New dimensions in privatisation
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Ten years after Tony Blair took office pledged to sweep away the "costly and wasteful" internal market system, ministers are committed to imposing a market system that is even more costly and wasteful; they have almost trebled health spending but increased ten-fold the NHS spend on private sector health care, and in the process have fostered the artificial creation of a brand-new private sector which has no viable existence in its own right, and is entirely dependent on government sponsorship.

Worse, the obsessive focus on market-style reforms and expanding the private sector mean that the real achievements that have been notched up since 1997 – the dramatic reductions in waiting times and improvement in cancer, cardiac and other key areas of care – have been wrongly attributed to the "reforms", and not to the simple, old-fashioned expansion of bed numbers, staff and budgets that really did the trick.

New Labour seems to have lost the plot: their 'third way' mantra of rejecting 'dogmatism' against use of the private sector has become a dogmatic insistence that the private sector has a key role to play – regardless of the lack of any real evidence in this country or elsewhere to support this view.

Of course ministers hotly dispute the word 'Privatisation': they argue that the NHS as a whole remains a public service funded through taxation, delivering services free of charge at point of use.

But in reality they have added a new dimension to the term "privatisation", which in the context of the National Health Service used to mean the contracting-out of non-clinical support services to private companies – a policy driven forward in the mid 1980s by a Thatcher government that always insisted that clinical care would remain within the NHS.

Competitive tendering was introduced across the NHS ancillary services: a terrible price was paid, in terms of a loss of a skilled and dedicated NHS workforce and declining standards of hygiene, for the minimal, largely short-term "savings" that were achieved, mainly through cuts in the numbers, pay and working conditions of already low-paid staff.

But the onslaught was largely on support services. Even when Kenneth Clarke embraced the notion of the Private Finance Initiative as a means to privatise the provision of capital for NHS projects, he and successive ministers were at pains to stress that this would not involve the privatisation of clinical care.

New Labour has swept away this distinction: under Blair and Brown, a growing number of services in hospital, community and primary care are also being handed

over to private providers. Multinational firms are bidding for contracts to run GP surgeries and a host of other services.

The expansion of private sector provision has been far larger and more rapid than many expected. Under John Major's government prior to 1997 the NHS was buying no more than an estimated £96 million of operations a year from private hospitals, mainly through the activity of fundholding GPs: the entire private market in NHS services was less than £200m a year (Timmins 2005).

This year, contracts for patient care with private hospitals, treatment centres, diagnostic services, psychiatric services and nursing homes amount to more than ten times that total, over and above the continuing contracts for hospital ancillary and other non-clinical services "outsourced" since the mid 1980s, and the soaraway sums involved in Private Finance Initiative hospitals and primary care services privately financed through LIFT schemes, all of which have taken place since 1997.

The Tory government never succeeded in signing a single hospital deal under PFI, because ministers would not make sufficient concessions to ensure the private sector carried no real risk. Now PFI payments for the hospitals already completed are estimated to be already costing an extra £500m a year above the equivalent cost through public financing, with many of the very biggest schemes still in the pipeline and yet to levy their first charges. The cost of PFI in the NHS has been officially estimated at a staggering £53 billion repayments on investments totalling £8 billion – with upwards of £20 billion available as a guaranteed profit stream for shareholders, and even more to be made in windfall profits from refinancing deals.

In addition the first contracts are already being signed for a second wave of "independent sector treatment centres" (ISTCs) which are expected to cover up to 200,000 elective operations a year, despite growing doubts on whether this additional capacity is genuinely needed, or whether the first wave ISTCs are delivering value for money (Timmins 2007).

The second wave ISTCs are now expected to bring the private sector total to around 370,000 patients a year – a significant number, but well short of the 500,000 originally proposed, and even further short of the 15% of elective operations, as suggested by John Reid when he was Health Secretary (which would equate to 900,000 a year). The total spent on private treatment and diagnostics may fall short of the target £1 billion per year.

So is all the concern over the impact of the private sector exaggerated?

Ministers claim that the NHS cannot deliver its ambitious targets to reduce waiting times without using "extra capacity in the private sector" – but they have never bothered to explain why it would not be better value and more sustainable to expand NHS capacity. They wildly exaggerate the impact of the policies implemented so far, claiming last autumn that:

> "400,000 people have been taken off hospital waiting lists since 1997. 114,000 – 1 in 4 – have had their operation in an ISTC …" (PLP 2006)

In fact the NHS carries out around 6 million elective operations a year: the pinprick of the 1.3 percent of elective operations carried out last year in ISTCs must be set against the loss of revenue from NHS Trusts, which is even now destabilising local NHS orthopaedic, ophthalmic and other departments as cash is pumped out to private providers.

Ministers now admit that the average surplus paid on ISTC contracts is 11.2% above NHS tariff – which effectively means that for every 9 patients treated in ISTCs, the NHS could have afforded to treat 10 if the cash had been kept in the public sector. But the caseload is not comparable: the ISTC and diagnostic contracts specify that the private sector will accept only the most straightforward and uncomplicated cases, which are cheaper to deliver – and leave all the more expensive and risky cases to the NHS.

These private sector contracts have brought with them a requirement to restructure the financing of NHS Trusts, to allow a chunk of the public sector budget to be spent elsewhere. This is why ministers have imposed the complex system of "payment by results" which pays NHS Trusts on a fixed tariff per item of treatment delivered – but ensures that each and every patient who chooses or is directed to go elsewhere for treatment takes the money with them, and leaves a hole in the budget.

The private sector is exempt from payment by results: instead ISTCs get long-term contracts – many of them on a guaranteed "play or pay" basis, which mean private for-profit providers are assured of an annual payment regardless of how few patients opt or can be cajoled into using their services.

Ministers say they want "contestability" with s "sustainable independent sector" as a means to improve NHS services (DoH 2005): but the "contest" is purely a one-way process, since NHS Trusts and Foundations are explicitly barred from bidding for ISTC contracts, while the private sector gets subsidies for start-up costs, preferential rates, and is exempt from "payment by results".

So ALL of the risk, uncertainty – and prospect of cutbacks and closures – remain firmly in the public sector, with Trusts with £200m and larger turnover now left to guess how much they will receive for patient care, while the private sector is encouraged to expand.

The expansion of the private sector since 1997 increasingly threatens to take place at the expense of and in place of NHS provision, rather than delivering "additionality" by supplementing NHS capacity.

The case for private sector involvement has always been ideological rather than financial – since, like most of New Labour's restructuring reforms, it has resulted in higher costs and overheads, and been delivered despite the absence of any supporting evidence to show its effectiveness. This helps explain how ministers have combined the double whammy of increasing spending to record levels while at the same time annoying, confusing and demoralising such large sectors of the NHS workforce.

No relief or rethink seems to be in sight. Pensions Secretary John Hutton in a speech to the CBI business lobby on May 16, argued that the 'reforms' imposed on the NHS

and other public services, including "marketisation" and "an open-minded approach to who provides" have now been "built into the DNA" of public services, and "Gordon Brown has been at the heart of this process".

Cabinet Secretary Gus O'Donnell, speaking to a Price WaterhouseCoopers forum has also praised the role of market-style policies, insisting that "we need market incentives to improve efficiency". Apparently unaware of the contradiction, O'Donnell also admitted that an essential element to usher in the level of "choice" that Blair and Brown have promised is that "you have to have some spare capacity".

But the existence of unused spare capacity – especially if some of it is additional capacity provided by the private sector at increased cost above NHS rates – is by definition LESS efficient than making full use of the appropriate amount of capacity. In fact the new system of "payment by results" ensures that the NHS cannot afford to maintain spare, unused capacity: Trusts are forced into contemplating cutbacks and closures when patients are diverted to private treatment centres.

This is the backdrop to the round of rationalisation and closures that has been looming in the wings across much of England since last autumn, and which has only been held back by the political impact of strong local protests. New Labour seems set on a course of cutting back popular public provision … to make room for private companies that no campaigners have demanded or endorsed.

One classic current case study underlines the contradictions of New Labour's privatisation and "reforms". Despite having apparently complied with virtually every aspect of the government's regime of targets and reforms, Hinchingbrooke Health Care Trust (HHCT) in Huntingdon has become one of the most obvious victims of the market-style reforms introduced by New Labour.

- As a historically low cost provider, but unable to claim additional cash under the new tariff, HHCT has lost out under Payment By Results;
- its Treatment Centre – funded through PFI at a total cost of £93m for a £22m unit – has been starved of referrals, as PCTs have reneged on agreements;
- its caseload has been squeezed by Foundation Trusts in Peterborough and Cambridge;
- its budget is to be cut to allow the PCT to send NHS patients to private hospitals;
- and the merger of Cambridgeshire's PCTs has lumbered Huntingdonshire's health services with new deficits, squeezing HHCT's budget.

Efficient, low-cost NHS Trusts like HHCT have been denied any opportunity to compete on level ground with private providers: and as a consequence the public sector provision is being run down to create space for a new private sector.

Ministers are pressing ahead regardless. R. Channing Wheeler, a senior executive from the American health insurance market, recently secured one of the top positions in the NHS management structure, commissioning services from private and NHS providers.

Wheeler was chief executive of a subsidiary of UnitedHealth, collecting a seven-figure salary plus perks for administering a system which makes its hefty profits by selecting risks and limiting coverage to the young and prosperous, and excluding those most likely to get sick and make claims. Exactly what aspect of this private sector expertise equips him to play any useful role in the delivery of universal and comprehensive health care services to the British public has not been explained.

But his appointment is symptomatic of the dominant thinking among New Labour ministers: that despite the facts and figures which show that around the world private medicine is more expensive, more exclusive, more dangerous, more bureaucratic and less efficient, and despite the fact that nowhere in the world does the private sector deliver – or aspire to deliver – a comprehensive or universal health service, somehow private is superior to public sector provision of health care.

As Gordon Brown eases into office, and prepares to reinforce the drive for "reform" of public services, it's high time he heard more high profile voices calling for a rethink on policies that could well make him a one-term PM, send the private sector laughing all the way to the bank, and leave all the rest of us feeling sick.

REFERENCES

DoH Department of Health (2005)Independent Sector Procurement Programme, (Phase 2 - Elective Care Services PQQ Part 1) 8 September.
PLP (2006) *Brief from Labour's Health Team*, November
Timmins N (2005) Election 2005: from millions to billions in eight years, *Financial Times* April 19.
Timmins N (2007) Healthy predictions fall short, *Financial Times*, April 30