Britain: Foundation hospitals mean health inequality is official government policy

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19 May 2003

The Labour government's Health and Social Care bill setting up Foundation Hospital Trusts (FHTs) is central to measures aimed at opening up public hospital services to private sector corporations and the banks and so establish a market for healthcare. These measures, to be introduced initially in health, provide a template for the rest of the welfare state.

It means the end of a planned comprehensive and universal service free at the point of use that was the hallmark of the National Health Service (NHS). It will lead to huge inequalities in healthcare provision and cause untold suffering, hardship and early death to workers and their families.

Secretary of State for Health Alan Milburn has introduced foundation hospitals with the rhetoric of "devolving power", "freedom from Whitehall control", "greater local autonomy", "localism", "patient choice", "diversity of provision" and "competing on quality not price". But the legislation and the raft of measures that accompany FHTs show that these are empty concepts to provide a figleaf for the Labour government's dismantling of welfare.

Under the new legislation, hospitals will apply for foundation hospital status. While in the first instance only the best performing hospitals will be allowed to apply, Milburn expects that within five years all hospitals will be FHTs.

Foundation hospitals will be independent companies or public benefit corporations—a new legal entity for public assets and the operation of services in a no-man's land between the public and private sectors. They will be ostensibly run on a not for profit basis, like the mutual societies of yesteryear and subject to an Independent Regulator, but will be tied to the profit motive by a host of contracting arrangements.

They will be able sell their non-core assets (as defined by the regulator) and raise finance for new facilities from the capital markets subject to the government's overall borrowing limits. Investment will therefore be a function of the financial viability of the hospital and its possession of disposable assets rather than its ranking in terms of national and regional need. Under a system of capital rationing by government, irrespective of its source, the ability of one hospital to borrow will be at the expense of the rest.

Foundation hospitals also will be able to set up joint ventures with the private sector. The foundation hospital could for example, in order to access finance for new equipment or wards, subcontract the entire running of the hospital, including clinical services, to the private sector.

Free from NHS and thus state control, foundation hospitals will be able to break with national bargaining arrangements and negotiate or impose their own pay scales and conditions of service, leading to inequalities and distortions in the allocation of trained staff and the provision of quality healthcare services.

Their income will come from the Primary Care Trusts that will be free to purchase healthcare treatments from the Foundation Hospitals, NHS hospitals where they still exist, or private hospitals, instead of sending patients to their local hospitals. While the NHS sets a fixed price per treatment, with patients soon to be free to choose where they are treated on the basis of reputation, perceived quality and location—subject to capacity constraints—hospitals' income will be dependent upon the number of patients treated and the case mix. As Nigel Edwards, the policy director of the NHS Confederation, the employers' organisation, said, "He [the secretary of state for health] is calling for a system in which money follows the patient and there is a negotiation between people who buy services and those who provide them."

Some hospitals could lose up to 30 percent of their revenues, according to a study by John Appleby, chief economist at the King's Fund health policy research institute, as hospitals compete like grocery stores. And the results will be very similar: good service for some in the more privileged areas and healthcare deserts in others as hospitals are reduced to providing a very limited and shabby service: a two tier service. Without access to additional revenue streams, and the bill specifically outlaws increasing the proportion of income derived from private charges, some hospitals will "fail". In that case, the Regulator may require the hospital to bring in a private sector management team or even wind up the hospital.

It means a return to the situation that prevailed before the establishment of the NHS when, according to Professor John Mohan of Portsmouth University, author of *Planning, Markets and Hospitals* in an article in *Catalyst*:, "Reconciling Equity and Choice? Foundation hospitals and the future of the new NHS, 2003", there were fivefold variations in the chance of obtaining treatment in a hospital, depending upon where you lived.

New Labour is instituting an even more vicious form of the Conservative government's hated internal market that it pledged to abolish in 1997. Indeed, the architect of Thatcher's healthcare reforms, health economist Alan Enthoven from Stanford University said, "It's very much an extension of the ideas I had in mind with the internal market."

Under conditions where hospitals are cash strapped and chronically short of both physical, financial and human resources, and revenues are being diverted to administering contracts with the Primary Care Trusts, it will be their bankers that control the purse strings. FHTs would be encouraged to generate new sources of income and spin off companies in order to exploit the intellectual property of patients and their tissue samples, taken from patients during surgery, for research. Indeed, patient data has become a valuable commodity that many genetic and biotech companies would like to own and exploit.

These independent hospitals will be nominally run by a board of governors made up of local "stakeholders". More than half the board are to be elected by "the public constituency" and at least one member by the "staff constituency", the Primary Care Trusts that purchase healthcare from the hospital, and the university, if it is a teaching hospital. But it is the board of directors that will exercise executive power on the governors' behalf. The governors' sole power will be to elect the non-executive directors who will appoint or remove the hospital's chief executive, who in turn has the power to appoint and remove the executive directors. With such few powers, local participation from anyone other than those with commercial interests in the hospital will be zero. As it is, recent research from Nottingham University shows that few people attend the annual general meeting of their local hospital, even though it is open to the public.

Thus the much vaunted localism and local control is nothing but a sham—Members of the amorphous and undefined "public" will elect board members who will rubber stamp the selection of a chief executive to do the bidding of the banks and private sector corporations that will really run the hospital. According to research cited by Mohan, all the evidence from the US shows that competition forces the not-for-profit hospitals to "abandon their community orientation" and "act in a commercial manner". Supposedly representative governing bodies are soon reduced to approving business strategies devised by managers.

In so far as "localism" appears plausible and indeed welcome to some hospital managers and medics, it is an expression of the widespread recognition of the lack of democracy at national level and the hatred of the constant interference, new initiatives, directives and performance targets set by government ministers without having allocated commensurate resources. But hospital managers will soon find to their cost that "freedom from Whitehall" will throw them into the iron vice of the free market, where "freedom" means the freedom to do as you're told.

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. It signifies a return to the situation prevailing pre-1948 when access to healthcare for more than 50 percent of the population was dependent upon the ability to pay.

The foundation trusts will operate under a licence from a so-called Independent Regulator, appointed by the Secretary of State for Health, who will have the power to alter the range of services provided for NHS patients. In other words, 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. Thus the effect of the Regulator will be twofold: to introduce user charges—which Prime Minister Tony Blair has already indicted that he is in favour of—and to establish the private sector as the main healthcare provider in some areas, under the guise of diversity of supply and patient choice. It means a massive redistribution of resources provided by the taxes of ordinary people to the corporations and banks.

Furthermore, the foundation hospitals will 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 on a regional basis must go. Each hospital will be able to carry out those activities and treat patients that meet its own financial needs. It means the end of a universal and comprehensive service as increasingly the NHS becomes a rump service.

Milburn in a speech to the Social Market Foundation claimed that the legislation contains an "equity guarantee", but this is a blatant lie. There is not a single mention of the word equity in the bill. Instead the general duty of the FHTs is to exercise their functions effectively, efficiently and economically.

The record shows that it is impossible to reconcile equity with the market. The demand for publicly provided healthcare grew precisely because nowhere in the world has it been possible to satisfy even the most basic needs of the entire population on a commercial basis. It was the top down centralised planning of the NHS—that the government now likes to decry as the "Stalinist command and control bureaucracy" akin to the running of the Chinese Red Army—with its the strategic direction of investment and service provision to meet social need that was so effective in reducing health inequalities in the post-war period. Its removal under the banner of "localism" and the "market" presages a return to the wretched conditions of the pre-war era in Britain and in the less developed countries today.

That the Labour government should have succeeded in getting such a vicious, socially regressive and ideologically driven piece of legislation through Parliament demonstrates its complete break with its former programme of social reformism.