

Liberating the NHS: source and destination of the Lansley reform

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29 August 2011

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1. Introduction

The Financial Times Public Policy Editor has noted of the current NHS reform:

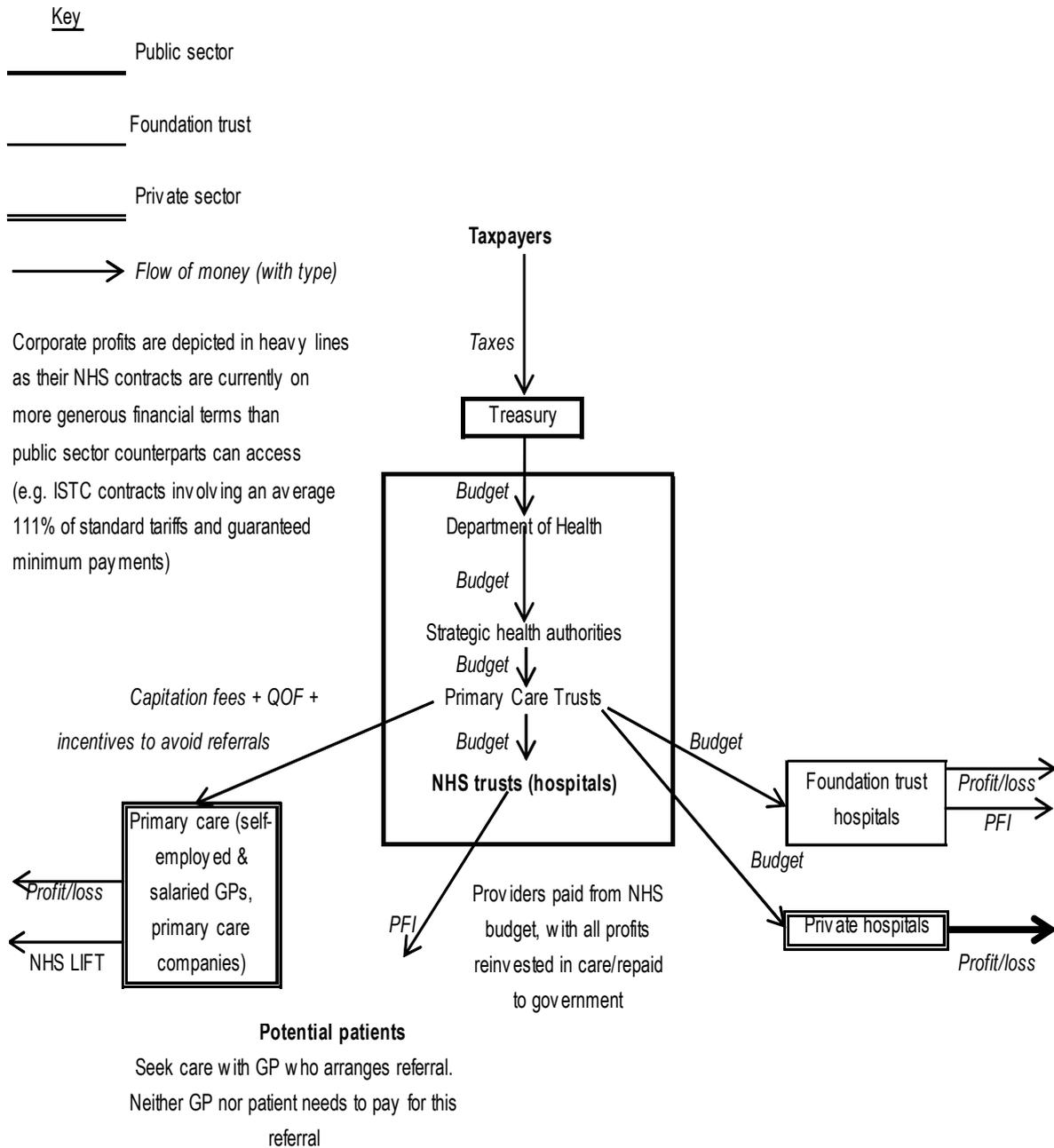
“what is still missing is a narrative that explains how these changes, carried out in this way at this time, will help the NHS to address its central task – making £20bn of efficiency savings over the next four years in order to meet rising demand within a budget that is flat in real terms. Instead, the opposite is more likely.”¹

A narrative for this reform, far more transparent than the double-speak of the White Paper, can indeed be located. It is described in the following pages. It maps a move away from the tax-funded NHS based on the principles of contribution according to ability to pay, and use according to medical need. It takes the NHS towards a US-style arrangement of individual health insurance with access to care based on payment of health insurers at a level based on the insuree's state of health. In other words it removes the pooling of risk which underlies the post-war social solidarity compact, involving subsidy of health care for poorer and less healthy citizens by richer and healthier compatriots. A plan for the end-state system to be jointly funded by the state and the individual solves the perplexing riddle of how the new system could generate £20 billion of savings, given that it involves more providers, fragmented procurement, more complex administration, the marketing costs involved in market competition, and multiple layers of profit extraction from the NHS budget,. Cost reductions will be achieved through de-skilling and poorer employment terms for medical professionals as the NHS hospitals which employ them are shifted into the private sector².

The changes to the NHS funding system which will result initially from the reform can be depicted as follows:

Figure 1:

CURRENT ARRANGEMENTS FOR HOSPITAL SERVICES



* <http://www.civitas.org.uk/wordpress/2009/08/13/the-value-for-money-of-istcs/>

Figure 2

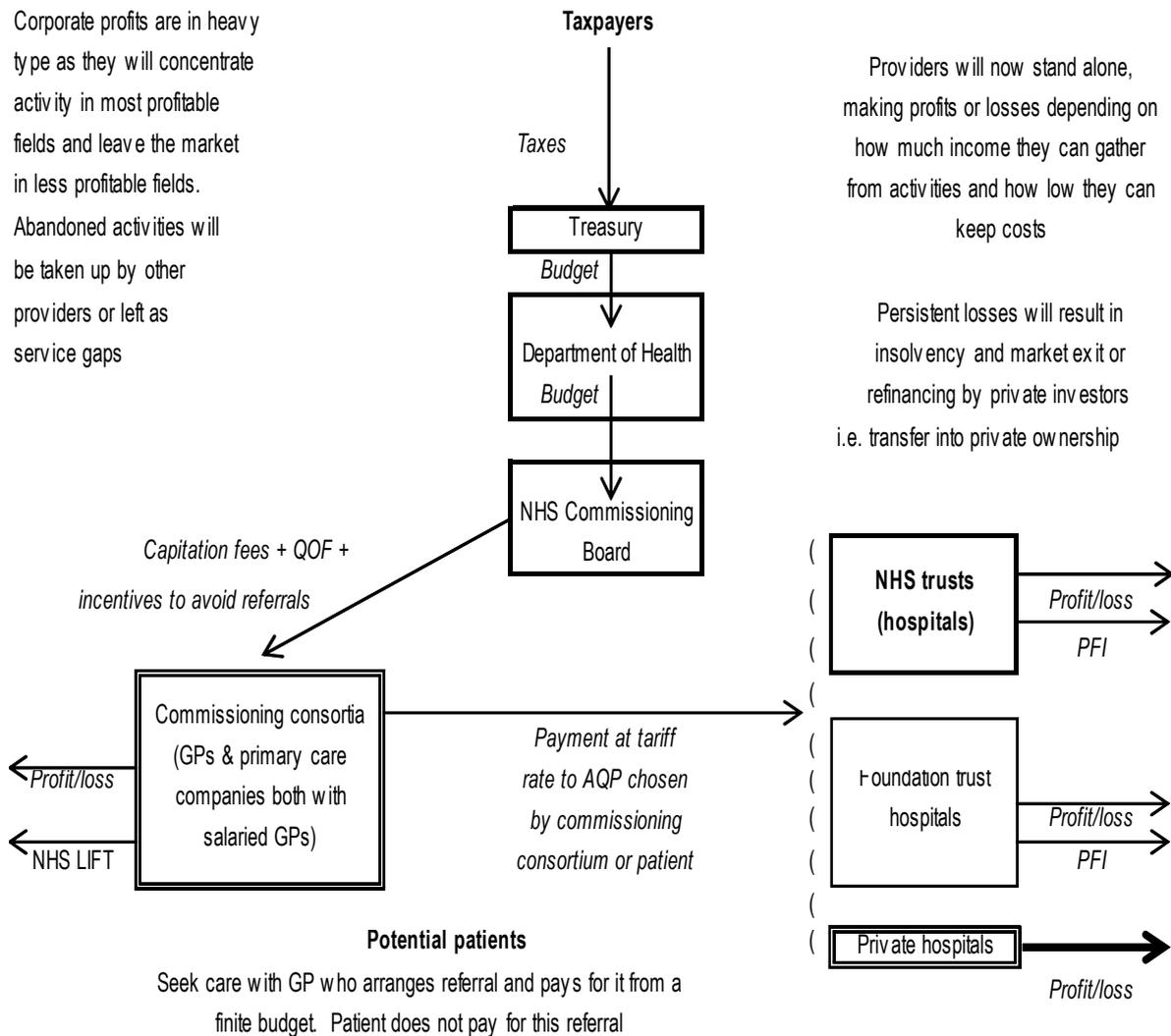
ARRANGEMENTS JUST AFTER THE BILL IS PASSED - market-led, mixed provision

This is a transitional arrangement which is unlikely to be financially or organisationally stable in a market-led system. Government has stressed that the market-led system relies on easy entry and exit to/from the market therefore failing providers in primary or referral care will not be rescued from insolvency unless they provide "designated services" (s 69 of the Bill), which are likely to include accident and emergency services, at the choice of local commissioners.

Corporate profits are in heavy type as they will concentrate activity in most profitable fields and leave the market in less profitable fields. Abandoned activities will be taken up by other providers or left as service gaps

Providers will now stand alone, making profits or losses depending on how much income they can gather from activities and how low they can keep costs

Persistent losses will result in insolvency and market exit or refinancing by private investors i.e. transfer into private ownership



2. History of the Lansley Reform

The pro-market Centre for Policy Studies (CPS), the key Conservative think-tank in the 1980s, published a series of papers setting out options to increase private health care provision within the NHS. Conservative MPs Oliver Letwin and John Redwood presented a pamphlet³ suggesting an NHS reform which we can now see provides a coherent justification for the trajectory of change to the NHS that we have seen implemented by the governments in power since that time.

John Redwood's website notes that:

*"In the mid-1980s he was Chief Policy Advisor to Margaret Thatcher. He urged her to begin a great privatisation programme, and then took privatisation around the world as one of its first advocates before being elected to parliament. He was soon made a minister, joining the front bench in 1989 as Parliamentary Under-Secretary in the Department of Trade and Industry."*⁴

During this period Redwood also headed the International Privatisation Unit for pioneering privatisers NM Rothschild and Sons Bank⁵. It has been reported that Letwin has also held directorships and shareholdings of several members of the Rothschilds Group from 1991 to 2009^{6,7,8}.

Oddly, this 1988 pamphlet on the need for NHS reform does not mention health outcomes. Instead it sets out its stall with a critique of NHS administration. An attack on public sector administrative functions is a typical part of the "rolling back the state" narrative used to justify privatisation.

The other main issues which Letwin and Redwood consider as grounds for radical reform are the lack of luxury in NHS facilities, and waiting lists, which at the time had indeed grown to be a serious problem due to chronic underfunding, a matter since rectified.

The authors set out a staged plan to resolve these issues:

1. *NHS to be established as an independent trust (or trusts)*
2. *Increased use of joint ventures between the NHS and the private sector*
3. *'Extending the principle of charging', commencing with a system of 'health credits' to be combined with a contributory national health insurance scheme based on personal health budgets*

These recommendations were not implemented at the time by the Thatcher government, but the first two steps of the plan have since commenced.

We are about to see the next stage evolve if the 2010/2011 Health and Social Care Bill passes into law; this is the enabling legislation needed for the last step to be put in place.

3. Implementation of the Redwood/Letwin Plan in the Lansley reform

Oliver Letwin is now in the Cabinet, where he serves in the newly-created post of Minister of State for Policy. He was recently rated Number 2 out of the top 100 most influential people in the NHS by the Health Service Journal⁹.

The Health and Social Care Bill requires that all NHS hospitals that are not already foundation trusts must become FTs as soon as they can, and the government has made clear that they will be encouraged to leave the public sector entirely¹⁰ through management buy-outs thereafter.

The Bill abolishes strategic health authorities and Primary Care Trusts, and sets up an almost-independent quango to dispense the NHS budget. 80% of the total budget will be paid to the different free-market providers who will win contracts to supply treatment and care to patients, administered by GP commissioning consortia (now renamed clinical commissioning groups¹¹).

The Bill prepares the ground for outsourcing of all other NHS activities into the market. Existing NHS hospitals are to be gradually moved into the private sector via foundation trusts and management buy-outs, where they will compete against the new market entrants for opportunities to be paid for treating patients.

Key corporate players under the new competitive regime seem likely to include:

- UnitedHealth, a health insurance company and health maintenance organisation (HMO) already involved in NHS commissioning¹², which has settled an accusation of major fraud out of court against the US Medicare scheme which funds health coverage for elderly US citizens¹³;
- Hospital Corporation of America, which admitted its guilt in a case of Medicare fraud, leading to the then largest ever fraud settlement in US history¹⁴;
- General Healthcare Group (GHG), a subsidiary of the South African corporation Netcare, which pleaded guilty to illegal organ transplants¹⁵;
- Care UK, owned by private equity firm Sovereign Capital; just before the last election, the wife of one of the owners of this firm allegedly contributed £21,000 to Andrew Lansley's private office, according to the Daily Telegraph¹⁶.

4. Subsequent steps once the Lansley Health and Social Care Bill is enacted

In 1988 Letwin and Redwood discussed the merits of charging for care as a way of reducing waiting lists (by excluding those unable to pay from joining the list), and then explored the idea of transitioning into a US-style health insurance regime via a system of credits and top-up private health insurance.

Later in 1988, still writing for the Centre for Policy Studies, Redwood¹⁷ proposed that groups of GPs could act as HMOs, purchasing services from the marketplace. This is clearly the model for the current move to GP commissioning consortia. Another 1988 CPS publication¹⁸ co-authored by MP David Willetts explicitly suggested importing the US model of competing HMOs into NHS provision.

Conservative think-tank Reform has according to the BMJ been funded by at least three of the prospective entrants to the new English healthcare regime (GHG, and management consultants KPMG and McKinsey who are involved in NHS commissioning)¹⁹. Its 2008 paper on the NHS sets out a plan for conversion of the NHS to an insurance-based system with personal top-up payments²⁰.

Informed observers have concluded that this arrangement is the one we are seeing being put into place now:

“The unavoidable conclusion is that the Government is aiming to install the ‘managed care’ framework prevalent in the US, characterised by corporate-controlled service delivery and commissioning governed by the risk-minimising and profit-maximising principles of the health insurance industry.....

Service delivery, once based on the assessment of needs, will be reassessed on the basis of financial risk. Those patients most in need will, of course, constitute the greatest risk, and can hardly expect to be well served by the cost containment and “cherry-picking” characteristic of the Health Maintenance Organization (HMO) model.”²¹

This plan is alluded to in the 2010 White Paper, in the opaque phrase:

“money will follow the patient”²²

Private healthcare insurers are already introducing compatible products for the English market²³ in preparation for the move to an insurance-based system.

Figure 3 embodies our best guess at the NHS structure as it may look five to ten years from now:

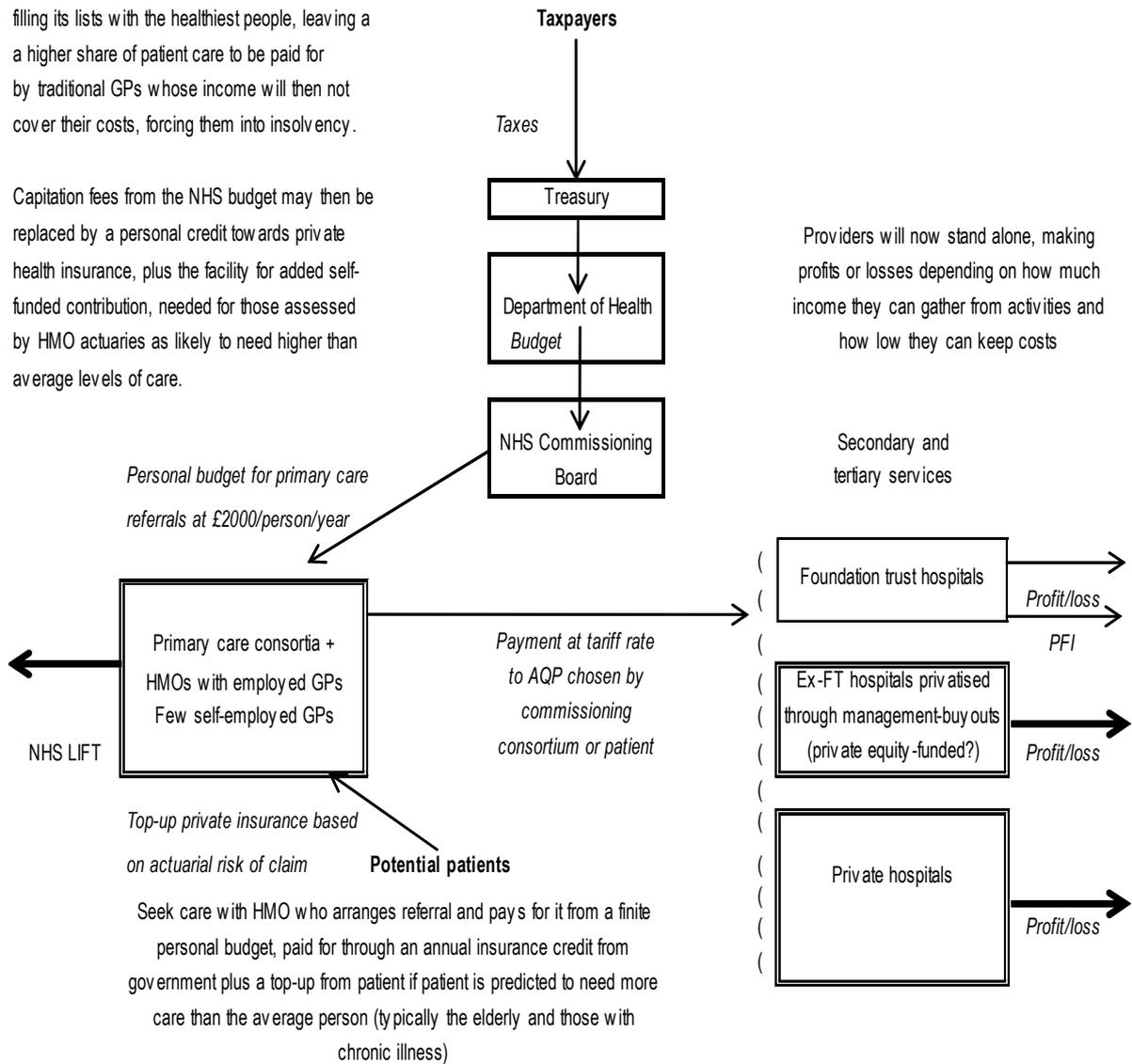
Figure 3

EXPECTED ARRANGEMENTS IN A FEW YEARS - market-led, mixed provision, managed care model dominates

Balance of provision expected to shift away from public sector into private sector as NHS hospitals become foundation trusts, FTs are bought out or fail financially and are taken over, and the corporate sector uses advertising to build market share in the most lucrative services.

Independent GPs may mostly have been driven out of the market through HMOs' manipulation of the capitation fee system to maximise profits by filling its lists with the healthiest people, leaving a higher share of patient care to be paid for by traditional GPs whose income will then not cover their costs, forcing them into insolvency.

Capitation fees from the NHS budget may then be replaced by a personal credit towards private health insurance, plus the facility for added self-funded contribution, needed for those assessed by HMO actuaries as likely to need higher than average levels of care.



* The Economist. Waste Measurements: US healthcare spending. 17 June 2011. Plus 2009 OECD spending figures and 2010 US Census data <http://www.economist.com/blogs/daily-chart/2011/06/us-health-care-spending>

** Okma KGH, Marmor TR, Oberlander J. Managed Competition for Medicare? Sobering Lessons from the Netherlands. N Engl J Med 2011; 365:287-289 July 28, 2011

5. “Liberating” the NHS

In 1988 the book "Privatising the World: A study of International Privatisation in theory and in practice", was published; it was authored by Oliver Letwin, and prefaced by John Redwood²⁴. It includes a ten-page guideline for privatising public assets against the wishes of the electorate, a formula which has been faithfully followed in the case of our health care system²⁵. The recommendations focus strongly on misdirection and misinformation, tactics in this case evidenced by the government's justification for the reform as necessary to improve substandard health outcomes and the comparative costliness of the NHS system: neither of these assertions is supported by the evidence^{26,27,28,29,30}. The stage-managed “listening pause” is another example, generating many amendments, none of which threaten the privatisation plan^{11,31}, and many of which are likely to cause extra chaos as the NHS is dismantled³².

A former NHS Director of Commissioning has been marketing commercial opportunities arising from the NHS privatisation to US private equity firms. In his new role as Head of Health for the management consultancy firm KPMG (which has been instrumental in designing the NHS reform³³) he addressed a conference of potential investors in late 2010 about the plans. They were explained to this audience with a clarity missing from our domestic debate about the reform³⁴:

“In future, the NHS will be a state insurance provider not a state deliverer. In future ‘any willing provider’ from the private sector will be able to sell goods and services to the system. The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years.

GPs will have to aggregate purchasing power and there will be a big opportunity for those companies that can facilitate this process.

The monolithic arm of state control will be relaxed which will provide a huge opportunity for efficient private sector suppliers.”

It seems we are now close enough to envisage the end game of NHS privatisation^{35,36,37,38}, with the new owners of the bulk of our healthcare system HMOs and private equity investors rather than the British people.

In his book on privatisation, Letwin observed that without rigorous and extensive enforcement of contractual performance, privatisation produces services of inadequate and sometimes unsafe quality: he cites outsourcing of hospital cleaning as one example³⁹. Ironically, he was writing before that particularly unwise course of action resulted in the MRSA epidemic^{40,41,42} that has claimed many lives: between 1993 and 2009 it was cited as the cause of death for 3,440 people in England (excluding newborns)⁴³. It also resulted in huge extra costs for the NHS when whole wards had to be quarantined for decontamination. The private sector has by now concluded that, in its own operations, outsourcing is often more expensive and more troublesome⁴⁴; large-scale outsourcing

“may represent a false economy once the risks and hidden costs of this approach are factored in properly”⁴⁵

Nevertheless our elected leaders are intent on outsourcing the whole of the NHS, with regulation to be sure, but by regulators whose budgets will be wholly insufficient to safeguard patients from predatory practices in the pursuit of profit due to the simultaneous Coalition battle against regulatory “red tape”⁴⁶.

Perhaps the politicians behind the NHS privatisation reform understand these drawbacks, and thus are disingenuous in their claims that the planned changes will save money and improve service^{47,48,49}. Perhaps they do not understand them, and merely follow the guidance of their advisors, their sponsors, and the beneficiaries of their policies (too frequently these are the same organisations and individuals^{50,51}). Neither possibility is acceptable in the matter of something so important to our country as the fate of the NHS.

6. Party positions and policy drivers

The Conservative position on privatisation is documented above. The outsourcing next year of 10% of the NHS budget, that relating to community health services, was announced by the Coalition in July 2011, and the next tranche of this privatisation will be announced shortly⁵².

Liberal Democrat David Laws attempted unsuccessfully to have his party adopt a move to the kind of individual health insurance arrangement described above⁵³, and in the “Orange Book” he set out an argument for a shift away from the NHS as an exclusive provider and towards wholesale outsourcing of NHS provision into the private sector⁵⁴. As John Redwood himself has recently stated:

“extensive NHS reform was also proposed in the Lib Dems 2010 Manifesto, which said nothing about ending privatisation or ending the Labour cuts to management”⁵⁵

Labour’s travel down the same path, and the story of how they extended and developed the necessary legal and organisational framework within the NHS (conversion of NHS hospitals into stand-alone foundation trusts, subsidies to the private sector from the NHS budget, and the introduction of competitive commissioning) is comprehensively documented in a recent book by Leys and Player⁵¹.

In 2000 Gordon Brown was allegedly already briefing financiers on opportunities to invest in:

“core services, which the government is statutorily bound to provide, and for which demand is virtually insatiable. Your revenue stream is ultimately backed by Government. Where else can you get a business opportunity like that?”⁵⁶

So why such cross-party unanimity about something so much against the public will and the public interest? The key may be found in

“Political economist Thomas Ferguson’s ‘investment theory of politics’...the thesis that to a good first approximation, we can understand elections to be occasions in which groups of investors coalesce to control the state, a very good predictor of policy over a long period, as he shows.”⁵⁷

It seems that the companies interested in moving into NHS-funded provision are content with the progress of the reform. The 2011 post-script to Leys and Player’s book says:

“The chief executive of the largest private healthcare provider, the General Healthcare Group, expects the private sector to expand both from competing for NHS work and from the fact that the NHS won’t be able to meet demand, thanks to the cuts, so that demand for private care will also increase. A majority of private sector health company chief executives think that the government will follow through on most of the promises made to the private sector in Lansley’s Bill (Dowler, 2011⁵⁸). This calculation will be based partly on their close links to Lansley and his supporters in the Conservative Party, but also on the fact that Primary Care Trusts are already being dismantled and replaced by ‘shadow’, or so-called ‘pathfinder’, GP Consortia”⁵¹

So we are already moving from a system where, in general, clinicians are driven by patient need and the medical evidence, to one in which providers are keen to perform as many tests and treatments as possible in order to maximise their income, with commissioning groups/HMOs endeavouring to stop them doing so in order to maximise their own profits. This will be a much more expensive arrangement, due to the need to pay for all the extra administration involved, to cover marketing costs, and to fund shareholder dividends. Some patients will be denied care they need, while others will receive unnecessary interventions^{59,60}, due to the perverse behavioural incentives inherent in the new system⁶¹. All this is for the benefit of the commercial interests which seem to have effectively taken control of our democratic process.

7. What now?

It is time to defend our system of health care, provided to those in need from pooled contributions across society which are made when people are most able to pay. Our current system has benefitted from substantial recent investment, simultaneously producing strong health outcomes in comparison with other developed countries and excellent cost-effectiveness^{26,27,28,29,30}.

The general public rates the services they have received highly⁶², but they have been misled by all the talk of “modernisation” and “choice” into believing that this reform is intended to improve the NHS and not to destroy it. The evidence presented here clearly refutes these beliefs.

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