



Argumentum

E-ISSN: 2176-9575

revistaargumentum@yahoo.com.br

Universidade Federal do Espírito Santo
Brasil

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Argumentum, vol. 3, núm. 2, julio-diciembre, 2011, pp. 190-210

Universidade Federal do Espírito Santo

Vitória, Brasil

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ARTIGO

British social policy: the case of health policy¹

A política social britânica: o caso da política de saúde

Paul BYWATERS²

Abstract: This paper is about the targeting of the UK health service by private international health care corporations who want to get their hands on the £200b annual budget and the collusion in that project by successive governments, including the present administration led by David Cameron which is the most ideologically driven government that we have had in the UK in my lifetime – more radical in their dismantling of our welfare state than Margaret Thatcher in the 1980s but building upon her legacy. It is a tale about neo-liberalism, about the power of global business interests, about privatisation, about reducing the role of the state, and about a weak democracy. And so it is a cautionary tale about progress – even when affordable universal health care has been secured, it is not immune from attack and from being reversed.

Keywords: Health policy. UK. Social policy.

RESUMO: Este trabalho aborda as medidas direcionadas ao serviço de saúde do Reino Unido por empresas internacionais de saúde, que querem colocar as mãos no orçamento anual de £200 bilhões e na conspiração desse projeto que vem de sucessivos governos. Isso inclui a atual administração de David Cameron, que é o governo mais ideologicamente impulsionado que tivemos em toda minha vida — mais radical em dismantlar nosso estado de bem-estar social que Margaret Thatcher na década de 1980, mas que é baseado no legado desta última. Trata-se de um texto sobre o neoliberalismo; sobre o poder dos interesses empresariais globais; sobre a privatização; sobre a redução do papel do Estado e sobre uma democracia fraca. Trata-se também de uma advertência sobre o progresso — mesmo quando cuidados de saúde universais e acessíveis são garantidos, eles não são imunes à reversão.

Palavras-chave: Política de Saúde. Reino Unido. Política Social.

Submetido: 21/7/2011

Aceito: 2/9/2011

¹ Partes dessas reflexões foram apresentadas no 6º Encontro Nacional de Política Social em Vitória (ES) entre os dias 28 e 30 de setembro de 2011.

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Introduction

The WHO World Health Report for 2010, published last December, was entitled 'Health Systems Financing: The Path to Universal Coverage'.

It acknowledged what the Commission on the Social Determinants of Health had said in 2008, that the circumstances in which people grow, live, work, and age - education, housing, food and employment and the distribution of power in societies - are the most significant influences on how people live and die. But timely access to health services a mix of promotion, prevention, treatment and rehabilitation - is also critical.

'Recognizing this, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them.' (Executive Summary 2010)

But as I started to write this paper in late July I received an email. It was a report of a newspaper article in the Daily Telegraph, a leading serious, right wing national newspaper in the UK, under the headline. 'The day they signed the death warrant for the NHS' - the English National Health Service. I suspect that you will have heard much more about President Obama's struggle to improve health coverage in the USA, but there is also a profound fight in the UK to try to save our national health service. While

the world is trying to move towards universal health coverage, in England our government is pushing through policy changes which will end universal equality of access, increase costs and reduce the quality of our health care system. How can this be?

So this paper is about the targeting of the UK health service by private international health care corporations who want to get their hands on the £200b annual budget and the collusion in that project by successive governments, including the present administration led by David Cameron which is the most ideologically driven government that we have had in the UK in my lifetime - more radical in their dismantling of our welfare state than Margaret Thatcher in the 1980s but building upon her legacy.

It is a tale about neo-liberalism, about the power of global business interests, about privatisation, about reducing the role of the state, and about a weak democracy. And so it is a cautionary tale about progress - even when affordable universal health care has been secured, it is not immune from attack and from being reversed.

How does the NHS Work?

Let me go back a step or two to explain to you what has been happening in the UK. In a sense the English National Health Service is the story of my life. The birth of the NHS came in 1948, the year before I was born. And the NHS was founded on two key pillars. It gives everyone access to comprehensive health

care that is 'free at the point of delivery' – when you go to see a doctor or a nurse or go to hospital you do not have to pay anything. And the second pillar is that health care is paid for out of general taxation. The UK does not have an insurance based scheme, we pay our national taxes, and some of the money is used to pay for the NHS. And with tiny exceptions, there are no co-payments.

When a doctor recommends that you take medicine or drugs you have to pay a prescription charge but this is less than £10 per go and many groups – pensioners, the unemployed, pregnant women – are exempt.

At the moment, the English health service works like this from the patients' perspective. Virtually everyone is registered with a small group of primary care doctors, what we call General Practitioners, GPs. If you are feeling ill, or need a vaccination or other preventive treatment, you simply make an appointment with your GP and usually see them the same day. GPs are based locally – mine is about half a mile away from where I live – and grouped in surgeries or clinics, usually half a dozen or so doctors with some nurses and other health professionals and administrative staff. Numerically, the vast majority of health concerns for which the health service is consulted are dealt with by GPs. Some investigations – blood tests, for example – will also be done through the GP. But if you need more specialist care the GP will refer you to an NHS hospital where you will see

an expert in the aspect of medicine that is relevant.

You cannot usually go directly to a hospital to see a specialist doctor unless you have an accident or are suddenly taken seriously ill. In that case you can go directly to an Accident and Emergency Department in a hospital and get emergency treatment.

All of this is free – no money changes hands between you as a patient and any of these services and effectively the doctors prescribing treatment have no personal interest in the cost of the treatments they prescribe – they cannot make more money by prescribing one form of treatment, one drug rather than another, although there are some general controls on this to prevent waste. And so patients can trust their doctors not to be acting out of personal gain.

There is a relatively small market in private health insurance in the UK which is complementary to the state provision, buying faster access to specialist care, or choice of private care provider.

However, by 2006 only 1% of total health expenditure went on private health insurance with only 10% of the population having some complementary private health insurance (Thomson and Mossialos 2009). And a larger group of people will sometimes use private health care services, paying for the care themselves without insurance.

By contrast social care – care services for adults who are disabled or with learning disabilities, and care services for older

people who are no longer able to look after themselves without help because they are frail or suffering from dementia, for example – including services provided through social workers, are mostly not free in England and are run in through a completely different system to the NHS. These services are heavily rationed in two main ways: first you have to be assessed as sufficiently in need to be eligible for a service, and secondly, any services that are provided through the state are means tested. Your income is assessed and the level of payment you make is dependent on your income level. In other words it is a kind of co-payments system. The assessment of eligibility is made by a worker employed by the locally elected council which holds the budget for services. Increasingly that budget is then handed to the individual to spend in the way they want to on care services. Care services are now mostly not provided by the state but by numerous private companies and some voluntary sector organisations, usually charities. But essentially you will only get state support for these services if you have a low income and few savings, otherwise you must just buy these services yourself.

Health Care and Health Outcomes

The NHS system is still seen as about the best in the world in terms of quality of care and value for money. The 2010 Commonwealth Fund International Health Policy Survey showed that the UK health service was the most cost efficient and high quality service of 13

developed countries. It was particularly effective at making access to health care independent of how wealthy you are (Schoen et al 2010). As Table 1 shows, this is reflected in exceptionally high levels of adult confidence in the NHS. The UK was the only country in which more than 90% of the adults surveyed said that they were confident that if they were seriously ill they would receive the most effective health care including drugs and diagnostic tests and that they would be able to afford any care that was needed. Most importantly, the UK was the only country where access to good quality health care was not significantly correlated with people's social class or income.

However, despite this, over the past thirty years, especially since the rise of the dominance of neo-liberal economic and political ideologies, right wing critics, in particular, have raised increasing concern about the costs of the English health service and its quality (Lees and Player 2011; Reynolds et al 2011). Throughout the Conservative governments of 1979 – 1997 the NHS was consistently underfunded (growing at 2% p.a. compared to an OECD average over forty years of 5.5%) so that, by the end of the period, expenditure on health in the UK as a percentage of gross domestic product (GDP) was amongst the lowest in the OECD countries at 6.9% compared to an average of 8.2% (Bywaters and McLeod 2001). The result was a health service in a poor state with long waiting lists for operations and other medical procedures alongside big and growing health inequalities and

increased social inequalities. The state of the health service was one of the big political dividing lines between the right wing Conservative party of Margaret Thatcher and Tony Blair's New Labour. In the 1997 election, after 18 years of Conservative party government, the Labour party manifesto warned that only the Labour party could 'save the NHS' (Peedell, 2011). After the Labour party won that election, expenditure on the NHS massively increased during the subsequent 13 years, particularly from 2000 onwards. There was a huge programme to build new hospitals,

numbers of doctors and other health professionals in training increased greatly and waiting lists fell to the point where no one was expected to wait more than 18 weeks between a referral to hospital from their GP and their hospital appointment. However, alongside that investment in public services, which the Thatcherite conservative governments would never have implemented - repeated attempts at reforming the structures of the NHS increasingly moved it towards privatisation - of which more later.

Table 1

EXHIBIT 2

Adults' Confidence In And Cost-Related Experiences With Health Care In Eleven High-Income Countries, 2010

Country (sample size)	Percent of adults who							
	Were confident/very confident that if seriously ill they would		Had problems with access because of cost in previous year			Had out-of-pocket medical spending in previous year		
	Receive most effective treatment, including drugs, diagnostic tests	Be able to afford care needed	Did not see doctor when sick or did not get recommended care	Did not fill Rx or skipped doses	Had either access problem	\$200 or less	\$1,000 or more	Had serious problem paying or were unable to pay medical bills in previous year
AUS (3,552)	76	64	18	12	22	35	21	8
CAN (3,302)	76	68	8	10	15	51	12	6
FRA (1,402)	85	73	9	7	13	47	4	9
GER (1,005)	82	70	23	6	25	41	8	3
NETH (1,001)	88	81	4	3	6	39	9	4
NZ (1,000)	84	75	12	7	14	61	7	6
NOR (1,058)	70	69	8	6	11	33	16	5
SWE (2,100)	67	70	6	7	10	50	2	5
SWI (1,306)	89	78	9	4	10	20	25	6
UK (1,511)	92	90	5	2	5	76	1	2
US (2,501)	70	58	28	21	33	31	35	20

SOURCE 2010 Commonwealth Fund international health policy survey in eleven countries. **NOTE** Significance tests are available in the Technical Appendix, which can be accessed by clicking on the Technical Appendix link in the box to the right of the article online.

So when we look at health expenditures decade we see this picture. and outcomes at the end of the last

Table 2
Health Expenditure (2008) and Outcomes (2009)

Country	Per capita total expenditure on health (\$US)	Total expenditure on health as % of GDP	Government expenditure on health as % of total health expenditure	Private expenditure on health as % of total health expenditure	Life expectancy at birth both sexes	Under 5 mortality rate (per 1000 live births)
Brazil	721	8.4	44	56	73	21
China	146	4.3	47.3	52.7	74	19
Cuba	672	12	95.5	4.5	78	6
India	45	4.2	32.4	67.6	65	66
Japan	3190	8.3	80.5	18	83	3
South Africa	459	8.2	39.7	60.3	54	62
UK	3771	8.7	82.6	17.4	80	5
USA	7164	15.2	47.8	52.2	79	8

WHO Human Development Report 2010 UNDP

What this table reveals is quite a complex picture.

1. Two countries have average life expectancies of 80 years or over (this is data for 2008): Japan and the UK. Both of these countries also have the lowest under-five mortality rates. In each country, total per capita expenditure on health is between \$3000US and \$4000US per annum. In both countries the government's expenditure accounts for over 80% of total health expenditure, with a small private sector. In the UK the % of expenditure on private sector went down between 2000 and 2008, as the government increased the spend on the NHS. In each country the

health spend is a bit over 8% of GDP.

2. The only other country in this table where expenditure per head on health is more than \$1000US pa is the USA, which spends almost twice the proportion of GDP on health care compared to Japan or the UK. But in the USA the balance of private and public expenditure is completely different with more than half the spend being private expenditure. And despite this immense drain on household expenditure the outcomes are worse: lower life expectancy and higher under-five mortality. Something like one in three of all US health care dollars are spent on administration and management costs compared to

one in 7 in the UK (Lees and Player, 2011).

3. In fact, life expectancy in the USA is comparable to that of Cuba while under-five mortality is higher. Cuba spends about one tenth as much per head of the population on health services as the USA but gets very similar outcomes. One big difference, apart from the total expenditure, is in how the money is spent. In Cuba there is almost no private expenditure, the state provides.

4. Brazil and China also have many similarities. The average life expectancy in 2008 and the under-five mortality rates are similar as is the balance of public and private expenditure. The big difference is in the total spend per head and the proportion of GDP spent on health. Both are much less in China.

5. Finally, South Africa and India both have much higher under-five mortality rates and much lower life expectancy. India spends very little on health care and only a small proportion of that is state expenditure. South Africa spends more but the outcomes are not good. In both countries the reliance on mainly private health

care expenditure means that most people cannot afford good health care. Inequality, measured by the gini coefficient, is much higher in South Africa.

Of course, life expectancy and infant mortality are not primarily or even mainly a product of health care services. They depend in the main on the social determinants of health I mentioned earlier. That is why some countries and regions within countries do relatively well considering their wealth overall and their expenditure on health services while others do poorly. Societies where there is less inequality and where education is universal (particularly if women are included in compulsory education) do much better.

Japan is more equal and cohesive a society than the UK, where inequality has increased greatly over the last thirty years and hence its health outcomes are better with similar levels of spend. The USA, for all its riches, bears a heavy price for two factors, first the very high levels of inequality for a developed country and limited state social protection, and secondly, its reliance on private health care providers which despite the claims for the benefits of competition push up the costs in a variety of ways, including through over-investigation, over-diagnosis and over-intervention – the profit motive meaning

that it is in the interests of providers to sell people more products rather than to maximise their health and well being (Reynolds 2011).

The 2010 Election and the Dismantling of the NHS.

In the election of 2010 David Cameron, the leader of the Conservative party sought to neutralise the NHS as a political issue by promising to keep to the Labour Party's spending plans and explicitly saying that he would not carry out any major top down reform. His slogan was that the NHS was safe in the Conservative's hands. And for a variety of reasons, particularly the economic crisis of 2007/8 and Labour government mistakes, including the Iraq and Afghanistan wars, the electorate accepted these promises and voted for change after 13 years of Labour government.

In the UK, the government is formed by whichever party has a majority of seats in the lower house of Parliament, the House of Commons, which has over 600 MPs each of which represents a geographical area of around 100,000 population. These seats are decided on a first past the post system, so candidates with 40% of the votes, or even less, commonly win and governments are usually elected with a minority of the total votes cast. Since 1945, the government has always been either Labour or Conservative. The third national party, the Liberal Democrats, usually gets between 10% and 20% of the votes but wins fewer than 50 seats.

In 2010, despite Labour's massive unpopularity, the Conservatives were not entirely trusted and only beat Labour by a small number of seats.

Table 3

Party	Number of seats	Per cent of vote
Conservative	307	36.1
Labour	258	29.0
Liberal democrat	57	23.0

This meant that they did not have an overall majority in the House of Commons and had to make a coalition with the Liberal Democrats. This was completely new territory for post-war

Britain and some people thought it would act as a break on the more radical neo-liberal policies of the Conservatives. However, that has not proved to be the case.

Using the poor state of the economy following the global financial crisis of 2007/8, the Conservatives are pushing through a raft of neo-liberal social policy changes, claiming that the budget deficit means that there is no alternative. Social security payments are being cut or their eligibility restricted (child benefit, previously a universal benefit for all children is to be restricted to those earning under about \$70,000 US; sickness benefits are being withdrawn from hundreds of thousands of people by means of a very narrowly defined test of capacity to work; working family tax credits payments are being reduced). Budgets for services provided by local authorities are being cut by up to a quarter. These cover such services as schools, roads, rubbish collection and social care. The state is withdrawing support for university education for the whole area of the arts and humanities, with university fees set to increase 300% from around \$5,000 US pa to \$15,000 US pa for most courses from 2012. But cuts cover almost every area of government including defence. Many thousands of jobs are being lost or have been lost already and pensions for public sector workers are under major attack. The economy is stagnating with virtually no growth over the last nine months (<http://www.statistics.gov.uk/cci/nugget.asp?id=192>).

The politics of cutting the NHS presented some difficulties because of the promise that Cameron had made in the election that he would match the Labour party's spending plans and not inflict major reform. He has claimed that NHS spending will not be reduced, although at the same time £20b of so called efficiency savings are being required over a four year period – a level of savings which have never before been achieved and the rate of inflation built into the budget is below the level of health costs.

But Cameron did decide to support the health minister, Andrew Lansley's, long planned desire to restructure the NHS. Again Cameron and Lansley have used the deficit as cover to justify reforms. But essentially they have simply ignored the promise made during the election to bring in the most radical changes since the NHS was founded. However, as a recent analysis by Lees and Player (2011) has made clear the groundwork for the privatisation had been carried out under the previous Labour government prompted by powerful lobbying from private sector corporations. Tony Blair, with successive ministers of health, had already made the changes to the NHS which made it ripe for fuller privatisation.

What is the plan? As Pollock and Pryce (2011, 800) describe it the plan is, 'to replace the NHS system of public

funding and mainly public provision and public administration with a competitive market of corporate providers in which government finances but does not provide healthcare.'

The precise details are profoundly complex, and are still changing as I write, with political opposition being mounted in Parliament and outside and changes being made by government in response and as they realise that parts of the plans will not work. The key elements are as follows.

1. Responsibility for ensuring services are provided
 - Secretary of State for Health (the government Minister) will no longer have a direct responsibility to provide Health Services but only to 'act with a view to securing' comprehensive health services through the NHS management board.
 - All Trusts providing services (hospitals or community services) will become independent foundation trusts – effectively operating as separate businesses - and therefore will not be directly managed by the NHS management board.
2. Planning and purchasing of health services
 - Primary care trusts – geographically based organisations which have been responsible for planning and purchasing health services – are to be abolished and replaced by GP commissioning consortia, which all GP practices must join. GPs are, of course, not trained in these roles: public health, management and planning services. GP services can be run by for-profit or not-for-profit organisations not necessarily by the GPs themselves whose main role is treating patients. 23 for profit organisations already run 227 GP practices in the UK (Pollock and Pryce 2011).
 - Consortia will purchase services not for all people within a geographical area but only for those patients registered with the consortia. GP boundaries will be abolished so that GP consortia can take on patients wherever they live 'effectively allowing patients to choose their commissioner'. This means that consortia will be able to advertise for and compete for patients as private health care corporations and insurance companies do now.

- Commissioning consortia do not have a duty to provide a comprehensive range of services but only 'such services or facilities as it considers appropriate'.
- There is no duty to provide equality of access to health services. Annual commissioning plans only require attention to financial viability and 'continuous improvement'.
- Commissioning consortia will have the power to impose charges for services, a power which previously rested with the Secretary of State (and was only used in the case of prescription charges).
- There are parallel plans to bring in personal health budgets – individual budgets which create the immediate likelihood that they will be linked to top up charges through out of pocket payments or insurance.
- As private, independent bodies, commissioning consortia will not be directly controlled by the government minister for health but will be able to enter into contracts with 'any qualified provider' and will set terms and conditions for staff (eliminating national pay bargaining). There have already been talks with private companies including the German company Helios (Ramesh 2011). They will have a formal obligation to work within their budget and so responsibility for making choices about cuts is removed from the government and passed to commissioning consortia, whose Boards will include GPs and nurses. Patients will not know whether the recommendations GPs make for their care is affected by how much the care will cost and this is thought likely to undermine trust between patients and their doctors.
- The provider of last resort will be the local council if consortia decide that providing comprehensive services will threaten their financial viability. But local councils' income is determined by central government, they do not have the power to raise extra money to spend on health care even if the councillors were democratically elected under that mandate and they have

no experience of providing health services.

3. Quality Control and Management of the Provision of Health Services

- Provider regulation will be overseen by a market regulator called Monitor whose first duty is to promote competition. 'The government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically led contracting rather than the hierarchical management by regions of the centre.' (Department of Health (DH) 2010) But markets are widely thought by economists not to be efficient and effective mechanisms for controlling health care. 'When market contracts are used to regulate providers and commissioners, managers have an incentive to exploit the information deficit on the part of patients and government by reducing service quality in order to maximise profits' (Pollock and Pryce 2011, 800). Regulation will be limited by the duty of 'maximising the autonomy of individual commissioners and providers and minimising the obligations placed upon them (DH 2010)'. Regulation may be dispensed with as more providers enter the market

place. The necessity for public regulation can be challenged in court by private health care companies and this is already happening.

- The cap on service provider trusts' ability to generate funds by selling services and resources to the private sector is being abolished. A cash strapped Foundation Trust may restrict their own services and lease its assets to private providers to make its accounts balance. They may increase access to private patients and restrict access to NHS patients.
- Health care provider Trusts will be able to sell, or sell and lease back, or raise money against assets they own (up to now what the public have owned). This opens the way for private equity companies who may be contracted to run Trusts, to take over public resources and asset strip.
- New competition duties will allow remaining public controls over health services to be challenged by multinational companies and investors anywhere in the world.

4. Public Health

- Public health responsibilities are being removed from the NHS and passed to local councils.

Essentially, then the government's plan is to demolish the NHS and replace it with a market for health care which will be increasingly fragmented and privatised. The pace of change is extremely rapid and change is always easier when budgets are growing not when £20b is being taken out of the budget. Many experienced managerial staff have already left the NHS, many services have already been transferred to private businesses, much of the process of establishing the new consortia has been undertaken even before the legislation which is supposed to bring this into being has been passed by Parliament. There is the likelihood that within a relatively short period, patients in some areas will be asked for co-payments or offered the choice of topping up the quality of their care and that will inevitably create an incentive for extending health insurance. Given that the NHS is the favourite institution of the UK and its political sensitivity, it is an enormous political gamble that the Conservative Party is taking.

How was this possible?

The policy conditions under which this raft of changes has been made possible have been established by successive governments since the Thatcher governments of 1979 – 1997. Paradoxically, the Labour Government

of Tony Blair pressed forward with reforms opening up the NHS to privatisation despite a commitment to public services reflected in the level of the overall NHS budget (see the detailed analysis by Lees and Player, 2011). Tony Blair propounded the idea of a 'third way' (Giddens 1998) in which while the state would still be responsible for major public services such as health and education, they should be opened up to competition and the rigours of the market because it was believed – against all the evidence from the USA – that the market could run such services more efficiently and effectively. Major international private health care providers such as United Health, particularly those based in the USA, working hand in hand with leading consultancies such as McKinseys, private equity companies such as Bridgepoint, and policy think tanks such as the Kings Fund and the Nuffield Trust, had developed an intricate, inter-twined lobbying network which persuaded successive politicians that the NHS should be changed from a single public organisation to a market of private companies operating under the NHS as a brand name or kite mark.

The ways in which this was done are multiple and complex but they involved broadly three stages of preparation (Lees and Player 2011):

- Openings had to be created for private companies to provide NHS services
- The NHS had to be split up into relatively small units operating as businesses
- The clinical workforce had to be detached from the NHS and contracted to the individual businesses.

providing added capacity for the NHS or negatively as necessary to make the NHS more efficient, to provide better value for money. There was never an open declaration that a market was being introduced into the NHS and this has allowed the Conservative government to say with much truth that their plans are only a development of what Labour had been doing.

During the period from the 1980s onwards, multiple opportunities were created for private companies to take over different aspects of NHS care. This began with such tasks as hospital cleaning (with disastrous results in terms of hospital infections), and developed into providing front line health care services, IT and office functions, management, commissioning and policy making tasks. Frequently the private sector was utterly unable to compete with the NHS on quality or price and special conditions were set for them which were both more costly to the NHS and carried no risk. For example, where private companies carried out medical and surgical treatments in a contract with the NHS they were not liable to any negligence claims and patients whose treatment went wrong were simply transferred back into the NHS.

None of these profound changes to the NHS were ever presented honestly to the electorate. They were always presented either positively as quickly

What about opposition to the plans?

Opposition to the plans have been widespread, creative but somewhat disparate. The plans have been sold as giving control over health care to GPs, who command considerable public respect, but a large majority of both GPs and the doctors' union, the British Medical Association have rejected the reforms and called for them to be withdrawn rather than amended. A million people marched in a demonstration against cuts in general. At least two thirds of the public indicate their opposition to the changes. As I write today, 150 medical experts have written again to Andrew Lansley, the Health Minister, calling for the Bill to be scrapped and pointing out its lack of democratic legitimacy (http://www.guardian.co.uk/society/2011/sep/11/doctors-letter-resists-nhs-reform?CMP=twf_fd). They also cite a recent British Medical Journal poll of 1000 doctors in which 93% called for the

bill to be withdrawn. The Commonwealth Fund survey mentioned earlier (Schoen et al 2010) found that 62% of those lay people surveyed thought that only minor changes were needed to the NHS, a far higher proportion than in any other of the 13 countries. The Trades Union Congress – the national body of UK Trades Unions – has led a national campaign against the changes as have several smaller lobbying groups. There has been the usual range of lobbying activities, contacting MPs, signing petitions, holding public meetings, letters to the press and so on. The Liberal Democrat party's grassroots voted for wholesale rejection of the Bill and this forced the leadership to take a stronger hand within the coalition government in which they are the minority player. But the Liberal Democrat leadership is economically liberally as well as socially liberal – in other words it supports privatisation.

There have been some really creative forms of opposition in which modern social media and the internet. At one point in the campaign against privatisation a You Tube video 'The NHS is not for sale' (<http://www.youtube.com/watch?v=Dl1jPqgTdNo>) went viral and made Andrew Lansley a laughing stock. Films made available on the internet, such as 'In Place of Fear'¹ (<http://www.vimeo.com/26379391>) and

Wake Up Call Episode 1 - No Decision About Me Without Me (<http://www.vimeo.com/20667467>)

graphically demonstrate how the public service NHS is being dismantled and replaced with private profit making.

This opposition, including the opposition of the Liberal Democrat party, forced the government to announce a period of listening in April and May of this year. But the government put in charge of the listening process, the so-called Future Forum

(<http://healthandcare.dh.gov.uk/new-forum/>), a GP who was known to support the government's general approach. It was clearly rigged from the start but nevertheless came up with some possibly significant findings that the Bill as drafted was unworkable and could destabilise services. Some slowing down of the changes might be detected and a number of amendments are being made to the Bill. But none of them will significantly protect the NHS from fragmentation and privatisation.

Opposition to the cuts was underlined by two major scandals in private health and social care which emerged in the UK this year. The first was the recent collapse of the largest private provider of residential social care in the UK – nursing homes and residential care homes mainly for older people – Southern Cross. Southern Cross was

caring for 31,000 residents in around 750 homes across the UK when its business model collapsed (<http://www.guardian.co.uk/business/2011/jul/16/southern-cross-incurable-sick-business-model>). Most of the income from those residents actually came from the state in the form of local councils who placed the older people in the care homes. These residents have little income and little or no savings of their own and hence their care is the responsibility of the state. In 2004 the then medium sized provider was taken over by a private equity firm, Blackstone. Blackstone applied a business model in which the homes owned by Southern Cross - the buildings – were sold and then leased back. In many of these deals, the new owners of the properties built in annual increases in the rental payments which would apply whatever the state of the care market. Particularly after the global financial crisis of 2007/8, three major constraints affected the residential care market: the budgets of local authorities in England were increasingly squeezed, the numbers of older people needing care continued to rise and the costs of providing care were increasing faster than the general rate of inflation. These three factors meant that local authorities began to refuse to pay increased fees and so Southern Cross began to find itself with contractual increases in rental costs but a relative decline in income because

of falling occupancy levels. By the summer of 2011 they were unable to pay their debts and the company is being wound down. Blackstone floated Southern Cross on the stock market in 2007 one year after taking over the group and secured a profit of £1.1 billion. For the residents and their families this has been a long summer of insecurity. The homes are being sold on to a variety of other providers, because someone has to care for the residents, with more disruption and uncertainty for residents.

The second major scandal in private health care this year concerned the quality of care. Winterbourne View is a privately owned and run hospital which caters mainly for people with learning disabilities. A BBC reporter filmed a series of serious assaults and other kinds of abuse of resident and this has led to 6 members of staff being arrested and charged with offences. The owners, Castlebeck, are a private investment fund based in Geneva (<http://www.guardian.co.uk/society/2011/aug/17/castlebeck-care-homes-close-unit?INTCMP=SRCH>). Since the abuse in Winterbourne View was screened on television, the company has been forced to close three homes after investigation by the Care Quality Commission (CQC), the organisation which regulates the quality of private care homes. However, the Care Quality Commission itself has run into severe criticism for failing to

detect and prevent the abuses from taking place. The CQC, now responsible for inspection of the NHS as well as residential and social care, has had its budget cut by a third since 2009, with the result that many inspections are now done on paper only (<http://www.guardian.co.uk/society/2011/jun/07/disability-abuse-winterbourne-view-care-regulator-review?INTCMP=SRCH>).

However, the government has continued to press on with the reforms, determined to make them a *fait accompli* by dismantling existing structures even before the Bill becomes law. One reason for this is the power of the private health care lobby groups. As Figure 1 indicates, the tentacles of the private health care sector reach right into government and have been cultivated for many years. As the Spinwatch video 'The Health Industry Lobbying Tour' (<http://www.spinwatch.org.uk/blogs-mainmenu-29/tamasin-cave-mainmenu-107/5417-take-a-tour-of-lansleys-private-healthcare-supporters>) illustrates, millions of pounds have been spent securing the private health companies extraordinary access to the UK's top political leaders. In return many of those politicians and policy advisors have been rewarded with highly paid roles in private companies. I see this as corruption on a large scale – another sign of the weakness of western democracies. Similar pro-business policies are now dominating the government's approach to public health. Andrew Lansley has put multinational

fast food chains and drinks producers like MacDonald's and Pepsico at the heart of the bodies advising on obesity and alcoholism while negotiating voluntary agreements rather than legally binding obligations against the evidence for likely effectiveness (<http://www.guardian.co.uk/politics/2010/nov/12/mcdonalds-pepsico-help-health-policy>). I see this as corruption on a large scale – another sign of the weakness of western democracies.

Why was this done?

The government's public answer to this question is that the NHS cannot continue as it is, given the rise in demand especially due to increased numbers of older people, and the need to increase efficiency. The values of individual choice and economic competition are often presented as the rationale for the changes. The reforms are talked about as putting the NHS in the hands of GPs rather than 'bureaucrats' (experienced and trained managers), but the reality is that a few GPs will sit on Boards while the real work of commissioning will still be done by managerial and administrative staff. These tasks are already being outsourced to private companies by many GPs. These public excuses are just a smokescreen for the reality of wholesale privatisation, the creation of an insurance based health system.

Given the political risk, you might ask why this has been done. In the face of the evidence about the poor quality, increased costs and unethical and fraudulent behaviour of private health

care companies (Lees and Player 2011, Lister 2011), I can only see four possible reasons:

- An ideological belief in the market as the best mechanism to deliver efficiency and effectiveness.
- A desire to transfer costs and responsibility for health care from the state to individuals reducing the power of the NHS as an electoral issue which benefits the Labour Party.
- The power and effectiveness of the lobby built by the nexus of health care, management and finance companies who saw their opportunity to get their hands on the hundreds of billions of pounds in the NHS budget.
- Personal greed by politicians and senior policy makers. Tony Blair and successive health ministers have made themselves profoundly rich through politics. Alan Milburn and Patricia Hewitt, for example, both took on a series of directorships in health related national and international businesses within months of leaving office. Many officials in the Department of Health moved between private companies and public service with little or no restriction. (Lees and Player 2011)

To make a wider point, the demise of the NHS reflects a profound weakness in our democracy which can also be seen in the USA. The UK has had a major public scandals over MPs fraudulent claims for expenses, but they are nothing to the benefits from directorships and other payments from private interests that our politicians have received while in office or shortly afterwards which have received much less attention. We have had the scandal of phone hacking, with Rupert Murdoch's News International Corporation spying illegally on private individuals and public figures while exerting excessive power over both the investigations of the police and the actions of politicians. The three key pillars of a democracy: the rule of law, political integrity and a free press have all been heavily undermined in the past thirty years, with the result that the excesses of the rich have been increasingly uncontrolled while the rest of the population pays the price.

Conclusion: does it have to be like this?

There is clear evidence that there is no need to take this direction. The changes apply to the NHS in England but not to the NHS in the other countries in the UK, particularly Wales and Scotland, which have for years pursued separate NHS policies completely at odds with the UK government plans for England (Lees and Player 2011). In neither devolved administration is there any

prospect of this wholesale privatisation and in each country the Conservative party forms only a small minority in the national assembly. In Scotland, the split between purchasers and providers, a key element in creating a market in health care, was ended in the middle of the last decade. The health service in Scotland remains directly managed through Area Health Boards with plans having been introduced for the majority of Board members being democratically elected. Moreover, in Scotland, personal care for older people living at home is free, instead of means-tested as in England. Hospital parking charges have been abolished, there are plans to abolish prescription charges and the one independent sector treatment centre has been taken into public ownership. These measures have been achieved with outcomes that are at least comparable with those in England (Lees and Player 2011).

Wales has followed a very similar path. Again the purchaser provider split has been abandoned in favour of a small number of geographically based Local Health Boards which directly plan and run health services in Wales with a strong emphasis on public health and links with social care. Wales led the way in abolishing prescription charges and hospital parking charges and in tackling means testing for social care (Lees and Player 2011).

Of course, there are other models than these for running effective national health services, but right on the English government's doorstep here is evidence that the claim that the NHS is failing and that marketisation is the only answer is patently false.

What has been largely lost from view since the Conservative dominated coalition came to power is any focus on the social determinants of health (WHO 2008) or on the social causes of health inequalities. Health care in England is being commodified and privatised. Health is increasingly to be seen as a matter of individual responsibility in which the ability to pay for diagnosis, investigation, treatment and care will become more and more significant. In this climate, while low income families and individuals are suffering most from the economic crisis, inequalities in health and health care will continue to increase. By the next election, whatever conclusion the electorate then comes to about these changes, the NHS in England will have ceased to exist as a national, publicly owned institution.

Notes

1. Aneurin Bevan was the government minister who established the NHS in 1948. In 1952 he published 'In Place of Fear' (Quartet Books 1978), including a passionate defence of the NHS. Widely quoted from In

Place of Fear is the argument that 'The collective principle asserts that... no society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means'.

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Figure 1 The Political Private Health Care Nexus

From Lees and Player 2011

