UK government pushes ahead with privatisation of healthcare

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8 February 2005

The UK's Department of Health (DoH) is seeking urgent help to create a "failure regime" in the National Health Service (NHS) market, the *Financial Times* reported last month.

In a clear indication of an impending crisis within the NHS, the newspaper reported that the new regime would be tasked with identifying "the warning signs of failure" and acting to prevent it where possible amongst hospitals, primary care trusts (PCTs), foundation trusts and the growing number of private providers of NHS operations and services. The regime will also have to make contingency plans to keep the NHS patient services going in case a failure does occur.

The DoH has issued an urgent tender, initially giving potential partners only 10 days to respond, since it wants a failure system in place by April. This is due to its planned extension of a "payment by results" system, and also because it brings online private treatment centres at that time, which have contracts that guarantee them payments whether NHS patients get sent to them or not.

The new measure is largely a response to the failure of Bradford Royal Infirmary, which was forced to cut costs dramatically after it ran over budget towards the end of last year.

Built in the Victorian era, Bradford was one of the first 10 NHS hospitals to be given "foundation trust" status by the government in April of last year. It serves a city where 66 languages are spoken, and where there are high rates of poverty and heart disease.

Last February, Bradford predicted a £2.4 million surplus for the first year of foundation status. Monitor, which regulates the government's flagship foundation trusts, approved the figures. But then the new consultants' contract, covering revised working arrangements, cost the trust an additional £2.9 million.

The main problem, however, was the government's introduction of "payment by results," which was intended to reward hospitals for seeing more patients more quickly. Hospitals that release patients within 48 hours—particularly those admitted via Accident & Emergency (A&E)—automatically trigger a £1,200 invoice to be paid by the patient's PCT. "Payment by results" also rewards hospitals for the number of non-emergency patients on which they operate. It was introduced to foundation hospitals last year and is to be extended across all NHS acute trusts in April.

Last year, patient numbers at Bradford increased by 11 percent, increasing costs for its PCTs and causing a dispute with them over how much the PCTs should be paying. Consequently, Bradford faces a deficit that is likely to top £11 million this year.

The problem is not confined to Bradford. Leeds is heading for a deficit of almost £16 million, and the West Yorkshire Trust is heading for a deficit of £35 million but has been bailed out by the DoH. Foundation Trusts cannot be given this assistance, however, since they are independent and the government has washed its hands of them.

As the imposed cuts begin to bite, the Royal College of Nursing says that many items are now in short supply, including clean linen and tubing. Temporary nursing staff and caterers have also been cut. The provision of sandwiches or snack boxes to very ill patients is now considered to be an unnecessary expense, as are security guards in the hospital's car parks.

Despite obvious problems highlighted by the case of Bradford, Health Secretary John Reid is looking to extend the foundation trust system. He has drawn up a list of 32 NHS bodies that have passed a preliminary test of fitness to operate outside government control, of which 10 will be given foundation status in April. For the first time, this list includes eight mental health trusts.

The creeping privatisation of the NHS was started under the previous Tory government. It rested on the Private Finance Initiative (PFI), introduced in 1992 as an alternative to direct funding from central taxation for new investment, which has proved to be a very expensive and inefficient system.

Under the PFI, NHS hospitals are handed over to private sector companies such as Jarvis, Tarmac, Siemens and Rentokil to run. They raise the finance for capital investment in return for which they receive a contract or lease to design, build and operate services. Non-clinical services, such as cleaning contracts, are commissioned from the private sector. This has led to a decline in cleanliness and a corresponding rise in diseases such as the potentially fatal methicillin-resistant Staphylococcus aureus (MRSA).

Labour came to power in 1997 promising to abolish the "internal market" and replace it with a more collaborative quality-based approach by cutting waiting lists and driving up performance. But it has accelerated the privatisation process. In 2002, the government replaced the existing district health authorities and GP fund-holding system with PCTs, which commission services and pay the bills. They are often made up of groups of GPs (general practitioners) and locally elected representatives.

A central thrust of the Labour government's privatisation of the NHS is the move towards foundation trust hospitals. Foundation status proposals were drawn up by the UK government and its policy advisors, including the chief executive of the Californian health maintenance organisation and a representative from the Institute of Directors, which is known to advocate the break up of the NHS and the switching of provision to the private and voluntary sectors.

Foundation trusts were established as so-called "public benefit corporations" in April of last year. The government claimed that by freeing certain hospitals from central control, local people would be able to "own" their own hospital, with the independence to set budgets, buy services from the private sector, and borrow money.

But the real purpose of this move was for trusts to be able to enter joint ventures with the private sector, either through raising private finance or through contracting with private companies for the provision of clinical services. Launched last April, there are now 20 such hospitals, with only those considered the best able to "go foundation." This has made Bradford's financial crisis all the more embarrassing for the government.

The DoH had promised improved pay for hospital staff plus better

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working conditions, largely as a ruse to win support for the foundations. This support has waned fast as it has become clear that the government expects radical changes to working practices in return.

The DoH continues to peddle the myth that unless the NHS turns toward a more market-based approach, the public will turn away from it and seek healthcare elsewhere. This conveniently ignores the fact that for the vast majority of people there is no alternative. Indeed, the break-up and privatisation of the NHS will leave people who are unable to pay with a rump of a healthcare system—underfunded and overcrowded.

Existing NHS organisations are being told to shift 10 percent of their work to the private sector. The so-called "patient choices" agenda gives patients and PCTs the "right to choose" to go to a private clinic or other hospital for routine surgery. Many doctors have complained that this measure is hurting hospitals and will add to the destabilisation of the NHS. Philip Bickford-Smith, anaesthetist and chair of Bradford's medical staff committee, explained: "It's the routine day surgery that is profitable for us, so, if we lose a lot of that to other centres, we are undermined."

The government is facing huge opposition from NHS trust chiefs over plans to contract out up to 15 percent of non-emergency operations and diagnostic tests. A January 20 survey by Health Service Journal of more than 100 trusts found that 73 percent believed that the scheme was not good value for money, and 37 percent said that it was being enforced by DoH "bullying." In addition, 79 percent of chief executives of acute hospital trusts said that their organisations were being required to take fewer patients or forgo expected growth to make room for private sector expansion.

The NHS has signed contracts with eight independent healthcare providers to set up fast-track treatment centres to treat 250,000 NHS patients over the next five years, mostly those needing routine operations. There are expected to be tenders in the spring on a second wave of contracts to double this capacity. The programme is forcing some NHS hospitals to close wards.

The NHS Confederation, representing managers and trusts, is concerned that foundation hospitals are admitting more A&E patients for further treatments rather than releasing them within the four-hour deadline set by ministers, so as to increase their revenue under the new system of "payment by results." It has called for a government inquiry into the issue.

The Health Service Journal found that A&E attendances at four foundation hospitals fell in the six months to October, but admissions via A&E rose by 17 percent or more. The government called these figures exceptions but admitted that the system could "overcompensate" hospitals. The DoH will halve the £1,200 currently paid from April, and announced that the "payment by results" system will cover only 30 percent of most hospitals' activity this year, rather than the intended 70 percent.

The break-up of the NHS, which is already well advanced, looks set to be accelerated if the Bolkestein Directive is accepted as law within the European Union (EU) later this year. There have been mass protests against its proposals in France, Belgium, Sweden and Denmark, though there has been little mention of it within the UK.

One year ago, European Commissioner Frits Bolkestein submitted a directive relating to the liberalisation of service provision within the EU's internal market.

David Rowland from UCL (University College London), writing in the Guardian, believes that Britain is seeking to push through the Bolkestein Directive once it assumes the EU presidency later this year.

The directive has two key aims—firstly, to erase any national laws and standards that make it difficult for European companies to enter the markets of other member states, or that slow the establishment of a company on the territory of a member state; and secondly, to allow any business to operate anywhere in the EU according to the rules of its "country of origin."

Healthcare under this system would be treated as any other business—i.e., no longer as a public service but rather as an "economic activity," or tradable commodity. Healthcare amounts to about 10 percent of the EU's GDP, and therefore the potential for profit is vast. The UK's healthcare market represents around £75 billion.

Under the proposed "country of origin principle," European healthcare companies providing services in the UK on a temporary basis (e.g., mobile treatment units, or homecare agencies) would not be required to meet the standards of the Healthcare commission, or the Commission for Social Care Inspection, but only those standards pertaining in their "country of origin."

Indicative of the real issues at the heart of this proposal, the Department of Trade and Industry (DTI), rather than the DoH as one might have expected, is negotiating on behalf of the UK government at the EU.

Under British Medical Association pressure, the UK government has promised to exclude publicly funded healthcare from the directive, but the DTI has made clear that it does not want to deny market opportunities to private healthcare providers and has also stated that there is no clear definition of "publicly funded healthcare" in EU law. The DTI has further said that concerns about safety and quality should not be allowed to outweigh the potential benefits to British businesses.

In the UK, "control of entry" regulations mean that pharmacies are granted licences to dispense prescriptions only in areas accessible to those most in need. Asda Walmart tried to persuade the DoH to deregulate, but this caused a public outcry since it would mean the destruction of many community chemists. Under the Bolkestein Directive, the UK would be required to remove these rules, as they constitute an illegal barrier to entry.

The directive also proposes to scrap many licensing procedures, making it impossible to impose compulsory maximum or minimum prices for medicines and fees, minimum standards in care homes or quality standards in general.

The directive also allows the possibility of employment agencies, or indeed any business, "posting out" workers to other member states on a temporary basis. Accommodation may be withheld from the wages of such workers, who could be sent out across the EU at low wage levels.

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