# Britain: Labour government moves to dismantle public health care

**Jean Shaoul**
**6 January 2003**

Alan Milburn, the secretary of state for health, has announced a series of measures designed to dismantle the comprehensive and publicly provided system of public health care in Britain. The National Health Service (NHS) will become little more than funder and regulator, not provider, of health care services that will be drastically reduced in scale, causing untold suffering and hardship to millions of workers and their families.

The Labour government indicated that not only will these measures provide a model for the rest of Britain's public services, but it is also actively promoting them all over the world on behalf of British corporations.

The new arrangements presage a move to what ministers are referring to as a social insurance system, where patients are treated by a diversity of providers including the private sector, overseas corporations, the voluntary sector as well as traditional NHS bodies and new foundation trusts. A regulator will determine which services will be provided at public expense and by which hospitals, a system akin to the US Health Management Organizations (HMOs).

By far the most important measure is the intention in April 2003 to devolve 75 percent of the Strategic Health Authorities' three year budget allocations to the Primary Care Trusts (PCTs) to pay for patients' health care needs. This must cover the cost of running General Practice (GP) surgeries, including doctors' and Practice nurses' salaries, clinics and drugs as well as the cost of commissioning hospital and other services on behalf of their patients.

Under the new system, set out in the Department of Health's *Reforming NHS Financial Flows: introducing payment by results*, the commissioners, predominantly the PCTs, will pay hospitals and other providers on the basis of the number of treatments they carry out. National tariffs will be introduced for almost every non-emergency procedure, weighted to take into account higher costs in the London area. Fees will also be weighted to encourage greater efficiency—the use of day case surgery for example—or to reduce waiting lists for certain specialist areas.

This constitutes a major change from the present system whereby hospitals are paid a fixed amount regardless of the number of patients they treat. Once the fee per service and the PCTs' budgets come into play, patients may find that their GPs have run out of cash to pay for their hospital treatment. GPs will be forced to determine treatment on the basis of cost and to do deals with private insurers—many of whom are financing their new surgeries—to sell insurance to their patients.

NHS finance director Richard Douglas told a recent conference of the Healthcare Financial Management Association in London, "This [the present system] does not incentivise efficiency, it doesn't reward performance, it doesn't provide a firm basis for planning. It won't support a system where patients exercise choice and will not work with a diversity of providers."

Milburn has also announced a second range of measures designed to break up the monopoly position of the NHS and open health care up to the private sector.

Firstly, a network of 25 clinics is to be set up which will carry out fast track diagnostic tests and routine surgical treatments such as hip replacements and cataract surgery for NHS patients. The clinics will be built and run by the private sector and British and overseas firms are to be invited to bid to set them up. The private operators will be guaranteed a minimum volume of patients, encouraged to run a chain of clinics rather than just single units and use overseas staff. These clinics are expected to handle more than 150,000 patients by 2004. The government has said that the clinics will also be allowed to treat private patients.

Secondly, three of the eight acute NHS hospitals that failed to achieve any "stars" in the government's review of hospital performance last July are to be taken out of normal NHS management and run under three year management contracts. The Royal United Hospital in Bath, United Bristol Healthcare and the Good Hope Hospital in Birmingham are the first hospitals to be franchised out, under a scheme announced by Milburn last May for approved NHS hospitals and private sector corporations to take over "failing" NHS hospitals.

The other five hospitals deemed to be failing would be given longer to improve their performance.

Milburn has given eight private sector corporations the right to bid: Bupa and BMI, Britain's largest hospital groups, the Swedish owned Capio, Interhealth Canada, Hospitalia activHealth from Germany, Serco the British owned facilities management company, Secta Group and the consultancy firm Quo Health. This is despite the fact that some of these corporations have never run hospitals before and none have run hospitals the size and complexity of NHS hospitals—which are at least 10 times the size of a typical private hospital specialising in elective surgery.

By far the most contentious of the government's proposals is the establishment of foundation hospitals. These proposals were devised by the government's advisers that include private insurers such as Kaiser Permanente and were first given an airing in the Institute of Directors' policy paper, "Healthcare in the UK: the need for reform" that advocates breaking up the NHS and switching health care provision to private and voluntary sectors.

The prize is enormous: the government's health budget is currently £58 billion, of which the acute hospitals constitute by far the largest component.

According to the Department of Health's *Guide for NHS Foundation Trusts* published earlier in December and to be enacted during this parliamentary session, the top performing hospitals will be allowed to apply for foundation hospital status. Foundation Hospital Trusts (FHTs) will be independent hospitals, free from NHS control and run nominally by a board of local "stakeholders" on a not for profit basis. While they will not be allowed to sell their core assets, they will be allowed to raise finance for new facilities from capital markets and to set up joint ventures with the private sector. Free from NHS control, foundation hospitals will be able to break with national bargaining arrangements and negotiate or impose their own pay scales and conditions of service.

FHTs would be encouraged to generate new sources of income. Hospitals currently do this by opening private beds, leasing out parts of their estate or allowing private sector companies to operate services on their premises. For example, National Car Parks run hospital car parking, Capita and Serco provide visitor and staff catering, retail outlets such as McDonalds or WH Smith operate on the hospital forecourt and Patient Line supply telephones and televisions. The hospitals will be able to spin off companies in order to exploit the intellectual property of patients and their tissue samples, taken from patients during surgery, for research. Patient data has become a valuable commodity that many genetic and biotech companies would like to own and exploit.

The inherent but unstated logic of foundation hospital status is twofold. Firstly the private sector "partners" and finance providers will take over the running of the hospital in all but name. Secondly, the NHS, paid for out of taxation and largely free at the point of use, will be reduced to a basic service forcing patients to take out top up private insurance. The foundation hospital could, for example, subcontract the entire running of the hospital to the private sector.

Foundation trusts will operate under licence from an "independent regulator", who will have the power to alter the range of services provided for NHS patients. The licence to provide various services could be withdrawn and NHS patients would be entitled only to a basic menu of treatments as currently occurs under the US system of managed care.

One has only to look at what has happened to the NHS dental service to know what is in store. Under the NHS, patients are offered a limited range of treatments that are only free to the young, the elderly and those on benefits. The net result is that it is almost impossible to find an NHS dentist in London and the South East. Extensive dental treatment not on the NHS menu means going into debt.

The foundation hospitals would only be required to meet a "reasonable" level of demand—commensurate with their business plans and contractual commitments. As more and more hospitals move to foundation status, any conception of a planned service to meet the needs of all would go. Each hospital would be able to carry out only those activities that met its own financial needs. It means the end of a universal and comprehensive service.

The new measures will lead, as private provision invariably does, to unequal provision. A few examples from the US health care system make this abundantly clear. While some US citizens have access to the most modern health care facilities in the world, a staggering 44 million people (17 percent) have no health care at all because of the crippling costs of insurance. Others have to pay at the point of need when they discover that their insurance does not provide full cover. One third of all personal bankruptcies are the result of health care bills. Despite a massive 14 percent of GDP being spent on health care, including nine percent of GDP from government sources, the US ranks 37th out of 191 countries in terms of the health of its citizens—the lowest of any industrial country.

The cost of running such an inefficient system accounts for one quarter of total costs and fraud has spiralled out of control. For the years 1991-1995, the FBI estimated that fraud alone was costing a massive $418 billion.

The government has announced its proposed changes at a point where the NHS has all but collapsed after years of underfunding. The recently published Wanless report estimated that between 1972 and 1998, the British government had underspent by £267 billion between 1972 and 1998 compared to the European average that includes the poorer Mediterranean countries.

Hospitals have a £3.2 billion backlog of maintenance and repairs. More than one third of beds have gone in the last 10 years. Hundreds of thousands of people wait months to get a hospital appointment and even longer for hospital treatment because of lack of capacity. Much of the system is in deficit. Many trusts predict that they will not achieve financial balance this year and it is widely rumoured that only three Primary Care Trusts believe they will do so.

Senior hospital officials fiddle the waiting lists—a key performance indicator—in an attempt to stop their hospitals falling into the "failing" category.

Work conditions are so stressful that nurses are leaving the NHS in droves. They are replaced by nursing agencies that charge huge commissions and, according to the Audit Commission, cost the NHS nearly a billion pounds a year.

A recent King's Fund Report, *Great to be Grey*, warned that one in seven health service workers could retire in the next five years. The NHS in England plans to recruit at least 15,000 more GPs and hospital consultants, 30,000 more therapists and scientists, and 35,000 more nurses, midwives and health visitors by 2008. But these plans, insufficient in themselves to redress the problem, could be scuppered since there are 150,000 staff aged over 50 and many of them plan to take early retirement because they are so fed up with heavy workloads, long hours and low morale. Fewer young people want a career in the health service, according to Sandra Meadows, the report's author.

There is an acute recruitment and funding crisis within NHS laboratories responsible for identifying and monitoring diseases. According to the Royal College of Pathologists, the laboratories are 1,000 staff short—hardly surprising when some technicians start on just £11,000 a year. Its president, Sir John Lilleyman, accused the Department of Health of failing to recognise the consequences of under-investment. "There is a huge threat and they are not noticing it. If we don't do something, with the increasing demand on pathology services it is going to collapse," he said.