‘Protecting the NHS’ - and its limits

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We must fight for truly public universal healthcare – but struggles based on nostalgia risk co-opting support for the NHS into an exclusionary, nationalist politics

What can we learn from the public continuing to hold the National Health Service so dear despite decades of neoliberalism? The affection in which it is held has never been in much doubt, but the pandemic renewed declarations of love for the health service as a ‘great British institution’, there for us in times of need. And there remains intense attachment to the NHS - as a residual of the post-war national welfare state - with popular support for universal healthcare remaining strong, even in these troubling times. As we are often so rightly reminded, we need only look across the Atlantic to see why the idea of a truly public, universal health service must be defended. So how, then, should we interpret the present conjuncture, when even right-wing politicians declare the need to ‘protect the NHS’?

Defending the NHS has been an almost unshakeable constant within political struggles on the left against what Stuart Hall termed the ‘long march of neoliberalism’. The reach of market forces into the health service has been met with continued resistance throughout times when the ideological grip of the neoliberal consensus has seemed almost unbreakable. Indeed, the collective outpouring of solidarity with care workers echoing down streets, calling to ‘save our NHS’, might even appear to present new opportunities for challenging dominant ideas promoting selfish individualism and the promise of the free market. It is surely vital for the political left to be seeking out such emergent possibilities to help rupture the dominance of ‘common-sense’ neoliberal hegemony - and the right to universal healthcare is one such opportunity.

But what are the limits of articulating political struggles around the NHS and the imagined geographies of the nation? And just what ‘nation’ is this, anyway? These are concerns that have been occupying us both for some time. In particular, we suggest that the NHS doesn’t necessarily always sit in opposition to dominant neoliberal politics, and that the very idea of the ‘national health’ is far more slippery than is sometimes assumed.

We argue that there is a risk that the NHS may be co-opted into a particular nationalist, exclusionary politics, as the health service is pushed further into deep, sustained crisis; and we therefore warn of the limits of evoking national imaginaries as a framing for political resistance. To help make this argument we retrace some of the times and spaces of the NHS, including how nostalgia for the post-war British welfare state downplays how imperialism was integral to its formation. We then discuss how the current re-imagining of the nation as a space of ‘protectionism’ in relation to the present crisis brings with it renewed political dangers.

When was the NHS?

Given that the NHS is soon to be celebrating its seventy-fifth birthday, this might sound like a trick question. After all, since its formation in 1948 as a comprehensive national healthcare service, the NHS continues to exist as an enduring British institution - despite continued political restructuring, devolution and dismantling. Asking this question, however, isn't simply to foreground how the idea of the NHS remains, despite the efforts of prevailing political forces to rupture ideas of welfare framed around universalism and collective social provision. Rather, we do so to hint towards the ways in which the trailing and long history of the health service has *actively constructed* shifting ideas of a nation in constant flux.

The NHS took its place at the heart of the post-war British welfare state, tackling one of Beveridge's 'five giants'. Categorically not a charity - which Clement Attlee disclaimed as a 'cold, grey, loveless thing' - the universal collective principles of the welfare state, as embodied in the NHS, would provide social security 'in place of fear', as Nye Bevan later put it. And, though it may be a residual from a different moment, we must not downplay the continued emotional and political resonance of 'our NHS' across a deeply divided Britain. In fact, a romanticised nostalgia for the post-war NHS has taken hold in recent times, among liberals - as encapsulated in the London 2012 Olympics ceremony - as well as socialists. For many, the NHS evokes a sense of loss, a certain left melancholia; it represents what's left of the 'golden age' of the post-war national welfare state, long since lost at the hands of Thatcherism, and what we might now term neoliberal globalisation.

Unquestionably, the NHS has not remained the same all this time; it has been profoundly reshaped by the dominant forces of marketisation and privatisation under both Conservative and Labour governments over recent decades. And devolution has also profoundly reshaped the way it is organised. As is so often forgotten by some in England, there is no 'one' NHS. Different health systems exist across Wales, Scotland, Northern Ireland and England, and it is the latter that has most succumbed to market logics.

The creation of an 'internal market' in the 1990s transformed the NHS by separating the 'purchasers' and 'providers' of healthcare. The promotion of market competition, and, later, aspects of privatisation, soon followed, including contracting-out of clinical services to the private sector and funding of new hospitals through the Private Finance Initiative (PFI). Following political devolution from 1999, the purchaser/provider split has since been abolished in Wales and Scotland. Yet, subsequent reforms in England under the Conservative-led government were the strongest attempt yet seen to embed less publicly-visible market logics into an increasingly fragmented English NHS. Concerns are now growing over what impact the latest turn to local 'integration' will have on the future of an under-funded national health service. Despite their differences, we can certainly trace similar tendencies across all healthcare systems in the UK. Meanwhile a decade of pay cuts, chronic underinvestment in training and infrastructure and growing waiting lists - a situation made worse by the fallout of the pandemic - has further intensified the growing

crises in the NHS, which is now facing the greatest threat of collapse of any time since its creation.

It is not surprising, then, to hear calls to 'go back' to how things once were. Against Labour's current positioning, the political left must surely seek to undo the reach of privatisation and marketisation that now runs deep into the organisation of the health service - however messy and entangled such logics and contractual arrangements may now be. We must, to be clear, keep fighting for a truly universal public healthcare system.

But when, exactly, was this golden age to which we should return? As Raymond Williams warns, we must be careful about longing for an idealised past that was never quite what it seems. Certainly, the NHS has always been more Methodism than Marxism. And it was almost fifty years ago that Marxist geographer David Harvey bemoaned the early 1970s reforms that 'eliminated all trace of community control and placed the provision of health care firmly in the hands of providers who favour a centralized, hospital-based, health care delivery system'.[i] Harvey was right to be concerned then, and no doubt would be even more so now. But if the NHS has sometimes been seen as exemplifying 'socialism in action', it has never been democratic - in spite of occasional attempts at embedding local representation - and nor was it ever really intended to be.

In fact, we suggest that the idea of universal services free at the point of delivery also remains something of an article of Methodist welfare faith. Charges for services have existed since 1948, and there have always been inequalities of provision. In 1951, Nye Bevan resigned over the introduction of prescription and appliance charges. Pay beds for private patients were retained in NHS hospitals until the 1970s, and started growing again as part of income-generation policies during the 1990s. Local authorities constituted a major pillar of the NHS - paid for by local rates rather than central taxation - until the 1970s, and many of the services they provided were directly chargeable. The quantity and quality of clinical care dispensed by nurses, doctors and others has always varied widely by place. From its inception, the NHS has struggled to rebalance and redistribute the deeply unequal private and public health services it inherited in 1948. These inequalities remain today, entrenched further by both privatisation and marketisation. The flourishing private sector relies upon publicly trained and funded NHS consultants, alongside the length of their waiting lists. Drugs, treatments, technologies, research, endowments and charitable fundraising show the extent of apostasy. The list goes on.

Certainly, shifting social and political forces over time have reshaped the health service and its wider relations to welfare, spanning social care, housing and more. But the question of *when* the NHS was a truly nationalised health service is much less easy to pin down than is often imagined in popular narratives. As a residual of the post-war national welfare state, the NHS persists not just as something from the past, but co-exists with neoliberalism and all the troubles of the present moment.

So, to ask the question 'when was the NHS' prompts us to think about the articulation of universal healthcare in the *political conjuncture* - by which we mean a complex moment within which multiple, overlapping tensions and contradictions are condensed. The health service was created under the conditions of the post-war period, which was characterised by public ownership, welfare and re-distribution through taxation in the long shadow of Empire. But, after the crises of the 1970s, the unleashing of market forces profoundly unsettled and transformed existing relationships between nation, state and welfare; and the de-stabilising forces of neoliberal globalisation, led to the emergence of new contradictions, antagonisms and tensions. In the moment of Brexit, for instance, particular nationalist and racist sentiments were articulated through calls to 'protect the NHS', but so too was a longing for the old post-war social settlement in a deeply divided and dis-United Kingdom.[ii] Not only is the idea of a British nation far more shifty and discontinuous than is sometimes acknowledged, so too is the idea of the NHS as a national healthcare service, there for us all.

Where is the NHS?

Despite frequent attacks from right-wing think-tanks and print media, which label the health service an 'outmoded monolith' in dire need of reform, the NHS is far from being one big, static, institution. And this is not simply a question of the perpetual policy churn of devolution and centralisation. Examining the whereabouts of the NHS therefore poses another fundamental question: in what sense is it a *national* health service?

In a way, this corresponds with long-standing debates over whether the NHS is best understood as a national health service organised locally, or as a collection of local health systems assembled into a national service. Is it top-down or bottom-up? Certainly, following devolution of health responsibilities to Scotland, Wales and Northern Ireland in 1999 - as part of a new constitutional settlement - we cannot even take for granted that we're all thinking about the same 'nation' when we talk of the National Health Service. The Welsh have ambitions for 'Clear Red Water' against the tide of marketisation; liberal Scottish nationalists pursue stability, cooperation and continuity over competition; and the legacy of nationalisms shapes the state structures of the health and social care partnership in Northern Ireland. All these developments hint towards both overlapping and divergent imaginings of nation and how to organise health services. In short, there is no one, single UK National Health Service.

But the whereabouts of the NHS is about more than territorial politics and the relocating of power from one place to another. Consider, for instance, the ways in which the health service is enrolled into the 'hostile environment' policies of the UK government, whereby borders are stretched and re-embedded into hospitals and GP surgeries, to be policed by nurses and receptionists. The notion of a universal public healthcare service there for us all further fragments as migration surcharges force international migrants - including those many workers keeping the health service going - to pay to access a 'free-at-the-point-of-need' healthcare system. All this, whilst patients from a wealthy global elite pay for privileged access to the clinical expertise provided by this same 'public' healthcare system.

The NHS has a central role in the contested processes of nation-building and imagined solidarities: from lapel badges worn by politicians to demands to 'keep our NHS public' by activists resisting the closure of their local hospital - and, of course, those seductive claims promoted on the side of a Brexit bus. Crucially, the re-imagining of Britain in the current political moment - and the particular role of the NHS within that - is made through different sets of social relations that stretch out around the world, unsettling any idea of a nation defined solely by what goes on within its borders.

Space - as a central concern for geographers - is far more than lines drawn on a map. We often talk about time as the dimension of change and politics: space is more-or-less implicitly reduced to a background upon which different social and political struggles take place. Yet, we insist, space, too, must be understood as lively and always in the process of being made, forged through a multitude of connections (and disconnections), from the most proximate through to the more global. This is a profoundly *political* understanding of space as socially produced. As geographer (and founding editor of *Soundings*) Doreen Massey writes forcefully: 'not only is space utterly imbued with and a product of relations of power, but power itself has a geography. There are cartographies of power'.[iii] Thinking along these lines, the task at hand becomes to examine *on whose terms* particular places and spaces are made - and, therefore, to ask: what is politically at stake?

Despite its national credentials, the NHS cannot be disentangled from its imperial origins. As Gurminder K. Bhambra emphasises, colonialism has been integral to the making of a 'national' welfare state - including a health service - forged through the movement of wealth, resources and people. Though the collapse of the British Empire abruptly ended elite colonial career trajectories, it led many to embark upon lucrative 'second careers' in the upper echelons of the NHS and the Ministry of Health, with swathes of former colonial officials, governors, doctors and bureaucrats moving seamlessly across the frontiers of the British state from empire into welfare. The health service, then and now, depends on doctors, nurses and other workers from (post)colonial places, although they have always faced more barriers than their former colonial rulers. It is not possible to imagine the formation of the British NHS without talking about the British Empire.[iv]

We shall return later to consider the geographies of responsibility that are bound up with an NHS kept going by international migrant workers, and what kind of political response this demands. But, first, we consider another political struggle that requires attention, one forged through a rather different set of spatial connections - 'Americanisation' - and explore how policy ideas from elsewhere in the world are being circulated and embedded within the NHS.

Resisting the Americanisation of the NHS

The threat of Americanisation has long loomed over the NHS - including worries about its wholesale replacement with a 'US-style' insurance system. This way of conceptualising

such concerns draws on a powerful spatial imaginary, which helps to articulate what will happen if we don't fight to protect a public health service.

Concerns over the creeping privatisation of the NHS stretch well back to the reforms in the 1980s. Despite privatisations of different utilities and industries under Thatcher, healthcare has appeared somewhat harder to restructure in the interests of private capital. Yet repeated efforts have been made by UK governments to embed the logics of the 'free market' in the health service - as already suggested. The notion of a like-for-like replacement of healthcare systems, however, elides neoliberalism with 'Americanisation', and is therefore analytically problematic (let's not forget that London has been central to the invention and promotion of neoliberalism) - though it is certainly politically effective. However messy, partial and incomplete it may be, the influence of neoliberal politics within healthcare across Britain cannot be ignored.

Americanisation is more than simply a spatial metaphor. Thinking about policy-making beyond national governments brings into focus how policy ideas circulate and get reworked in a globalised world (an approach often referred to as 'policy mobility'). Facilitated by a seemingly ever-expanding cast of management consultants and think-tanks, policy-makers increasingly 'learn' from places elsewhere whereby a careful selection of 'exemplars' and 'best practices' are deployed to quietly encourage reforms along the lines of 'modernisation' and 'efficiency'.[v] This not only has the effect of depoliticising policy-making - all that work to 'take the politics out': it also tends to downplay the social and ideological dynamics that are shaping policy on the move.

One example of the mobility of policy is the circulation of Accountable Care Organisations (ACOs): across England, campaigners resisting ACOs have linked them to ideas of Americanisation. Broadly speaking, ACOs are complex multi-organisational contractual arrangements intended to incentivise improvements in healthcare, and reduced expenditure, through 'integrated care'. Their travels and mutations are a complicated story - they have many 'origins' across different times and spaces. But they are most often associated with the Affordable Care Act in the United States, and, before that, its Health Maintenance Organisations (HMOs). HMOs became notorious for restricting access to healthcare in the US, and this is precisely the concern raised by health campaigners in response to the latest round of reforms across England, which have been proposed in the name of local 'integrated care systems' in times of austerity.[vi]

Concerns over privatisation are legitimate, warrant attention and demand political resistance, even if the process is not always as linear or totalising as some might suggest. But the way such concerns are framed can have unintended consequences. For example, privatisation is often conflated with marketisation, and protests couched in these terms tend to be dismissed by health policy commentators. Part of the problem, we suggest, is the tendency within anti-privatisation campaigns for the NHS to be presented as a 'big thing' - thus, ironically, replicating the 'big monolith' notion of the health service used to target reforms by the political right. Privatisation is often defined along the lines of the

privatisation of British Telecom, for example - and this looseness of definition is one of the reasons it can be dismissed. This is not to deny that there are many reasons to be deeply critical of what is happening: PFI; private-sector contracting for services and amenities; the shift towards rationing and private payment; the growth of commercial representation on organisational bodies; staff shortages and shifts to non-NHS terms and conditions, and much more.

Where the latest turn to 'integrated care' has been profoundly depoliticised, framing resistance in terms of Americanisation has proven to be emotionally and politically powerful. And it is a spatial imaginary that NHS England - and the UK Government - have found hard to shake. Apprehending how Britain is changing with reference to the USA - particularly given the Atlanticism of the broad left in the UK - is perhaps understandable. But political resistance organised around national and international spatial imaginaries has its limits.

Making this argument, however, requires care: there is a risk of misinterpreting what we are calling for, as well as what we are arguing against. Our concern is that political struggles to resist neoliberal hegemony get pushed through the imagined geographies of the nation - and by extension, nationalism - so that it becomes the central terrain for political organisation. Our aim for the remainder of this article, therefore, is to warn of some of the dangers inherent in evoking ideas of the nation within NHS campaigning, and its potential co-option by the political right.

National imaginaries in unsettling times

The pandemic gave rise to the weekly 'clap for carers' as a public display of solidarity with health and care workers - later extending to encapsulate the seemingly surprising news that working-class 'key workers' are indeed essential to keep society moving. From people on doorsteps to politicians on TV, the display of rainbows and the sound of clapping was an expression of popular support for the NHS as a vitally important public institution in these troubling times.

And yet the Conservative government's call to 'protect the NHS' and save lives evoked a wartime spirit, in claims to unite, and simultaneously reconstruct, the idea of the British nation. At that very same moment, the UK had departed the European Union - and central to the Leave campaign had been the promise of taking money from the EU and spending it on 'our NHS' instead. Of course, the NHS sat awkwardly in debates over Brexit. And migration of workers from the EU certainly remains central to the running of the health service. But - especially when severed from the internationalist, anti-austerity politics of Corbynism - what dangers lie in basing a defence of the NHS on nostalgia for the post-war Attlee government? And how does this relate to the appeals for 'patriotism' at the heart of Keir Starmer's vision for Britain? Recent statements about ending Britain's 'immigration dependency' give some strong clues.

'Protecting the NHS', we argue, can be rather easily reworked into an explicitly nationalist politics. Take the rush to vaccine nationalism, for instance, as new forms of exceptionalist 'pride of the world' rhetoric took hold following the outbreak of the pandemic. It does not take a giant leap to see how otherwise progressive notions of universal healthcare can be appropriated into very different visions for Britain - or perhaps, rather, England. Consider, then, how Keir Starmer proclaims protecting the NHS as a 'patriotic duty', as an act of pride in the nation (and again, there is slippage between England and Britain), whereby the NHS is moulded around ideas of nation, community and security. In this way, nostalgia for the NHS created under a post-war Labour government sits remarkably comfortably alongside the insistence of an unquestioning commitment to NATO - evading the role of imperialism in relation to both. From undermining nurses in the fight for a pay rise through to flag-wavering patriotism about how Britain 'made the modern world', there are reasons to be deeply suspicious of what underpins current Labour Party calls for governing in the 'country's interests'.

How, then, can we best intervene and engage the public over concerns about the complexities of marketisation and privatisation of the NHS - in ways that emphasise the need for political resistance without slipping into national (and nationalist) protectionism? What kind of politics is required to forge alternatives in a way that avoids assumptions that the nation is a 'natural' space for resisting neoliberal globalisation?

Universal healthcare and a popular politics?

There is no guarantee that the NHS will always secure a progressive politics against the prevailing political forces of neoliberalism. As both a residual of the national welfare state and an emergent site of political and cultural work, the idea of the NHS is being continuously reworked into the dominant politics of the present moment. With the NHS now plunged further into crisis following a decade of austerity and growing spatial inequalities, the political left needs to construct, and mobilise around, new visions of the right-to-health in these unsettling times - one that does not rely on nation and nationalism; on under-valued and under-paid migrant workers drawn from historically colonial recruitment routes; and on restrictions over who is provided care, when and where.

Against a headwind of right-wing and 'centrist' anti-migrant rhetoric, the Corbyn-led Labour Party largely resisted the overtones of nationalism entrenched within its history, and instead sought to forge a new politics of universalism and internationalism. It was here that the politics of the NHS offered a platform for universalism beyond healthcare - for moving the idea into other arenas of policy in ways that have been, in recent years, rendered seemingly impossible (though, that's not to understate the highly problematic anti-migrant rhetoric at moments along the way, whereby Corbynism never quite broke from the 'clamour of nationalism' entirely, as Sivamohan Valluvan has outlined).[vii]

So how can we continue to struggle for universal, nationalised healthcare while also fostering awareness of the exclusions and injustices associated with the current remaking of the state, expressed as exclusionary nationalism? On what terms should the political left re-

establish the nation as a progressive political project, if at all, and what alternatives might there be without legitimising neoliberal globalisation?

The far-right insistence, adopted by Conservative politicians, that 'it's a *national* not international health service' needs to be pushed back against, but this requires more than the frequent resort to foregrounding how utterly and historically dependent the NHS is, and has been, on migrant workers. This argument is, of course, absolutely right. And there has been widespread championing of this point, often combined with liberal celebrations of multiculturalism and diversity. But, on its own, this argument allows avoidance of responsibility for places elsewhere, where those workers are trained before being then drawn into the NHS. The argument must never be to proclaim, as Gordon Brown did, a need for 'British jobs for British workers', a call now being replicated by Keir Starmer. Instead, there is a need to think through the many spatial interrelations that make possible the 'national health' - to ask what responsibility we have and what kind of political response this demands.

These are precisely the questions posed by Doreen Massey in her insistence on the power of our geographical imaginations - and the inherently political nature of the spatial. Writing with a view from London as a 'world city', Massey turns attention to the migration of healthcare workers into the UK capital city from Ghana, among many other places. For the political left, responsibility for these uneven relationships, she argues, demands recognising the interrelations between places - not least an acknowledgment of the perverse subsidies of public investment in training healthcare workers in poorer countries who emigrate to richer places; but it also demands that we address how and why such spatial inequalities have been made and sustained. Understanding London's role as a place in which hegemonic forms of globalisation have been invented and promoted around the world, and thinking differently about space and the uneven relations between places, makes it possible to imagine directly paying restitution for the Ghanaian part of interrelated health systems, within 'local' political strategies focused on building transnational solidarities to foster an alternative globalisation.[viii]

This is not, therefore, a simple question of national politics. Rather, following Massey, there is a need to build alternative political visions through rearticulating struggles for universal healthcare in terms of 'a politics of place beyond place'. This involves an altogether different geographical imagination, one that does not rest on the politics of territorial protectionism, which is so easily framed in explicitly racist, nationalist terms, or on free-market demands for opening up new global flows of capital - or, for that matter, on liberal appeals to openness in the shadow of Brexit, which have often downplayed or outright denied racialised violence at the EU's borders.[ix] For the left, therefore, national spatial imaginaries - reproduced within different calls for 'protecting the NHS' - may be insufficient for grasping the many, different political struggles in the present moment.

When talking about geographies of responsibility, then, we are not referring to things like the recent uptake of fundraising for NHS charities. We mean - in recognition that the

NHS was, and continues to be, made possible through spatial relations with elsewhere in the world - asking how we reconcile this with ideas of universalism and 'our NHS'? Liberal championing of diversity and multiculturalism is inadequate for dealing with the violence of colonialism, and continued racialised exclusions today, in healthcare and many other spheres. Nor does resisting 'Americanisation' fully grasp why we must demand the right to public healthcare as a transnational matter of social justice.

Where to from here?

To be absolutely clear, we are not arguing against the National Health Service. Nor are we denying that there are legitimate concerns over corporate interests in the health service, which should not be dismissed by policy commentators. However complex and incomplete these processes may be, it is essential to get to grips with the embedding of private interests and market logics within the organisation of healthcare - often framed in terms of the 'Americanisation' of the NHS. But we maintain that nationalised healthcare should not be seen as, or become, the upper reaches of what is politically possible. There are clear analytical limits, and political dangers, in evoking national spatial imaginaries when seeking to 'protect' the NHS in these times of crisis.

If we are to follow Doreen Massey in thinking through the ways in which places are made up through relations - the many connections *and* disconnections - with places elsewhere, it becomes necessary to recognise the NHS as a distinctly international health service. And rather than simply appealing to liberal platitudes about openness, we must also address the geographies of responsibility that are associated with a health service kept going by workers from around the world. Categorically rejecting Keir Starmer's dog-whistle claims of an over-reliance on foreign workers in the health service, the political task must be to insist that the health service has always been more-than-national. It is impossible to imagine the NHS without grappling with the intimate relationship between colonialism and the formation of the post-war national welfare state.

Building transnational solidarities is vital. Caring relations must not be understood solely in terms of proximity - resting on an assumed notion of 'nation' or 'community'; our political imagination must at the same time incorporate those seemingly distant relations and responsibilities with people and places elsewhere. The demand for truly public universal healthcare that is genuinely free-for-all has to simultaneously come to terms with how the NHS is made possible through uneven relations with other places and their health systems across the world. At the same time, to talk about the NHS as the 'envy of the world' risks closing down opportunities to learn from progressive policy experiments happening elsewhere.

Recognising that the health service is made up through many spatial connections and disconnections forces us to frame political struggles around the NHS *differently*. Ideas of universal healthcare, and notions of nation, state and welfare, shift with - and are articulated to - specific political conjunctures. In these troubling times, we must continue struggling for universal public healthcare - but must also understand that nostalgia for the

post-war welfare state may lead to the NHS being co-opted for an exclusionary, nationalist politics.

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Notes

[i] D. Harvey, 'What Kind of Geography for What Kind of Public Policy?' *Transactions of the Institute of British Geographers*, 63, November, 1974.

[ii] On the times and spaces of conjunctural thinking, see J. Clarke, 'Finding place in the conjuncture: A dialogue with Doreen'. *Doreen Massey - Critical Dialogues*. M. Werner, J. Peck, R. Lave, and B. Christophers (eds) Agenda Publishing. 2019

[iii] D. Massey, 'Concepts of space and power in theory and in political practice', *Documents d'anàlisi geogràfica*, 55, p18. 2009. This relational understanding of space - and associated terms mentioned here such as 'geographies of responsibility' and a 'politics of place beyond place' - has been elaborated extensively by Doreen Massey elsewhere.

[iv] M. Lambert, 'Gentlemanly collectivists: post-colonial administrative careering in the British National Health Service', *Centre for Alternatives to Social and Economic Inequalities*. Forthcoming

[v] See, for example, C. Temenos and E. McCann, E., 'Geographies of policy mobilities'. *Geography Compass*, Vol 7, No 5. 2013

[vi] For a full discussion of ACOs and 'Americanization' of the NHS, see C. Lorne, 'Repoliticising national policy mobilities: Resisting the Americanization of universal healthcare'. *Environment and Planning C: Politics and Space*, Forthcoming. https://doi.org/10.1177/23996544211068724

[vii] S. Valluvan, *The clamour of nationalism: Race and nation in twenty-first-century Britain*. Manchester University Press. 2019

[viii] D. Massey, 'World City', Sage. 2008

[ix] A. Isakjee, T. Davies, J. Obradović-Wochnik, J. and K. Augustová, 'Liberal Violence and the Racial Borders of the European Union'. Antipode, Vol 52, Issue 6. 2020.