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The replacement of a national health service by a health care market in England

Colin Leys

These notes briefly describe and comment on what is happening to health services in England (and broadly in the UK, but health care is devolved to the Scottish Parliament and the Welsh Assembly, and there are some significant differences).

The Blair government has aligned itself fully with the US-led drive to open all service markets, including health care, to international provider competition. It does this for *two main reasons*; *first* it thinks competition from global for-profit health care providers will raise efficiency inside the NHS; *second*, it wants to build a British health care industry capable of competing with foreign providers anywhere in the world; and *third*, it wants to deny the theme of 'choice' in health care to the Conservative Party, and for this it needs a market in health care.

Three stages of marketisation.

The NHS established in 1948 was a *universal* and *comprehensive* health care system, covering all residents from the cradle to the grave and *free at the point of delivery* – i.e. fully funded from general taxation. It was fully accountable to parliament via the Secretary of State for Health and locally, after 1974, via Community Health Councils which had significant powers to influence local health service changes. Its accounts were also detailed and fully available. It was and remains very popular, in spite of constant misrepresentations by a hostile press.

Its chief vulnerability was underfunding. From its inception it was starved of funds, and remained so until the early 21st century, relative to continental European systems. The infrastructure was severely neglected and staff and equipment shortages led to long waits for elective surgery. This created an incentive for the development of a significant private sector – about 10 per cent of the population – better paid executives and their families - are covered by full private medical insurance, above all to secure fast treatment for 'elective' surgery.

Since 1980 the NHS has gone through *three phases of marketisation, one in each of the last two and a half decades..*

First, in the 1980s the hospital sector – which accounts for over 50 per cent of the cost - was *reorganized internally on business management lines*. Power was transferred from hospital doctors to general managers and non-clinical work – cleaning, catering, portering, parking, etc - was outsourced to for-profit providers. At the same time a process of removing NHS coverage from specific elements of health care was

accelerated. Routine eye care and long term in-patient care for the frail elderly and mentally ill ceased to be provided by the NHS, or were provided with user fees, if at all (this was the case with dental care). NHS care became less and less comprehensive.

Second, *in the 1990s* it was *reorganized as an 'internal market'* through a 'purchaser-provider split'. All hospitals became semi-independent 'trusts', 'selling' their services to 'purchasers', namely district-level 'health authorities' funded by the Dept of Health. The infrastructure also began to be privatized through the Private Finance Initiative. All significant hospital and primary care clinic building is now done by private firms who lease the premises complete with non-clinical with services to the NHS.

Third, *since 2000* the policy is to *create a full health care market*, open to for-profit providers – but with all providers fully funded from tax revenues, free to patients whichever provider they choose. This is being accompanied by a major increase in government spending – a 30 per cent real increase in annual spending by 2008 compared with 2002.

This last change is so sensitive that it has been announced covertly – step by step, the key steps being buried in official documents that seem to be about something else. The. whole picture has never been presented to the public and is understandably not understood abroad.

How the new market is supposed to work

All NHS organizations have been converted into 'trusts' (self-financing, quasi-businesses, with boards of directors).

Three main elements (see attached diagram): 300 so-called *Primary Care Trusts*, which receive 80% of NHS budget, allocated on a population/need formula, with which they commission primary care from independent *General Practices* (and, increasingly, from private healthcare corporations), and secondary care from *Hospital Trusts*.

By 2008 (or perhaps sooner) all NHS hospital trusts are to become 'foundation' trusts (FTs): these are non-profit 'public benefit corporations', independently owning their assets and free to borrow on the private market, make individual pay agreements with their staff, and form joint ventures with for-profit companies. FTs cease to be controlled by the Dept of Health or accountable to parliament. They are regulated by an independent market regulator called Monitor, in the same way as other markets such as gas, electricity and water, the railways and telecommunications.

PCTs are also to commission 15% of routine elective surgery (mainly hip and knee replacements, and cataracts) from 34 for-profit companies in specialist Treatment Centres (out of a total of 82 – the rest being NHS-run). PCTs are also to commission a wider

range of elective surgery and other non-emergency care from for-profit or independent non-profit hospitals.

Private health care corporations are also moving into the provision of primary care, via two main routes. *First*, general practitioners (GPs) no longer have to provide 24-hour care; 55% of 'out of hours' care is already being commissioned from for-profit companies employing GPs on salary. Normal weekday hours of primary care are also being commissioned from for-profit health care corporations in some areas. *Second*, Local Improvement Finance Trust companies are being set up as joint public-private ventures to build and lease primary care premises to doctors, but they are also being encouraged to offer primary care clinical services themselves.

Other key steps in the formation of a market are:

- Payment by results: from the end of this year, hospital trusts will be paid per treatment, according to a national tariff, set at the average cost across the NHS.

- Patient choice: for non-emergency treatment, patients are to have a choice of any hospital in the country, including any private hospital that will accept the prices in the national tariff.

The result will be an open market, but competition will be in terms of quality and cost, not price (at least officially, for now). The way competition is intended to work is as follows:

A low cost foundation trust (FT) hospital offering high quality services will earn a surplus that it can spend on higher salaries or more staff or improved facilities. A low cost private hospital will make high profits. But a FT hospital with *high* costs, or one with poor quality that patients avoid, will have a deficit. To survive, it will have to cut costs, by cutting staff, or staff salaries, or by closing loss-making services.

Monitor has power to intervene if hospitals are losing money and enforce the closure of money-losing services. The government says it will let non-essential services close – accident and emergency services are given as an example of essential services that will be kept open.

This is presented as a market that will be fully funded from tax revenues, and so still universal and equal because free to all patients. But with profit-oriented private providers in the market, competition for patients is supposed achieve greater efficiency.

Analysis and critique

Two lines of criticism are relevant. One points out the costs, in terms of both money and loss of quality and equality in health care. The other points out that the market is

inherently unstable and will be fairly quickly transformed into a residual publicly financed system for the poor, alongside a more or less private, but publicly subsidized, full health care system for the more affluent.

I won't go into the money costs except to say that the transaction costs of full market now have to be added to the administrative costs of operating it, compared with the former centrally-run system. In the 1970s the administrative costs of the NHS were estimated at 5-6% of the budget. In the 1980s the management reforms raised this to 11-12%. In the 1990s the internal market was expected to raise administrative costs again to 17%. The PFI is also variously estimated to cost an extra billion pounds a year, perhaps 1.5% of the total budget, compared with public procurement. And now the full market, with 'payment by results' and patient choice, far more complex contracting, billing, accounting, auditing, legal work, marketing, etc, seems bound to push total administrative and transaction costs up towards the levels found in the US system, variously estimated at 25% for publicly-owned hospitals, up to 50 per cent in for-profit hospitals. Even if the English figure is just 20 per cent, the alleged efficiency gains would have to be enormous to be equal to the value of the services the additional money this represents, over the 1970s, could have paid for.

I won't go into the costs in terms of health care either. They are the well-known costs that arise from forcing clinicians to make cost-saving and 'revenue-generation', rather than patients' needs, the primary goals.

Instead I want to end by considering the dynamics of the market that is being established.

The prospects for the new market in health care

There are four requirements for commodifying a public service:

1. the service must be broken down into saleable items – packages that can be priced and sold individually
2. the workforce must be converted from one motivated strongly by a service ethic to one oriented to generating profits
3. in order to induce private capital to produce the commodity the risk must be assumed by the state
4. people must be induced to want to buy what was formerly available free at the point of delivery

The process of creating a market in the UK has followed points 1, 2 and 3 to the letter.

1.The national tariff will soon cover every treatment offered by acute hospitals. To deal with pricing for complex cases, HRGs are being developed along US DRG lines.

2.The contracts of everyone involved in the NHS have been re-written, from hospital specialists to the remaining support staff, to allow foundation trusts and private providers treating NHS patients to employ people on whatever terms they can secure.
3. Private capital is being offered a special premium of up to 40 per cent above the national tariff, and a guaranteed supply of patients, for 5 years, and the chance to 'cherry-pick' the lowest-risk patients and treatments, by setting up so-called Treatment Centres specializing in routine elective surgery (cataracts and hip and knee replacements). The premium above NHS tariff rates is called a 'market forces' factor and is supposed to be phased out later. In reality, it is being paid to avert a collapse of the private health sector as the new money going into the NHS reduces waiting times, and so removes the main incentive to take out private medical insurance.

What is not being done is point 4 - forcing patients to buy their own health care by making free, tax-funded services hard to get (at least as regards routine primary care and all secondary care – as we have already noted, some elements of care such as dentistry has already become charged for). Patients are being allowed to choose their doctors and hospitals, private or public, anywhere in the country, without payment; while the national tariff limits the cost to the government – at least in the long run, when special private providers are supposed to compete at the same prices as the NHS.

The question is, regardless of the cost, whether this can be conceived as a stable system.

I think it is obvious that it can't. People will be alienated by

-- the inequalities that flow from market provision, especially for less financially rewarding forms of ill health like mental illness, chronic diseases, but also for the poorest parts of the country – Tudor Hart's Reverse Care Law (which states that the level of care provided is inversely related to the level of need) will apply.

-- the financial instability caused by patient choice and other market forces that will lead to service closures and even whole hospital closures, leading to the local unavailability of important health services

-- the factory-like conditions in hospitals induced by competition – and competition on unequal terms with the private sector

-- the decline in standards and loss of morale due to lower and more unequal salary scales and the loss of training caused by the pressures of competition and the lack of obligation on private providers to undertake any

-- the loss of confidence in locally available provision that is implied in patient choice of a hospital 'anywhere in the country'

So in practice point 4 above will occur after all – people *will* be induced to want to buy what they formerly had free. They will want to buy protection from all these problems. Meantime the capacity of the private sector will have expanded, through its feather-

bedded investment in the NHS market. Its political power will also have been enormously enhanced. And the individualization of health care, the promotion of self-diagnostics, branded drugs, and all sorts of 'extras' that can be profitable in a market system will also make people distrustful of the service offered by the core public system.

So the middle class will want to buy private care, which they will think of as better, or 'enhanced', care - with state support. Policies for this are already being promoted by pro-market think tanks financed by the private health care industry, and are already part of the programme of the Conservative Party, which is at last looking capable of winning office again.

The result will be a version of the US system, with a residual, understaffed and patchy publicly-provided health service, and a full-service system, funded through tax-subsidised treatments, or tax-subsidised insurance, for those willing to pay more.

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