

## **Press Briefing**

# **Andrew Lansley's Health and Social Care Bill: Privatising health care**

This massive 367-page Bill follows on last year's White Paper entitled 'Liberating the NHS,' which was mainly summed up by the media as a proposal to hand £80 billion of NHS commissioning budgets to GPs, and scrap Primary Care Trusts and Strategic Health Authorities.

However the Bill, like the White Paper is about much more than GP commissioning and unpopular management structures: it represents the most concerted-ever attempt to privatise the provision of health care in England – indeed the biggest privatisation of health care anywhere in the world. Nobody voted for this. The proposals did not appear in either coalition party's election manifesto.

### **Competition**

Despite strenuous denials by Lansley and David Cameron that it is ideologically driven, the Bill is based not on any evidence that any of its largely experimental proposals and organisational structures can deliver the promised results, but rests purely on the ideology of the market. Central to the Bill is the Thatcherite belief in competition as a way to drive down costs and improve quality – regardless of abundant evidence from the UK, the US and elsewhere that this is not the way competition works in health care.

To clear the decks for a new competitive market in health care, all of the public sector bodies managing and providing NHS care in England – Primary Care Trusts, Strategic Health Authorities and the remaining NHS Trusts – are to be abolished, and replaced by a system in which commissioning will be done by private companies acting in the name of GP consortia, and services will be provided by a range of providers including a growing number of social enterprises and for-profit private companies, as well as Foundation Trusts.

### **Fragmentation and inequality**

The Bill does not require GP consortia to work together with each other, and this leaves a real possibility of neighbouring consortia taking very different decisions over access and services from local providers, potentially triggering financial problems in Foundation Trusts and reductions or loss of local services which cease to be viable.

The danger of a new "postcode lottery" of unequal access to health services from one area to the next is also increased by entrusting GPs, whose track record on commissioning and financial controls has been consistently poor, to handle such large budgets for which they have no training or expertise.

Previous experiments in GP Fundholding in the 1990s saw huge surpluses retained as wealthy GP practices held on to funds, while Labour's efforts at "Practice Based Commissioning" have revealed a consistent pattern of under-achievement and overspending.

Nor is there evidence that GPs are the best drivers of quality improvement: as the Health Service Journal points out, uneven performance at primary care level has persisted despite repeated attempts to use incentives and other measures to improve it: many of the poor cancer outcomes cited by Lansley as a reason for the reforms are the reflection of poor rates of early detection in primary care, which will not be addressed by the policies in the Bill.

## **Obstructing quality improvement**

Clearly GP services are not the only ones which need to be improved. However the new system will obstruct any coordinated attempt to improve quality of care, by entrenching divisions between medical professionals, and loading most of the financial pressures on to the hospital sector. Despite the fact that collaboration and sharing best practice is recognised as the most effective way to improve the quality of care, competition law will also obstruct the healthy collaboration and cooperation between health professionals and specialists. Instead of integrating services, they are being split and fragmented to create a competitive market.

## **Price competition**

European and British competition laws and a more powerful NHS regulator, Monitor, will ensure that GP consortia, regardless of their wishes, can be obliged to put any service out to tender to "any willing provider", with no protection for the existing public sector providers which carry the heavier risks, costs and caseload.

Lansley's Bill opens up for the first time the reality of competition on clinical services between rival providers based on price – in the threatening context of an NHS seeking £20 billion of "efficiency savings" by 2014.

Even NHS chief executive Sir David Nicholson has warned of the dangers of price competition in health. Under Thatcher in the 1980s the tendering of hospital cleaning services inseparably linked the concepts of privatisation and poor quality, demonstrating beyond doubt that price competition in health care brings a race to the bottom in quality of service. More than two decades later hospitals are still carrying the consequences of privatisation in the prevalence of MRSA and other hospital-borne infections, and in many hospitals a casualised domestic workforce.

While the private sector is now to be offered big new opportunities to pick off profitable sectors of clinical services, it also retains the freedom to pick and choose which services it wants to bid for. As a result Foundation Trusts will be left carrying the costly responsibilities for sustaining other areas of care the

private sector sees as financially unattractive – notably emergency care, the frail elderly and chronic sick, and most mental health.

## **Cap lifted on income from private care**

But FTs are also to be encouraged to act more like private businesses, and to take more private patients. All limits on the amount of income FTs can raise from private practice will also be removed by the Bill, allowing them to maximise private work – at a time when NHS budgets are frozen for years to come despite rising costs, and NHS tariffs for treatment are being reduced.

In other words many FTs are certain to see expanding their income from private patients as the only escape from the cash squeeze; the only way they can increase their revenue and hope to balance their books. Private patients from the UK or overseas will be much more financially attractive to FTs than NHS patients, who will become second class citizens in their own local hospitals.

## **One million staff face privatisation**

The combination of cuts and privatisation mean that up to 1 million of today's NHS employees in England could be out of the NHS by 2014, being either employed in a variety of private for-profit or social enterprise providers, or having lost their jobs altogether. Tens of thousands of jobs will be axed, whether through large-scale cuts and closures triggered by the £20 billion savings target, or through the abolition of PCTs and SHAs, or through their NHS employers losing contracts to private providers, whether for-profit or non-profit.

But the privatisation will affect all providers: Lansley has also made it clear that he wants FTs, currently part of the NHS, with staff enjoying NHS pay scales and terms and conditions, to be removed from the NHS and Treasury balance sheet, and transformed into social enterprises – putting the NHS terms and conditions and pension rights of staff into doubt. This seems to be the Conservative 'final solution' to the NHS pension gap.

## **Less local accountability**

For the wider public, the Bill is also a disaster for local accountability. For all their weaknesses, and the arrogance of many chief executives and senior managers in pushing through unpopular policies, PCTs and SHAs are public bodies: their meetings are open to press and public, they publish their board papers and have to consult over major changes.

They are to be replaced by GP consortia and a remote, centrally-controlled NHS Commissioning Board. These bodies will meet behind closed doors, publish little or no information on their finances, their plans or their discussions, and be required to hold just one token meeting a year open to the public.

This means that these new commissioning bodies, operating under massive, unprecedented cash constraints, will be able to take far-reaching decisions to

close, remodel or reduce access to local services with no public consultation or prior debate. The first you will hear about your A&E closing or a change of provider of a local service will be through a Press Release after the decision has been made. £80 billion and more of public money will be handled behind closed doors, with no scrutiny by public or press. With such large sums being signed over in contracts there must be concerns over conflicts of interest and possible corruption.

The same secrecy will apply in the providers of health care. NHS Trusts are required to become Foundations or be taken over by one by 2013: but most Foundation Trusts have so far also exercised their right to meet in secret, publish no board papers, and hold just one meeting a year. Social enterprises and for-profit companies are not even obliged to do that. Under Lansley's NHS you will know less about your health services than ever before.

### **Excluding services from the NHS**

It's important to see this in the context of the rapidly growing lists of services and treatments which local Primary care Trusts have already begun to exclude from the NHS as they seek to cut spending. In some PCTs over 200 treatments, including those of proven effectiveness such as joint replacements, are already routinely denied to NHS patients to save money, with rationing of IVF treatment and AIDS drugs: concerns over this were recently highlighted by the Royal College of Surgeons. GP consortia, under massive financial pressure, will have to take over this rationing function, becoming little more than rationing boards.

'Patient choice' for those denied the treatment they need under the NHS will be a simple one: either go private, and pay through the nose for treatment that used to be free at point of use – or go without.

### **Privatising commissioning**

In practice most consortia will of course not carry out the actual commissioning work themselves. The GPs are not trained or properly resourced to do this. They will employ management consultants, either regrouped staff who formerly worked for PCTs and SHAs, or through private companies such as KPMG and United Health which have welcomed Lansley's reforms, seeing the profitable openings that they may be able to exploit.

In West London the Great Western consortium covering the whole of Hounslow has already recruited a team from hard-faced US health insurer UnitedHealth to police all referrals for hospital care, with a brief to reduce spending. This "referral management" is likely to become the norm, bringing profits galore for consultancy firms, but over-riding GP decisions and making a nonsense of "patient choice" and Lansley's ridiculous claim of "nothing about me without me".

However the reduction in management resources, and the transfer of responsibilities to GP consortia raises huge doubts over the 100+ statutory

duties and roles currently undertaken by PCTs, on which Lansley's Bill appears to be silent – including crucial areas such as child protection and mental health. There are also doubts over the future of medical and nursing education, currently controlled by SHAs.

### **Public health hived off**

Public health responsibilities, up to now shouldered by PCTs, are to be passed to local councils – at a time they are already reeling from massive 28% cuts in their government funding, and struggling to maintain even their statutory obligations. Social care for the frail elderly of course has since 1993 been largely consigned to council social services, where it remains subject to means-tested charges and to rigorous “eligibility criteria” leaving many vulnerable people lacking the support they need and facing more cuts.

This miserable track record gives little reason to believe that even though the public health movement began in local government in the 19<sup>th</sup> century, today's hard-pressed councillors or council officers will be willing or able to give the priority that is needed to the kind of preventive and proactive public health measures that should improve health and reduce illness in the long term. This change seems above all to be a means of shrugging off central government responsibility for an under-resourced sector, and setting up councils to take the blame for future problems.

### **Ignoring medical advice**

In forcing through these experimental changes Lansley has chosen to ignore not only the health unions and the views of the hundreds of thousands of front line staff they represent, but also a majority of GPs, and virtually every body of health professionals including the Royal College of GPs and the BMA, and more or less every think tank and serious academic: he has brushed aside concerns from the Commons Health Committee and a GP from his own parliamentary party. Only the private sector providers and management consultancies have welcomed proposals which they see offering billions in lucrative contracts – at the expense of existing public sector providers.

The Bill also gives the lie to Lansley's bogus promise of no more top-down change or major reorganisation in the NHS – which have been consigned to the bin along with his discarded promises of a moratorium on cuts and closures of A&E and maternity units, and of real terms increases in health spending in each year of the government (in practice the nominal 0.1% annual increase in spending is far below levels of inflation and rising cost pressures).

### **Ignoring patient views**

The White Paper itself contained another cynical promise of patients playing a greater role in the mantra “nothing about me without me”: in fact the so called ‘pathfinder’ GP consortia have already been established with no prior

consultation or public support, giving a foretaste of the complete lack of any local accountability in the new market-style NHS Lansley seeks to establish.

The much-vaunted Health and Wellbeing Boards – which will replace councils' existing Oversight and Scrutiny committees, but have even less power to intervene and challenge decisions – will be stitched up between council officers and local consortia, with only token involvement of elected councillors and no requirement to include patient representatives or the wider public.

The “Local Healthwatch” groups will also be toothless information and advice bodies, controlled from the top down by the Care Quality Commission, and are also not obliged to include more than token public involvement.

## **No mandate**

The coalition has no mandate for these policies, which go far further than even Margaret Thatcher attempted down the road of privatising our health care. If Lansley gets his way the “National Health Service” will be little more than a fund of taxpayers' money controlled by private management consultants on behalf of GP consortia, and used to finance treatment from a range of private for-profit and non-profit providers.

The new system would be more fragmented, more unequal and far less locally accountable than ever, but also less efficient, with potentially billions siphoned off in private profit rather than spent on patient care.

Campaigners opposed to these policies will be fighting tooth and nail to kill the Bill and stop the ConDem coalition carving up our NHS and turning it into a National Health Market. There is a broad popular consensus of health workers, health unions, service users, pensioners groups, the wider public which is opposed to the plans, or would be if they know what was coming.

This Briefing has attempted to distil the key areas of concern. Campaigners will now seek to turn that concern into political action.

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