart of the Act, they argued, would result in further, and indeed core, NHS services being handed over to large international corporations (McKee 2015, xxii), leading to increasing health inequality, a two-tier system of provision favouring only those who can afford to pay for private care rates. The British Government, however, in the voice of Andrew Lansley, the then Health Secretary, claimed that the new legislation was essential in order to safeguard the future of the NHS, to make it more cost effective and to promote innovation and better management – arguments put forward by other advocates of

competition in health care (Le Grand 2013). The government's modernisation plans would, Lansley argued, put patients first, offering them more information about, and control over, the care they received, while practitioners, shorn of operational independence from government, would have the freedom to deliver care in the way they saw appropriate. (2)

To achieve these ends, the structural reforms ushered in by the Act have seen the replacement of Primary Care Trusts, which hitherto had commissioned services for their local populations, by CCGs. Headed by general practitioners, these new CCGs, or GP Consortia, are responsible for managing health budgets and commissioning care services for patients – services which can be purchased from a variety of public and private providers. Understandably, faced with this extra administrative and managerial burden, many doctors have questioned whether they, *qua* medics, are best placed to carry out their new expanding role (Holder et al. 2015), handing over, in some cases, these new responsibilities to management consultants who are now, according to Davis, Lister and Wrigley (2015, 10), running CCGs 'from behind the scenes'

Although GPs have control over this service tendering process, deciding where and how their budgets should be spent, the Health and Social Care Act requires GP commissioners to observe 'competitive tendering' (Department of Health 2012), making it harder, in other words, for commissioners opposed to using the private sector to avoid purchasing services from within it (Davies 2013). This competitive clause has ensured that significant amounts of money have gone to private health providers. Indeed, as a report by the NHS Support Federation (2014) reveals, more than £9 billion of NHS contracts have been secured by private sector bids since 2013. Formerly such public NHS funds would have been spent on NHS services and hence flowed back into the NHS, rather than into the hands of private companies seeking to generate profit out of health care (Davis, Lister and Wrigley 2015, 7).

The analysis presented in this paper does not take issue with the process of privatisation *per se*, but, rather, regards the ongoing and specific corporatisation of UK healthcare services critically on the grounds that it is likely to erode the founding principles of comprehensiveness, universality and equity on which the NHS was originally founded (see Pollock 2005). Indeed, by further opening up the NHS to market and competition, the changes induced by the Act are likely to put strain on existing services and result in a model of healthcare provision, the quality of which is predicated on financial capability and geographical location (Pollock et al. 2002; Pollock 2005) and which is judged according to metrics of financial viability and profitability, rather than the actual standards of healthcare services it provides (Player 2013). This paper examines how the online presentation of linguistic and visual semiotic resources in the design of clinical commission consortia potentially background and obscure the controversial reality of the new model of healthcare provision emergent from the Act.

### **3. Data and Method**

The majority of the 212 CCGs across England have their own dedicated websites, which serve as their main source of audience outreach and as a means for constructing a positive brand image to compete with other CCGs. In order to provide a detailed description of one of these texts, our analysis is necessarily restricted to one CCG website – that of our local, Nottingham North and East CCG (henceforth NNE). The website consists of approximately 64 pages, with fresh news-related pages added all the time. The target audience appears to be both internal and external users, including established and prospective patients, GPs and private health companies. Although our focus is confined to this particular website, it should be noted that, in terms of multi-semiotic content and layout, this particular platform is not dissimilar from those of other CCG websites, and thus our analysis also sheds light on the kind of discourses in operation in other such websites across England. We first accessed the NNE website in November 2014, studying it closely between this point through until August 2015.

Given the proclivity of contemporary websites to convey messages not just verbally, but through a combination of semiotic modes (Martinec and van Leeuwen 2009), it is necessary to examine and critically engage with the NNE website in its full multimodal array. Accordingly, we adopt a multimodal critical discourse analysis (hereafter MCDA) (Machin and Mayr 2012) analytical approach. This approach is underpinned by the central tenets of critical discourse analysis (Fairclough 1995) and a social semiotic theory of multimodal communication (Hodge and Kress 1988) and which conceives of discourse as the broad ideas and values that are communicated by texts through a combination of co-present semiotic modes, including language, image, layout, sound and so forth (Kress and van Leeuwen 2006).

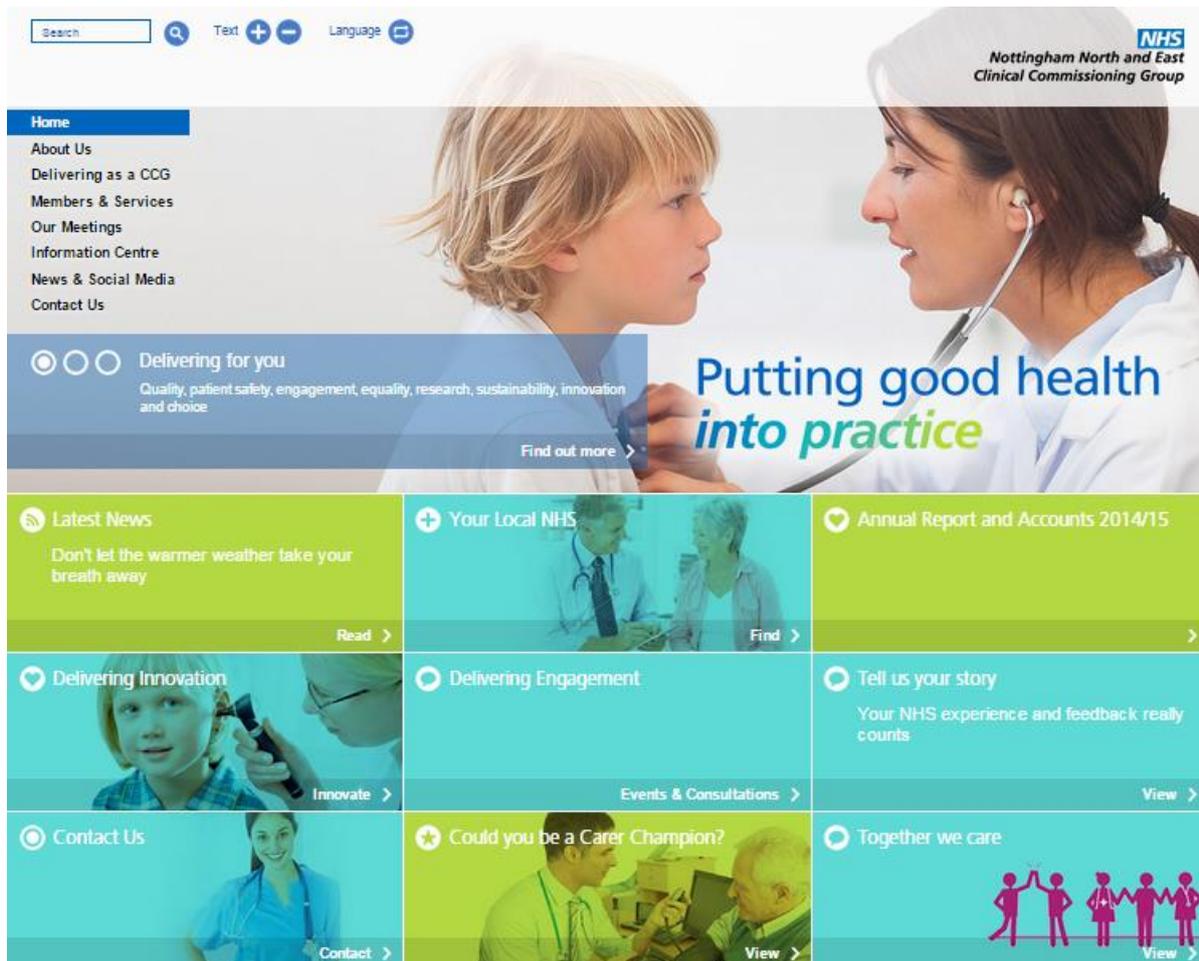
Following the approach to MCDA outlined by Machin and Mayr (2012), our analysis of the NNE website focuses on three key areas of multimodal representation: (i) the design of the NNE brand, (ii) the representation of the social actors involved in the provision and receiving of health care, and (iii) the representation of the processes involved in health care provision itself. Our analysis seeks to show how the strategic interplay of semiotic modes in this website foregrounds certain idealising neoliberal values in the context of healthcare.

## **4. Analysis**

### **4.1. The NNE commercial brand**

Examining the NNE website, we observed the recurrence of what might broadly be described as commercialising discourse. According to Guseva, commercialism in health care involves ‘an application of operating and managing principles typically found in business and commerce (financial incentivizing, profit-making, competition, marketing/advertising, and focus on the bottom line) to health care delivery’ (2014: 772). The commercialising discourse

evident in this website promotes a corporate-style NNE brand in order to distinguish this CCG from other CCGs, and presumably to appear attractive to a range of health care providers and patients (see plate 1 below). Indeed, as CCG marketers themselves recognise, any poor public perception of their Consortia may discourage private companies from tendering services, electing instead to do business with other CCGs which have better reputations (Cannock Chase CCG 2012, 44).



**Figure 1.** Screenshot of the NNE CCG website homepage

The website homepage is saturated with numerous lexical items which closely resemble the kind of discourse redolent of mission statements and commercial advertising (Swales and Rogers 1995), all of which contribute to this CCG’s brand identity. For example, the NNE refers to its ‘visions and values’ and describes itself as ‘delivering’ entities such as ‘engagement’, ‘sustainability’ and ‘innovation’, a vocabulary which invokes generic, if complex, qualities and ambitions (Machin and Mayr 2012, 34). Indeed, the website in its entirety is larded with upbeat lexical descriptors which testify, collectively, as a kind of ‘corporate boast’ (Sauntson and Morrish 2011, 80), for example describing the NNE and the

individuals working within it as ‘visionary’ and as possessing such sought-after qualities as ‘drive’, ‘leadership’ and ‘innovation’.

These lexical features are purposively complemented by certain visual aspects of the homepage, which possesses a number of semiotic features which closely resemble corporate advertising and through which the commercial-style NNE brand is further enhanced. These include: logos and emblems, advertisement-style stock images of generationally-diverse smiling and happy patients and practitioners and the consistent use of a selective palate of closely coordinated hues, with a notable commitment to various shades of blue and green which dominate throughout. These hues also have a particular cultural significance in this clinical context, where in Western cultures the colour blue is often used to symbolise calmness, soothing and even healing (van Leeuwen 2011). In addition, its recurring combination with green across these website pages echoes the signature colours of two iconic symbols of health care provision in the UK: the blue of the NHS mark (reproduced on the top right-hand side of every page of the NNE website) and the green of the Pharmacy Cross. This visual blending potentially aligns the NNE with these already trustworthy and well-established health care services and their familiar logos.

The kinds of values conveyed by these various verbal and visual branding topographies centre on a curious combination of, on the one hand, commercial values such as productivity, quality and innovation and, on the other hand, the kinds of principles more traditionally symbolic of health care provision, such as caring, safety and togetherness. The resulting NNE brand identity therefore appears to strike a strained balance between the seemingly incompatible domains of commercialism and health care. To resolve the inherent tensions between these two sets of conflicting values, many of the semiotic choices made in the design of the NNE website appear to naturalise this combination and potentially obscure the afore-discussed controversies that surround the Health and Social Care Act. Such choices can be observed in the design of the website homepage (plate 1). The box graphics located in the bottom half of this page arguably symbolise such healthcare and commercial values, such as being a ‘carer champion’ and information about ‘annual reports and accounts’. However, the relations between these seemingly incompatible sets of values are, we argue, visually reconciled through their sharing size, shape and colour; a series of calculated visual choices which collectively forge a link between the various values represented, recontextualising their potentially problematic and controversial synthesis into a systematic, organised and seamless blend of components as part of a complex and dynamic system of health care information (Ledin and Machin 2015). However, these homogenising representations apparently reveal little detail about how these seemingly incompatible values precisely fit together in the actual day-to-day delivery of health care; such details are partially obscured by this naturalising visual arrangement.

## 4.2. Representing social actors: the patient-practitioner partnership

Social actors are often textually represented in ways that benefit (and indeed fulfil) text producers' ideological and commercial preoccupations (van Leeuwen 2008). Two broad types of social actor loom large across the NNE website: patients and practitioners. These social actors are consistently represented, multimodally, through a neoliberal discourse of patient/public engagement and empowerment (Brown and Baker 2012) which serves to remind and perhaps even persuade website users/patients of their personal responsibility to make positive health care-related choices in order to ensure their own and their families' wellbeing.

On the linguistic level, looking specifically at patient-referring terms, we find that, interestingly, the term 'patient' is used relatively infrequently throughout the website. Instead, we regularly encounter rather ambiguous but arguably more empowering and agentive terms such as 'stakeholder', a word which collocates more eminently with the world of business shares and profits than it arguably does with public health care, and which realises an individualistic healthist philosophy (Brown and Baker 2012), according to which it is the party with the biggest stake in an individual's health (i.e. the individual him/herself) who assumes the lion's share of health care responsibility. The most frequently-used patient-referring term across this website, however, is the expression 'service user', where the word 'user' implies an active role on the part of the patient, who, according to this formulation, does not *receive* health care passively, but is active in *accessing* and *using* the health care services so provided.

Examining the website further, we also encounter slogans and other instances of corporate discourse couched in the imperative mood which places the onus on patients (rather than health professionals) to successfully harness the health care system, for example: 'choose the right service, get the right care'; a formulation which in turn implies that individuals' receiving the 'right care' is very much contingent on their actively choosing the best GP practice within their local CCG. The NNE also promises to 'deliver' (that dependably dynamic material process again) 'engagement', 'partnership(s)', to work both 'for and *with* you' (the website user/patient) and, most strikingly, 'choice'. The lexical item 'choice', which for us conjures notions of health care as a kind of market (Fouquier 2006), recurs across this website and is integral to the neoliberal ideal of choice enshrined in the **Social Care Act**.

The discourse of patient empowerment is also realised through a series of what can be described as 'equalising visuals', woven into all parts of the NNE website. Such images serve to visually portray the practitioner-patient relationship as an equal one, wherein the practitioner's focus is patient-centred. Taking as an example the page header in plate 2, this image is instantly recognisable as representing a consultation between a medical practitioner and patient, signified through objects such as the medicines located on the shelving in the

background and the stethoscope which hangs, in traditional fashion, around the practitioner's neck.



**Figure 2.** Header from page entitled 'Members and Services'

The participants represented in this image, evidently of similar age, engage each other in a manner that we might expect from two participants of equal social standing: they visually address each other at eye-level, share a close physical proximity and are not separated by any object or graphic (in another context these participants might even be mistaken for lovers!). The participants' simulated laughter and enjoyment-filled expressions seemingly provide a mutually-positive visual evaluation of the empowering neoliberal discourse of shared health care responsibility that the image no doubt seeks to convey (Hansen and Machin 2008, 786-787). This picture would look quite different, and the same sense of mutual involvement not necessarily connoted, had neither participant been smiling, the practitioner not returned the patient's gaze and the participants been formally separated by some physical object, such as a desk.

So far, we have considered how harmonious representations of patients and practitioners, observable across the NNE website, might serve to idealise this clinical relationship according to the neoliberal ideal of the empowered patient/consumer. At this point it should be borne in mind that the values of empowerment and responsibility that underpin neoliberal frameworks enjoy a mutually supportive relationship with the kinds of commercialising discourses unpacked in the previous section (Whitehead and Crawshaw 2014), the combination of which positions (seemingly) empowered members of the public as what Mautner describes as 'hybridised citizen-consumer[s]' (2010a: 55) who are, in this instance, responsible for choosing the right kind of care. However, such representations offer very little in the way of exact detail regarding the expectations placed on both practitioners and patients within this model of health care provision. Such information, the precise nature of which would likely throw into sharp relief the kinds of tensions and ambiguities inherent within this corporate-driven, neoliberal framework (Brown and Baker 2012), is seemingly backgrounded in such generic and idealising representations (Machin 2004).

### 4.3. Representing processes: the idealised and abstracted health care encounter

Like social actors, the ways that social actions or processes are represented also often benefit (and fulfil) text producers' preoccupations (van Leeuwen 2008). On the linguistic level, the precise nature of what website viewers can potentially expect from a health care encounter is offered in terms of the conspicuously-worded 'deliverables', a series of pledges which details how health care services are provided to the patient population. The lemma 'deliver' is overlexicalised (Teo 2000, 20) across the website, featuring prominently and in recurring formulations throughout, but particularly on the dedicated 'Delivering as a CCG' page, the header of which is reproduced in plate 3, below.



**Figure 3.** Header taken from 'Delivering as a CCG' page

Semantically, the lexical verb 'delivering' is an interesting and unusual piece of business jargon to appropriate in the context of health care provision, although one very much in keeping with the corporate identity assumed by the CCG branding. Poole (2013, 69) argues that, '[t]o say that you are *delivering* (e.g. results) sounds nice and dynamic, as well as concretely physical, as though space were being traversed in order to give someone an important package' (our emphasis). The choice of this concrete and dynamic term, not to mention its reiteration across the pages of this website, reveals how the NNE operates – or at least seeks to *show* how it operates – like a corporate outfit, striving towards generating output that is in some way tangible and measurable (Mautner 2010a, 68). Yet, when inspecting precisely what is so delivered (i.e. quality, safety, engagement, equality, research, sustainability, innovation and choice) website users are again presented with an extension of the kind of corporate discourse encountered earlier. It is perhaps, then, because of their undefined and intangible nature that such promises of what this CCG 'delivers' are both overlexicalised (Machin and Mayr 2012, 37-38) and nominalised (Billig 2008), formulated in

abstract and agentless constructions which background specific details about *what* is precisely delivered and *how*.

This linguistic rhetoric of delivery does not function in textual isolation but, as in so many other of the NNE's corporate messages, is complemented by a number of arresting visual configurations. Turning our attention back to the page header in plate 2, for example, we notice that the faceless practitioner represented is holding a bright red heart that might be described as a 'love heart' in terms of its shape and colour. This object constitutes a cultural symbol of love, caring and compassion – qualities which are subtly attributed to the NNE through the stethoscope, draped around the practitioner's neck, which forges a visual, physical connection between the NNE (represented by the practitioner) and the heart, including all that it symbolises here. Significantly for the delivery metaphor, this practitioner is actually *holding* the heart, almost as if the humanistic qualities that it symbolises – and which are connected to the NNE through the stethoscope – are actually being physically delivered to website users/patients by this practitioner. The heart, we suggest, potentially serves as a metonym for the both the human-centred and purportedly palpable nature of the services provided by the NNE (Ledin and Machin 2015, 469). In other words, the love, care and compassion 'delivered' by this CCG are made to appear so real, so manifestly tangible, that they can actually be held – very much in the same kind of way that commercial products such as jewellery and cosmetics are tantalisingly foregrounded (within reach of the viewer's grasp) in consumer advertising (Kress and van Leeuwen 2006).

It should be noted that, while we do not dispute the validity of concerns such as patient safety and equality or take issue with the actual services so provided, it is possible to question the seeming commodification of these concerns when framed as tangible 'deliverables' (Mautner 2010a, 66). One potential consequence of this framing is that serves to promote the NNE and its fusion of commercial and health care principles, rather than provide any concrete details of the ways in which the ideological changes realised by the Health and Social Care Act, of which this fusion is a significant consequence, are actually helping to improve and uphold standards of health care provision in any meaningful way.

Observe next how the website as a whole, not just the page header in plate 2, contains photographs of practitioner-patient encounters which offer particular representations of the processes involved in the NNE's provision of health care services. For instance, the homepage screenshot displayed in plate 1 contains various photographic images which portray eminently routine aspects of clinical encounters, such as the use of an otoscope and blood pressure monitor – minimal props or objects (Barthes 1977) which imbue the various scenes depicted with a somewhat generic, but easily identifiable, medical character. Yet, despite their generic quality, these photographic representations of routine service encounters are highly stylised and schematic. They are 'offered' (Kress and van Leeuwen 2006) to website users in abstract interior spaces – in some cases with faded backgrounds (Machin 2007, 51-52) – in highly saturated hues (Kress and van Leeuwen 2002). Moreover, none of the participants featuring in these images appear to be actual NNE practitioners or patients involved in real-life consultations or medical examinations (depictions which would convey a

truer sense of the actual reality of health care provision provided by the NNE). Instead, with their staged, studio-designed quality, these photographs are evidently stock pictures taken from a commercial image bank, and as such are not only recontextualised, transferred from one (artificial) context to another, but are also ideologically pre-structured – in harmony with consumerist values (Machin 2004). The participants are models – posed and attractive (in some instances angelic-looking: note for example the boy at the top of plate 1), chosen no doubt to symbolically represent marketable concepts, positive moods and affective states (ibid.), such as wellbeing, contentment, harmony, and cooperation.

Such confected and homogenised depictions, we would suggest, all but fetishize the health care processes they depict, transforming them from everyday mundane procedures with which most people are already familiar, already receive and to which they are already entitled, into idealised and sought-after services which are made to appear desirable and conditional upon website users'/patients' choosing to receive care via this particular consortium. Whether consciously motivated or not, such representations arguably have the effect of suppressing the precise, concrete details of the processes involved in actual health care provision (and all its contingencies), and in so doing background or obscure potentially problematic and controversial aspects of the neoliberal model of healthcare provision, such as how reduced government funding of primary care services has restricted ready patient access to GPs (Mooney 2014).

## **5. Conclusion**

Focusing on three key areas of multimodal representation – the creation of an particular CCG brand, the representation of social actors and the representation of social processes – our analysis has revealed how the strategic interplay of semiotic modes in this GP Consortia website functions to idealise and render natural the commercial, a neoliberal model of healthcare provision. Specifically, the linguistic and visual choices made in the design of this website serve to foreground seductive representations of a unique and specific brand image, empowered patient-consumers, and idealised health care encounters, all the while potentially backgrounding the controversial reality of an increasingly commercialised model of UK healthcare provision ushered in by the 2012 Health Social Act, a piece of legislation which, according to a number of commentators, threatens to undermine the founding principles of comprehensiveness, universality and equity on which the NHS was originally founded.

Like many other critics of the commercialisation of public health care, we take issue with the application of a pro-market philosophy to the provision of health care, arguing that it is not necessarily congruent with acting in the best interests of patients' health (Lister 2013). While we accept that health care providers are now required to operate within certain budgetary confines, the nature and profuseness of the corporate discourse we have examined hints at the deep-rooted influence that such a corporate ideology is having on the ways CCGs are now compelled to function. One might not unreasonably question just for whose benefit is all this

market-driven discourse? Although it is not our aim to dismiss CCG websites as a dedicated and reputable source of patient advice and information (nor do we take issue, of course, with the primary care service and its provision of health care), one is perhaps entitled to question some of the neoliberal motives behind such corporately-inflected discourse – and just how relevant and useful is it to patients who simply wish to make practical day-to-day decisions about accessing health care. Since the advent of the Health and Social Care Act, corporate ideologies would appear to have become an integral part of the new health care landscape.

## Notes

1. The importance of discourse in establishing structural change in the NHS has not been lost on policymakers and health care reformers themselves. As an internal NHS document, designed to advise hospitals on how best to push through recent reforms, puts it: ‘the success or failure of NHS reconfiguration programmes largely depends on communication’ (NHS Confederation 2014, 5).

2. The legislation removed the responsibility of the Secretary of State (i.e. the head of the British Government’s Department of Health) to provide comprehensive and universal health care, meaning that the health secretary no longer had (or still has) a legal duty to provide services and personnel such as hospitals, doctors and nurses throughout England (Pollock and Roderick 2015, 2257).

## References

- Barthes, Roland. 1977. *Image, Music, Text*. New York: Hill and Wang.
- Billig, Michael. 2008. “The language of critical discourse analysis: the case of nominalization.” *Discourse and Society* 19 (6): 783-800.
- Brown, Brian J., and Baker, Sally. 2012. *Responsible Citizens: Individuals, Health, and Policy Under Neoliberalism*. London: Anthem Press.
- Cannock Chase Clinical Commissioning Group. 2012. *Communications and Engagement Strategy*. URL <http://www.cannockchaseccg.nhs.uk/news-events/documents/131-x-cc-ccg-communications-and-engagement-strategy/file> (Accessed 8/8/2015).
- Davis, Jacky, Lister John, and David Wrigley. 2015. *NHS For Sale*. London: Merlin Press.
- Davies, A. C. L. 2013. “This time, it's for real: the Health and Social Care Act 2012.” *The Modern Law Review*, 76 (3): 564-588.
- Davies, Bronwyn, and Bransel, Peter. 2007. “Neoliberalism and education.” *International Journal of Qualitative Studies in Education* 20 (3): 247-259.
- Department of Health. 2012. *Health and Social Care Act 2012: Chapter 7, Explanatory Notes*. London: The Stationery Office.
- Fairclough, Norman. 1993. “Critical Discourse Analysis and the Marketization of Public Discourse: The Universities.” *Discourse and Society* 4: 133-168.

- Fairclough, Norman. 1995. *Critical Discourse Analysis*. London: Longman.
- Fougner, Tore. 2006. "The state, international competitiveness and neoliberal globalisation: is there a future beyond 'the competition state'?" *Review of International Studies* 32: 165-185.
- Hansen, Anders, and Machin, David. 2008. "Visually branding the environment: climate change as a marketing opportunity." *Discourse Studies* 10 (6): 777-794.
- Hodge, Robert, and Kress, Gunther. 1988. *Social Semiotics*. Cambridge: Polity Press.
- Holder, Holly, Robertson, Ruth, Ross, Shilpa, Bennett, Laura, Gosling, Jeni, and Curry, Natasha. 2015. *Risk or reward? The changing role of CCGs in general practice*. London: Nuffield Trust.
- Kress, Gunther, and van Leeuwen, Theo J. 2002. "Colour as a semiotic mode: notes for a grammar of colour." *Visual Communication* 1 (3): 343-369.
- Kress, Gunther, and van Leeuwen, Theo J. 2006. *Reading Images: The Grammar of Visual Design (2<sup>nd</sup> edition)*. London and New York: Routledge.
- Le Grand, Julian. 2013. "Will 1 April mark the beginning of the end of England's NHS? No." *BMJ*, 346.
- Ledin, Per, and Machin, David. 2015. "How lists, bullet points and tables recontextualize social practice." *Critical Discourse Studies* 12 (4): 463-481.
- Lister, John. 2013. "Breaking the public trust." In *NHS SOS: How the NHS Was Betrayed – And How We Can Save It*, ed. by Jacky Davis, and Raymond Tallis, 17-37. London: One World.
- Machin, David. 2004. "Building the world's visual language: the increasing global importance of image banks in corporate media." *Visual Communication*, 3 (3): 316-336.
- Machin, David. 2007. *Introduction to Multimodal Analysis*. London: Arnold.
- Machin, David, and Mayr, Andrea. 2012. *How to Do Critical Discourse Analysis: A Multimodal Introduction*. London: Sage.
- Machin, David, and Thornborrow, Joanna. 2003. "Branding and discourse: the case of Cosmopolitan." *Discourse and Society* 14 (4): 453-471.
- Martinec, Radan, and van Leeuwen, Theo J. 2009. *The Language of New Media Design: Theory and Practice*. London: Routledge.
- Mautner, Gerlinde. 2010a. *Language and the Market Society: Critical Reflections on Discourse and Dominance*. London and New York: Routledge.
- McKee, Martin. 2015. "Introduction." In *NHS For Sale*, ed. by Jacky Davis, John Lister, and David Wrigley, xvii-xxvii. London: Merlin Press.
- Mooney, Helen. 2012. "CCGs fail to engage 'apathetic' GPs." *Pulse*, 14<sup>th</sup> September.
- Mooney, Helen. 2014. "Funding crisis to lead to 34 million fewer appointments per year." *Pulse*, 24<sup>th</sup> February.
- Morrish, Liz, and Sauntson, Helen. 2013. "Business-facing motors for economic development: an appraisal analysis of visions and values in the marketised UK university." *Critical Discourse Studies* 10 (1): 61-80.
- NHS Confederation. 2014. *Reconfigure It Out: Good Practice principles for Communicating Service Change in the NHS*. London: NHS Confederation.

- NHS Support Federation. 2014. *Private firms win 70% of NHS contracts*. URL: <http://www.nhscampaign.org/news-and-views.html> (Accessed 10/08/2015).
- Player, Stewart. 2013. "From cradle to grave." In *NHS SOS: How the NHS Was Betrayed – And How We Can Save It*, ed. by Jacky Davis, and Raymond Tallis, 38-61. London: One World.
- Pollock, Allyson. 2005. *NHS Plc: The Privatisation of Our Health Care*. New York: Verso Books.
- Pollock, Allyson, and Roderick, Peter. 2015. "Why the Queen's Speech on 19 May should include a bill to reinstate the NHS in England". *BMJ*, 350, h2257.
- Pollock, Allyson, Shaoul, Jean, and Vickers Neil. 2002. "Private finance and 'value for money' in NHS hospitals: a policy in search of a rationale?" *BMJ* 324: 1205-1209.
- Poole, Steven. 2013. *Who Touched Base in My Thought Shower?* London: Hodder and Stoughton.
- Sauntson, Helen, and Morrish, Liz. 2011. "Vision, values and international excellence: the 'products' that university mission statements sell to students". In *The marketisation of higher education and the student as consumer*, ed. by Mike Molesworth, Richard Scullion, and Elizabeth Nixon, 73-85. London and New York: Routledge.
- Swales, John, and Rogers, Priscilla. 1995. "Discourse and the Projection of Corporate Culture: The Mission Statement." *Discourse & Society* 2(6): 223-242.
- Teo, Peter. 2000. "Racism in the news: A critical discourse analysis of news reporting in two Australian newspapers." *Discourse and Society* 13 (1): 7-49.
- van Leeuwen, Theo J. 2008. *Discourse and practice: New tools for critical discourse analysis*. Oxford: Oxford University Press.
- van Leeuwen, Theo J. 2011. *The Language of Colour: An Introduction*. London and New York: Routledge.
- Whitehead, Philip, and Crawshaw, Paul. 2014. "A tale of two economies: the political and the moral in neoliberalism." *International Journal of Sociology and Social Policy* 34 (1):19-34.