View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Queen Mary Research Online

"Liberalizing" the English National Health Service: background and risks to healthcare entitlement.

Filippon, J; Giovanella, L; Konder, M; Pollock, AM

Este é um artigo publicado em acesso aberto sob uma licença Creative Commons
This is a pre-copyedited, author-produced PDF of an article accepted for publication in Cadernos de Saúde Pública following peer review. The version of record is available http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2016000802001&lng=pt&nrm=iso&tlng=en

For additional information about this publication click this link.
http://qmro.qmul.ac.uk/xmlui/handle/123456789/14470

Information about this research object was correct at the time of download; we occasionally make corrections to records, please therefore check the published record when citing. For more information contact scholarlycommunications@qmul.ac.uk

CSP_0347/16

“Liberalizing” the English National Health Service: background and risks to healthcare entitlement

Jonathan Filippon [1]
Ligia Giovanella [2]
Mariana Konder [3]
Allyson M. Pollock [1]

[1] Centre for Primary Care and Public Health, Queen Mary & University of London, London, U.K.
[2] Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz, Rio de Janeiro, Brasil.
[3] Faculdade de Ciências Médicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brasil.

Correspondence
J. Filippon
Centre for Primary Care and Public Health, Queen Mary & University of London.
58 Turner Street, London / London - E1 2AB, U.K.
jonathanfilippon@gmail.com

REVISÃO
Filippon J et al.
BACKGROUND OF THE RIGHT TO HEALTH UNDER THE INFLUENCE NEOLIBERALISM

ID: e00034716

DOI: http://dx.doi.org/10.1590/0102-311X00034716

REVISÃO

"Liberalizing" the English National Health Service: background and risks to healthcare entitlement

A "liberalização" do Serviço Nacional de Saúde da Inglaterra: trajetória e riscos para o direito à saúde

La "liberalización" del Servicio Nacional de Salud de la Inglaterra: trayectoria y riesgos para el derecho a la salud

Jonathan Filippon [1]*

Ligia Giovanella [2]

Mariana Konder [3]

Allyson M. Pollock [1]

[1] Centre for Primary Care and Public Health, Queen Mary & University of London, London, U.K.

[2] Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz, Rio de Janeiro, Brasil.

[3] Faculdade de Ciências Médicas, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brasil.

* Correspondence: jonathanfilippon@gmail.com

Abstract:
The recent reform of the English National Health Service (NHS) through the *Health and Social Care Act* of 2012 introduced important changes in the organization, management, and provision of public health services in England. This study aims to analyze the NHS reforms in the historical context of predominance of neoliberal theories since 1980 and to discuss the "liberalization" of the NHS. The study identifies and analyzes three phases: (i) gradual ideological and theoretical substitution (1979-1990) – transition from professional and health logic to management and commercial logic; (ii) bureaucracy and incipient market (1991-2004) – structuring of the bureaucracy focused on administration of the internal market and expansion of pro-market measures; and (iii) opening to the market, fragmentation, and discontinuity of services (2005-2012) – weakening of the territorial health model and consolidation of health as an open market for public and private providers. This gradual but constant liberalization has closed services and restricted access, jeopardizing the system's comprehensiveness, equity, and universal healthcare entitlement in the NHS.
Keywords: Health Systems; Health Services; Health Policy; Health Programs and Plans

Resumo:
A recente reforma do Serviço Nacional de Saúde (NHS) inglês por meio do *Health and Social Care Act* de 2012 introduziu mudanças importantes na organização, gestão e prestação de serviços públicos de saúde na Inglaterra. O objetivo deste estudo é analisar as reformas do NHS no contexto histórico de predomínio de teorias neoliberais desde 1980 e discutir o processo de "liberalização" do NHS. São identificados e analisados três momentos: (i) gradativa substituição ideológica e teórica (1979-1990) – transição da lógica profissional e sanitária para uma lógica gerencial/comercial; (ii) burocracia e mercado incipiente (1991-2004) – estruturação de burocracia

voltada à administração do mercado interno e expansão de medidas pró-mercado; e (iii) abertura ao mercado, fragmentação e descontinuidade de serviços (2005-2012) – fragilização do modelo de saúde territorial e consolidação da saúde como um mercado aberto a prestadores públicos e privados. Esse processo gradual e constante de liberalização vem levando ao fechamento de serviços e à restrição do acesso, comprometendo a integralidade, a equidade e o direito universal à saúde no NHS.
Palavras-chave: Sistemas de Saúde; Serviços de Saúde; Política de Saúde; Planos e Programas de Saúde

Resumen:
La reciente reforma del Servicio Nacional de Salud (NHS) inglés a través de la *Health and Social Care Act* de 2012 introdujo cambios importantes en la organización, gestión y prestación de los servicios de salud pública en Inglaterra. El objetivo de este estudio es analizar las reformas del NHS en el contexto histórico del predominio de las teorías neoliberales desde 1980 y discutir el proceso de "liberalización" del NHS. Fueron identificados y se analizaron tres momentos: (i) sustitución gradual ideológica y teórica (1979-1990) -transición de la lógica profesional y de salud para una lógica de gestión/negocio; (ii) la burocracia y el mercado incipiente (1991-2004) -estructuración de la burocracia dedicada a la gestión del mercado interior y la expansión de las medidas pro-mercado; y (iii) la apertura del mercado, la fragmentación y la discontinuidad de los servicios (2005-2012) -fragilización del modelo de salud territorial y consolidación de la salud como un mercado abierto para los proveedores públicos y privados. Este proceso gradual y constante de la liberalización ha provocado el cierre de los servicios y la restricción del acceso, comprometiendo la integridad, justicia y derecho universal a la salud en el NHS.
Palabras-clave: Sistemas de Salud; Servicios de Salud; Política de Salud; Planes y Programas de Salud

Submitted on 01/Mar/2016

Fnal version resubmitted on 08/Jun/2016

Approved on 24/Jun/2016

The British Parliament's approval of the *Health and Social Care Act* [1] in 2012 was a milestone in the history of international public health in the new millennium [2]. The National Health Service (NHS) is acknowledged as one of the most efficient and accessible state systems in the West and was a pioneer in universal access to health services and hierarchical organization of an evidence-based system of healthcare and primary care [3]. Maintained by public taxes, the NHS and its principles date to 1948. At a favorable historical moment for the concepts of universal, free coverage, under Labour Party aegis, the NHS was established as part of the Welfare System that leveraged the United Kingdom's socioeconomic recovery in a politically polarized post-World War II scenario [4].

Despite sharing values and denomination, since 1999 each member country of the United Kingdom has an independent national health system: NHS Scotland, NHS Northern Ireland, NHS Wales, and NHS England. The *Health and Social Care Act* 2012 [1] only regulates the reform of the English

115 health system, responsible for the healthcare of 53.5 million people. The Act of Parliament scarcely
116 modified services from the population's perspective, since access to healthcare was not altered
117 immediately. While maintaining public financing via taxes, the system underwent an extensive
118 internal reform that may affect the universal right to health. Mediated by the new legislation,
119 previously incipient processes of healthcare's organizational fragmentation in the administrative,
120 institutional, and especially financial areas (vis-à-vis public spending) were radically intensified,
121 multiplying the intermediaries between purchasers and providers of services. Although the NHS has
122 undergone administrative reforms since it was founded in 1948, the 2012 proposal deepens the
123 system's liberalization, both in the reform's underlying theoretical basis and its administrative
124 measures: structural changes in the health system; demise of social consensus in the Welfare
125 System; defense of the market's legitimacy for meeting social demands via downsizing the state's
126 role [5,6]; and stimulus for pro-market organizational elements within the public administration.
127 Why could administrative changes in the English NHS be significant for a large share of the world's
128 health systems? The NHS is benchmark for universal health systems and symbolizes (or
129 symbolized) the necessary limit on the market's influence for guaranteeing universal access to
130 health as a social right [5]. NHS reforms are publicized quickly and influence health policy debates
131 and implementation in other countries.
132 Pioneering public health systems like the English NHS are sensitive to the hegemonic social
133 theories prevailing in each historical conjuncture and express the historical moment in which they
134 occur. The creation of the NHS in the late 1940s allowed the consolidation of universal human
135 rights in the United Kingdom [7] in a political period of social and economic reconstruction of post-
136 War Europe. In the last 30 years, the NHS was modified beginning with the economic crises of the
137 1970s, under the influence of the conservative Margaret Thatcher government [8], shifting to Labour
138 in the late 1990s and returning to the Conservatives 2010. The current scenario reflects the force of
139 market relations that extend beyond commercial relations to influence the public services sector that
140 guarantees social rights [3]. The current article intends to illustrate the theoretical links between the
141 successive reforms in the English NHS, beginning with the so-called Thatcher Era (1979) and
142 combining analysis of the reforms with a broader conceptual discussion. Despite its relevance, the
143 theme has received scanty attention in the Brazilian literature [9,10,11], concentrated on specific aspects
144 or on analysis of reforms prior to 2012. The current article thus aims to help fill this gap.
145 This article aims to analyze NHS reforms in England, discussing the system's growing
146 "liberalization" in this historical context of predominance of neoliberal theories since the 1980s [8].
147 Analysis of the reforms starts with the division proposed by Pollock [12], who defines this process as
148 privatization/breaking up of the NHS, divided into four periods up to 2003: (i) 1980-1990
149 strangulation and the end of comprehensiveness; (ii) 1990-1997 the "internal market"; (iii) 1997-

150 2000 continuous fragmentation under New Labour; and (iv) 2000-2003 pointing New Labour to a
151 "mixed healthcare economy" [12,13].
152 This article adapts the division proposed by Pollock. It expands the analysis by adding other authors
153 and the historical narrative, and extends the study to 2012. The periods of liberalization, which were
154 more components and moments in a process rather than chronological phases, are analyzed and
155 named according to their characteristics: (i) gradual ideological and theoretical substitution (1979-
156 1990) – transition from professional and health logic to a management/commercial logic; (ii)
157 bureaucracy and incipient market (1991-2004) – structuring of the bureaucracy focused on
158 administration of the internal market and expansion of pro-market measures; (iii) opening to the
159 market, fragmentation, and discontinuity of services (2005-2012) – weakening of the territorial
160 health model and consolidation of health as an open market for public and private providers. The
161 "bureaucracy and incipient market" phase is organized in three chronological sub-periods that add
162 the last three stages from Pollock's analysis [12].
163 The analysis includes characteristics of the NHS before and after the 2012 reform, as well as its
164 historical development (Figure 1). To situate the liberalization process, the article's first section
165 summarizes some historical antecedents and characteristics of the English health system.
166
167
168
169 # Antecedents: from social health insurance to the single, integrated NHS
170
171 Social stratification and disordered urbanization produced by England's two Industrial Reforms
172 provided fertile ground for the country's pioneering trade unions; these in turn increased the social
173 pressure for better working conditions and health services in the early 20th century. Implementation
174 of the National Health Insurance in 1911 insured workers that made up to a given wage cap and
175 guaranteed primary medical care, without hospital coverage, which was generally provided by
176 charitable hospitals. General practitioners (GPs) worked as self-employed physicians, and
177 specialists in many cases worked for very low pay in hospitals. Some one-third of the population
178 was covered, with financing through social contributions by workers, employers, and government
179 [14].
180 The *Beveridge Report* of 1942, commissioned by the Conservative-Labour coalition government
181 during World War II, laid the theoretical foundations for the NHS and spearheaded the proposal of
182 redistributive social policies, the main objective of the Welfare State. The NHS began its activities
183 as a universal health system in 1948. Since its implementation the system has undergone reforms in
184 response to the economic, social, and political changes over the decades, intensified since the

185 economic crises of the 1970s, plus increasing healthcare costs and complexity. The Departments of
186 Health and Social Security were unified in 1968 as the UK Department of Health and Social
187 Security. The system's local organization was altered in 1974 by the National Health Service
188 Reorganization Act in an attempt to promote greater integration among services, creating the local
189 health authorities. The purpose of these reforms was to decrease healthcare fragmentation, modify
190 the scenario of financial favor for teaching hospitals, and extend priority to services other than
191 hospitals for acute cases. Reform promoted the transition from a system of financing by institutions
192 to integrated services planning through Area Health Authorities (AHA), territorial organization, and
193 use of a needs-based resource allocation formula [15]. A methodology was established to measure
194 local health needs (Resource Allocation Working Party – RAWP), replacing the financial transfers
195 that followed historical averages. These changes innovated by improving the system's efficiency
196 and equity and eventually influenced other countries' health policies in subsequent decades [16].
197 The predominance of market theories in the social area began to gain shape and political influence
198 in England when Thatcher won the 1979 general elections. Previously, Labour governments had
199 sought to limit the market's influence in some social areas like health. Favored by the global
200 economic crisis, the Conservatives' scale-up to power marked the beginning of what we refer to as
201 liberalization of the English NHS.
202 When the Conservatives returned to government in the late 1970s, the NHS was a politically and
203 administratively centralized system (Table 1). Structurally speaking, hospitals were state property,
204 managed and financed by the state. NHS workers were salaried, with the exception of GPs and
205 dentists, who worked as self-employed professionals [17] on a fulltime basis with the NHS. Funds
206 came from the Exchequer and were administered by the Department of Health. The fourteen
207 Regional Health Authorities were responsible for managing health services in a given territory,
208 executing a population-based budget to provide community and hospital services. Strategic
209 planning and management of community and hospital services were subdivided into 90 AHA and
210 205 district management teams. Provision of primary care was monitored by Family Physician
211 Committees, financed directly by the Department of Health [17].
212

213 **Gradual ideological and theoretical substitution (1979-1990)**
214

215 The *Griffiths Report* of 1983, commissioned by Thatcher, made harsh criticisms of the NHS
216 institutional management, launching a period of recommendations and structural changes in the
217 manner of corporate flowcharts [11,12]. Rather than the horizontal administrative relations previously
218 characterizing the NHS, the report established hierarchical boards, similar to corporate
219 shareholders' boards, and emphasized and valued the local service manager. As part of the new

220 NHS management culture throughout the 1980s, the system administrator's role gained increasing
221 importance. Administrative control began to shift away from health professionals, forcing the
222 replacement of an organizational culture thitherto marked by health professionals' influence and
223 leadership and the systematic use of epidemiological evidence with a typically managerial modus
224 operandi, common to the corporate environment [18].
225 During this period, in step with transformation of the prevailing organizational culture, there was a
226 first wave of health service outsourcing. Hospitals' clinical activities were spared, but a large share
227 of support activities was outsourced, including: cleaning, laundry, nutrition, and general
228 maintenance. There was also a strategy to reduce coverage, charging fees for optometry services
229 (previously free), fee hikes for dental services, and closing of the majority of existing long-term
230 hospital beds in the NHS [11]. Public hospitals were also encouraged to explore potential commercial
231 areas such as snack bars, charging for use of TV sets, telephone services, and car parks – items that
232 were previously free for NHS users. Such services, not linked directly to healthcare, became
233 potential sources of financial gain for public institutions.
234 In addition to re-separation of the Departments of Health and Social Security in 1988, this initial
235 phase was heavily marked by the *National Health Service and Community Care Act* of 1990. This
236 reform came to be known in the literature as the Market Reform [12,18,19,20], since it opened specific
237 sectors of the system to private organizations and introduced the so-called internal market into the
238 NHS, separating the acts of purchasing and providing services (the purchaser/provider split).
239 Purchasers would receive funds directly from the Department of Health, and providers would
240 compete with each other to obtain funds and provide services, based on commercial contracts. The
241 theoretical justification for the internal market's competitive nature was that it would offer the
242 necessary incentives for providers to improve their performance (efficiency and response to
243 demands). Financial and management decisions were decentralized, shifting from the central level
244 in the Department of Health to the local level, personified by purchasers and providers [17,21].
245 The internal market was structured in stages, with two types of purchasers: District Health
246 Authorities (DHAs) and General Practitioners Fundholders (GPs were invited to manage budgets
247 and were called GP Fundholders – GP-FH). The GP-FH budget covered the provision of primary
248 care services per se and the purchase of secondary care services for their patient lists (average of
249 10,000 persons per GP group). DHAs were responsible for assessing the local population's health
250 needs and acquiring the totality of hospital and community services for populations linked to non-
251 FH GPs. For the GP-FH, the DHAs were in charge of purchasing the non-commissioned part of
252 services (80%). Covering populations up to 200,000 persons, DHAs had a needs-adjusted per capita
253 population-based budget.

254 Hospitals and community health services became independent providers, called trusts, with
255 financing that depended on contracts with the DHAs [17,21,22]. With the development of the internal
256 market in this format, the DHAs were later replaced by the Health Authorities (HA), also in charge
257 of purchasing services for patients of GPs who had not joined the fundholding system [21].
258 The reform was so sweeping that it was echoed in the incipient Brazilian scientific literature on the
259 theme. Akerman [9] asked whether the creation of the internal market in the late Thatcher Era
260 signaled the beginning of the end of the Welfare State or a daring management model, perhaps
261 alluding to the coming new century. Fomenting an internal market of purchasers and providers was
262 the fundamental administrative, theoretical, and bureaucratic change in this initial period of
263 liberalization. Inserting the basic commercial act of purchasing and providing services internally did
264 not necessarily impact health services' universal coverage. However, it did introduce competition
265 among organizations in the system and produced a fundamental organizational paradigm shift. This
266 change paved the way for the system's subsequent liberalization. The internal market allowed the
267 later marketization and privatization of the NHS [18]. The fundamental market principles proposed in
268 the 1990 reform were maintained and gradually expanded, despite alternating power between
269 Conservatives and Labour in the following decades.
270 To stabilize a market relationship of purchase and sale of services between primary care, specialties,
271 and hospital care and the public budget [23], the system needed to adapt administratively to the new
272 reality, entering into a new liberalization phase.
273

274 Bureaucracy and incipient market (1991-2004)

275

276 The recently established internal market of the NHS, triggered by the separation between
277 purchasers/hirers and providers, required the system's administrative reorganization. A new
278 bureaucracy was shaped, focused on administering the internal market and the proposed new
279 contractual relationships. The entire English public sector drew closer to the business sector in the
280 1980s [24], with organizational and financial restructuring. The health sector followed this trend in the
281 1990s, turning its institutions into public companies. The state hospital trusts began to present cash
282 flow statements, balanced budgets, and accounting records aimed at financial return and, if
283 necessary, divestiture of goods and property to balance their books at the end of each fiscal year [12,25].
284

285 • Consolidating the internal market: John Major (1992-1997)

286

287 John Major, the Conservative Prime Minister that replaced Margaret Thatcher, took charge of
288 consolidating the internal market and combatting state bureaucracy in the NHS.

289 Major's government eliminated 14 HAs (a Labour legacy prior to Thatcher) and made adaptations
290 to the GP-FH model. To allow greater diversity in the provision of primary care, the possibility of
291 salaried payment for GPs was introduced [17]. Several variants of GP-FH were developed, generally
292 promoted by managers and GPs that had not joined the FH model: Community fundholders, which
293 only purchased community services associated with primary healthcare; so-called Multi-funds, or
294 groupings of GP fundholders that shared the management of their budgets and respective
295 administrative costs of their purchases; Purchase Groups, in which collectives of GPs that did not
296 manage budgets acted with the HAs to influence purchase of services in their geographic areas of
297 care [22]. GP-FH were implemented gradually to sidestep the initial rejection by physicians and to
298 keep a drastic change from destabilizing the NHS vis-à-vis the population. Adherence to the GP-FH
299 model enjoyed an initial wave of enthusiasts, followed by a wave of people interested in acting as
300 groups (Community fundholders and Multi-funds), and finally a third wave consisting of a cascade
301 effect from the proposed model's growth [21]. In 1996, 50% of the GPs had joined the fundholding
302 model [17,21]. Cost containment with prescriptions was the most immediate effect of the GP-FH,
303 leading to government incentives to induce GPs that were still independent. The fundholding
304 models generally produced gains in the extent and effectiveness of services, but with increasing
305 administrative expenses, transaction costs between services, and inequalities in access between
306 users of different models (GPs in the fundholding model versus independents) [21,22].
307 The internal market encountered various structural difficulties. For purchasers, the GP-FH model
308 led to numerous small-scale, limited-scope purchasers whose purchasing power was insufficient to
309 impact price competition in the local health services market [15,22]. DHAs also faced structural
310 obstacles that limited their performance as purchasers, such as: lack of demand-side integration;
311 lack of information for making purchases (incipient price system, leading to market asymmetry);
312 and local services monopolies [15,22].
313 Underfinancing of certain activities related to social needs and that involved long-term costs (e.g.,
314 care for the elderly) sparked negotiations over the definition of fundamental healthcare activities as
315 opposed to extra activities, not necessarily covered by the same budget [21].
316 State hospitals were turned into trusts, semi-independent, non-profit organizations with a reasonable
317 degree of freedom to set pay thresholds, staff composition, and types of services offered. By 1996
318 there were already 350 NHS Trusts [21].
319 In short, the Conservative reform focused on the system's efficiency, assuming that market
320 competition would naturally increase the services' quality and efficiency. The three basic principles
321 were: provider/purchaser split, stimulus for entry of private providers, and initiatives for
322 administrative decentralization, in response to bureaucratic central control that was considered
323 unresponsive [6]. The period emphasized health services consumption through an approach that

324 required greater responsiveness to demands and power to choose (Choice Initiative), and
325 management techniques from the private sector, to replace the public management model [6]. With the
326 introduction of market mechanisms, citizens would be treated as consumers, amenable to making
327 consumption choices [17].
328 The model shaped in this intermediate phase in which liberalization of NHS began to materialize is
329 termed quasi-market [26]. Health was not the only public sector affected: other sectors in which the
330 explicit privatization of services faced social rejection also became quasi-markets through these
331 modernizing reforms of the state apparatus. In such systems, the state provides the financing for
332 transactions, demand is controlled by purchase agents indicated by the state itself that act in
333 consumers' place, and the service is finally provided by non-profit social organizations or public
334 companies that compete which each other to provide products [26,27].
335 According to Aldridge [27], in new market societies, based on support from neoliberal political
336 leaders, traditional social institutions like hospitals and schools introduced market mechanisms in
337 their structures, treating citizens as clients or consumers. England is thus not an isolated case in this
338 period, but part of a global phenomenon.
339

340 - **New Labour: the first Blair government (1997-2000)**
341

342 This period was marked politically by the Conservative demise and the rise of so-called New
343 Labour represented by Tony Blair. Although Labour had harshly criticized the Thatcher-Major
344 period, it did not abandon indispensable principles for liberalization of the NHS. Labour not only
345 maintained the purchaser/provider split, the internal market's mainstay, but reinforced corporate
346 culture within the system.
347 The founding of the Primary Care Groups (PCGs), later grouped into Primary Care Trusts (PCTs),
348 consolidated the split between purchasers and providers, universalizing the GP-FH model. By 1999,
349 all GPs were required to join one of the 481 PCGs, created by the *New NHS Act* of 1997. Still, the
350 return of territorial responsibility centered on the population's health, represented by the PCGs
351 (PCTs, since 2000) and reinforcement of the budget focus in primary care were responses to the
352 GP-FH model's failures and limitations. Meanwhile, starting in 2000, the introduction of trusts as a
353 legal figure in the Primary Health Care as well and the creation of Foundation Trusts (FTs),
354 organizations with greater independence vis-à-vis central government in the legal, financial, and
355 performance areas, consolidated the predominance of the commercial-corporate ethos in healthcare
356 management and provision [6,15,17,18,21,22].
357 The *NHS Plan* of 2000 inaugurated a period of steady financial support for the NHS and greater
358 emphasis on primary care through transformation of PCGs into PCTs [6,18]. PCTs included all GPs in

359 a given geographic area, covered some 200,000 persons, and were responsible for that population's
360 healthcare with three functions: improve health (public health); commission/hire and purchase
361 health services (hospital and specialized); provide and develop primary care services and
362 community health services (children with disabilities, mental health). As the NHS administrative
363 agency at the local level, PCTs were in charge of managing budgets sized by capitation, including
364 pharmaceutical expenditures, performing a broad role in commissioning specialized and hospital
365 services; and providing community and primary care services [17]. In 2000 there were 17 PCTs, a year
366 later in 2001 there were 164, and by 2003 they had increased to 211, when the remaining PCGs
367 were turned into PCTs [18,22].
368 The HAs also underwent mergers, resulting in 28 Strategic Health Authorities (SHA). Once the
369 PCTs absorbed the entire extent of commissioning, the SHAs were in charge of strategic planning
370 and performance management for health organizations in the so-called "New NHS" [6,17,22].
371 Consolidation of this new structure encountered major problems. The main obstacles were initially
372 organizational development, teamwork, and management of the consequences of abolishing the GP-
373 FH. Later, improvement of primary care provision, access to care, and the extent of professionals'
374 roles became the focus of Labour policy [22]. Limited management capacity and budget constraints in
375 the PCTs hindered the commissioning role and development of inter-sector work [22].
376 The Department of Health gradually delegated the system's administrative functions to new
377 organizations established specifically for this purpose. These featured the National Institute for
378 Health and Care Excellence (NICE), created in 1999, initially responsible for health technologies
379 assessment, regulation of the incorporation of new medicines based on cost-benefit, and quality of
380 care, aimed at greater clinical efficiency in resource allocation [28]. Its scope of action was gradually
381 expanded to include the proposal and revision of evidence-based clinical care guideline, solving
382 clinical problems posed by health services, and commissioning universities for research on relevant
383 questions for the system. The decision-making processes, functional organization, responsibilities,
384 and political strength of the NICE in relation to the Department of Health are constantly questioned
385 in the literature [29,30,31,32,33]. Other institutions created in the same period and that took over functions
386 previously exclusive to the Department of Health were: Care Quality Commission (CQC), founded
387 in 2009 to regulate the independent portion of the health sector through licensing, annual inspection,
388 and quality improvement and performance assessment of NHS and independent organizations; the
389 Monitor, independent regulator of FTs, and the Health Protecting Agency, responsible for defending
390 public health interests.
391 The establishment of these organizations meant a transition to a regulatory model independent of
392 the Department of Health within the NHS [18]. This period was marked by administrative delegation,
393 gradually reducing the state's central responsibility in the figure of the Secretary of Health, a

394 position equivalent to the Minister of Health in the Brazilian executive branch. The reformist
395 rhetoric in the NHS moved from competition promoted by the Conservatives to regulation
396 promoted by Labour [15].
397 A shift away from traditional population-based public health planning occurred with the state's
398 retreat from responsibility vis-à-vis citizens, a clear sign of the theoretical paradigm in the NHS. In
399 keeping with the decrease in state responsibility for public health, there was a perceptible increase
400 in persons' accountability for their own healthcare.
401 Due to the multiplicity of agencies and agents acting in the name of the Department of Health,
402 Jones et al. [34] argue that beyond the quasi-market, the NHS shifted from a hierarchical and
403 bureaucratic system to a more complex network, not necessarily hierarchical, with the internal
404 market and previous bureaucratic hierarchy existing side by side [35,36]. A form of resistance to the
405 market reforms was the tacit agreement between some organizations to not compete with each other
406 resisting the reforms that appeared mainly in the first decade of the 2000s [34].
407

408 • **Second Blair government: competition for targets and performance (2001-**
409 **2004)**
410

411 Despite the administrative impact of the first wave of Labour reform starting in 1997, the problem
412 of waiting lists for elective procedures and public concern over quality in the NHS led to a second
413 wave of reforms. These increased regulatory control over the system, introducing performance
414 targets and measures and further inciting participation by the private sector in the supply of services
415 [37], aimed at competition by these providers with the public sector. Such measures by Labour were
416 considered a definitive overture by the NHS to market mechanisms, materialized in the achievement
417 of targets and performance by establishments not necessarily linked to the Department of Health's
418 central administration, consolidating the logic of services consumption/production in the public
419 system [38]. Belief that the private sector could lead the way to greater efficiency in the public sector
420 directly influenced the second phase of the Labour period under Tony Blair. Previous Conservative
421 objectives like plurality of providers, the possibility of consumer choice, and competition were
422 resumed and implemented practically by direct private provision. This period was characterized by
423 Labour's introduction of the private ethos and status for NHS providers [6,15,39].
424 One basic policy in the second Labour phase was the introduction of Payment by Results (PbR),
425 similar to the Diagnosis-Related Groups (DRGs) system in Medicare in the United States, a strategy
426 that proposed that financing would follow the user [15,17]. In practice it consisted of payment to
427 providers for activities, incrementing the values according to results, forcing competition for better
428 quality rather than a price competition system. Implementation of this process resulted in

429 prioritization of easier-to-bill procedures with the possibility of larger volume, jeopardizing
430 complex care for patients with chronic conditions, besides failing to guarantee quality improvement
431 [40,41]. Another strategy was Choice Initiative: supported by the discourse of expanding users' choice,
432 it promoted provider diversification, allowing private initiative's entry into services provision. The
433 supply of a private provider among the alternatives became commonplace in cases of referrals for
434 specialized care [17,39].
435 Backed by the discourse of improving quality in healthcare provision, Labour was not detained by
436 ideological or organizational barriers to develop and implement Private Finance Initiatives (PFI), a
437 direct recourse to intermediation of private investments in the NHS Trusts [15,17]. The PFIs, conceived
438 in the early 1990s during the Conservative government, allowed consortia of private companies
439 (like construction companies, general services companies, and banks) to raise funds (by issuing
440 shares and taking out loans) in order to build and operate installations with public functions, like
441 hospitals. Hospitals, in turn, would rent these installations (private property), including maintenance
442 services and support teams, for 25-30-year periods. The companies would profit through these
443 consortia with guaranteed long-term financial, and government could build new hospitals without
444 incurring immediate budget outlays or increasing taxes. The Labour government adhered to this PFI
445 strategy in its initial years, presenting a project for expanding the number of hospitals belonging to
446 the NHS. The policy outlined in the *Delivering the NHS Plan* of 2002 projected expansion of the
447 hospital network through the PFIs, consolidating the Labour government's pro-market tendencies [12].
448 In the broader scenario of opening health services to private initiative in European Union member
449 countries, this process can also be seen as a state policy to favor British companies in the emerging
450 international health market [13].
451 In short, Labour government retained the internal market created by the Conservatives, shifting the
452 emphasis from competition to cooperation with performance-centered management. Recourse to an
453 alternative vocabulary – the rhetoric of cooperation and regulation – allowed avoiding allegations of
454 connections to throwbacks from the Thatcher era [6,39]. But the introduction of mechanisms for
455 institutional competition to promote changes reinforced the previous tendency to transform the
456 state's role from financer/provider to financer/regulator [5,42]. The Conservatives' market rationale
457 persisted in reforms by Labour, steadily expanding the acceptable limits of reform from the public
458 sector's point of view. The private sector's involvement increased, resulting in steady erosion of the
459 limits between the two sectors in health services provision [5,42].
460 Pollock's analysis dates to 2004, drawing this period to a close [12]. The author already concluded that
461 the NHS was drawing closer to the private sector as never before, a process that continued in the
462 subsequent phase, analyzed next.
463

464 **Market opening, fragmentation, and discontinuity of services (2005-2012)**
465
466 The third stage in the liberalization of the NHS was the system's actual opening to the market,
467 peaking in the *Health and Social Care Act* of 2012. Previously the Practice Based Commissioning
468 (PBC) policy beginning in 2005 had reintroduced the possibility of GP groups managing budgets to
469 purchase services and implement standardized care plans. PBC also included peer review of GP
470 referrals, contradictorily restricting the freedom of individual characteristics in these same
471 healthcare plans. PBC meant internal decentralization of the PCTs, simultaneously turning the
472 previously cooperative ties between primary and secondary care into competitive relations [6,43],
473 serving as an administrative embryo for implementation of the Clinical Commissioning Groups
474 (CCGs) in the 2012 reform.
475 The actual opening of the health system to the market was the extinction of the basic territorial
476 health models (PCTs) in favor of the CCGs and the possibility of private entities selling services in
477 the name of the NHS, changes allowed by the *Health and Social Care Act* of 2012, the apogee of
478 the public health service liberalization initiated by Thatcher in 1979. While the intermediate phase
479 of liberalization concentrated on the system's commercial and administrative bureaucratization, the
480 interstices between this phase and the new legislation of 2012 was marked by the gradual shifting of
481 so-called soft services to legally private entities: administration of routine data produced by the
482 system (Health and Social Care Information Centre), pathology and radiology services,
483 administrative services, and commissioning of scientific research [44,45].
484 The *Health and Social Care Act* of 2012 potentially modifies government obligations and was
485 considered a waiver by the English government, represented by the Minister of Health, in taking
486 mandatory responsibility for providing comprehensive/integral health services, putting an end to so-
487 called duty of care (the equivalent of the right to health as a duty of the state, provided in the
488 Brazilian Constitution). Although this waiver has not materialized immediately as changes in health
489 services' routine practice, other provisions of the new law effectively open the way for private
490 entities (such as support services for CCGs in the purchase of specialized and hospital health
491 services) to determine the scope of procedures to be purchased, controlling the supply.
492 Simultaneously with this weakening of guaranteed access to services and their scope, another
493 fundamental change is the abandonment of the geographic criterion as the basis for allocating
494 resources and structuring services. The CCGs become responsible only for the patients registered in
495 their client lists rather than for all the residents in a given territory, except for emergency services.
496 This means not only that a CCG does not have to purchase health services for a given region's
497 population, but that it can count on patients from other regions in its registered patients list,
498 whatever the geographic distance. A similar process (with separate legislation) applies to primary

499 care, with the suspension of geographic limits as a factor limiting GP choice. The result of this
500 change in practice is that both GPs and CCGs can compete throughout England for patients/clients
501 for their respective services. Under this new format, resource allocation becomes highly complex,
502 and population-based allocative mechanisms are no longer useful due to elimination of the
503 geographic criterion. Under the new structure, budgets based on the size of the "client portfolios"
504 are similar to the sickness fund models of Continental Europe and private health insurance in
505 general. Such models commonly lead to risk selection, co-payments, and the need to acquire
506 complementary insurance [46].
507 Under the NHS legislation passed in 2012, the purchasers of services, CCGs, manage the budgets
508 and are subordinated to NHS England (initially called the NHS Commissioning Board), the
509 organization that regulates and oversees the CCGs. All GPs must join a CCG, and the services to be
510 purchased are provided by the Foundation Trusts (administrators of the former public hospitals), as
511 well as by "any qualified provider" of health services. On the providers' side, the regulatory and
512 supervisory entities are the Monitor and the Quality Care Commission, the mission of which is to
513 maximize the respective providers' autonomy, while stimulating competition. Pollock et al. [46]
514 highlight that the regulatory entities have limited sanctioning power and that the relations between
515 purchasers and providers become commercial contracts and no longer agreements with the public
516 sphere of the NHS [46]. Such changes have serious implications, since they expose the NHS to legal
517 precedents to guarantee competition in international economic and trade agreements [46].
518 Extensive administrative decentralization in the new NHS following the 2012 reform, plus waiver
519 of the previous territorial budget planning logic, poses a risk to equity in the English health system.
520 First, the CCGs have limited capacity to exercise commissioning activity with a view towards
521 equity. Maintenance of equity in a universalist health system like the NHS requires the production
522 and analysis of population data, which the CCGs have neither the conditions to generate nor the
523 responsibility to analyze. The professionals qualified for the task are the public health experts.
524 Following decentralization of public health activities, they work in the local/municipal
525 governments, not in the CCGs. Besides, local governments' administrative jurisdiction does not
526 coincide with that of the CCGs. In addition, a system with multiple independent purchasers, with
527 little capacity to influence providers' behavior, poses risks to health services' supply/demand
528 balance [4].
529 The main characteristic of this third phase of liberalization is the legal crystallization of the shift
530 from a risk-sharing culture to the institutional organization of payment for the act of assuming the
531 risk, similar to the logic of private health insurance in the United States [46]. The main source of
532 financing is still public, but providers are not necessarily public entities as before. As long as they
533 are properly registered and meet the legal requirements, any private entity can compete to supply

534 health services in the liberalized NHS [13]. For the first time in the system's history, Foundation Trusts
535 Hospitals can generate up to 49% of the revenue from provision of services to private patients,
536 previously limited by law. Another precedent is the possibility of discontinuing services that are not
537 in the provider's interest, directly affecting the system's universality.
538 In the European Union, the local and international context is marked by the controversial
539 immigration issue. Warfare in the Middle East sparked the resurgence of xenophobic social
540 movements, threatening "illegal" and socially disadvantaged European immigrants, especially from
541 Eastern European countries, straining universal entitlement in Central European countries. The
542 "Brexit" issue (whether the United Kingdom will exit or remain in the European Union), expressed
543 in the national referendum in 2016, relates to these processes. Meanwhile, the global financial crisis
544 has resulted directly in the fiscal austerity proposed by the EU, such that member countries decrease
545 the public revenue in social sectors, jeopardizing access to health again.
546
547

548 # Final remarks
549

550 The establishment of the internal market, transformation of the relationship between financers and
551 providers, corporate management, and liberalization of the NHS for private providers are part of a
552 global historical, economic, and political context that affects universal entitlement.
553 The article addressed the effects of economic liberalism on the right to health in the NHS. Although
554 technically complex, the reforms reflect the contemporary influence of market theories and
555 economic globalization, with a turnaround in social services in the last two decades of the 20th
556 century. The article emphasizes the reduction in the state's role as provider and an increase in its
557 regulatory action. There has been an institutional retreat from humanist risk-sharing theories and
558 solidarity that formed the basis for the creation of the British NHS following World War II. In the
559 process, corresponding concepts and practices such as competition between providers, services
560 commissioning, and responsibility for user lists rather than by geographic area (de-territorialization)
561 are included in the system as part of public health policy.
562 The health market in England, previously incipient, tends to expand, making the public system
563 hybrid as relates to the mix of state establishments and private services, gradually channeling public
564 resources to private entities. State responsibility for the population's health is thereby restricted. As
565 part of the new bureaucracy needed for a system closer to the market, fundamental changes are
566 occurring in the collection and processing of epidemiological data routinely produced by the system
567 [44,45], affecting the planning, evaluation, and production of fundamental health indicators for

568 individual and collective curative and preventive actions. Such changes jeopardize classical public
569 health action based on epidemiological, demographic, and territorial criteria.
570 The analysis of the liberalization of NHS in phases, initially proposed by Pollock [12] and Pollock &
571 Price [47] and explored in this article, facilitates the understanding of a complex political and
572 administrative process, focused in the ultimate analysis on the change in the public ethos of the
573 NHS. A health system that originated as part of a redistributive social policy, guaranteeing universal
574 entitlement, has gradually become part of a mechanism for exploiting services, oriented towards
575 extracting profit in a commercial relationship with the use of health services. As in any commercial
576 relationship, situations that tend not to favor dividends are rejected by financers, leading to financial
577 unfeasibility and closing of services, already observed in the first years following the 2012 reform
578 [48].
579 The principal and most serious consequence of the gradual but steady liberalization of the NHS as a
580 whole is the restriction of universal entitlement. This restriction materializes in barriers to access to
581 health and discretionary reduction of coverage by CCGs in services supply and commissioning. The
582 reforms also involve stratification of the population clientele by risk selection, abandonment of the
583 territorialized planning and healthcare model, and separation of individual care from collective
584 actions. Expanded control of access to secondary services leads to closing of unprofitable services,
585 undermining the comprehensiveness of care [49]. Cutbacks and closing of services have occurred
586 since 2013, and some cases are still pending in the UK Supreme Court [48].
587 Liberalization of the English NHS is still under way. The NHS is one of the developed countries'
588 most efficient and effective systems. Countries that spend more on health, like the United States,
589 still display worse health indicators, despite their high budget. Support for the NHS as a public
590 system remains high in the English population, who consider it a "national treasure", a symbol of
591 social pride displayed in the opening ceremony of the London Olympic Games in 2012.
592 The British system is an international historical reference for health entitlement, prioritizing
593 universality, and organizing a system with primary care as the portal of entry with case-resolution
594 capacity, acting in cooperation with other sectors of care to ensure comprehensive healthcare. Such
595 administrative reforms, part of an adverse political and economic context, interpose market logic in
596 clinical and epidemiological reasoning in management decisions, thereby jeopardizing the reason
597 for being of the public health system itself: the population's universal right to care and prevention.
598
599

600 # Contributors
601

602 J. Filippon, L. Giovanella and M. Konder contributed to the study conception, edition, and revision
603 of manuscript. A. M. Pollock contributed to the revision and edition of manuscript.
604
605

606 # References

607

608 (1) Department of Health. Health and Social Care Act of 2012. London: Department of Health;
609 2012.

610 (2) Yeates N. Understanding global social policy. Bristol: Policy Press; 2014.

611 (3) Stuckler D, Reeves A, Karanikolos M, McKee M. The health effects of the global financial
612 crisis: can we reconcile the differing views? A network analysis of literature across disciplines.
613 Health Econ Policy Law 2015; 10:83-99.

614 (4) Wenzl M, McCuskee S, Mossialos E. Commissioning for equity in the NHS: rhetoric and
615 practice. Br Med Bull 2015; 115:5-17.

616 (5) Cribb A. Organizational reform and health-care goods: concerns about marketization in the UK
617 NHS. J Med Philos 2008; 33:221-40.

618 (6) Green A, Ross D, Mirzoev T. Primary Health Care and England: the coming of age of Alma
619 Ata? Health Policy 2007; 80:11-31.

620 (7) Donnelly J. Universal human rights in theory and practice. Ithaca: Cornell University Press;
621 2013.

622 (8) Scott-Samuel A, Bambra C, Collins C, Hunter DJ, McCartney G, Smith K. The impact of
623 Thatcherism on health and well-being in Britain. Int J Health Serv 2014; 44:53-71.

624 (9) Akerman M. O sistema de saúde britânico após as reformas de 1991: uma avaliação inicial.
625 Saúde Soc 1993; 2:85-99.

626 (10) Jardanovski E, Guimarães PCV. O desafio da eqüidade no setor saúde. Revista de
627 Administração de Empresas 1993; 33:38-51.

628 (11) Tanaka OY, Oliveira VE. Reforma(s) e estruturação do Sistema de Saúde Britânico: lições para
629 o SUS. Saúde Soc 2007; 16:7-17.

630 (12) Pollock A. NHS plc.: the privatisation of our health care. Bath: Verso Books; 2004.

631 (13) Pollock AM, Price D. Duty to care: in defence of universal health care. London: Centre for
632 Labour and Social Studies; 2013.

633 (14) Leichter HM. A comparative approach to policy analysis: health care policy in four nations.
634 Cambridge: Cambridge University Press; 1979.

635 (15) Bevan G, Robinson R. The interplay between economic and political logics: path dependency
636 in health care in England. J Health Polit Policy Law 2005; 30:53-78.

637 (16) Porto S, Martins M, Travassos C, Viacava F. Avaliação de uma metodologia de alocação de
638 recursos financeiros do setor saúde para aplicação no Brasil. Cad Saúde Pública 2007; 23:1393-404.

639 (17) Oliver A. The English National Health Service: 1979-2005. Health Econ 2005; 14 Suppl
640 1:S75-99.

641 (18) Boyle S. Health system review. Brussels: European Observatory on Health Systems and
642 Policies; 2011.

643 (19) Enthoven AC. Internal market reform of the British National Health Service. Health Aff
644 (Millwood) 1991; 10:60-70.

645 (20) Propper C. Market structure and prices: the responses of hospitals in the UK National Health
646 Service to competition. J Public Econ 1996; 61:307-35.

647 (21) Whynes DK, Baines DL. Primary care physicians' attitudes to health care reform in England.
648 Health Policy 2002; 60:111-32.

649 (22) Wilkin D. Primary care budget holding in the United Kingdom National Health Service:
650 learning from a decade of health service reform. Med J Aust 2002; 176:539-42.

651 (23) Harrison S. Working the markets: purchaser/provider separation in English health care. Int J
652 Health Serv 1991; 21:625-35.

653 (24) Macedo ME, Alves AM. Reforma administrativa: o caso do Reino Unido. Revista do Serviço
654 Público 2014; 48:62-83.

655 (25) Howell J. Re-examining the fundamental principles of the NHS. BMJ 1992; 304:297-9.

656 (26) Le Grand J. Motivation, agency, and public policy: of knights and knaves, pawns and queens.
657 Oxford: Oxford University Press; 2003.

658 (27) Aldridge A. The market. Cambridge: Polity; 2005.

659 (28) Rawlins M. In pursuit of quality: the National Institute for Clinical Excellence. Lancet 1999;
660 353:1079-82.

661 (29) Maynard A, Bloor K, Freemantle N. Challenges for the national institute for clinical
662 excellence. BMJ 2004; 329:227.

663 (30) Claxton K, Sculpher M, Drummond M. A rational framework for decision making by the
664 National Institute for Clinical Excellence (NICE). Lancet 2002; 360:711-5.

665 (31) Culyer A, McCabe C, Briggs A, Claxton K, Buxton M, Akehurst R, et al. Searching for a
666 threshold, not setting one: the role of the National Institute for Health and Clinical Excellence. J
667 Health Serv Res Policy 2007; 12:56-8.

668 (32) Steinbrook R. Saying no isn't NICE: the travails of Britain's National Institute for Health and
669 Clinical Excellence. N Engl J Med 2008; 359:1977-81.

670 (33) Trowman R, Chung H, Longson C, Littlejohns P, Clark P. The National Institute for Health and
671 Clinical Excellence and its role in assessing the value of new cancer treatments in England and
672 Wales. Clin Cancer Res 2011; 17:4930-5.

673 (34) Jones L, Exworthy M, Frosini F. Implementing market-based reforms in the English NHS:
674 bureaucratic coping strategies and social embeddedness. Health Policy 2013; 111:52-9.

675 (35) Exworthy M, Powell M, Mohan J. Markets, bureaucracy and public management: the NHS:
676 quasi-market, quasi-hierarchy and quasi-network? Public Money & Management 1999; 19:15-22.

677 (36) Allen P. An economic analysis of the limits of market based reforms in the English NHS. BMC
678 Health Serv Res 2013; 13 Suppl 1:S1.

679 (37) Stevens S. Reform strategies for the English NHS. Health Aff (Millwood) 2004; 23:37-44.

680 (38) Roland M, Rosen R. English NHS embarks on controversial and risky market-style reforms in
681 health care. N Engl J Med 2011; 364:1360-6.

682 (39) Warwick P. Back to the future in NHS reform. J Health Organ Manag 2007; 21:194-204.

683 (40) Ellis RP, Vidal-Fernandez M. Activity-based payments and reforms of the English hospital
684 payment system. Health Econ Policy Law 2007; 2:435-44.

685 (41) Goddard AF. Health reforms: are doctors onboard or overboard? Clin Med (Lond) 2007; 7:380-
686 2.

687 (42) Hassenteufel P, Smyrl M, Genieys W, Moreno-Fuentes FJ. Programmatic actors and the
688 transformation of European health care states. J Health Polit Policy Law 2010; 35:517-38.

689 (43) McDonald R. Market reforms in English primary medical care: medicine, habitus and the
690 public sphere. Sociol Health Illn 2009; 31:659-72.

691 (44) Pollock A, Price D. The break-up of the NHS: implications for information systems. In: Watson
692 P, editor. Health care reform and globalisation: the US, China and Europe in comparative
693 perspective. Oxford: Routledge; 2012. p. 25-39.

694 (45) Pollock AM, Roderick P. Trust in the time of markets: protecting patient information. Lancet
695 2014; 383:1523-4.

696 (46) Pollock AM, Price D, Roderick P, Treuherz T, McCoy D, McKee M, et al. How the Health and
697 Social Care Bill 2011 would end entitlement to comprehensive health care in England. Lancet 2012;
698 379:387-9.

699 (47) Pollock A, Price D. The final frontier: the UK,'s new coalition government turns the English
700 National Health Service over to the global market. Health Sociol Rev 2011; 20:294-305.

701 (48) Pollock A, Kondilis E, Price D, Kirkwood G, Harding-Edgar L. Blaming the victims: the trust
702 special administrator's plans for south east London. London: Centre for Primary Care and Public
703 Health, Queen Mary, University of London; 2013.

704 (49) Giovanella L, Stegmüller K. The financial crisis and health care systems in Europe: universal
705 care under threat? Trends in health sector reforms in Germany, the United Kingdom, and Spain. Cad
706 Saúde Pública 2014; 30:2263-81.

707 **Table 1:** Characteristics of English Nationa Health Service (NHS) England before and after
708 liberalization.

Characteristics	NHS pre-liberalization	NHS post-liberalization
Financing	Public (taxes)	Public (taxes); Private (PFI investments)
Financial allocation	Defined by: Geographic area; Population characteristics; Health needs	Defined by: Clinical Commissioning Groups decisions based on specific clinical demands of registered clients; List of registered clients per GP; Commissioning
Services provision	Cooperative combined provision between different areas of healthcare; State ownership; Salaried payment in specialized and hospital sector; GP: capitation payment per population covered; Financing in bloc; High complexity services exclusively public	Competition between services based mainly on cost-effectiveness models; Independence between services previously combined in collaborative/complementary fashion; Overlapping supply; GP local budget proportional to productivity indicators based on diagnosis-related groups; Stimulus for health market independent from NHS through incentives for private participation for services with waiting lists – private commissioning with public financing (mainly for elective procedures)
System management	Health Planning Authorities: Primary, secondary, and tertiary services defined hierarchically by geographic area; Legal responsibility of the Secretary of Health	Regulatory agencies (NICE, CQC, HSCIC, Monitor); Shared/obscure legal responsibility (elimination of Secretary of Health's duty of care); Individualized management focused on GP clients list
Emphasis on administrative control	Social control: Department of Health; Health professionals; Users	Corporate control: Shareholders; Management boards; Department of Health decentralized in independent agencies

709 CQC: *Care and Quality Commission*; GP: *General Practitioners*; HSCIC: *Health and Social Care Information Centre*;
710 NICE: *National Institute for Health and Care Excellence*; PFI: *Private Finance Initiatives*.
711 Source: Prepared by authors, adapted from and based on Pollock [12], Pollock & Price [13,47], and Pollock et al. [46,48].

712

713

714 **Figure 1:** Schematic history of the National Health Service (NHS) and its subsequent phases of

715 liberalization.

716

717 CCG: *Clinical Commissionning Groups*; CQC: *Care and Quality Commission*; GP: *General Practitioners*; NICE:

718 *National Institute for Health and Care Excellence*; PCT: *Primary Care Trusts*.