Britain: White Paper heralds dismantling of National Health Service

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7 June 2002

Britain is leading the way in the privatisation of healthcare in Europe. With promises of extra cash and under the guise of a "devolved health service, offering wider choice and greater diversity", the Labour government plans to dismantle the National Health Service (NHS) and turn the provision of healthcare over to private health care corporations.

Its plans are nothing short of a looting operation that will enrich a few at the expense of the vast majority of people, who will face pain, suffering and even death from lack of treatment.

All the attention has focused on the Chancellor's announcement in his budget speech last April of an extra £42 billion in funding for the NHS over six years. He proudly claimed that it would take Britain's spending on health as a percentage of GDP up to the European average by 2008. But even then, Britain will still be well below Germany and France. It comes after years of under-funding, estimated in the recently published Wanless report to be £267 billion between 1972 and 1998 when compared to the European average—an average that includes the poorer Mediterranean countries.

It is not even sure that the extra funding is enough to maintain the present inadequate level of healthcare. Most of it is not new, but made up of a number of initiatives that had already been announced and includes both capital and annual revenue expenditure.

The sting in the tail is a new set of targets for the NHS to achieve. Any under achievement will lead to financial penalties, further exacerbating financial problems and paving the way for "failing" providers to be taken over by the private sector.

Most of the NHS's budget goes on acute and specialist hospitals. These have been struggling with massive deficits for years and now have an accumulated deficit of £1.5 billion. Under-resourced for decades, they have a £3.2 billion backlog of maintenance and repairs.

There has also been a huge rise in the drugs bill, as the pharmaceutical companies have profiteered at public expense. Staff costs have risen, in part because of European Union regulations limiting the excessive number of hours that junior hospital doctors work, and in part because of the albeit paltry 3.6 percent increase in nurses' pay. For decades, the NHS has run on the back of one of the most exploited workforces in the country. Fed up with their pay and conditions, nurses have left the NHS in droves. The NHS has been forced to recruit staff from private nursing agencies at an exorbitant cost and bring in nurses from developing countries.

Staff shortages and an increased workload has led to medical errors and a mounting tide of compensation claims. Finally, the debt structure imposed on hospitals, whereby they are required to pay for the cost of past capital, has plunged them into the red.

Many Health Authorities have produced budgets that show that they can either meet the increased costs and sort out their deficits, or satisfy the government's new health initiatives to cut the time patients wait for hospital treatment and operations. The government has stipulated that waiting times for operations must fall from a current maximum of 15 months (in reality these can be very much longer since it can take that long just to get an out-patient appointment) to six months by 2005 and three months by 2008. The government has instructed Health Authorities that at least £40 million of the £50 million earmarked for waiting list initiatives has to be spent in the private sector.

The Health Authorities say that there is simply not enough money to do all that is being demanded of them. The government admits that most of the new money will not go on base line services It will be used to train new health professionals—although the government does not say where the capacity to train more doctors will come from. By 2008, there will have to be more than 15,000 GPs and consultants, 30,000 therapists and scientists, and 35,000 more nurses, midwives and health visitors.

The extra staff will add millions to the pay bill, while *Agenda for Change*, the restructuring of NHS pay scales due to be introduced next year, could cost an additional £3 billion over five years, according to the Royal College of Nursing.

The money will also go towards investment in capital infrastructure projects and new information technology, already announced under the government's Private Finance Initiative. In other words, much of the new spend is capital expenditure, not an annual cash injection, that will itself cost more to service.

According to Secretary of State for Health, Alan Milburn's White Paper, *Delivering the NHS Plan*, published last April, the NHS nominally remains publicly funded out of taxation. But the government plans to "reform the supply side" by opening up the publicly funded NHS to the private sector. The NHS will no longer be the sole or even the main provider.

The *plan* sets in place the structures and mechanisms—a "new national architecture"—that will privatise the *provision* of healthcare. Its logic, although not explicitly stated, is to take the NHS down the Health Management Organisation (HMO) route that has proved such a disaster in the US—where HMOs offer insurance at vastly inflated prices for a restricted package of care. More than 44 million US citizens, unable to afford the insurance premiums, have no access to healthcare at all unless they pay up front.

Delivering the NHS Plan can only be understood in the context of a range of measures already introduced or announced by the government.

Under the new system, there will be 470 Primary Care Trusts (PCTs), consisting of doctors, nurses and other health professionals,

serving about 100,000 patients. They will have control of 75 percent of the NHS budget. This will have to cover their own costs, the cost of pharmaceuticals and treatments that they will purchase on behalf of their patients. In other words, they will have a capped budget that must lead to them rationing care at the point of consultation. Alternatively, they will have to make careful decisions about which patients they enrol.

The PCTs will have the commercial freedom to do deals with NHS hospitals locally or elsewhere, the new privately commissioned diagnostic and treatment centres, private or voluntary hospitals and even hospitals overseas. In future, PCTs' contracts with hospital providers will be based on a government determined "fee for service", based on a regional tariff.

Like HMOs, the PCTs will be free to carry out commercial activities. Many PCTs have already negotiated deals with private sector consortia that include insurance companies such as the Norwich Union, via the government's Private Finance Initiative (PFI), to design, build, finance and operate their surgeries, clinics walk-in centres, pharmacies, home-call and other services, in return for an annual fee.

PCTs with cash limited budgets will increasingly be forced to turn to income generation: private health insurance, or encouraging patients to pay. Not only will they have to contend with capped budgets, but also with the effect of the government's commissioning of more than 40 new hospitals under the PFI that have up to 30 percent fewer acute beds and will shift the acute caseload into "intermediate care" and the community.

As yet, few intermediate care beds have been planned for the NHS. The government intends to commission intermediate beds from the private sector, but it has already announced that only six weeks of "intermediate care" will be free to patients. Last year's Health and Social Care Act for the first time gave GPs the power to charge for social care. Thus, following the example of dental services and long term care for the aged, recuperation or "intermediate care" that was once the province of the NHS will now fall on the patient or his relatives.

The White Paper also outlines a series of proposals to dismantle the system of NHS controlled and operated acute and specialist hospitals. The "best" will be encouraged to become Foundation hospitals, free from NHS control and NHS pay scales, able to borrow money and dispose of their assets as they see fit.

The government is also to legislate to set up an NHS Bank that will invest capital in the Foundation's hospitals. While the government has said very little about it, it is likely that the Bank will be staffed with private sector personnel on secondment to the Civil Service, like the PFI Treasury Task Force, or operated as a "strategic partnership" with the private sector like the Task Force's successor, Partnerships UK. The bank will play a crucial role in the firesale of NHS assets by forcing hospitals into joint ventures with the private sector that are likely to involve sale and lease back of assets to finance new equipment. Whereas under PFI, new hospitals belong to the private sector, the NHS Bank will provide one of the mechanisms that will transfer existing hospitals to private corporations.

The government proposes to radically reorganise NHS staff's job descriptions and work patterns, putting an end to existing demarcations. Existing contracts for GPs, consultants, nurses and other staff will be torn up. There will be an end to national pay scales and an increased dependency on discretionary pay based on productivity gains. There is to be a system of inspection and regulation of hospitals, designed to facilitate their privatisation. The management of hospitals that fail to perform to the required standard, almost guaranteed in such a cash strapped service, will be franchised to the private sector.

The health secretary has made it quite clear that contracts already under negotiation with private hospitals and overseas clinics and hospitals, ostensibly introduced as a short term measure to reduce waiting lists, will be long term contracts. "These new providers will be a permanent feature of the new NHS landscape", he told the NHS conference in Margate last week.

In the first year of the government's Health Concordat, whereby the NHS purchases treatments for its patients from the private sector, 100,000 NHS patients, two percent of the total, were treated in private hospitals. This is expected to rise to 150,000 this year.

In an interview with the *Observer* newspaper, Chai Patel, a Labour Party donor who runs Priory Healthcare and sits on numerous influential health policy forums, confirmed that 50 percent of Priory's business, whose income this year is expected to be about £120 million, is coming from the NHS for psychiatric cases such as drug or alcohol dependency. Like most private sector operators, Priory runs at only 50 percent capacity so NHS work is vital to its financial viability. According to the *Observer*, its charges to the public sector are nearly always more than the rate negotiated with private insurers such as BUPA. The huge cost of outsourcing clinical work inevitably leads to the severe rationing of psychiatric services.

The health secretary is meeting the Health Management Organisations, Kaiser Permanente and United Health Care of the US, Germedica from Germany, and Capio from Sweden, as well as other corporate health care executives in Spain, Switzerland and France, to invite them to take over the running of parts of the NHS and provide health care services. Milburn said, "I expect to see a growing number of these new providers in place, beginning later this year. Like NHS use of existing private sector providers, this is not a temporary measure. It is a fundamental change in the organisation of the NHS."

What little remains of the NHS's planning capacity is to be dismantled. The one hundred Health Authorities are to be replaced by 28 Strategic Health Authorities, to be run on three-year franchises awarded after competitive bids, with a mandate only to "hold to account the local health service, build capacity and support performance improvement." It marks the end of a comprehensive planned service that was the hallmark, at least in principle, of the old NHS.