Britain/Health service

An update on the British government's piecemeal privatisation of healthcare

Wednesday 6 July 2011, by LISTER John (Date first published: 8 May 2011).

This article is based on one of the reports at the European healthworkers conference, held in the International Institute for Research and Education in May 2011. The European conference for the defence of a public health service and Statement from the European Conference for the defence of a public health service have also been posted on ESSF.

The situation in England's health care system reflects the broader picture on the European and a world scale. Healthcare is the world's biggest industry with a turnover in excess of $5 trillion annually, 85% of which is spent in the wealthiest countries, in most of which the majority of spending takes place through tax funded systems all through social health insurance. The private sector, looking to rebuild its profit margins, is determined to recapture a larger share of this health budget, especially in Europe.

But because of the political obstacles to most European governments being seen to break up and privatise healthcare systems, which currently deliver near- universal care – in general with few copayments or charges at point of use – the privatisation process has been of a special kind.

This is very different from the process of privatisation in the UK and in other countries in the 1980s, in which whole utilities such as gas and telecoms and electricity were sold off to shareholders and became private for-profit businesses.

There are three reasons for this: the first is the political sensitivity of the issue for parties, which in general are trying to appear different from the old style Thatcherite neoliberal parties of the 1980s: and in a political climate in which there is little sympathy for the private sector and privatisation.

The second rason is that the private sector itself has limited interest in taking over the whole of healthcare systems: their focus is primarily on cherry picking those parts of the system which appeared to offer them a profit, primarily uncomplicated elective surgery – the mainstay of private medicine around the world. Certainly in England there has been very little pretence from private sector companies of any interest in taking over for example work on accident and emergency services, complex and risky surgery, or chronic care for older people and community services of any type.

And finally there is the issue of resources in the private sector: healthcare systems are far larger than the utilities of the 1980s, while the private health care sector is centred on small-scale hospitals and providing services to an elite wealthy minority of the population: it therefore has nowhere near the management or capital resources required to contemplate a takeover of the entire health

systems.

In England the process of slicing off particular sections of health care for privatisation began in the mid-1980s with Margaret Thatcher’s government deciding to put non-clinical hospital services such as cleaning, catering, porters and other services out to competitive tender. The result of this was to stimulate the emergence of a new range of small-scale and untested private companies, and in the context of labour intensive and generally low paid work, these companies attempted both to undercut existing costs to win contracts and at the same time make a profit focused on employing fewer staff, working harder, and offering them worse pay and conditions.

This in turn brought the virtual casualisation of hospital cleaning in much of the UK, but also undermined staffing levels and standards of cleaning and hygiene, even in those hospitals where services remained in-house, since public sector managers were obliged to compete with the low standards and low wages of the private sector.

A generation later the legacy of this privatisation is still haunting the National Health Service in much of the UK, and especially in England, where fewest services have been brought back in-house in recent years. Hospital-borne infections, poor standards poor morale and gaps in staffing levels continue to create problems and often to dump work which should be done by private companies onto nursing and other staff who have other responsibilities as well.

The privatisation process in support services was linked in the UK with a massive squeeze on public sector spending on health care in the mid-1980s, with three successive years of cuts in real terms spending. This drove up waiting lists and waiting times, and was intended by the Thatcher government to press more people into paying for private health insurance. Despite this pressure private health insurance covers only a small minority – fewer than one in eight – of the population in the UK, and far less than this in Scotland Wales and Northern Ireland.

In 1989 Thatcher’s government published a White Paper entitled ‘Working for Patients’ which set the agenda of establishing an internal market, to create competition between NHS providers for NHS contract income. This market brought with it a split between the “purchasers” and “providers” of health services, and a split between “fund-holding” GPs who were given additional resources and freed up to “shop around” for the best deal for their patients, and other GPs, whose patients were dependent on contracts negotiated in bulk by local health authorities.

This split in turn brought a very large increase in bureaucratic costs and administration, diverting resources away from front-line patient care, But it also re-created the idea that health care was some form of financial transaction rather than a public service. It was the first step to re-commodifying health care which had been taken out of the market system in the massive reforms which established the National Health Service in 1948.

The 1989 White Paper also run alongside the privatisation of a growing share of continuing care services provided by social services through local government. The reason for this expansion in local government involvement was that while services provided by the NHS have since 1948 been tax funded, and free to all at point of use, social services, run by local councils have always been subject to means tested charges payable by the user at point of use.

This privatisation opened the door to the closure of tens of thousands of specialist publicly provided elderly care beds in NHS hospitals, but also the closure of tens of thousands of places in local authority residential care homes, as councils were compelled to spend upwards of 70% of the money they received to finance continuing care in the private sector. The private nursing home sector, in which the larger chains run by for-profit companies, began a rapid expansion, fuelled by contracts

with local councils and funded with public money and individual charges levied on patients. These changes took place from 1993, after a general election had been held. In the first year the Financial Times estimated that upwards of 40,000 people in England had been obliged to sell their homes to pay for care under this new system.

In 1997 Tony Blair won his famous electoral victory over the Conservatives, promising to “save the NHS,” and to “sweep away the costly and bureaucratic internal market” in health. But while there was some restructuring and the abolition of GP fundholders, new Labour retained the purchaser provider split, and therefore retained the foundations of a new, even more competitive market in health care – in which NHS hospitals would effectively be forced into a one-sided competition with private sector providers, something the Thatcher government never attempted.

In 2000, after three years of maintaining Conservative spending cuts, Tony Blair’s government unveiled a new NHS Plan, under which spending would be substantially increased year after year for 10 years, but a growing share of this money would be spent on private providers.

The government had already begun signing deals for the building of hospitals funded through the Private Finance Initiative, an extremely expensive way to pay for new buildings, and pay back the money with interest and profits guaranteed to the private sector for 25, 30 or more years to come. [1] Already in 2011 we can now see some of the first wave of PFI hospitals in England that have paid 2 to 3 times the capital cost of their new buildings, but still face another 20 or so years of payments, while the costs of the so-called “unitary charge” of the PFI contract mean that they are forced into making cuts, closing beds and wards and sacking staff. In total up to now something like £11 billion of new hospitals has been built or signed contracts under PFI, with a net cost to the NHS of £64 billion over the next years up to 2045.

2000 also saw the first ‘Concordat’ signed by Health Secretary Alan Milburn with the private hospitals: under this arrangement NHS trusts locally would pay for the treatment of NHS patients in private hospitals, allegedly to help relieve waiting lists during times of extra pressure (such as winter). However the catch was that the costs of these minor elective treatments were far higher than the cost of treatment in the NHS; in many cases as much as 40% higher.

In 2003 legislation was pushed through by the Labour government to create a new type of autonomous hospital organisations, to be known as as NHS “Foundation Trusts”: these were to stand outside the management and accountability structures of the NHS.

Local MPs can no longer ask questions in Parliament about issues relating to the local hospitals where they have become foundations. Foundations – the best-resourced and top-performing hospitals – gained the freedom to retain any surpluses they may generate from their work, irrespective of the financial problems that may be faced by other health providers and services in their local area. This controversial policy scraped through the House of Commons with a majority of just 17 votes. One of the concessions by the government that helped secure sufficient votes in Parliament was the imposition of strict limits on the amount of income that the foundations would be allowed to generate from private medicine and the treatment of private patients.

Significantly in 2011 one of the controversial points of the “reforms” now being proposed by the Conservative-led government in England is to remove that limit on the amount that Foundations can make from private medicine, effectively encouraging the elite foundation trusts in London and other big cities to focus not on caring for publicly funded NHS patients, but on attracting wealthy paying customers from around the UK and around the world.

Also central to the NHS plan was the use of for-profit private hospital chains from outside the

country to set up new “ independent sector treatment centres” (ISTCs) which would provide uncomplicated elective surgery, almost exclusively on a daycare basis. These contracts required stimulus payments from the government upfront to encourage these companies to get involved and to invest in facilities in England.

They also involved payment of premium rates, admitted by ministers to average 11% above the standard NHS payment, for all operations carried out by ISTCs, despite the fact that all of the most serious and complicated cases remained in the NHS, and only the most minor cases were treated by the private sector. These contracts, which were centrally negotiated by Department of Health bureaucrats, were also remarkable in that they guaranteed payment for a fixed number of patients in advance, and that payment was irrespective of the numbers of patients who could be persuaded to accept treatment in ISTCs rather than use their existing local NHS hospitals.

In many cases it proved difficult to persuade sufficient patients to use these new services, and as a result many thousands of operations – costing tens of millions of pounds – were paid for under these contracts which never took place.

However in the second wave of ISTC contracts, the claim that they were “additional capacity” to deal with waiting times was effectively dropped, and ministers began to argue openly that they were there to create what was called “contestability” [i.e. competition] among NHS providers, and some ministers even argued that they wanted to destabilise NHS providers in order to spur them into improving services.

However the competition was extremely one-sided, since the contracts for ISTCs were not open to any NHS providers, leaving competition between various private sector providers who could secure the guaranteed profits over a five-year contract period.

In other words these arrangements ensured that money was taken from existing NHS providers and used to subsidise the emergence of a new private sector, for which there was no organic market, and no other basis for its existence other than government sponsorship.

Time and again when critics accused the New Labour government of piecemeal privatisation of services by bringing in private providers, the response from ministers was to argue that there was no privatisation since NHS services remained “free at point of use”. Interestingly exactly the same argument is now being used by the Conservative led coalition in 2011 to defend their policies of even more sweeping privatisation of health care provision.

In 2005 a further step was taken to breaking up the structure of the NHS with a directive from the chief executive of the NHS which was entitled “Commissioning a Patient-led NHS”. The key word here is “commissioning”: the entire proposal centred around a new competitive market, and in particular breaking away community services from their organisational link within local healthcare body in the primary care trusts, and opening up these services to competitive tender and possible take-over by non-profit “social enterprises”.

Social enterprises it should be stressed are outside of the NHS, so this was effectively the threat that the community health services workforce of up to 250,000 in England, and the community health services budget of up to £10 billion a year could be put up for tender and effectively privatised.

These proposals would hugely controversial in 2005 and triggered a political row and a temporary retreat by the ministers. In 2006 the focus was more on a round of spending cuts being forced through by local health management to balance the books of many local services up and down England: in many cases threatened hospital closures were successfully beaten back by vocal

campaigns in some very unlikely areas of “middle England”.

But ministers had not given up on their objective of restructuring the NHS and bringing in ever more private providers to be paid out of NHS funds. In 2009 and another attempt was made to open up in particular community services to what was said to be “any willing provider”, whether this be a non-profit social enterprise or a for-profit multinational company.

At the same time local GP contracts were being put out to tender to private companies, and dozens of GP contracts even now are in the hands of multinationals and middle sized companies.

It also became clear that the private sector had been expanding behind-the-scenes in the provision of mental health beds, filling a gap in NHS provision at much higher cost: by 2009 private sector mental health beds were costing the NHS in excess of £800 million a year.

The attempt to bring private providers into community health services, an area of health care that the private sector had previously shown little interest in taking over, was coupled with the establishment of a new “Cooperation and Competition Panel”, which was to act as a complaints body to which aggrieved private sector providers could appeal if they felt they had unreasonably been excluded from bidding for work in a particular area.

Behind the scenes, pressure was also applied very strongly in the other direction by the large health unions, affiliated to the Labour Party, which made clear that this was one policy they were not prepared to go along with, and that a failure to show preference to the NHS would undermine the link with the unions.

Towards the end of 2009 the Health Secretary, Andy Burnham, announced a retreat from the policy of “any willing provider” and instructed local commissioners of services that unless there were overwhelming reasons to the contrary the NHS (public sector) should be the “preferred provider” of services. Private sector bosses were furious.

Early in 2010 the Competition Panel was approached by the body representing voluntary sector organisations, who joined with other private sector providers to complain that some services in the East of England were being preferentially given to NHS providers rather than to “any willing provider”. They demanded that Andy Burnham’s policy be abandoned. Surprisingly Gordon Brown sided with Burnham, and the policy remained intact until the general election of May 2010.

The new Conservative led coalition government in July last year unveiled a new White Paper which centred on breaking up the NHS and replacing it with a fund of taxpayers money purchasing services from a range of largely privatised providers.

The very first clause in the Bill flowing from the White Paper abolishes the duty of the Secretary of State to ensure access to comprehensive and universal health care free at point of use. Instead of the direct accountability to Parliament embodied in this duty, instead all commissioning will be overseen by a new NHS Commissioning Board, a bureaucratic body with no public accountability.

All of the existing local and regional management structures of the NHS are to be abolished if the Bill is carried: currently the NHS in England is run by 150 Primary Care Trusts (PCTs) which hold £80 billion in commissioning budgets to purchase care for their local population, and the PCTs in turn are overseen by 10 Strategic Health Authorities would also take responsibility for the training and education of medical and nursing staff. These bodies are to be scrapped.

Instead the Bill proposes that £80 billion of commissioning budgets are to be devolved to local consortia of GPs, which will decide how best to spend the money. The Bill lays down no specific

requirements in terms of the size of population to be covered by a consortium, the organisational structure of a consortium, or for any public or non-GP involvement. The Bill specifically excludes hospital doctors however senior, and nursing staff and other health professionals from any specific role in this new management structure.

GPs have a poor track record over the years in managing budgets, and in achieving the benefits for patients which the Conservatives seem certain will arise from these changes. In the period of GP fundholding in the 1990s many GPs did precisely a hold on to funds – to the tune of millions of pounds – while local hospitals, mental health, and other services faced major financial problems.

More recently experiments in "practice-based commissioning" have also shown that almost all GP practices have struggled to remain within cash limits or have simply overspent, even in those experimental areas which are held up as examples of success.

It's also clear that GPs are not trained as managers, and in only a few cases have they got the time, will, or energy to effectively carry out the commissioning role themselves. Instead they will almost certainly delegate this role to new teams of managers they will employ, or contract it out to private management consultants, some of which are already getting ready for lucrative contracts managing commissioning budgets on behalf of GPs.

Another important component of the proposals in the White Paper and the Bill is that all clinical services – not just community services as under Labour, and not just elective hospital treatment as in ISTCs – should be opened up to "any willing provider", whether non-profit or for-profit. The register of willing providers is to be kept NOT by local GPs and consortia, but nationally by Monitor, currently the regulator of foundation trusts, which is to take on the role of financial regulator of the whole NHS. It will have a specific brief to maximise competition, and therefore to place the fewest possible barriers in the way of new entrants to the provider market.

All those NHS hospitals which are not currently foundation trusts, mainly as a result of financial problems, are required by the Bill to become foundations by 2014, or be broken up or taken over by foundation trusts.

Health Secretary Andrew Lansley has made clear his personal ambition to go further and ensure that all foundation trusts are removed from the NHS balance sheet as soon as possible – and become social enterprises.

This would mean that the staff working in foundation trusts, almost all of whom currently are NHS employees, would lose their NHS terms and conditions, pay scales, access to training, pensions and other rights.

The NHS workforce of around 1 million in England will be effectively reduced to a mere handful. Healthcare provision would not be carried out by NHS bodies, but by foundation trusts, other social enterprises, or by for-profit companies.

It's important to recognise that these changes take place in the context of an estimated £20 billion of "efficiency savings" to be made by 2014: this was in the opening paragraph of Andrew Lansley's White Paper last July and is already driving a rapid process of cuts and closures and job losses across the country.

This makes it even less plausible that handing £80 billion in commissioning budgets to GPs could result in anything other than the GP consortia acting as than rationing boards, deciding which services to cut or to withhold from local patients in order to balance the books. Monitor has recently warned that the cuts might actually have to be even bigger, and that the real target for efficiency

savings could be as high as £30 billion by 2014.

This is why the Bill has become more and more contentious as the background and the content of the Bill have become clearer to those who were initially confused by the deceptive rhetoric, or by the complexity of the Bill (the Bill itself is 360 pages long: much bigger than the legislation which set up the NHS in 1948, and bigger than any piece of legislation on health care since).

At its spring conference the Liberal Democrat party, which has supported the bill at each stage through the House of Commons suddenly discovered fundamental flaws and demanded a series of far-reaching amendments be made.

The party leader Nick Clegg, having suffered a bruising defeat for his party in the local elections on May 5, has subsequently also toughened his rhetoric on this, making NHS policy an area in which to demonstrate the independence and robustness of the Liberal Democrats as a force within the coalition.

All this can be taken with a pinch of salt, but it runs alongside growing unease throughout all of the professional bodies related to health care, notably the Royal College of General Practitioners, the British Medical Association, many high profile think tanks, including many on the right, along with Parliamentary committees, the trade unions, and the wider public.

It appears very much that under pressure David Cameron may abandon his Health Secretary rather than face the prospect of major political damage to the more respectable Tory image he has laboured to create.

This crisis the government sadly comes not as a result of trade union pressure or activity, or as a result of the main Labour opposition: but it does reflect the political difficulties that right wing establishment parties face in Europe as they seek to undermine comprehensive and universal services and to find ways to break up popular public provision in order to allow the inroads of private profit.

The task for campaigners is to maintain the pressure until the Bill is completely abandoned, and to continue the pressure against the cuts, which are inflicting major damage on health services and in many areas leading to a growing list of treatments no longer being available on the NHS.

Organisations such as Keep Our NHS Public will continue to play an important role in maintaining and developing the ideological fight against those that argue it matters not at all where the services are provided publicly or privately.

John Lister

May 2011

Health Emergency

P.S.

* From International Viewpoint.

Footnotes

[1] 1. Thus the trust covering all the nospitals in north-west London is now financed at one-third by in the framework of the PFI. In November 2003 the NHS signed a contract with Bouygues to build an ultra-modern establishment at Central Middlesex, the first of a series of 29 hospitals to be entirely privately financed.