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The final frontier: The UK's new coalition government turns the English National Health Service over to the global health care market

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ABSTRACT

The authors describe the incremental approach to the marketisation of the English National Health Service (NHS) since the introduction of an 'internal market' in 1990 until the 2010 White Paper, 'Equity and Excellence: Liberating the NHS', and the subsequent Health and Social Care Bill published in January 2011. The introduction of a competitive market for a universal, tax-financed health system requires fundamental changes in regulation in order that market bureaucracy can be substituted for direct management. The components of reform are insufficiently captured by the framework of hierarchies and networks in new public management theories of decentralisation.

Keywords: sociology; National Health Service; health system reform; privatisation; health care markets; new public management

Introduction

The UK National Health Service (NHS) was established in 1948 as a universal service free at the point of delivery and available on the basis of need. It replaced a highly inequitable provision based on charity, municipalities and private provision. In common with several other developed country health systems, the UK has been experimenting with market reforms for the last three decades (Mills and Broomberg 1998). However, market orientated changes have taken place within the statutory framework of a government responsibility to provide a comprehensive health service to the whole population free at the point of delivery; successive changes to the establishing legislation (1946–2006), have therefore retained the health minister's duty to provide a 'comprehensive health service to secure the improvement in the physical and mental health of the people … and the prevention, diagnosis and treatment of illness' [National Health Service Act, 1946: clause 1; House of commons 1946]. It is this duty that is now being removed under current legislation making its way through parliament.

The Liberal Democrat–Conservative Coalition Government's 2010 white paper, Equity and Excellence: Liberating the NHS (Department

of Health 2010b) and subsequent Health and Social Care Bill 2011 herald the most controversial proposals in the history of the NHS in England (Anon 2010; Campbell 2010). The intention is to replace the English NHS with a commercial market in which potential suppliers of health care and patients will compete for NHS funds from commercial commissioning consortiums. Public administrative bodies known as primary care trusts (PCT), currently responsible for, and funded to secure, the health care needs of geographic populations, will be abolished and replaced by consortiums of general practices (family doctors) with responsibility for commissioning (or purchasing) care on behalf of their membership. Patients will be enrolled into consortiums via the patient lists of constituent general practices (House of Commons 2011a). Like the privatised utilities, the health care market will be policed by an economic regulator, known as 'Monitor', to be independent of the health secretary. The role of ministers and the Department of Health will be limited to providing public funding. The effect will be to overturn the basic principle of the NHS whereby health services to the whole geographic population are largely publicly administered with provision largely under public ownership and control. It will also permit local discretion over what is publicly provided and how much will be generated through private financing.

The market reform process has been described as a long-term trend or plan (Pollock et al. 2005; Tudor Hart 1994). In this article, we briefly describe the precursors and main provisions of the new bill and we show how the systems of public administration have been dismantled under previous legislation to allow in private finance. We begin by setting the scene and examining the theoretical impulse behind market reform.

Background

The 1948 UK NHS was designed to ensure a comprehensive, universal service based on the principle of equal care for equal need. Gilson's account of the World Health Organisation's interpretation of 'universality' captures well the founding principles:

- a situation where the whole population of a country has access to good quality services according to needs and preferences, regardless of income level, social status, or residency;
- an absolute concept in relation to population coverage (100%) with the same scope of benefits extended to the whole population (but the range of benefits varying between contexts); and which
- incorporates policy objectives of equity in payments (the rich should pay more than the poor), financial protection (the poor should not become poor as a result of using health care), and equity of access or utilisation (implying distribution according to need rather than ability to pay, and requiring equity in the distribution of spending and resources; Gilson et al. 2007:27).

For more than 60 years this goal has been pursued through tax financing to ensure services free at the point of delivery and a statutory duty on the health secretary to provide health care to the whole population. Cost-sharing, solidarity or cross-subsidisation among hospitals, clinics and other curative services was achieved by integrating services into administrative tiers on a geographic basis instead of differentiating provider units as separate accounting entities and cost centres. These arrangements, together with global budgeting and cost controls, were key features of a publicly administered, population-based service. Inroads have increasingly been made into these equity mechanisms, as we will show.

The picture in the UK is complicated by devolution in 1999. Following the establishment of a Scottish Parliament, Welsh Assembly, and Northern Ireland Assembly, health services became a devolved responsibility. In Scotland and Wales, administrations have repealed earlier

market legislation in order to promote and strengthen service planning and integration of services. Northern Ireland has experienced a number of rounds of direct rule over the last 12 years. On these occasions, Whitehall has continued to have a direct influence on policy. To avoid confusion, our account is limited to the NHS in England.

Theory and evidence

Contracting out publicly financed provision to the private sector is a standard component of 'new public management' reforms in the developing and the developed world (Mills and Broomberg 1998). Insofar as it is possible to refer to a unified theory (Hood 1991), exponents of new public management hold that the public sector is inefficient because of the absence of private financial incentives (property rights theory) and because of failures arising from the undue influence of interest groups within government (public choice theory) (Walsh 1995). It is argued that the price mechanism introduced by contracting out will shift the locus of control from politicians and professionals to consumers with a consequent improvement in cost efficiency (Boyle 2007; NHS 2000; Shen and Melnick 2004; Walsh 1995). The theory suggests that competition exerts downward pressure on costs by reducing slack and providing incentives for the efficient organisation of production and for innovation (Liu et al. 2008; Nickell 1996). However, there is little or no empirical verification of these claims (Liu et al. 2007; Loevinsohn and Harding 2005; Perrot 2004). Moreover, the policy has continued to give rise to concerns about the consequences for equity (Liu et al. 2007). Scientific evaluation of the policy's impact on cost-sharing (or solidarity) across geographic populations, the key goal of universal health systems, remains virtually nonexistent (Liu et al. 2008; Peters et al. 2009). Researchers have focused instead on questions about the effects of contracting out on price, output, and, to a lesser extent, the difficult to define variable of 'quality' (Liu et al. 2007).

Despite a weak evidence base, contracting out has been influential in shifting theoretical preoccupations to the design and implementation of financial incentives in place of risk pooling and social solidarity mechanisms. Transaction cost economics has been especially concerned with problems in incentive structures arising from information asymmetries among parties to a contract (principal agent theory; Williamson 2000). This focus on opportunistic behaviour (according to which agents may defeat the goals of principals) is different from, and does not support, analyses of system level effects on equity, which have been left largely unexamined (Liu et al. 2008) and untheorised.

This is not to say that there have been no theoretical concerns. For example, economists often argue that health services cannot be sufficiently controlled through market regulation because the complexity and unpredictability of treatment and patient needs makes it impossible to set out all eventualities in a contract. This problem of 'incomplete contracts' was first described by the founding father of health economics, Arrow (1963:950) who argued that because producers of healthcare services will always have more information than purchasers their services can never be fully evaluated. According to Arrow, incomplete contracts can explain why 'the association of profit-making with the supply of medical services arouses antagonism and suspicion on the part of patients and referring physicians'. However, this analysis was not intended as a critique of the effects of markets on solidarity.

Theoretical insights derived from institutional economics have heavily influenced the design of commissioning frameworks within the NHS as the architects of reform have sought to introduce incentive structures to achieve market competition. Davies et al. (2005:83) cites arguments that this economic emphasis, conveyed in the conceptual framework of 'hierarchies and

networks', has displaced other conceptions of bureaucracy. We show how the long series of changes culminating in market governance has targeted forms of public administration underpinning a universal, tax-financed health system, displacing the structures and mechanisms of population-based care.

The transition from internal market to external market

Commissioning (or purchasing from a range of providers) was first introduced to the NHS in 1990 in a form loosely based on Enthoven's conception of 'managed competition'. Managed competition refers to strategies adopted by groups of employers, government bodies or other purchasing groups to adjust competitive market conditions in order to reduce costs (Enthoven 2000). The NHS variant of managed competition was the 'internal market', an arrangement known more generally as the 'purchaser-provider split' in which organisations within integrated, comprehensive systems are differentiated into commissioning or payer groups and provider groups. 'Internal' was used to indicate that all organisations remained within the publicly administered health system.

Commissioning underwent a number of manifestations in the succeeding 20 years and, according to two recent reports by the House of Commons Health Committee, has still to fulfill its objectives (House of Commons Health Committee 2010, 2011a). Four main competitive models were tried between 1991 and 2008 (House of Commons Health Committee 2010), involving district health authorities and general practice or family doctor 'fundholders' (1991–1998), health authorities and 'primary care groups' and subsequently 'primary care trusts' (1998–2002), and PCTs and 'practice-based commissioners' (2002–2006). The bodies referred to can be understood as alternative institutional solutions within the commissioning process that differ in degrees of financial autonomy and risk. In 2002, possibilities to commission from outside the NHS were introduced under the rubric of contestability and plurality which brought in new opportunities for the private-for-profit sector through the 'independent sector treatment centres' (ISTCs) programme. ISTCs are mainly privately run elective care centres serving NHS patients. In 2006 choice of provider was formally vested with patients through a policy of 'Choose and Book', with 'free choice' from 2008. The principle of 'any willing provider' for secondary care (that is, freedom to choose between NHS and non-NHS hospitals) was introduced in 2008 but was scaled back in 2009 when the secretary of state declared the NHS the 'preferred provider' (House of Commons Health Committee 2010). Subsequent analysis has highlighted the poor value for money and high public costs that have resulted from the ISTC programme (Pollock and Kirkwood 2009).

Commissioning changes were premised on parallel reforms to the legal and institutional status of several NHS bodies. Most important among these was the establishment of NHS service provider bodies such as hospitals (and subsequently commissioning bodies) as legal corporations. Again, advances on this front were made in a number of separate steps.

(i) Capital funding – from block grants to capital charges (loans) and from directly managed hospitals to foundation trusts (firms)

The NHS and Community Care Act 1990 fundamentally altered the financing of capital investment and paved the way for the private finance initiative (PFI) through a new capital charging system (Gaffney et al. 1999). Hospitals had previously been funded separately for revenue and capital expenditure and capital needs were met by grants not loans. In a major break with the past, the 1990 act made capital financing dependent on loans and the responsibility of newly created hospital 'trusts' (semi-autonomous bodies that provide services to the NHS via the internal market), not the government (Shaoul

1998). New financial duties modelled on the relation between a private sector corporation and its bankers and shareholders were imposed on trusts, which in line with commercial practice were required to pay for the use of capital; in effect, hospitals were being taxed for capital consumption (Pollock and Gaffney 1998). However, trusts were not at this stage legal businesses incorporated under the Companies Act (legislation under which businesses are registered as legal entities for contracting purposes and their statutory duties defined). Accordingly, the link between trusts and the rest of the NHS was by agreement (so-called 'NHS agreements') not commercial contract.

That changed with the Health and Social Care (Community Health and Standards) Act, 2003, which abolished government control of NHS trusts by turning them into competing independent corporations called 'foundation trusts' and placing them under a regulator, 'Monitor', which was independent of the department of health (Pollock et al. 2003). These trusts were incorporated under a bespoke non-profit legal form called the public benefit corporation and were given new powers. The reform served to detach providers (initially only hospitals) from the control of the secretary of state for health and to increase the role of commercial contracting as the basis of the relationship between trusts and the rest of the health service. It also increased scope for private sector provision by permitting foundation trusts to enter into contracts with the commercial sector.

(ii) Private debt finance

Meanwhile, the 1990 reforms directly contributed to a new capital finance policy known as the PFI. Under PFI, a consortium of investment banks, builders, and service contractors raises the finance for public infrastructure project, and designs, builds, and even operates the facilities for the public authority through a company established for this purpose (special purpose vehicle). The PFI consortium may additionally provide soft facilities management (FM) services within the project such as laundry, maintenance services, catering, and cleaning. As of December 2009, 159 PFI hospital contracts with a capital value of £13.16 billion had been signed in the UK, with NHS England being the biggest procurer in terms of numbers (72%) and capital value of the assets (86%; Pollock et al. 2011). In England's NHS, of the 135 new hospitals constructed between 1997 and 2009 or currently under construction 101 are financed under PFI. This accounts for around 90% of the £12.2 billion committed under successive building programmes in the period (Pollock et al. 2011).

The private finance initiative was an explicit move towards private provision of public services. On the policy's inauguration in 1992, a cabinet office white paper declared its position on what would become known as 'the third way': 'Distinctions between services delivered by the public and the private sector are breaking down in many areas, opening up the way to new ideas, partnerships and opportunities for devising and delivering what the public wants' (Cabinet Office 1999:2). The PFI in the NHS was part of a wider policy agenda affecting all government departments, including transport, schools, and prisons.

Contracting out primary care services to private health care companies was inaugurated by the NHS Plan, a strategy document published by the department of health in 2000 (NHS 2000). A key implementation step was reform of the relationship between the state and primary care doctors (general practitioners, family doctors or GPs; Heins et al. 2009). This relationship had formerly been enshrined in an agreement known as the General Medical Services (GMS) contract between GPs and the state. Under the old GMS contract GPs were directly contracted to the NHS via a contract between the health secretary and the individual practitioner. Although GPs have always been independent contractors to the NHS, under this arrangement they were subject to national terms and conditions stipulated by the

so-called 'Red Book', an extensive set of guidelines and regulations covering range and quality of services, staffing, and premises (Pollock et al. 2007). Moreover, few GPs undertook private practice. In April 2004, a new GMS contract was agreed that provided for greater flexibility in the range of services provided, including provision for opting out of additional services and out-of-hours care.

The reform achieved two important things. Crucially, the contract ended GPs' monopoly in primary care, opening the door to commercial provision through a range of new contract forms (Pollock et al. 2003) Secondly, it broke the contract between each GP and the state ending a direct contractual relationship and replacing it with a contract between the commissioning authority (PCT) and the practice or firm. The department of health's role was reduced to providing a national framework, but it now became the responsibility of the local PCTs to decide which services to commission. Today, under the new standard contract it is contractors, not GPs, who have the duty to provide appropriate services. GPs may continue as partners in a practice; as employees of practices, trusts, or corporations; as directors or shareholders of commercial companies providing primary care; or as subcontractors to the primary contract holder. These bodies are regulated largely through the market mechanism of commercial contracting involving a competitive tender process.

The reform also broke up integrated primary care by 'unbundling' services. This was done by limiting the GMS contract to a core service that could be topped up with locally negotiated additional elements, thereby providing an entry point into primary care for large corporations. For example, many out-of-hours services throughout England are now offered by commercial firms which have been accredited to deliver these services. New contracting routes were also established permitting provision of primary care services by a wider range of agencies e.g., non-profit and for-profit private providers, as well as all types of GP practices and NHS trusts. Until recently the growing commercialisation of primary care has been 'substantially understated', private-for-profit firms now running over 200 surgeries and health centres across England and many companies rapidly expanding their business: 227 GP surgeries and health centres in England are now run by 23 commercial companies, with nine firms, including Chilvers McCrea, Care UK and Assura Medical (recently taken over by Virgin), holding ten or more contracts (Anon 2011).

Thus by 2004, GPs were under the control of contracting firms or practices, not the department of health (Pollock et al. 2005), and commercial health care companies were free to bid for the provision of GP services and, to a more limited extent, hospital services too. The Health and Social Care Bill was to build on these developments by extending commercial arrangements to all clinical care and also to service commissioning. We turn next to these reforms.

Health and social care bill 2011: Repeal of duty to provide a comprehensive public service

The bill, which introduces substantial new freedoms to constituent parts of the health service, requires as its foundation a fundamental shift in government duties; without such a shift the secretary of state will be required to continue current levels of oversight and control (Pollock and Price 2011). The change is engineered by a substantial dilution of the health minister's responsibility for providing a comprehensive health service. Accordingly, the bill's first clause repeals the minister's duty 'to provide or secure the provision' of a comprehensive health service. As we have seen, this statutory duty has underpinned all NHS legislation since the establishing act of 1946.

The House of Commons Health Committee is sceptical that the minister can renounce this fundamental duty. In their most recent report (House of Commons Health Committee

2011b:3), the authors speculate that 'Voters will […] rightly continue to regard the Secretary of State as accountable for the development of the NHS – there can and should be no doubt that ultimate responsibility rests with him'. They go on to urge that the 'Government […] put in place structures which enable the Secretary of State to respond to this political reality'.

However, whatever the political realities, the repeal has enormous strategic significance because it relieves the minister from the necessity of devising the administrative structures and mechanisms to deliver comprehensive care. Instead, the health secretary of state's general powers of direction over NHS bodies and providers are abolished, and the focus of his or her role will shift to public health functions, which become the responsibility of local authorities. In effect, provision ceases to be the direct concern of ministers.

The repeal has other important consequences. Where formerly local administrators of the NHS were under a delegated duty to provide a comprehensive health services, the new 'commissioning consortiums', the board of which will include GPs and may include private sector, are not. Instead they are required only to 'arrange for' the services necessary 'to meet all reasonable requirements' (clause 9). Such a freedom reposes in the consortiums the power to determine the range of health services that will be publicly provided. Moreover, consortiums' only have a duty to arrange for health service provision for their enrolled population, that is, for the patient list of their constituent general practices; they do not have a duty to a geographic population as do PCTs and therefore for the first time in the history of the NHS there is a break with responsibility for geographic populations in coterminous areas and a loss of planning and resource allocation mechanisms at the commissioning level (Pollock and Price 2011).

A complicating factor of the bill is that a series of changes crucial to its effect are being made outside the legislative process. For example, the government has pledged to abolish general practice boundaries, which restrict patients' entitlement about where they can register, in order to 'give every patient a clear right to choose to register with any GP practice they want with an open list, without being restricted by where they live' (Department of Health 2010b:17). This will mean that 'practices can accept patients regardless of where they live, effectively allowing patients to choose their commissioner' (House of Commons Health Committee 2011a) or commissioners to choose their patients. If this happens, practices and consortiums will be able to compete (and advertise) for patients from across the whole country just as private healthcare corporations and health insurers do now.

Some geographic responsibilities are retained. For example, the bill makes consortiums responsible for services such as emergency care with respect to 'persons who have a prescribed connection with the consortium's area' (clause 9) but in general these responsibilities are not defined and services for people who are not enrolled with consortiums are not prescribed.

Freedom to select services and patients is central to these arrangements. Duties with respect to equity are vague and likely to be unenforceable. For example, the health minister has a duty to 'have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service' (clause 3); and consortiums will only be required to 'have regard to the need to reduce inequalities between patients' (clauses 19 and 22). Clearly the government is not inclined to limit inequalities arising from the new structures. This is confirmed by a new policy on health care charging. Since its creation, the principle of services free at the point of use has been central. A power to charge was granted to the health minister in 1952 but only with respect to items expressly allowed for in legislation. Charges were subsequently introduced for dentistry, pharmaceuticals, opticians' services, and even carparking, but primary and hospital health care has

remained free. In 2006 the House of Commons Health Committee highlighted disparities in this system (House of Commons Health Committee 2009). The bill, however, transfers the power to charge from the minister to consortiums: consortiums will determine which services are part of the health service and which are chargeable (clause 9), and they have been given a general power to charge under clause 7 of the Health and Medicines Act 1988.

Along with new mechanisms to introduce charges, caps on privately funded health care offered by foundation trusts are also removed. The effectiveness of this cap has been in doubt for some time. In 2007, foundation trusts circumvented the cap to levy an additional private income of £70–100 million (Gainsbury 2008) However, attempts by Monitor, the regulator, to formalise this avoidance were overruled by the courts and the government has now decided on its outright abolition. A range of options now become available and some have already been tested. For example, in 2005, the NHS authorised co-payments for midwifery when the Queen Charlotte's and Chelsea hospital in London introduced the 'Jentle Programme' guaranteeing one-to-one midwife care for a one-off fee of up to £4,000 (Atkins 2006). Again, in 2008, former health secretary, Alan Johnson, approved top-up fees for certain cancer care drugs following a review published by the so-called 'cancer czar', Professor Mike Richards (Department of Health 2009).

Mechanisms for allocating resources

The Bill also dispenses with the current system for allocating resources to geographic areas on the basis of health care need, an essential element in planning comprehensive care. Currently, funds allocated to PCT are determined by using 'weighted capitation' formulas adjusted for area based population. (Weighted capitation means resources calculated on a per-person basis adjusted with additional adjustments for age and mortality). Allocations so based become impossible when budgets of consortiums are derived from aggregations of general practice patient lists rather than geographical populations (Department of Health 2010a).

The government has been unable to explain what will take the place of weighted capitation as no formula is currently available for allocating resources and the problems of developing one are acknowledged to be formidable, a point stressed by the House of Commons Health Committee: 'The challenge will be to develop a workable methodology which allows the formula to reflect need when patients are free to register with practices, and practices are free to join consortia, which do not reflect geography. This requires a more complex formula than a simple allocation to geographic communities, particularly when each consortium will have a population-based responsibility as well as a responsibility for the care of its practice population' (House of Commons Health Committee 2011b:28). The problem is that there is no geographic foot-print, and therefore no routine data, available for consortium populations. Person-based allocation methods are not currently recommended by the government's own advisors, the Advisory Committee on Resource Allocation, although they will be required under the new system. However, without person-based data, methods of resource allocation to the new consortiums are in danger of becoming increasingly divorced from needs assessment.

To mitigate the risks of adverse selection (risks that some consortiums will attract sicker and more expensive patients) the bill proposes a risk equalisation mechanism in which consortiums can establish a pooled fund to off-set costs in consortiums that have different proportions of high and low risk patients (Department of Health 2010a). However, the absence of individual risk data and robust resource allocation methods is problematic, as are the high transaction costs associated with risk equalisation funds. Commissioning budgets based on

membership resemble European sickness funds, in which members share costs among themselves rather than across the whole society (Mossialos 2002). Sickness funds are associated with unequal risk bearing among pools, risk selection, patient charges, and supplementary insurance. Compensatory risk equalisation mechanisms are inefficient, expensive and increase risk selection because funds avoid high risk patients on financial grounds (Van de Ven 2011; Van de Ven et al. 2003).

Abolition of direct control over NHS provision

Consortiums will become budget holders and determine which primary services they contract, from whom, and at what cost. Patients may therefore be exposed to a plurality of primary care contractors for different services. All general practices will be required to join a commissioning consortium. Various bodies can apply to become a commissioning consortium, including foundation trusts and for-profit organisations that run general practices. The NHS Commissioning Board (a new national body created to oversee the reformed structures) and general practice consortiums will also have powers to form and invest in commercial companies (Schedule 4, part 10). The effect will be to switch from relations in the health service governed by non-legal agreement to relations governed by legally enforceable commercial contracts.

In order to cement and further develop arrangements of this type, the Bill imposes a primary duty on the system's regulators to promote competition and regulate largely through licencing and the contract (rather than via top-down norms). The activities of two principal regulators on the provider side, Monitor and the Quality Care Commission, will be limited by a duty of 'maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them' (Department of Health 2010a:83). Regulators are also prevented from imposing 'unnecessary burdens' and regulation can be dispensed with as more providers enter the market place (House of Commons 2011b).

These changes have substantial implications for the jurisdiction of control over the health service because by increasing commercialism they increasingly expose the system to application of international economic laws such as those of the European Union and the World Trade Organisation (WTO). The health minister has refused to provide the advice given by lawyers to the government and their analysis of the impact of European competition rules (House of Commons Health Committee 2011b); the likely impact of WTO rules has not even been publicly discussed. One difficultly is that complex rules in both jurisdictions determine which policies fall under competition disciplines. Nonetheless, there are serious potential effects. For example, a government decision to exclude commercial providers from hospital provision, as Canada does under the Canada Health Act, or to impose certain access and training standards on the community pharmacy industry, such as happens in many developed country health systems, can under certain circumstances count as trade barriers and therefore be challengeable through WTO courts (Pollock and Price 2000). The rules of the WTO can therefore take trade law into the heart of social and health policy-making.

The end of the NHS?

The latest reform package is the first to include a major modification of governmental duties with respect to the duty to provide comprehensive health care. The proposals promise a commercial system in which the NHS is reduced to the role of government payer, equivalent to Medicare and Medicaid schemes in the US. Strikingly, however, government belief that cost efficiency, improved quality, and greater equity flow from competition in healthcare markets is not supported by the Office of Fair Trading or the government's own impact assessment.

The Office of Fair Trading, the competition authority for the UK, concedes that there is as yet no 'clear evidence on the role of competition in driving performance in' health care (Office of Fair Trading 2010:66). The authors of an equity impact assessment accompanying the bill take the same view:

> There is limited intelligence on the impact of commissioning frameworks on health inequalities or the promotion of equality – most available evidence focuses on the commissioning processes or the cost and quality of commissioned services […] The policy has the potential to reduce barriers and inequalities that currently exist. However, there is not enough evidence to make this assessment with as much confidence as we would like (Impact assessment). (Department of Health 2011a:6, 18)

The proposals have met with such fierce opposition from the public and from within the coalition that in April 2011, extraordinarily, progress of the bill was halted mid legislative process. The government's call for a 'pause for reflections' casts an interesting new light on a set of proposals which many commentators say still lacks a rationale (Delamothe 2011). In explaining the government's position, the health secretary, Andrew Lansley, has declared 'no change is not an option' (Department of Health 2011b) because rising health care costs have to be addressed. Here for the first time was an account implying a link between the reforms and health care financing: one solution to financial pressures, it might be thought, would be to mobilise alternative financing mechanisms such as user chargers and co-insurance, two common characteristics of the sickness fund or US system. Increased inequalities in access such as the bill apparently engineers and which the government is content to see develop would be an ideal incentive for such developments and would mark the end of the NHS model of universal health care in England as the provision of health care is turned over to the market place.

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