CSP_0347/16

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

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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

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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

health system, responsible for the healthcare of 53.5 million people. The Act of Parliament scarcely modified services from the population's perspective, since access to healthcare was not altered immediately. While maintaining public financing via taxes, the system underwent an extensive internal reform that may affect the universal right to health. Mediated by the new legislation, previously incipient processes of healthcare's organizational fragmentation in the administrative, institutional, and especially financial areas (vis-à-vis public spending) were radically intensified, multiplying the intermediaries between purchasers and providers of services. Although the NHS has undergone administrative reforms since it was founded in 1948, the 2012 proposal deepens the system's liberalization, both in the reform's underlying theoretical basis and its administrative measures: structural changes in the health system; demise of social consensus in the Welfare System; defense of the market's legitimacy for meeting social demands via downsizing the state's role [5,6]; and stimulus for pro-market organizational elements within the public administration.

Why could administrative changes in the English NHS be significant for a large share of the world's health systems? The NHS is benchmark for universal health systems and symbolizes (or symbolized) the necessary limit on the market's influence for guaranteeing universal access to health as a social right [5]. NHS reforms are publicized quickly and influence health policy debates and implementation in other countries.

Pioneering public health systems like the English NHS are sensitive to the hegemonic social theories prevailing in each historical conjuncture and express the historical moment in which they occur. The creation of the NHS in the late 1940s allowed the consolidation of universal human rights in the United Kingdom [7] in a political period of social and economic reconstruction of post-War Europe. In the last 30 years, the NHS was modified beginning with the economic crises of the 1970s, under the influence of the conservative Margaret Thatcher government [8], shifting to Labour in the late 1990s and returning to the Conservatives 2010. The current scenario reflects the force of market relations that extend beyond commercial relations to influence the public services sector that guarantees social rights [3]. The current article intends to illustrate the theoretical links between the successive reforms in the English NHS, beginning with the so-called Thatcher Era (1979) and combining analysis of the reforms with a broader conceptual discussion. Despite its relevance, the theme has received scanty attention in the Brazilian literature [9,10,11], concentrated on specific aspects or on analysis of reforms prior to 2012. The current article thus aims to help fill this gap.

This article aims to analyze NHS reforms in England, discussing the system's growing "liberalization" in this historical context of predominance of neoliberal theories since the 1980s [8]. Analysis of the reforms starts with the division proposed by Pollock [12], who defines this process as privatization/breaking up of the NHS, divided into four periods up to 2003: (i) 1980-1990 strangulation and the end of comprehensiveness; (ii) 1990-1997 the "internal market"; (iii) 1997-

2000 continuous fragmentation under New Labour; and (iv) 2000-2003 pointing New Labour to a "mixed healthcare economy" [12,13].

This article adapts the division proposed by Pollock. It expands the analysis by adding other authors and the historical narrative, and extends the study to 2012. The periods of liberalization, which were more components and moments in a process rather than chronological phases, are analyzed and named according to their characteristics: (i) gradual ideological and theoretical substitution (1979-1990) – transition from professional and health logic to a management/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; (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. The "bureaucracy and incipient market" phase is organized in three chronological sub-periods that add the last three stages from Pollock's analysis [12].

The analysis includes characteristics of the NHS before and after the 2012 reform, as well as its historical development (Figure 1). To situate the liberalization process, the article's first section summarizes some historical antecedents and characteristics of the English health system.

Antecedents: from social health insurance to the single, integrated NHS

Social stratification and disordered urbanization produced by England's two Industrial Reforms provided fertile ground for the country's pioneering trade unions; these in turn increased the social pressure for better working conditions and health services in the early 20th century. Implementation of the National Health Insurance in 1911 insured workers that made up to a given wage cap and guaranteed primary medical care, without hospital coverage, which was generally provided by charitable hospitals. General practitioners (GPs) worked as self-employed physicians, and specialists in many cases worked for very low pay in hospitals. Some one-third of the population was covered, with financing through social contributions by workers, employers, and government [14].

The *Beveridge Report* of 1942, commissioned by the Conservative-Labour coalition government during World War II, laid the theoretical foundations for the NHS and spearheaded the proposal of redistributive social policies, the main objective of the Welfare State. The NHS began its activities as a universal health system in 1948. Since its implementation the system has undergone reforms in response to the economic, social, and political changes over the decades, intensified since the

economic crises of the 1970s, plus increasing healthcare costs and complexity. The Departments of Health and Social Security were unified in 1968 as the UK Department of Health and Social Security. The system's local organization was altered in 1974 by the National Health Service Reorganization Act in an attempt to promote greater integration among services, creating the local health authorities. The purpose of these reforms was to decrease healthcare fragmentation, modify the scenario of financial favor for teaching hospitals, and extend priority to services other than hospitals for acute cases. Reform promoted the transition from a system of financing by institutions to integrated services planning through Area Health Authorities (AHA), territorial organization, and use of a needs-based resource allocation formula [15]. A methodology was established to measure local health needs (Resource Allocation Working Party – RAWP), replacing the financial transfers that followed historical averages. These changes innovated by improving the system's efficiency and equity and eventually influenced other countries' health policies in subsequent decades [16].

The predominance of market theories in the social area began to gain shape and political influence in England when Thatcher won the 1979 general elections. Previously, Labour governments had sought to limit the market's influence in some social areas like health. Favored by the global economic crisis, the Conservatives' scale-up to power marked the beginning of what we refer to as liberalization of the English NHS.

When the Conservatives returned to government in the late 1970s, the NHS was a politically and administratively centralized system (Table 1). Structurally speaking, hospitals were state property, managed and financed by the state. NHS workers were salaried, with the exception of GPs and dentists, who worked as self-employed professionals [17] on a fulltime basis with the NHS. Funds came from the Exchequer and were administered by the Department of Health. The fourteen Regional Health Authorities were responsible for managing health services in a given territory, executing a population-based budget to provide community and hospital services. Strategic planning and management of community and hospital services were subdivided into 90 AHA and 205 district management teams. Provision of primary care was monitored by Family Physician Committees, financed directly by the Department of Health [17].

Gradual ideological and theoretical substitution (1979-1990)

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

NHS management culture throughout the 1980s, the system administrator's role gained increasing importance. Administrative control began to shift away from health professionals, forcing the replacement of an organizational culture thitherto marked by health professionals' influence and leadership and the systematic use of epidemiological evidence with a typically managerial modus operandi, common to the corporate environment [18].

During this period, in step with transformation of the prevailing organizational culture, there was a first wave of health service outsourcing. Hospitals' clinical activities were spared, but a large share of support activities was outsourced, including: cleaning, laundry, nutrition, and general maintenance. There was also a strategy to reduce coverage, charging fees for optometry services (previously free), fee hikes for dental services, and closing of the majority of existing long-term hospital beds in the NHS [11]. Public hospitals were also encouraged to explore potential commercial areas such as snack bars, charging for use of TV sets, telephone services, and car parks – items that were previously free for NHS users. Such services, not linked directly to healthcare, became potential sources of financial gain for public institutions.

In addition to re-separation of the Departments of Health and Social Security in 1988, this initial phase was heavily marked by the *National Health Service and Community Care Act* of 1990. This reform came to be known in the literature as the Market Reform [12,18,19,20], since it opened specific sectors of the system to private organizations and introduced the so-called internal market into the NHS, separating the acts of purchasing and providing services (the purchaser/provider split). Purchasers would receive funds directly from the Department of Health, and providers would compete with each other to obtain funds and provide services, based on commercial contracts. The theoretical justification for the internal market's competitive nature was that it would offer the necessary incentives for providers to improve their performance (efficiency and response to demands). Financial and management decisions were decentralized, shifting from the central level in the Department of Health to the local level, personified by purchasers and providers [17,21].

The internal market was structured in stages, with two types of purchasers: District Health Authorities (DHAs) and General Practitioners Fundholders (GPs were invited to manage budgets and were called GP Fundholders – GP-FH). The GP-FH budget covered the provision of primary care services per se and the purchase of secondary care services for their patient lists (average of 10,000 persons per GP group). DHAs were responsible for assessing the local population's health needs and acquiring the totality of hospital and community services for populations linked to non-FH GPs. For the GP-FH, the DHAs were in charge of purchasing the non-commissioned part of services (80%). Covering populations up to 200,000 persons, DHAs had a needs-adjusted per capita population-based budget.

Hospitals and community health services became independent providers, called trusts, with financing that depended on contracts with the DHAs [17,21,22]. With the development of the internal market in this format, the DHAs were later replaced by the Health Authorities (HA), also in charge of purchasing services for patients of GPs who had not joined the fundholding system [21].

The reform was so sweeping that it was echoed in the incipient Brazilian scientific literature on the theme. Akerman [9] asked whether the creation of the internal market in the late Thatcher Era signaled the beginning of the end of the Welfare State or a daring management model, perhaps alluding to the coming new century. Fomenting an internal market of purchasers and providers was the fundamental administrative, theoretical, and bureaucratic change in this initial period of liberalization. Inserting the basic commercial act of purchasing and providing services internally did not necessarily impact health services' universal coverage. However, it did introduce competition among organizations in the system and produced a fundamental organizational paradigm shift. This change paved the way for the system's subsequent liberalization. The internal market allowed the later marketization and privatization of the NHS [18]. The fundamental market principles proposed in the 1990 reform were maintained and gradually expanded, despite alternating power between Conservatives and Labour in the following decades.

To stabilize a market relationship of purchase and sale of services between primary care, specialties, and hospital care and the public budget [23], the system needed to adapt administratively to the new reality, entering into a new liberalization phase.

Bureaucracy and incipient market (1991-2004)

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

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

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

Major's government eliminated 14 HAs (a Labour legacy prior to Thatcher) and made adaptations to the GP-FH model. To allow greater diversity in the provision of primary care, the possibility of salaried payment for GPs was introduced [17]. Several variants of GP-FH were developed, generally promoted by managers and GPs that had not joined the FH model: Community fundholders, which only purchased community services associated with primary healthcare; so-called Multi-funds, or groupings of GP fundholders that shared the management of their budgets and respective administrative costs of their purchases; Purchase Groups, in which collectives of GPs that did not manage budgets acted with the HAs to influence purchase of services in their geographic areas of care [22]. GP-FH were implemented gradually to sidestep the initial rejection by physicians and to keep a drastic change from destabilizing the NHS vis-à-vis the population. Adherence to the GP-FH model enjoyed an initial wave of enthusiasts, followed by a wave of people interested in acting as groups (Community fundholders and Multi-funds), and finally a third wave consisting of a cascade effect from the proposed model's growth [21]. In 1996, 50% of the GPs had joined the fundholding model [17,21]. Cost containment with prescriptions was the most immediate effect of the GP-FH, leading to government incentives to induce GPs that were still independent. The fundholding models generally produced gains in the extent and effectiveness of services, but with increasing administrative expenses, transaction costs between services, and inequalities in access between users of different models (GPs in the fundholding model versus independents) [21,22].

The internal market encountered various structural difficulties. For purchasers, the GP-FH model led to numerous small-scale, limited-scope purchasers whose purchasing power was insufficient to impact price competition in the local health services market [15,22]. DHAs also faced structural obstacles that limited their performance as purchasers, such as: lack of demand-side integration; lack of information for making purchases (incipient price system, leading to market asymmetry); and local services monopolies [15,22].

Underfinancing of certain activities related to social needs and that involved long-term costs (e.g., care for the elderly) sparked negotiations over the definition of fundamental healthcare activities as opposed to extra activities, not necessarily covered by the same budget [21].

State hospitals were turned into trusts, semi-independent, non-profit organizations with a reasonable degree of freedom to set pay thresholds, staff composition, and types of services offered. By 1996 there were already 350 NHS Trusts [21].

In short, the Conservative reform focused on the system's efficiency, assuming that market competition would naturally increase the services' quality and efficiency. The three basic principles were: provider/purchaser split, stimulus for entry of private providers, and initiatives for administrative decentralization, in response to bureaucratic central control that was considered unresponsive [6]. The period emphasized health services consumption through an approach that

required greater responsiveness to demands and power to choose (Choice Initiative), and management techniques from the private sector, to replace the public management model [6]. With the introduction of market mechanisms, citizens would be treated as consumers, amenable to making consumption choices [17].

The model shaped in this intermediate phase in which liberalization of NHS began to materialize is termed quasi-market [26]. Health was not the only public sector affected: other sectors in which the explicit privatization of services faced social rejection also became quasi-markets through these modernizing reforms of the state apparatus. In such systems, the state provides the financing for transactions, demand is controlled by purchase agents indicated by the state itself that act in consumers' place, and the service is finally provided by non-profit social organizations or public companies that compete which each other to provide products [26,27].

According to Aldridge [27], in new market societies, based on support from neoliberal political leaders, traditional social institutions like hospitals and schools introduced market mechanisms in their structures, treating citizens as clients or consumers. England is thus not an isolated case in this period, but part of a global phenomenon.

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

This period was marked politically by the Conservative demise and the rise of so-called New Labour represented by Tony Blair. Although Labour had harshly criticized the Thatcher-Major period, it did not abandon indispensable principles for liberalization of the NHS. Labour not only maintained the purchaser/provider split, the internal market's mainstay, but reinforced corporate culture within the system.

The founding of the Primary Care Groups (PCGs), later grouped into Primary Care Trusts (PCTs), consolidated the split between purchasers and providers, universalizing the GP-FH model. By 1999, all GPs were required to join one of the 481 PCGs, created by the *New NHS Act* of 1997. Still, the return of territorial responsibility centered on the population's health, represented by the PCGs (PCTs, since 2000) and reinforcement of the budget focus in primary care were responses to the GP-FH model's failures and limitations. Meanwhile, starting in 2000, the introduction of trusts as a legal figure in the Primary Health Care as well and the creation of Foundation Trusts (FTs), organizations with greater independence vis-à-vis central government in the legal, financial, and performance areas, consolidated the predominance of the commercial-corporate ethos in healthcare management and provision [6,15,17,18,21,22].

The *NHS Plan* of 2000 inaugurated a period of steady financial support for the NHS and greater emphasis on primary care through transformation of PCGs into PCTs [6,18]. PCTs included all GPs in

a given geographic area, covered some 200,000 persons, and were responsible for that population's healthcare with three functions: improve health (public health); commission/hire and purchase health services (hospital and specialized); provide and develop primary care services and community health services (children with disabilities, mental health). As the NHS administrative agency at the local level, PCTs were in charge of managing budgets sized by capitation, including pharmaceutical expenditures, performing a broad role in commissioning specialized and hospital services; and providing community and primary care services [17]. In 2000 there were 17 PCTs, a year later in 2001 there were 164, and by 2003 they had increased to 211, when the remaining PCGs were turned into PCTs [18,22].

The HAs also underwent mergers, resulting in 28 Strategic Health Authorities (SHA). Once the PCTs absorbed the entire extent of commissioning, the SHAs were in charge of strategic planning and performance management for health organizations in the so-called "New NHS" [6,17,22].

Consolidation of this new structure encountered major problems. The main obstacles were initially organizational development, teamwork, and management of the consequences of abolishing the GP-FH. Later, improvement of primary care provision, access to care, and the extent of professionals' roles became the focus of Labour policy [22]. Limited management capacity and budget constraints in the PCTs hindered the commissioning role and development of inter-sector work [22].

The Department of Health gradually delegated the system's administrative functions to new organizations established specifically for this purpose. These featured the National Institute for Health and Care Excellence (NICE), created in 1999, initially responsible for health technologies assessment, regulation of the incorporation of new medicines based on cost-benefit, and quality of care, aimed at greater clinical efficiency in resource allocation [28]. Its scope of action was gradually expanded to include the proposal and revision of evidence-based clinical care guideline, solving clinical problems posed by health services, and commissioning universities for research on relevant questions for the system. The decision-making processes, functional organization, responsibilities, and political strength of the NICE in relation to the Department of Health are constantly questioned in the literature [29,30,31,32,33]. Other institutions created in the same period and that took over functions previously exclusive to the Department of Health were: Care Quality Commission (CQC), founded in 2009 to regulate the independent portion of the health sector through licensing, annual inspection, and quality improvement and performance assessment of NHS and independent organizations; the Monitor, independent regulator of FTs, and the Health Protecting Agency, responsible for defending public health interests.

The establishment of these organizations meant a transition to a regulatory model independent of the Department of Health within the NHS [18]. This period was marked by administrative delegation, gradually reducing the state's central responsibility in the figure of the Secretary of Health, a

position equivalent to the Minister of Health in the Brazilian executive branch. The reformist rhetoric in the NHS moved from competition promoted by the Conservatives to regulation promoted by Labour [15].

A shift away from traditional population-based public health planning occurred with the state's retreat from responsibility vis-à-vis citizens, a clear sign of the theoretical paradigm in the NHS. In keeping with the decrease in state responsibility for public health, there was a perceptible increase in persons' accountability for their own healthcare.

Due to the multiplicity of agencies and agents acting in the name of the Department of Health, Jones et al. [34] argue that beyond the quasi-market, the NHS shifted from a hierarchical and bureaucratic system to a more complex network, not necessarily hierarchical, with the internal market and previous bureaucratic hierarchy existing side by side [35,36]. A form of resistance to the market reforms was the tacit agreement between some organizations to not compete with each other resisting the reforms that appeared mainly in the first decade of the 2000s [34].

- **Second Blair government: competition for targets and performance (2001-2004)**

Despite the administrative impact of the first wave of Labour reform starting in 1997, the problem of waiting lists for elective procedures and public concern over quality in the NHS led to a second wave of reforms. These increased regulatory control over the system, introducing performance targets and measures and further inciting participation by the private sector in the supply of services [37], aimed at competition by these providers with the public sector. Such measures by Labour were considered a definitive overture by the NHS to market mechanisms, materialized in the achievement of targets and performance by establishments not necessarily linked to the Department of Health's central administration, consolidating the logic of services consumption/production in the public system [38]. Belief that the private sector could lead the way to greater efficiency in the public sector directly influenced the second phase of the Labour period under Tony Blair. Previous Conservative objectives like plurality of providers, the possibility of consumer choice, and competition were resumed and implemented practically by direct private provision. This period was characterized by Labour's introduction of the private ethos and status for NHS providers [6,15,39].

One basic policy in the second Labour phase was the introduction of Payment by Results (PbR), similar to the Diagnosis-Related Groups (DRGs) system in Medicare in the United States, a strategy that proposed that financing would follow the user [15,17]. In practice it consisted of payment to providers for activities, incrementing the values according to results, forcing competition for better quality rather than a price competition system. Implementation of this process resulted in

prioritization of easier-to-bill procedures with the possibility of larger volume, jeopardizing complex care for patients with chronic conditions, besides failing to guarantee quality improvement [40,41]. Another strategy was Choice Initiative: supported by the discourse of expanding users' choice, it promoted provider diversification, allowing private initiative's entry into services provision. The supply of a private provider among the alternatives became commonplace in cases of referrals for specialized care [17,39].

Backed by the discourse of improving quality in healthcare provision, Labour was not detained by ideological or organizational barriers to develop and implement Private Finance Initiatives (PFI), a direct recourse to intermediation of private investments in the NHS Trusts [15,17]. The PFIs, conceived in the early 1990s during the Conservative government, allowed consortia of private companies (like construction companies, general services companies, and banks) to raise funds (by issuing shares and taking out loans) in order to build and operate installations with public functions, like hospitals. Hospitals, in turn, would rent these installations (private property), including maintenance services and support teams, for 25-30-year periods. The companies would profit through these consortia with guaranteed long-term financial, and government could build new hospitals without incurring immediate budget outlays or increasing taxes. The Labour government adhered to this PFI strategy in its initial years, presenting a project for expanding the number of hospitals belonging to the NHS. The policy outlined in the *Delivering the NHS Plan* of 2002 projected expansion of the hospital network through the PFIs, consolidating the Labour government's pro-market tendencies [12]. In the broader scenario of opening health services to private initiative in European Union member countries, this process can also be seen as a state policy to favor British companies in the emerging international health market [13].

In short, Labour government retained the internal market created by the Conservatives, shifting the emphasis from competition to cooperation with performance-centered management. Recourse to an alternative vocabulary – the rhetoric of cooperation and regulation – allowed avoiding allegations of connections to throwbacks from the Thatcher era [6,39]. But the introduction of mechanisms for institutional competition to promote changes reinforced the previous tendency to transform the state's role from financer/provider to financer/regulator [5,42]. The Conservatives' market rationale persisted in reforms by Labour, steadily expanding the acceptable limits of reform from the public sector's point of view. The private sector's involvement increased, resulting in steady erosion of the limits between the two sectors in health services provision [5,42].

Pollock's analysis dates to 2004, drawing this period to a close [12]. The author already concluded that the NHS was drawing closer to the private sector as never before, a process that continued in the subsequent phase, analyzed next.

Market opening, fragmentation, and discontinuity of services (2005-2012)

The third stage in the liberalization of the NHS was the system's actual opening to the market, peaking in the *Health and Social Care Act* of 2012. Previously the Practice Based Commissioning (PBC) policy beginning in 2005 had reintroduced the possibility of GP groups managing budgets to purchase services and implement standardized care plans. PBC also included peer review of GP referrals, contradictorily restricting the freedom of individual characteristics in these same healthcare plans. PBC meant internal decentralization of the PCTs, simultaneously turning the previously cooperative ties between primary and secondary care into competitive relations [6,43], serving as an administrative embryo for implementation of the Clinical Commissioning Groups (CCGs) in the 2012 reform.

The actual opening of the health system to the market was the extinction of the basic territorial health models (PCTs) in favor of the CCGs and the possibility of private entities selling services in the name of the NHS, changes allowed by the *Health and Social Care Act* of 2012, the apogee of the public health service liberalization initiated by Thatcher in 1979. While the intermediate phase of liberalization concentrated on the system's commercial and administrative bureaucratization, the interstices between this phase and the new legislation of 2012 was marked by the gradual shifting of so-called soft services to legally private entities: administration of routine data produced by the system (Health and Social Care Information Centre), pathology and radiology services, administrative services, and commissioning of scientific research [44,45].

The *Health and Social Care Act* of 2012 potentially modifies government obligations and was considered a waiver by the English government, represented by the Minister of Health, in taking mandatory responsibility for providing comprehensive/integral health services, putting an end to so-called duty of care (the equivalent of the right to health as a duty of the state, provided in the Brazilian Constitution). Although this waiver has not materialized immediately as changes in health services' routine practice, other provisions of the new law effectively open the way for private entities (such as support services for CCGs in the purchase of specialized and hospital health services) to determine the scope of procedures to be purchased, controlling the supply. Simultaneously with this weakening of guaranteed access to services and their scope, another fundamental change is the abandonment of the geographic criterion as the basis for allocating resources and structuring services. The CCGs become responsible only for the patients registered in their client lists rather than for all the residents in a given territory, except for emergency services. This means not only that a CCG does not have to purchase health services for a given region's population, but that it can count on patients from other regions in its registered patients list, whatever the geographic distance. A similar process (with separate legislation) applies to primary

care, with the suspension of geographic limits as a factor limiting GP choice. The result of this change in practice is that both GPs and CCGs can compete throughout England for patients/clients for their respective services. Under this new format, resource allocation becomes highly complex, and population-based allocative mechanisms are no longer useful due to elimination of the geographic criterion. Under the new structure, budgets based on the size of the "client portfolios" are similar to the sickness fund models of Continental Europe and private health insurance in general. Such models commonly lead to risk selection, co-payments, and the need to acquire complementary insurance [46].

Under the NHS legislation passed in 2012, the purchasers of services, CCGs, manage the budgets and are subordinated to NHS England (initially called the NHS Commissioning Board), the organization that regulates and oversees the CCGs. All GPs must join a CCG, and the services to be purchased are provided by the Foundation Trusts (administrators of the former public hospitals), as well as by "any qualified provider" of health services. On the providers' side, the regulatory and supervisory entities are the Monitor and the Quality Care Commission, the mission of which is to maximize the respective providers' autonomy, while stimulating competition. Pollock et al. [46] highlight that the regulatory entities have limited sanctioning power and that the relations between purchasers and providers become commercial contracts and no longer agreements with the public sphere of the NHS [46]. Such changes have serious implications, since they expose the NHS to legal precedents to guarantee competition in international economic and trade agreements [46].

Extensive administrative decentralization in the new NHS following the 2012 reform, plus waiver of the previous territorial budget planning logic, poses a risk to equity in the English health system. First, the CCGs have limited capacity to exercise commissioning activity with a view towards equity. Maintenance of equity in a universalist health system like the NHS requires the production and analysis of population data, which the CCGs have neither the conditions to generate nor the responsibility to analyze. The professionals qualified for the task are the public health experts. Following decentralization of public health activities, they work in the local/municipal governments, not in the CCGs. Besides, local governments' administrative jurisdiction does not coincide with that of the CCGs. In addition, a system with multiple independent purchasers, with little capacity to influence providers' behavior, poses risks to health services' supply/demand balance [4].

The main characteristic of this third phase of liberalization is the legal crystallization of the shift from a risk-sharing culture to the institutional organization of payment for the act of assuming the risk, similar to the logic of private health insurance in the United States [46]. The main source of financing is still public, but providers are not necessarily public entities as before. As long as they are properly registered and meet the legal requirements, any private entity can compete to supply

health services in the liberalized NHS [13]. For the first time in the system's history, Foundation Trusts Hospitals can generate up to 49% of the revenue from provision of services to private patients, previously limited by law. Another precedent is the possibility of discontinuing services that are not in the provider's interest, directly affecting the system's universality.

In the European Union, the local and international context is marked by the controversial immigration issue. Warfare in the Middle East sparked the resurgence of xenophobic social movements, threatening "illegal" and socially disadvantaged European immigrants, especially from Eastern European countries, straining universal entitlement in Central European countries. The "Brexit" issue (whether the United Kingdom will exit or remain in the European Union), expressed in the national referendum in 2016, relates to these processes. Meanwhile, the global financial crisis has resulted directly in the fiscal austerity proposed by the EU, such that member countries decrease the public revenue in social sectors, jeopardizing access to health again.

Final remarks

The establishment of the internal market, transformation of the relationship between financers and providers, corporate management, and liberalization of the NHS for private providers are part of a global historical, economic, and political context that affects universal entitlement.

The article addressed the effects of economic liberalism on the right to health in the NHS. Although technically complex, the reforms reflect the contemporary influence of market theories and economic globalization, with a turnaround in social services in the last two decades of the 20th century. The article emphasizes the reduction in the state's role as provider and an increase in its regulatory action. There has been an institutional retreat from humanist risk-sharing theories and solidarity that formed the basis for the creation of the British NHS following World War II. In the process, corresponding concepts and practices such as competition between providers, services commissioning, and responsibility for user lists rather than by geographic area (de-territorialization) are included in the system as part of public health policy.

The health market in England, previously incipient, tends to expand, making the public system hybrid as relates to the mix of state establishments and private services, gradually channeling public resources to private entities. State responsibility for the population's health is thereby restricted. As part of the new bureaucracy needed for a system closer to the market, fundamental changes are occurring in the collection and processing of epidemiological data routinely produced by the system [44,45], affecting the planning, evaluation, and production of fundamental health indicators for

individual and collective curative and preventive actions. Such changes jeopardize classical public health action based on epidemiological, demographic, and territorial criteria.

The analysis of the liberalization of NHS in phases, initially proposed by Pollock [12] and Pollock & Price [47] and explored in this article, facilitates the understanding of a complex political and administrative process, focused in the ultimate analysis on the change in the public ethos of the NHS. A health system that originated as part of a redistributive social policy, guaranteeing universal entitlement, has gradually become part of a mechanism for exploiting services, oriented towards extracting profit in a commercial relationship with the use of health services. As in any commercial relationship, situations that tend not to favor dividends are rejected by financers, leading to financial unfeasibility and closing of services, already observed in the first years following the 2012 reform [48].

The principal and most serious consequence of the gradual but steady liberalization of the NHS as a whole is the restriction of universal entitlement. This restriction materializes in barriers to access to health and discretionary reduction of coverage by CCGs in services supply and commissioning. The reforms also involve stratification of the population clientele by risk selection, abandonment of the territorialized planning and healthcare model, and separation of individual care from collective actions. Expanded control of access to secondary services leads to closing of unprofitable services, undermining the comprehensiveness of care [49]. Cutbacks and closing of services have occurred since 2013, and some cases are still pending in the UK Supreme Court [48].

Liberalization of the English NHS is still under way. The NHS is one of the developed countries' most efficient and effective systems. Countries that spend more on health, like the United States, still display worse health indicators, despite their high budget. Support for the NHS as a public system remains high in the English population, who consider it a "national treasure", a symbol of social pride displayed in the opening ceremony of the London Olympic Games in 2012.

The British system is an international historical reference for health entitlement, prioritizing universality, and organizing a system with primary care as the portal of entry with case-resolution capacity, acting in cooperation with other sectors of care to ensure comprehensive healthcare. Such administrative reforms, part of an adverse political and economic context, interpose market logic in clinical and epidemiological reasoning in management decisions, thereby jeopardizing the reason for being of the public health system itself: the population's universal right to care and prevention.

Contributors

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

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Table 1: Characteristics of English Nationa Health Service (NHS) England before and after 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

CQC: *Care and Quality Commission*; GP: *General Practitioners*; HSCIC: *Health and Social Care Information Centre*; NICE: *National Institute for Health and Care Excellence*; PFI: *Private Finance Initiatives*.

Source: Prepared by authors, adapted from and based on Pollock [12], Pollock & Price [13,47], and Pollock et al. [46,48].

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

CCG: *Clinical Commissionning Groups*; CQC: *Care and Quality Commission*; GP: *General Practitioners*; NICE: *National Institute for Health and Care Excellence*; PCT: *Primary Care Trusts*.