

Privatising the NHS

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The National Health Service (NHS) has barely been out of the news in recent months: the publication of the Francis Report on the events at the mid-Staffordshire hospital, which has now been put into administration; the measles outbreak in south Wales and elsewhere; children's heart surgery at the Leeds General Infirmary; the attacks on Lewisham Hospital as a result of the problems in the neighbouring South London Healthcare Trust; emergency patients being seen in a tent outside the A&E department of Norwich University Hospital at Easter and, on 2 April, the massive shift of responsibility for most of the healthcare budget from Primary Care Trusts (PCT) to Clinical Commissioning Groups. At the same time there have been large local demonstrations to defend hospital services, most recently of 25,000 in Lewisham and 30,000 in Stafford, approximately half the population of the town.

While the fundamental principles of the NHS, as a public provider of universal healthcare, free at the point of delivery, still underpin the NHS, they have been under systematic attack for some time, beginning in the 1980s and culminating in the 2012 Health and Social Care Act, which has opened the NHS up to likely privatisation. The changes to the NHS are in line with other current attacks on the wider welfare state: that it is too expensive, too big and replaces the role of individual responsibility. The whole tenor of these is that to be considered a worthwhile member of society you must be economically active. This has been most brutally demonstrated in recent years by the scandalous behaviour of Atos Origin in forcing the long-term sick and disabled back into the workplace, allowing the government to cut the benefits of those who do not pass their arbitrary and unfair tests, leaving some of the most vulnerable in society to live in constant anxiety. Other recent attacks on welfare payments aim to achieve the same result by making it impossible to live on benefits while penalising those who are not considered to be trying hard enough to find work, even though there is no evidence of increased job opportunities. Meanwhile the unemployed risk losing what meagre benefits they get unless they comply with "workfare" schemes, such as those that require them to work at unskilled jobs for free in companies which turn massive profits.

The irony is that there is plenty of evidence that capitalism actually makes you sick, particularly if you belong to the working class or are in anything other than a professional or senior level position, where you have power and control over your life. The link between social inequality, health inequality and life expectancy has been made many times: in the late 1970s by the Black Report,¹ the late 1990s by the Acheson Report,² and, most recently, by the London Health Observatory. They showed that by travelling just ten stops on the Jubilee Line from wealthy Westminster in west London to the deprived borough of Newham in east London, your life expectancy drops by nearly ten years, from 78.6 down to 72.8 years for men and 84.6 to 81.4 years for women.³ Most epidemiologists resist making the obvious leap that it is capitalism that causes health inequalities and reduces life expectancy, which is clearly demonstrated by the data, even though they do make the link between class and ill health.⁴ It is unsurprising, therefore, that the NHS, in providing care free at the point of need irrespective of the ability to pay, is so important and much loved by the working class.

The attacks on the NHS are not just an issue of underfunding and cuts: there is a political project being played out in the health service, with its roots in neoliberalism and globalisation. Behind the propaganda of the UK no longer being able to afford the NHS lies the fact that it is a huge organisation consuming around 10 percent of GDP⁵—lower than all other European countries, apart from Spain, Finland, Ireland and Luxembourg⁶—and one of the largest employers in the

world.⁷ It is potentially a multi-billion pound business, although no government would, politically, be able to sell it wholesale as a single business, assuming a company could be found to buy out such a large organisation. The resulting political uproar and public protest would make this next to impossible. However, what is being done is to weaken the structures of the NHS and break it down into separate competing organisations, which can be sold off piecemeal. In what follows I explain how this has been done, covering the three main pillars of healthcare—public health (briefly), hospitals and general practice. Before moving on to a discussion of the coalition’s reforms of the NHS, it is important to mention that we are talking about the English NHS. Following devolution to Northern Ireland, Scotland and Wales their national assemblies have taken over control of the organisation and delivery of health services within their borders, I return to this towards the end.

Public health

Public health services are some of the most effective health services, yet are often hidden from view. Public health is about keeping the general population safe, rather than the individual patient focus of the rest of the health service. Public health services monitor and address health inequalities; provide services dealing with sexual health, anti-smoking, obesity and exercise; prepare for and respond to health protection issues and emergencies, including environmental changes. It is public health services that are currently monitoring and working to combat the recent measles outbreaks. Up to April 2013 public health departments were firmly embedded in the NHS and were provided as part of the remit of PCTs.⁸ This reinforced their role as being responsible for the health of the populations in their areas, rather than just people who were registered with a GP. Following the changes introduced by the coalition government, public health services have been extracted as a block and moved to the control of local authorities and as such are no longer part of the NHS.

Health protection and disease control (dealing with outbreaks of infectious diseases, for example) are, in most countries, part of the responsibilities of the state and, because of this role in the general health of the population, public health is probably the health service least likely to be privatised. The infrastructure of public health departments is also likely to remain in public hands. Which is not to say that it isn’t manipulated in favour of the wealthy or that private companies have no role: broader public health services, such as stopping smoking, obesity and sexual health can be, and in some places already are being, hived off to private provision. Public health currently has a budget of £2.7 billion, to provide services; however, the share out across local authorities, in a blatant demonstration of where the government’s interests lie, favours the wealthier boroughs: the City of London was allocated £192 per head, Kensington and Chelsea £130 per head and Westminster £132 per head. Poorer boroughs are receiving much less, for example Newham gets allocated £75 per head, Stockport £43 per head and Birmingham £72 per head.⁹ This is a direct attack on areas of deprivation and the populations who live in them, those who are in the greatest need of health services in general, including public health.

Another area where the private sector is involved in public health is the quality of the food we eat. Here the coalition has completely abdicated its responsibility by refusing to instruct food companies to reduce the salt, sugar and fat in foods. Instead businesses are “encouraged to sign up to” the “collective pledges” to improve the quality of the food that we eat.¹⁰ This emphasis on voluntary participation is unlikely to have any effect on the quality and content of food if it is going to have an impact on profit.

Hospitals

There have been plenty of bad news stories about hospitals recently, and some of those that have hit the headlines this year are listed above. Although the reasons that these hospitals are in the news appear to be very different, their roots lie in the restructuring of the NHS that began under the Tory government in the mid-1980s, under the ideology of what was then called the “new right”, but we would now more easily recognise as neoliberalism.

During the 1980s the Thatcher government put the provision of public services by the state and local government under sustained attack. This was done in two ways—the introduction of private sector management practices into the public sector, on the basis that private businesses are run more efficiently and cheaply than publicly run services; and the direct contracting out of services through compulsory competitive tendering, again on the basis that the private sector can provide these more cheaply and that if services do not have to be provided by the state then they should be provided by private business. Thus it was that hospital cleaning, refuse collection and school meals and other services came to be provided by private companies, rather than by hospitals or local authorities themselves. This process, which came to be called “new public management”,¹¹ is a method of introducing private management style practices and systems into public services in order for the government to exert greater control over public service professionals and budgets. It has been applied in developed countries across the globe (from New Zealand to the UK) and, in the form of “structural adjustment” programmes, imposed by the International Monetary Fund and World Bank, across much of the developing world as well.¹² In the mid-1980s the process of managerialisation was begun in the health service, co-opting doctors and nurses into the management cadre as well as professional managers. This followed a report from Roy Griffiths, then head of Sainsbury’s, who had been asked by the Tory government to undertake an inquiry into how hospitals were run.¹³ The result was that by 2009, 42,000 (4 percent) of health service staff were managers (an increase of 82 percent between 1999 and 2009, when the Labour government was in office).¹⁴

In 1990 the government went further with the publication of the NHS and Community Care Bill, which introduced the purchaser-provider split into the NHS, also called the internal market. Central to this was the idea that the organisations that buy treatment and care should not also be responsible for providing them. Prior to this local health authorities were responsible for hospital provision (in other words, they were responsible for the overall management of the hospitals) and also funded them through annual contracts for services. Once the bill became law, hospitals were split off into semi-independent trusts—private business like organisations, which were intended to compete with each other for local health authority contracts.

Labour government “reforms”

The Labour government that was in power from 1997 to 2010 did much to ready the NHS for privatisation. In relation to hospitals, the main changes were the introduction of: Private Finance Initiative projects, payment by results, Independent Sector Treatment Centres and Foundation Trusts. As explained below, these work together to create a complex structure that, through increased debt, unfair competition and forcing hospitals to act as independent businesses, will always put NHS hospitals at a disadvantage when competing in this new “market”.

The Private Finance Initiative or PFI was first introduced by the Tory government in 1992. However, it was not perceived to be a particularly good scheme and was not heavily pursued, which demonstrates what a bad idea it is. The Labour government grabbed it with both hands and it is now the only way to fund new capital projects, such as schools and hospitals. The way it works is that rather than the government borrowing money to fund building programmes and thus increasing its debt, the hospital trust puts the project out to the private sector. Building contractors and developers go to the banks to borrow money to build a hospital and the completed building is then leased back to the hospital trust which no longer owns its own building. The government’s aim is that the private sector, by borrowing the money, holds the debt and takes the risk. However, the banks consider PFI schemes to be underwritten by the government—it will be the government which steps in should the hospital go bankrupt—so the schemes are given the same triple A credit rating as the government (while the government still has a triple A rating).

The hospital is then left with a massive debt to service in order to pay for the building and is usually tied into a high cost maintenance contract with the same company or one of its subsidiaries. PFI payments are ring fenced within a hospital’s budget to ensure that the debts are paid. Thus the government effectively delegates all the liability to the hospitals, reinforcing the idea that they are independent businesses, no longer part of a national system. Interest

repayments on PFI schemes have risen from £459 million in 2009-10 to £628 million in 2011-12. The Nuffield Trust, a centre-right health think tank, estimates that these payments constitute around 5 percent of the total income of hospitals,¹⁵ with the results that can be seen in the South London Health Care Trust and elsewhere, driving hospitals into financial deficit and putting them at risk of closure. Last year the government committed £1.5 billion to seven hospital trusts across the country which are struggling with PFI debts. One of these, in Barking, east London, had to find £50 million in 2012 to service a PFI debt it has been paying since 2004.¹⁶ In Carlisle the hospital was due to pay £18 million in 2012 on a hospital which cost £67 million when it was built in 2000.¹⁷ These financial problems are compounded by the way hospitals receive their income.

Payment by results is a system of payment to hospitals introduced by the Labour government to centrally determine the costs of treatments. Although the use of the word “results” implies an element of quality, it is in fact a form of piece rate—payment for the amount of work done. The aim of the national tariff is to encourage hospitals to be more efficient. They have to charge the centrally determined tariff and the only way they can keep within budget is to ensure that their costs are below the tariffs they earn for the work they do. However, there are many elements that determine how much it costs different hospitals to undertake the same procedures, for example the costs of buildings, salary differentials across the country and grades of staff, etc. Naturally old hospital buildings are expensive to maintain, but it is not hard to see that the excessively high costs of PFI repayments will quickly have an impact on how easy it is for a hospital to remain within its budget.

Further impacting on hospitals’ income are the Independent Sector Treatment Centres. These are run by private firms to undertake basic, routine operations—cataracts, knee and hip replacements, for example. They operate like factories: high volume, low cost, routine procedures. They are in direct competition with hospitals for patients and because they do low cost work they are able to keep their costs below their income. With the bulk transfers of routine work from hospitals to ISTCs, again it is easy to see how hospitals can run into financial trouble. Without the low cost, routine work, they are unable to subsidise more expensive treatments, the costs of which can take them above what they earn through the tariff. ISTCs have a record of poor quality, leading many patients to return to their local NHS hospital for corrective treatment.¹⁸

In 2002 the Labour government went one step further than the Tories and introduced Hospital Foundation Trusts. Foundation trust status makes hospitals more like private businesses, removing them from health authority control. Further, foundation trusts are not restricted to being run by NHS organisations: private companies can become foundation trusts as long as they run “effectively, efficiently and economically”.¹⁹ They can also carry out any type of business, although their primary aim must be to provide services to the NHS.²⁰ They are no longer accountable to the Secretary of State for Health, but to an independent quango called Monitor. They are not intended to be profit-making, but must at least break even and can retain a surplus (in other words a profit). They are free to borrow money from financial markets, but have to pay market rates of interest on any loans; furthermore, any money that they borrow is counted against the cash limits of the NHS, meaning that less money is available for non-foundation trusts. They are also able to keep money that they raise from selling off unwanted buildings; thus when University College Hospital sold the old Middlesex Hospital building, none of the £175 million raised went to other local healthcare providers in the area.²¹ Needless to say, once hospitals become foundation trusts, the pressure to compete with neighbouring hospitals for contracts from health authorities increases.

The coalition and hospitals

The coalition government has completed this process of breaking down the NHS hospital system, by determining that all hospitals should become independent foundation trusts. The government has already demonstrated that hospitals are not protected, by forcing both the South London Healthcare Trust and the mid-Staffordshire Hospital Trust into administration and bankruptcy when they found themselves in financial difficulty.

There were many reasons why the South London Healthcare Trust ran into financial problems, not the least of them the PFI contracts that the trust was paying for. It was made up of three hospitals, two of which were paying for PFI schemes at £25 million per year. As stated above, the national tariff does not take any account of large PFI debts that hospitals might be trying to pay. Hospitals run into financial problems because they are considered as single organisations that need to break even, not as part of a whole NHS. In 2011 the NHS underspent on its budget, returning nearly £900 million to the Treasury,²² but you would never guess this from the treatment of hospitals such as in south London, mid-Staffordshire or Hinchingsbrooke, which are allowed to go bankrupt and, in the case of Hinchingsbrooke, are handed over to a private company. Hinchingsbrooke Hospital in Cambridgeshire has been run by Circle, a hedge fund that makes substantial donations to the Tory party, since early 2012. Its contract states that Circle will receive the “first £2 million of any surplus”, then “a quarter of surpluses between £2 million and £6 million and a third of surpluses between £6 million and £10 million”,²³ money which could be reinvested in patient care. Circle is already failing to transform the hospital’s fortunes. It is £2 million behind its budget forecasts and the chief executive, Ali Parsa, stood down in December, only 10 months into the contract. However, it is intended as a “blueprint” for other failing hospitals, with the mid-Staffordshire hospital now very much in the same frame and both Virgin and Care UK, a private equity firm, already positioning themselves to take over parts of the South London Healthcare Trust.²⁴

In that trust, where the three hospitals within it were all in financial difficulty, the Department of Health sent in a “Special Administrator” to run the hospital. With the PFI payments ring-fenced, all savings had to come from somewhere else in the trust. This led him to look outside to the wider healthcare context, deciding that “business” could be transferred from nearby Lewisham Hospital, putting Lewisham’s A&E and maternity units under threat. If they could get away with it politically, the government would close whole hospitals, but very few ministers are prepared to do this, because they know that people will fight to keep their local hospitals open. In Lewisham 25,000 people took to the streets to protest against the plans for the hospital, helping to save the A&E department from complete closure. In Stafford people could see the writing on the wall for their own hospital and 30,000 marched to keep it open. In the 2001 general election the Labour government lost one of its MPs when Richard Taylor, a hospital doctor, won the seat as an independent, standing on the sole platform of stopping the closure of the A&E department at Kidderminster Hospital.

Because hospitals are paid by the quantity of work they do under a contract, you also get the phenomenon of hospitals “over performing”—treating more patients than the contract allows. These “extra” patients are not just extra “customers” that hospitals choose to see; they are people with real health problems that need to be treated, but the market that has been created in the NHS reduces them to figures on a balance sheet and excess costs. The answer for both the coalition and the Labour government that preceded it is to demand “efficiency savings”. In effect this means that hospitals have to meet increasing demand with the same or a smaller budget, which means they must either reduce the number of patients they see or treat them more cheaply. The whole premise on which this rests—that hospitals should operate as independent businesses—is fundamentally flawed, but while that is the terms of the debate, the only way a hospital can save money is to cut staff costs, either through redundancy, hiring freezes and closing wards or intensification of work, by increasing the number of patients each nurse is responsible for and re-skilling the work. This is done by passing routine work from doctors onto nurses and a relatively new medical professional in the UK: the Physician Assistant. Although common in the US, physician assistants have only been part of the UK health service since 2005. They are able to take patient histories, analyse test results, perform examinations and diagnose illnesses, but the salary of a physician assistant is only around £40,000 a year, compared to £100,000 or more for a consultant.

Nurses in turn pass their routine work down to another relatively new health occupation, the Health Care Assistant. This role has been extensively highlighted in the media recently in relation to the problems at the Mid-Staffordshire Trust, where it has been claimed that nurses no longer “care” for patients, leading the government to propose that all nurses should work for a year as health care assistants “to learn to care” before beginning their training. Health care assistants

undertake basic work with minimal training and are poorly paid. HCA jobs are currently being advertised starting at £7 per hour. But the problem is not that nurses (or doctors) go into the health service unable to care or needing to be trained to care, the problem is that they and the patients become brutalised by a system that has reduced illness and human suffering to matters of profit and loss. Although it makes a good headline, while the marketisation of the health service remains, some nurses will continue to find themselves pushed into behaving in ways that are the very opposite of the reasons they became nurses in the first place.

Now hospitals are run as businesses, their income depends on patients coming to the hospital to be treated. If patients are treated elsewhere, the hospital loses income. The whole healthcare system has been distorted by the primacy given to budgets and money. If we look at the case of paediatric heart surgery at Leeds General Infirmary, we can see this being played out. Kambiz Boomla, writing in *Socialist Worker*, is broadly correct to say that: “There is a clear clinical case for shutting children’s heart surgery centres to concentrate the best surgeons in a smaller number of teams to save more children”.²⁵ However, the argument is not as simple as that and cannot be detached from the marketisation of the NHS and the artificial competition created between hospitals.

There were two different but connected arguments being played out in Leeds, obscuring a dispute about clinical statistics. The first is that of specialisation. There is, of course, a case to be made that specialities such as children’s heart surgery should be concentrated in centres where surgeons and doctors gain experience and can hone their skills. In London, where there is a large concentration of hospitals within relatively easy travelling distance and good transport links, this might make sense. However, in the case of Leeds, these small and desperately sick children would be sent to Newcastle, a hundred miles away. Anxious and frightened parents would be removed from their family support networks to stay in hotels in unfamiliar surroundings, possibly splitting parents up if one has to remain at work, while the other travels alone to be with their child for an uncertain amount of time.

The second strand of this is the competition between hospitals. Senior managers will not want to see specialties, which provide income, moved to a competitor hospital. This has wider ramifications than patient income alone—there is also the potential for lost research funding and the recognition attached to it, as well as damage to a hospital’s national and international reputation. Allied to this is the issue of A&E versus minor injury units. The loss of specialist departments removes skilled personnel from the hospital, which means emergency doctors lose access to specialist help when difficult cases arrive and they are not able to learn from a specialist’s expertise. These cases are then automatically taken elsewhere by paramedics. How much of a leap is it for NHS managers to decide that A&E departments should be located at specialist and teaching hospitals only, downgrading more A&Es to minor injury units to save money, with subsequent loss of income to the hospital and, more importantly, service to the local population? A further consideration in this is the “golden hour” that clinicians often talk about. This is the crucial first hour after a trauma has been experienced—stroke, heart attack, etc—when good early treatment can have a massive impact on survival rates and the extent of recovery. The more widely dispersed the specialist teams and A&E departments are, the more of that hour is eaten up in travel time to get to them.

General practice

GPs are usually the first port of call when someone becomes ill. They are known as the “gatekeepers” of the NHS because patients can only access hospital services if they are referred by their GP (unless they are admitted via A&E departments). Like hospitals, general practice has also been opened up to privatisation, which happens in three ways—private companies running general practices; GPs running their own companies to compete for service contracts and private companies offering “commissioning support” to the new GP-led clinical commissioning groups. However, not many people realise that GPs have been operating as quasi-private businesses since the NHS was set up.

When the NHS was established in 1948, the settlement reached by Nye Bevan, Labour's minister of health, to overcome opposition from the professional medical bodies to the introduction of a nationalised health service, was that GPs would stay independent from the NHS (while hospital consultants would come into the service as salaried doctors, but still be allowed to treat patients privately if they chose to pay). GPs remain outside the NHS, most operating as self-employed professionals who contract with the NHS to provide general practice services,²⁶ and their practices are small businesses. The original idea was that GPs would work together in health centres with other clinical disciplines, such as health visitors, district nurses and physiotherapists. However, once it was agreed that the GPs could remain outside the NHS this was not an option and most operated from their own premises, often converted houses rather than specially built health centres, and many GPs, particularly in inner city areas, still operate from these types of premises. The desire of GPs to be independent also meant that many opted to work alone or with one other GP as a partner, rather than in the large partnerships that are more common today. However, in 2000 there were 29,987 GPs operating out of 11,500 premises, indicating that many GPs still operate as single handed practitioners or with one partner.²⁷

Up to April 2013 GPs had a contract with their local PCT, 152 across the country, to provide general practice services (since April GPs' contracts are with NHS England). The PCTs were responsible for buying hospital and community services on behalf of the patients and GPs in their area and for providing public health services. Each PCT covered a population of around 284,000 people. In the biggest recent change in the provision of health services, the PCTs were abolished this year and replaced by Clinical Commissioning Groups (CCGs), run by GPs, which, as of 2 April, control up to 80 percent of the health budget. All GPs are members of their local CCG and each one is run by a board, made up of local GPs elected by their colleagues, plus one nurse and one hospital consultant. These organisations are responsible for buying or commissioning all planned hospital treatments (referrals from GPs), urgent and emergency care, community services (district nurses, health visitors etc) and mental health and learning disability services. The theory is that GPs know what their patients need and should therefore be controlling the budget and making the decisions.

The problem is that, while CCGs are expected to act as businesses and the propaganda is that they are calling the shots over who provides services, they do not have complete independence over what they do. They are under the control of the National Commissioning Board, renamed NHS England, which is responsible for the performance management of GPs and to which GPs are accountable. They are also subject to the "Any Qualified Provider" provision in the 2012 Health and Social Care Act, the Section 75 rule. This states that, as long as there is more than one provider able to deliver a service, it must be put out to tender, with all qualified organisations being able to bid and no preferential treatment allowed for NHS services.

An example of what this means is the battle of GPs in Hackney to replace the company that provides their out of hours service (access to medical care when a practice is closed, for example at night or over the weekend). GPs were unhappy with Harmoni (owned by private equity firm Care UK), the private company awarded the contract by the PCT, and wanted to bring services back under the control of the GPs. To do this they set up their own social enterprise (a private but not for profit company) and were ready to begin operating on 1 April. However, in January this year NHS North East London and the City (responsible for commissioning services up to 1 April) pulled out of the contract, afraid that it would face legal challenges from private companies over lack of competition. The out of hours service, which the GPs considered to be below standard, is still being run by Harmoni, which has had its contract extended for a further nine months.²⁸ In April the health secretary, Jeremy Hunt, weighed in to the argument, telling GPs to "be brave" and go ahead with returning out of hours care to their control.²⁹ However, despite this apparent support from the minister in charge, the GPs are naturally reluctant to put themselves in the path of a potential legal challenge from Harmoni or other private companies over competition rules. And this is not the only arena in which GPs are in direct competition with big private health companies.

Before April 2013 GPs signed a nationally negotiated contract with their local PCT, to provide "general medical services". The majority of GPs are self-employed, working in their own, often

not so small, businesses, but many GPs are also now salaried employees rather than partners, usually employed by other GPs, but sometimes in practices run by nurses (a change made by the Tory government in the mid-1990s, which broke the GPs' monopoly over contracts to provide medical services). More significantly however, in 2004 the Labour government introduced the Alternative Provider Medical Services contract. This is a contract that anyone can sign, opening up general practice to the private sector. Whole practice contracts do not come up very often; usually practices are just looking to replace a partner who has left or retired. However, with the government's policy of opening GP-led health centres (or "polyclinics")³⁰ in many areas, the opportunities for private companies to tender for practices has increased and by 2009 there were 23 companies running 227 practices.³¹ The Practice PLC, set up in 2005, currently runs over 50 surgeries. Virgin, United Health (an American firm), Care UK and Atos, notorious for its treatment of people on disability benefits, are among the large multinational companies which won contracts to run surgeries, which they treat with the same cavalier attitude as any other part of their business.

This was demonstrated in Camden when United Health, which ran three practices in the borough, sold the general practice part of its company to The Practice PLC who promptly closed one of them. There was no public consultation and no scrutiny by the PCT—once the original contract had been signed over by the PCT to United Health, it no longer had any control over it.³² The patients were "redistributed" to other practices. A surgery in Tower Hamlets, taken over by Atos in 2008, was handed back to the PCT only three years into a seven-year contract,³³ leading to loss of continuity of care, and uncertainty and distress for the patients. As practice vacancies are now generally put out to tender, something local surgeries are ill-equipped to undertake,³⁴ local practices which would normally have applied to take over a vacant list are in competition with big multinational health corporations, with large marketing and legal departments available to put tenders together.

Now these privatised practices, whose parent companies often provide hospital services as well, will be working alongside regular surgeries in clinical commissioning groups, running tenders to determine who they will buy hospital and other services from. Many GPs themselves are getting in on the act, setting up their own companies which enter the tender process to bid for services. According to a *British Medical Journal* survey, this means that over a third of GPs have a conflict of interest,³⁵ because companies they own or have shares in are bidding for service contracts tendered by their own commissioning group. Some of these are not for profit social enterprises, but many are profit-seeking and different only in size from companies such as Care UK, Atos and Virgin.

The final way that private companies are getting a foothold in general practice is through providing "support" to clinical commissioning groups. Multinational companies are aiming to get a big chunk of the money now under the control of GPs by providing "back office" functions for the clinical commissioning groups. Undertaking the commissioning of all required services takes a huge amount of work, which inevitably takes GPs away from their surgery, leaving patients to see locum doctors who do not know them or their history and creating an alienated temporary medical workforce paid by the session. But while GPs will be deciding what services are provided, they won't be running the contracts or ensuring bills are paid. This still needs to be undertaken and will be done by firms such as United Health, which sold its general practice arm to The Practice PLC in 2008, having decided that there was more money to be made in commissioning support.³⁶ There are 19 commissioning support units across the country, providing help to the clinical commissioning groups in their areas and largely made up of ex-PCT staff. Given that the population covered by each Clinical Commissioning Group is similar to that covered by the PCTs (226,000 and 284,000 respectively), it seems that the whole architecture of primary care trust functions has been dismantled, at a cost of billions of pounds, only to be rebuilt to provide support to the clinical commissioning groups. Every single support unit has or is negotiating contracts with private management consultancies, including the "big five"—KPMG, Ernst & Young, PWC, Deloitte and, of course, McKinsey, but also Atos and other smaller private consultancy firms.³⁷ These companies will be involved in planning health services and conducting feasibility studies to determine which services the GPs should invest in and which should be closed.

One of the reasons GPs are being forced to make choices like this is because, perpetuating the myth that the NHS is unaffordable, the government expects them to make millions of pounds of savings in their budgets—Solihull CCG has to save £8 million in 2012-13, another £7 million in 2013-14 and nearly £4 million in 2014-15,³⁸ Nottingham North and East CCG has a £4 million overspend to correct.³⁹ The easiest way for GPs to save money is to not pay for hospital services by not referring people. This will fundamentally damage the relationship between the GP and the patient, as patients won't know for sure whether their doctor is not referring them to hospital because they really don't need hospital treatment, or because the doctor is worrying about the impact on their budget.

More and more services are being driven out of hospital to be delivered in primary care, in a bid to reduce the costs of hospital contracts. In general practice as in hospitals, a process of re-skilling is undertaken to deal with the extra workload this creates. In this way GPs and hospital consultants, instead of being professional colleagues working together in the same system, are put in competition with each other to grab patient "business"—hospitals have to increase patient throughput and reduce costs in order to make a profit; GPs have to reduce referrals to hospital and find cheaper treatment alternatives in order to make a profit or save money themselves. Routine cases that would normally be sent to a hospital consultant are now seen by a new layer of GPs called GPs with Special Interests, who have some extra training in specialities such as dermatology or ophthalmology (rather than the years of training and experience of a hospital consultant). They run special clinics, between their normal surgeries, for which they are paid extra, previously by the PCT, now by the CCG. In turn, GPs pass some of their workload to more highly trained nurses—nurse practitioners—and to physician assistants, who are appearing in general practice as well as in hospitals. The nurses then pass some of their basic work down to health care assistants.

This process of de-skilling and re-skilling is not necessarily a bad thing in itself. There is no reason why nurses should not become more skilled and advance their profession. In this the UK can learn a lot from low income countries in the developing world, where doctors are often concentrated in hospitals in large towns and nurses or community health workers are trained to deliver a lot of the care and treatment in rural areas. The problem is that it is often used to save money, with more and more work being transferred downwards to cheaper, less well trained staff who get an increasing workload, but have less power than doctors and senior consultants to resist pressure from management.

Where next for the NHS?

What has resulted from all of the changes to and attacks on the health service, which you will know if you have got this far, is a complex landscape of rules, regulations and organisations, in which the NHS is continually put at a disadvantage. It is forced to operate in an artificially constructed market, but its ability to do so is constrained by PFI payments and restrictions on income through payment by results; hospitals are placed in competition with each other and GPs in conflict with hospitals as the former try to save money by moving treatment out of hospitals and the latter need patients to maintain income. As distortions in treatment are created by the market, which should have no place in healthcare, and capacity is stripped out of the system in an attempt to enable hospitals to break even, you end up with patients being seen in tents outside Norwich and Norfolk Hospital, because the A&E department cannot cope and even the *Mail on Sunday* runs an exposé on a reported 37 percent increase in death rates following the closure of the A&E department in Newark.⁴⁰

Apart from the occasions when hospitals are directly under threat, the changes are mostly to do with controls and regulations. Privatisation is undertaken by the back door, where the provider is privatised, but the user still does not directly pay for treatment. In other words, services remain under the NHS banner, while being delivered by private companies looking to make a profit out of people's ill health. This makes it difficult for patients to see who is delivering their care, meaning that most opposition is in the form of localised protests around specific threatened closures—Lewisham, the Whittington, mid-Staffordshire, while behind the scenes the NHS is dismantled. Clinical commissioning groups are forced to tender for services, with contracts going

to private companies which are often part of much larger businesses, which can undercut the NHS and provide services as “loss leaders” to get a foothold in the healthcare market. NHS services meanwhile are not able to consider themselves as part of a larger organisation. They are forced to operate as individual small businesses competing against huge conglomerates. Thus even on the free market’s own terms the system has been biased against the NHS, underlining that this is a political project to hand control of the health service to unaccountable private firms which are in healthcare to make money, not to serve patients.

That there is no economic imperative to run the NHS in this way can be illustrated by considering the other three countries of the UK. When Northern Ireland, Scotland and Wales gained their own national assemblies they also took over the running of their health services, which are still delivered under the banner of the NHS. They have not followed the same path to privatisation as the English NHS, underlining the fact that what is happening in England is a political choice. As a result, the provision and organisation of health services in each country have begun to diverge and the differences between them and England are now significant. In Scotland and Wales, for example, prescriptions are free; in Scotland older people receive free personal care, whether at home or in nursing homes. Northern Ireland has remained closest to developments in the English system, maintaining the purchaser provider split in the internal market, but rejecting Hospital Foundation Trusts and GP commissioning. Wales has retained some contractual level of commissioning health services, allied to the internal market. In Scotland the internal market or “purchaser-provider” split has been broken down and replaced with a system of Health Boards, with a focus on planning not competition⁴¹ and a “trust in professionals and professional values” and partnership.⁴² The Scottish health system now consists of 14 health boards, which “makes the market impossible to start up again without considerable reorganisation”,⁴³ and as a result Scotland does not have hospital trusts or foundation trusts and it has not introduced clinical commissioning groups. However, this is not to say that healthcare in Scotland has returned to a pure form of the NHS. New public management is still the prevailing ideology, with resulting pressures on health workers, and although market mechanisms have been outwardly rejected, £40 million of NHS funds were still spent on private healthcare in Scotland last year, a 60 percent increase on previous years.⁴⁴

Many fear that we are heading towards a US style system of privatised healthcare, where people buy their own health insurance or it is provided by an employer, with many at the bottom of society left uninsured. Once the provider side of the NHS has been lost to private provision and attention focuses on users, it is more likely that England will move towards a compulsory social insurance scheme, such as those that run in some other European countries, such as France and Germany, supplemented by direct payment or personal insurance by those who can afford to pay. Although what happens in the future will depend very much on how hard we fight now to keep the NHS as a state funded system, free at the point of delivery.

How should our health services be organised?

We know, from looking across the Atlantic to the US healthcare system, that the market should have no place in the delivery of health services and where it does it brings misery and sometimes early death for patients unable to afford even basic treatment. The results of this type of healthcare provision can be illustrated by the number of “first day” deaths of new born babies (babies who die in the first 24 hours after birth). The US, the most powerful nation in the world, recorded a figure of 11,300 first day deaths in 2011, higher than all of the other industrialised nations put together.⁴⁵ We know that the NHS is affordable, because millions of pounds are handed back to the government each year. It is the distortions of the market and a health service that has been broken down into separate competing organisations which mean that money is not accessible by the hospitals which need it. We also know that many of those hospitals are in difficulty because of the massive inflated interest payments for PFI schemes, with millions of pounds handed over to developers instead of being invested in patient care.

The opposite of all this is a healthcare system which is run for the benefit of all of us, by patients, the public, doctors, nurses and other healthcare professions. All of these know and understand healthcare and are perfectly capable of planning good healthcare systems, with as much

emphasis on long-term prevention, which is lost in the rush for short term profits, as on treatment. Healthcare has changed immeasurably since the NHS was set up in 1948. Many treatments that previously required overnight stays in hospital can now be done as day cases. There is no reason why many of these cannot be done in the community closer to patients' homes rather than in hospital, but they need to be in facilities that are properly equipped and supported, not as a reason to save money and close hospitals. Many positive changes in treatment are lost because they become confused with cuts and are used as an excuse for closures. Health services which are properly planned and part of local communities, alongside hospitals with enough beds, enough nurses and doctors and enough slack in the system to deal with emergencies are all affordable as long as the market and the drive for profit are excluded from the system. The dismantling of the NHS for privatisation is being done by rules and reorganisation, obscure and abstract issues which are harder to fight against than the closure of a hospital building, but fight we need to, because once the NHS is privatised, it is unlikely it will ever be rebuilt.

Notes

1: Townsend and Davidson, 1982

2: Acheson, 1998.

3: www.slideshare.net/bentoth/the-jubilee-line-of-health-inequality

4: The relationship between capitalism and health has been detailed in an excellent article by Mike Haynes in this journal-Haynes, 2009

5: House of Commons Library, 2012.

6: King's Fund, 2010a.

7: UK spending on healthcare is in line with Italy and Spain but less than France and Germany (12 percent of GDP) as well as Cuba and Canada (11 percent GDP). The US meanwhile spends around 18 percent of GDP, but with far less coverage (the US still does not provide universal health coverage or recognise it as a human right)-Guardian, 2012a.

8: The geographically based organisations that were responsible for running health services have gone through many different names in the past 30 years, culminating in the Primary Care Trusts, which were abolished in April 2013. For the purposes of simplicity, this article uses the generic term "local health authority", except when referring to PCTs.

9: Prior to its separation from the NHS, public health was funded out of the general budget allocated to local health authorities by the Department of Health to pay for services. The budget allocation was derived from a formula based on an area's deprivation, age profile and disease prevalence; this money was then distributed across the different departments under the health authority's control, including public health provision.

10: Gov.uk, 2013.

11: See Hood, 1991, pp3-19.

12: Larbi, 1999.

13: Department of Health, 1983.

14: The King's Fund, 2010b.

15: Financial Times, 2013a.

16: Guardian, 2012b.

17: Whitehaven News, 2012.

- 18: For a more detailed critique of Independent Sector Treatment Centres, see Player and Leys, 2008.
- 19: Pollock and others, 2003, pp982-985.
- 20: Pollock and others, 2003, pp982-985.
- 21: Lister, 2008.
- 22: Pollock, 2012.
- 23: Financial Times, 2012.
- 24: Financial Times, 2013b.
- 25: Boomla, 2013.
- 26: Widgery, 1988.
- 27: Pollock, 2004.
- 28: Hackney Gazette, 2013.
- 29: Pulse, 2013
- 30: A polyclinic is basically an enhanced health centre, which may include consultant clinics and other services normally delivered in a hospital setting.
- 31: NHS Support Federation, 2010.
- 32: Camden New Journal, 2012.
- 33: Guardian, 2011.
- 34: See Cole, 2008.
- 35: Iacobucci, 2013.
- 36: George, 2012.
- 37: Campden Health, 2013.
- 38: Solihull CCG, 2012.
- 39: Lintern, 2013.
- 40: Rose, 2013.
- 41: Lister, 2008.
- 42: Greer, 2005, p504.
- 43: Greer, 2005, p506.
- 44: Scotsman, 2013.
- 45: Save the Children, 2013

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