

B2 | THE NATIONAL HEALTH SERVICE (NHS): PREY TO NEOLIBERAL LUST FOR MARKETS

For more than sixty years the National Health Service (NHS) of the UK has been the leading model of tax-financed, universal healthcare in Europe. But in 2012, the passage of the Health and Social Care Act (HSCA) (National Archives 2012) dealt a fatal blow by dismantling the constitutional basis of the NHS and paving the way for a market-driven system of healthcare. This chapter describes how the shift from NHS to ‘National Healthcare Market’ was made possible through various failures of democracy and professional leadership and reflects on the implications for the downfall of the NHS.

The NHS as it was conceived

The NHS, established in 1948, grew out of recommendations in the Beveridge Report (Beveridge 1942), which proposed widespread reform to the existing system of social welfare to address ‘Five Giant Evils’ in society: Squalor, Ignorance, Want, Idleness and Disease. As health minister Aneurin Bevan famously remarked to the first ever NHS patient, thirteen-year-old



Image B2.1 Aneurin Bevan, founder of the NHS, speaking to Sylvia Diggory, the first ever patient of the NHS, in 1948 (National Archive, UK)

Sylvia Diggory, the establishment of the NHS was ‘the most civilized step any country had ever taken’. The three core principles of the original NHS were: it would be *universal, comprehensive* and *free at the point of delivery*.

For the first thirty years of its life, the NHS evolved on the basis of rational planning, aimed at redistributing healthcare resources and services across the country on the basis of need. Strong systems of bureaucracy and political accountability included much devolution of decision-making power to regional and district health authorities, facilitating fluid and responsive planning processes. Crucially, all NHS organizations were directly accountable to the Secretary of State for Health through the Department of Health (DoH).

Universal access to health in Britain since 1948 has helped improve the health of the nation: life expectancy has increased by just over ten years for men and by more than eight years for women, while children are five times less likely to die in infancy than they would have been sixty years ago (ONS 2012). Moreover, recent comparisons of health systems in seven industrialized countries rated the NHS very highly on quality of, and access to, care; it was top (above, for example, Australia and the Netherlands) on efficiency (Ingleby 2012). Simply put, publicly funded, publicly owned and publicly provided healthcare worked: it was fair, inclusive and good value for money.

Thatcher and the attack on the NHS

Things began to change in the 1980s when Margaret Thatcher became prime minister, heralding the rapid ascendancy of neoliberal policy in the UK. Thatcher would not permit ‘the nanny state’ to ‘interfere’ in what she regarded as individual decisions about people’s health.

Thatcher’s government began the application of private sector management principles to healthcare. The two most important changes were linked: the NHS became subject to a particular form of *managerialism* that in turn led to marketization and the introduction of a *quasi-market and outsourcing in healthcare* centred around competition and ‘choice’ (Hunter 2008).

The introduction of ‘new public management’ (NPM) models in the 1980s and 1990s as part of an international trend in public administration introduced a new logic and culture into the NHS (Hood 1991). This new perspective resulted in a number of notable changes to the NHS. Among the most controversial was the policy of *outsourcing*, introduced in 1983, whereby health authorities were required to set up competitive tendering arrangements for their cleaning, catering and laundry services (Pollock and Talbot-Smith 2006: 5).

The encroachment of NPM advanced with the NHS and Community Care Act of 1990. Suddenly, NHS hospitals and other bodies such as ambulance and community health services were expected to operate as semi-independent ‘trusts’ – and thus behave like businesses in a marketplace. This introduced – for the first time – the *purchaser–provider split*. Health authorities were expected to act as ‘commissioners’ or ‘purchasers’ of health services, with trusts acting

as the ‘sellers’. The idea was to open up the provider side of the NHS to market forces – the so-called ‘Internal Market’ – as a stepping stone towards a full market system (ibid.: 6). NHS hospitals and other services could no longer rely on an annual block budget, and as a result they no longer had an incentive to give priority to patients’ health. They focused instead on generating their own income, cutting costs and competing with each other for business.

Trusts were no longer given free support for capital planning, estates management and information technology from the DoH. Rather, they were expected to buy these services from private management consultancies. Thus began the slow decline of almost a third of newly formed trusts into financial difficulties, mergers and service closures.

The extension of market logic to health reached its height in 1992 with the inception of the Private Finance Initiative (PFI). Proposed as an alternative way of mobilizing capital for public investments, PFI was touted as the key to the ‘biggest hospital-building programme in the history of the NHS’. The principle is this: the government goes to a consortium of bankers, builders and service operators, which raises the money on the government’s behalf – in return for which they get the contract to not only design and build a hospital, but also to operate the supporting facilities for thirty or more years (Pollock 2005: 27). But there’s a catch. The responsibility for paying back the debt – not to mention the interest and shareholders’ profits – rests not with the DoH, but with the hospital itself. And this money must come out of its annual budget for patient care. Even worse, PFI rapidly turned out to be much more expensive than expected: the private sector cannot borrow as cheaply as governments can, and moreover, there are costs incurred in servicing the new bureaucracies, which are needed to make and monitor all the contracts and subcontracts involved – costs that would not be incurred under normal government procurement.

The now universally condemned PFI hospital programme made extraordinary profits for the PFI consortia involved and reduced many of the NHS trusts involved to near-bankruptcy, leaving them with the obligation to go on paying for thirty years or more for buildings which experts now say are not fit for purpose (Leys and Player 2011: 91).

By 2000, even clinical services were opened up to the market. The eventual model was one of the NHS as a sort of holding company ‘*franchising*’ health services out to various public and private providers. Thus, the NHS was to be the government-funded payer, but less and less the direct provider of health services. This model enables for-profit companies to siphon wealth directly from public coffers supposedly set aside for national healthcare.

The DoH downsized as more and more of its functions were outsourced to the market. This was made possible when the NHS was forced to move to a system of ‘*payment by results*’. Each and every treatment was put up for sale in the private market at a price set by the DoH – the so-called ‘*national tariff*’; as in other sectors, the itemization and reduction of every service to

The original NHS

<p>Public finance general taxation pays for healthcare in a progressive system</p>	<p>Public budgets publicly managed</p>	<p>Public providers acting in public interest</p>
<p>Private finance paid by high-income people</p>	<p>Private insurance and out-of-pocket payments</p>	<p>Private providers acting for private interests</p>

This box represents the whole of the UK health system. The NHS comprises the unshaded portion – publicly financed, publicly provided and centrally planned. Only the small bottom portion (shaded) of the health system was private.



The NHS from the 1980s until 2012

<p>Public finance</p>	<p>Public budgets</p>	<p>Public providers increasingly acting as market-based actors with self-interest in 'internal markets'</p>	<p>→ Enactment of the HSCA</p>
		<p>Private providers able to take over more activities in the internal market</p>	
<p>Private finance</p>	<p>Private insurance</p>		

The box is slightly bigger, reflecting increase in health system spending in the 1990s and 2000s

B2.1 Progress of the NHS to a National Healthcare Market

The national healthcare market

<p>Public finance decreasing in significance</p>	<p>Mixed insurance system a residual public budget for health protection alongside an increasing proportion of private and public insurance and co-payments, operated entirely by insurance companies</p>	<p>Mixed provider market in which the majority private providers and remaining public providers compete for contracts on an equal footing</p>
<p>Private finance further increases in the form of co-payments or top-ups on personal budgets, affecting even low-income families</p>		

The overall size of the box has increased because health expenditure is expected to increase from 8.7% of GDP and approach US level of 16% of GDP. The public sector is now almost entirely privatized.

↑
Relentless commercialization in the future

The NHS in 2012 following the HSCA

<p>Public finance decreased in an era of austerity but further shrunk by diversion to local authority budgets used for other public services</p>	<p>Public budgets though held by statutory Clinical Commissioning Groups (CCGs), managed by Commissioning Support Units (CSUs), which are soon to be privatized</p>	<p>Public providers still the majority of provision, but Foundation Trust operating entirely in self-interest in a market</p>
<p>Private finance increases in the form of co-payments within and outside the NHS</p>	<p>Private budgets increase as insurance companies expand services</p>	<p>Private providers able to take over more services under 'Any Qualified Provider' (AQP)</p>

Though the size of the box remains the same, the amount of private ownership and provision is gradually increasing

Box B2.1 Implications of a market in health

1. *Reduced accountability* The HSCA controversially severs the duty of the Secretary of State for Health to secure comprehensive healthcare throughout England. Substantial powers will instead be extended to commissioners and providers of care. Public and private providers now compete with each other for customers, while legal contracts and commercial law have replaced direct political accountability for the health of the nation (Pollock and Price 2011).

2. *Fragmentation* The NHS is no longer a comprehensive and universal system. Instead it will be a reduced component within a larger system of a growing number of private providers, private management consultancies and private insurance companies.

3. *Increased costs* Competitive markets necessitate extra bureaucracy for individualized tracking of costs and compliance with competition legislation, pushing up costs. In addition, the service funding arrangements planned will almost certainly increase expense without improving outcomes. The new 'Any Qualified Provider' (AQP) system pays hospitals for what they do and allows them to keep any profits they make, incentivizing over treatment by for-profit hospitals. In the US system, which most closely approximates the model we are moving towards, up to 37 per cent of all healthcare expenditure goes on unnecessary treatment (Berwick and Hackbarth 2012).

4. *Regressive financing* Public financing for the NHS will not increase in an era of austerity. More and more private money will be necessary, much of this coming from individual users through co-payments and insurance, both within the NHS and with private corporations.

5. *Decreased efficiency* There is no evidence that the private sector is more efficient than the NHS; in fact competition between NHS providers has been shown to drive down productivity (Charlesworth and Jones 2013). The impact of efficiency gains differs between public and private sectors. Publicly provided health services exist only to provide healthcare, while the overriding goal of profit-making corporations is to generate profit. Efficiency gains in public services have the effect of increasing the value for money of the services they provide in exchange for the public funds they receive. In contrast, efforts to increase efficiency in the private sector are aimed at maximizing profit made for the money invested, i.e. maximizing the gap between what they receive for their healthcare efforts and what they spend on them.

6. *Decreased quality* Since the government demands higher productivity for the same budget, all this extra spending on unnecessary administration

and profits can only come at the expense of the amount and quality of care provided. The most vulnerable groups in society will bear the worst effects of this, including the chronically ill, the elderly and young children. Furthermore, market reform will leave many patients exposed to the conflict of interest between the profit motives of medical service companies and the professional medical ethics of their staff (Caleb Alexander et al. 2006). Because most patients lack the technical understanding to judge medical quality, strict regulation is needed to ensure that only care of high medical quality can lead to high profits – but the government explicitly favours ‘light touch’ regulation.

7. *Decreased professional control* Through their involvement in Clinical Commissioning Groups (CCGs), GPs have acquired new financial and legal responsibilities for balancing budgets and deciding whose care can be paid for and whose cannot. However, the result has been *less* professional autonomy, not more. Rather than being able to help patients navigate through the system and arrange optimal care, GPs won’t be allowed to advise patients on which provider to choose because it would ‘distort’ competition.

8. *Increased inequity* The sums for a comprehensive free-of-charge NHS don’t add up for a marketized system, despite the much-heard phrase ‘NHS care will continue to be free at the point of use’ (Reynolds and McKee 2012). An increasing proportion of care will no longer be available on the NHS, and such care may then not be free of charge. This has already happened to chiropody and physiotherapy. There are now structures that permit the introduction of charging for services that were previously free under the NHS; the rollout of transferable ‘*personal health budgets*’ in 2013 heralded the start of a transition to a contributory system for some types of care.

9. *Weaker public health* By devolving powers to disparate bodies the HSCA spelled the end of a coherent public health system in the UK. Public Health England (PHE) has now appropriated control over health protection issues such as environmental hazards and infectious outbreak control. However, as effective employees of the civil service, public health workers in PHE are under direct political control – essentially neutralizing their independence and ability to speak out in the public interest, especially on behalf of ordinary citizens and marginalized groups, and often against powerful or vested interests (Kmietowicz 2011). Marketizing the health system and dismantling of the geography-based architecture of the NHS weakens the ability of public health to: improve the uptake of screening and immunization programmes; coordinate multiple agencies for preventing and responding rapidly to public health emergencies; and conduct both population- and systems-based health surveillance and monitoring.

a cost figure allows private providers a way into the system. And since some treatments are more profitable than others, providers naturally want to do more of the former and fewer of the latter (Pollock and Talbot-Smith 2006: 9). The inevitable result: services for patients who need the less profitable services, such as chiropody and physiotherapy, have become unavailable.

The Health and Social Care Act (HSCA) and the new ‘National Healthcare Market’

As the latest key system change to the NHS, the HSCA goes even farther to promote neoliberal ideas such as competitive markets and mixed funding. From a *national health service* – publicly funded, publicly delivered and publicly accountable – the UK is steadily moving towards an increasingly privately provided ‘*National Healthcare Market*’ (see Figure B2.1). This is not just a question of whether health is in public or private hands. The marketization of health has much more fundamental implications (see Box B2.1).

The failure of democracy to save the NHS

The loss of the NHS signals a profound failure of democracy. The current government made no declaration that they would be dismantling the NHS; the British public was never asked to vote on reforming a healthcare system they were satisfied with and that was performing well. In place of the promise that there would be ‘no more top-down reorganizations of the NHS’, the government delivered the biggest restructuring of the NHS in its history. In short, they lied.

Thus the HSCA came into force on 1 April 2013 – with no democratic mandate and massive public opposition. How was this possible? Public interest and common sense were defeated by neoliberal ideology because of the combined failure of Britain’s politicians, media, medical establishment, trade unions and even the public – the erstwhile defenders of healthcare – to resist.

The politicians Though initiated by Thatcher, the privatization of the NHS was always part of a broader move from a welfare state to a market state (Bobbitt 2003) – a process that continues today. The reforms would not have been passed without persistent, behind-the-scenes lobbying and fixing by a network of insiders. The permeation of NHS management by ex-McKinsey and ex-KPMG personnel reflects this proclivity (Leys and Player 2011). The DoH now has a fast-revolving door to business, and neoliberal ideologues hold prominent positions in government, including the current head of the NHS, Simon Stevens, the former president of the multinational United Health group. Even worse, many of the politicians who voted the HSCA through stood to gain financially from it.

The government misrepresented the HSCA, using feel-good labels like ‘GP-led’, ‘diversity’ and ‘choice’. The DoH relentlessly drip-fed press releases



Image B2.2 Student nurses demonstrate against NHS reforms in 2011 (Guddi Singh)

calling into question whether the NHS was ‘sustainable’ or ‘affordable’. The public was repeatedly told that the public sector is bad at management; only the private sector is efficient and could manage services well.

The media The British Broadcasting Corporation (BBC) – the national public broadcaster – and other mainstream news outlets carried the government spin uncritically (Huitson 2013). They constantly referred to the reforms as ‘handing power to GPs’. Moreover, the BBC never questioned the government’s mistaken definition of privatization. The media fanned the flames by amplifying bogus research intended to promote the benefits of competition in healthcare. The government co-opted the media, using it to shake the public’s faith in its favourite institution.

The medical establishment Worse still was the role of the leaders of the medical profession. The very people who should have been its defenders ended up betraying the NHS. In the run-up to the passing of the HSCA, surveys showed that doctors did not back the reforms, despite government claims that they did (Kmietowicz 2011). Silence, a lack of leadership and the absence of a timely opposition to the reforms by the medical establishment, however, meant that this opinion was never effectively projected.

Why would the nation’s medical vanguard give up on health?

IGNORANCE Public health and the importance of socialized medicine are

not paramount in medical curriculums, so medical students are susceptible to the claim that the NHS is inefficient and unwieldy and that healthcare should be privatized. A misleading media made the NHS look increasingly incompetent – even to its own workers – justifying dismantling it from the inside out (Singh 2013).

FEAR Bullying and scare tactics were employed to silence voices of discontent. With jobs on the line, it became especially difficult for individuals to speak out against the reforms. Doctors and nurses concerned about the impact of marketization on their patients were suspended, even dismissed or forced to accept gagging clauses. Money bought their silence. When individuals did speak up they received little or no organizational support.

Clare Gerada, then chair of the Royal College of General Practitioners (RCGP), was a prominent voice of dissent. Patronized and dismissed, Gerada was on the receiving end of misogynistic rhetoric from both ministers and the predominantly male medical establishment for her critique.

The British Medical Association (BMA) – Britain’s foremost doctors’ trade union with 150,000 members – claims to be the ‘voice for doctors and medical students throughout the UK’. Yet when it came to the reforms it failed spectacularly: neither rising to the challenge of representing its members’ wishes nor standing up for the healthcare system it belongs to. It was a full five months after the reforms became public that the BMA finally came out in opposition to the healthcare reform bill – and not once did it mention that it was against privatization.

GREED Politicians stymied much of the political resistance to the NHS reforms by co-opting a layer of the medical profession to give a veneer of clinical leadership to the marketization of health. In exchange for positions of power or entrepreneurial opportunities, notable doctors – some of whom were leaders of medical bodies such as the BMA or Royal Colleges – sold out. Rather than opposing the reforms, these figures, such as chair of the BMA Hamish Meldrum, pushed for ‘critical engagement’ with the government (Davis and Wrigley 2013). Drawn into a process that was designed to shape rather than stall, the medical establishment became distracted by concerns about *how* the reforms should be implemented and not *whether* they should be. Such involvement, time and again, lent legitimacy to an otherwise undemocratic process.

Just as the birth of the NHS required cooperation from the doctors, so too were they necessary accomplices in its murder.

The trade unions Rather than looking at the big picture and rising to the NHS’s defence, the trade unions focused merely on aspects of pay and conditions. Their impotence raises questions about how the unions have become

increasingly inward looking, sectoral and neutered – and suggests that market ideology has reached deep into the labour movement.

The public Misinformed and duped by their politicians and media, the public came to know about NHS privatization only too late. Even then, it is clear that a generation of diminishing political participation (Morgan and Connelly 2001) makes mobilization around issues such as health and social welfare increasingly difficult.

But the fight for democracy goes on. Corporate interests continue to be maintained by several pieces of legislation which are either currently being debated or were recently passed, reflecting further incursions on democracy. Greater protections for commercial secrecy, a clamp-down on protest and limits to civil society campaigning are all in the offing. And it is no surprise that private providers of care are subject to a less rigorous ‘regulatory burden’ than public ones, when Monitor, the lead regulator of the NHS, is run by ex-McKinsey and ex-KPMG management consultants and heavily lobbied by those same companies.

Finally, and most worrying, is the irreversible nature of the changes. International trade laws, such as the controversial Transatlantic Trade and Investment Partnership (TTIP) (see Chapter E6), would essentially lock the health system into a competitive market arrangement (Hilary 2014). If it goes ahead, it could see multinational health giants – already poised to snap up billions of pounds’ worth of NHS contracts – file complaints directly to international tribunals should they perceive threats to their interests from government regulation, completely bypassing national courts. A future government would not be able to reverse the changes through new legislation without incurring the risk of trade sanctions and legal challenges, or having to pay out huge amounts of compensation.

The moral of the story of the NHS

What will the downfall of the NHS mean, both nationally and globally?

Since 2012 alone, widespread hospital closures have been leading to increasing mortality rates and delayed care, while thousands of nursing jobs continue to be lost. Given also the ‘unnecessary and unjust premature deaths of many British citizens caused by Thatcher’s policies in the 1980s’ (Scott-Samuel 2014), it is clear that the ‘National Healthcare Market’ harms patients, populations and professionals alike.

PFI illustrates how the increased financial costs of using private enterprise are linked to the human cost. PFI is projected to cost the UK taxpayer £300 billion (Campbell et al. 2012) by the time projects have been paid off over the coming decades – largely paid for by major cuts in clinical budgets and the largest service closure programme in the NHS’s history. At the height of the financial crisis in 2008, PFI cost the taxpayer an additional £1.6 billion

alone. What could this have paid for? Over 185,000 hip replacements, the salary for 78,000 more nurses or 5.2 million ambulance calls. Left with no alternative but to pare away services, hospitals sacrifice patient care in the interests of paying their creditors.

What has happened to the NHS is not unique: it is a story playing out across the world, where universal healthcare systems are being dismantled and privatized with disturbing rapidity and regularity. The global corporate takeover of health continues apace, guided and backed by the World Bank, the International Monetary Fund and the World Trade Organization – even the WHO is complicit. Just as we saw in the UK, catchphrases such as ‘public–private partnerships’, ‘modernization’ and ‘local ownership’ are being bandied around – all while the much-hailed ‘*Universal Health Coverage*’ takes a prominent place on the global health agenda. Universal health *coverage* is not the same as universal health *care*. We cannot allow it to become a convenient smokescreen for privatization (Sengupta 2013).

Already the same neoliberal methods at work in the NHS have been exported from the UK to new playing fields. Take the introduction of PFI to Lesotho, for example, where a massive 100 per cent increase in costs at the Queen Mamohato Memorial Hospital in Maseru will likely have the same disastrous effects on healthcare as it has in the UK.

The challenge for health professionals

Citizens’ rights in democracies are underpinned not just by limitations on government powers but also by legal duties imposed on governments – such as those that guarantee citizens’ access to healthcare. The HSCA and the loss of the NHS after a long process of privatization withdrew this legal underpinning.

Politics and health are inextricably linked. In the face of increasingly undemocratic governance, health professionals, alongside civil society, need to be prepared to confront power. In the UK, the aim now is to turn growing public dissatisfaction in the new ‘National Healthcare Market’ against the establishment, with the NHS acting as a political pressure point in the run-up to the 2015 general election.

In the meantime, it is the duty of doctors, scientists and academics to collate evidence of how political decisions affect people’s lives. As the government privatizes healthcare, it is crucial to have complete and high-quality data to monitor the impact of these policies. This watchdog function is vital if we are to hold the marketizers of health to account for their decisions.

History is replete with examples of the failure of the professions to challenge or resist egregious policies to the detriment of all concerned. The scale of the threat to the NHS – coupled with the government’s lack of a democratic mandate to end the NHS and its propensity to misinform the public – suggests that we are in a situation where professional dissent is not just appropriate, but urgently required.

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