

Selling off the NHS?

Many industries and banks may be sliding into recession world-wide, but private health care providers have a smile on their face as they look forward to rich pickings from our National Health Service. They love the government's determination to divert a growing share of the NHS budget from public services to the private and "independent" sector.

In this series of three articles, published originally in "the Morning Star" JOHN LISTER investigates.

1. "World Class Privatisation"

According to *Health Investor* magazine

"The UK healthcare market has remained resilient, stable and remarkably active despite the financial volatility. The combination of the government's NHS reform programme and the sector's strong fundamentals enables venture capitalists, private equity and banks to proceed with opportunities difficult to find in other sectors."

The speculators are right to regard Gordon Brown's government as their sponsors: behind the scenes, and out of the headlines, ministers are forcing through a massive new drive towards fragmentation, privatisation and marketisation of the NHS, reviving proposals which appeared to have been abandoned almost four years ago.

The main target now is primary care and community services, delivered until now by Primary Care Trusts, and employing around 250,000 health workers in England. They now face a 3-way onslaught from far-reaching government policies which few people will even be aware of:

- "World Class Commissioning", the apparently meaningless mantra of clichés promoted in the last year or so by Strategic Health Authorities and Primary Care Trusts as they set about splitting up and outsourcing services;
- proposals in Lord Darzi's Next Stage Review, and other policy guidance, to boost the creation of "social enterprises" (private sector organisations which generate surpluses from providing health care, but do not distribute profits or dividends to shareholders);
- and the establishment of a new hard-nosed body – the so-called "Cooperation and Competition Panel" – with a brief to force through a new, competitive, market system in what has until now remained one of the more integrated areas of health care.

In July 2005, just after the general election, then NHS chief executive Nigel Crisp attempted to split directly-provided services off from the PCTs, suggesting they should become simply commissioning bodies, with as many as possible of their services hived off – privatised, handed over to "social enterprises", or run at arms-length until some alternative could be found.

Crisp was looking at a model in which the NHS would effectively cease to be a provider of services: instead it would become a fund to purchase – or “commission” – services from a range of providers, whether these be Foundation Trusts, the private sector, or social enterprises, competing with each other. This “Commissioning” would be done by Primary Care Trusts as local budget-holders.

Crisp called his plan “Commissioning a Patient-Led NHS”, although there was no hint anywhere in his rambling and vague circular on how patients would have any say at all over the reorganisation he was proposing.

In fact the Crisp plan involved the merger of 25 Strategic Health Authorities into just ten even more remote and more arrogant super-quangos, and the forcible merger of over 300 PCTs into half that number, again much bigger and less accountable organisations than before, paying only lip-service to public involvement.

This part of the plan was carried through: however Crisp’s rapid-fire proposals to hive off the PCTs’ directly-provided services proved far more controversial, and ministers were forced by a tide of public anger to intervene and slow the process right down. But four years later, long after a disgraced Crisp was dispatched to the House of Lords with a fat pension pot, they are coming back to try again.

The buzz-phrase for commissioning is now “World Class Commissioning”. It appears to focus PCTs on eleven “competencies”, many of which are only included to divert attention from the central objective of creating a health care market, spelled out in Competency 7:

“Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes”.

This means ensuring a variety of providers compete for contracts to deliver services – in other words inviting in the private sector and social enterprises to take a slice of every local NHS budget.

PCTs are rated on their achievement of the various competencies, and Strategic Health Authorities, not satisfied with the level of privatisation that has been delivered, are piling pressure on many PCTs to step up their efforts and bring in more private sector providers, especially in primary care.

Even Camden PCT, which defied local protests to hand over three GP practices to UnitedHealth last year, has been found inadequate in its privatising efforts – and given the lowest score by NHS London. Other PCTs can also expect to feel similar pressure.

NHS London is setting up a powerful and costly structure, the London Clinical and Business Support Agency (LCBSA) to harness together the capital’s 31 PCTs. It is headed up by a former BUPA boss, Rhona McLeod, and will seek to coordinate the drive towards a health care market in the capital.

Other support is also on tap. The Department of Health guidance on World Class Commissioning repeatedly refers to the “Framework for procuring External Support for Commissioners” (FESC), which brings together 14 companies that have been “approved” by ministers to advise PCTs – among them three of the major US health insurers whose trustworthiness was so strongly questioned by Michael Moore’s film *Sicko*. One of them, UnitedHealth in the USA has just again been fined millions of dollars for fleecing elderly people subscribing to its so-called “Evercare” service in Texas.

Nowhere do ministers make clear exactly why these private profit-seeking companies should themselves be seen as “world class”, or what appropriate skills and knowledge they may have to offer NHS organisations tasked with delivering a universal and comprehensive health care system to the whole local population.

Of course World Class Commissioning involves many “competencies” in addition to stimulating local markets: and not all of the competences have the dangerous implications for fragmenting services, undermining them, and funnelling out NHS cash to bolster private profits.

PCTs are urged to become “recognised as the local leader of the NHS”, “work collaboratively with community partners”, “proactively build continuous and meaningful engagement with the public and patients”, lead “continuous and meaningful engagement of all clinicians”, and many other worthy objectives.

But much of this is window-dressing: ministers know there is no public pressure or support for many of the big changes they are imposing on the PCTs, and that the only public views which they will ever take on board are those which seem to echo their proposals.

The PCTs are being fashioned into instruments for top-down control by ministers and Strategic Health Authorities seeking to break our once unified NHS, with its planning and targeting of resources, into a competitive market ... whether we like it or not.

2. Darzi plan heads up a sneak attack

In this second article JOHN LISTER looks more closely at the government plans to fragment the NHS, and press-gang more health workers into so-called “social enterprises”.

250,000 health workers in England – nurses, midwives, health visitors, therapists and others – face two years or more of turmoil and insecurity as ministers force through yet another unwelcome reorganisation on services: this time the services directly provided by Primary Care Trusts.

Primary Care Trusts, which hold budgets to commission care for local people and also deliver primary care and community health services, are required by next month to have separated their services from their commissioner arm, and established a contractual relationship between them in place of a direct managerial link.

By October this year, PCTs are required to have developed a detailed plan for transforming their community services, and to have decided whether they wish to see them taken over by a Community Foundation Trust (which will allow staff to remain NHS employees) or by a social enterprise (which will not).

From October, the PCT commissioner arm is supposed to carry out a service review and an analysis of the local market for services, and by next year PCTs should be implementing their plans to “stimulate a competitive local market for services”.

PCTs will have to identify which services will be opened up completely to competition, by allowing patients to choose from “Any Willing PCT-accredited Provider”, and then make sure they accredit potential providers who can deliver adequate standards of care within the NHS tariff cost.

Given the character and scale of some of the community services, it is clear that by no means all of them are an attractive or profitable prospect for the private sector: but ministers are determined not to let that be an obstacle to privatisation and the creation of a new “market” – hence the central role of “social enterprises”, bodies outside the NHS, which run to deliver surpluses, but which do not distribute them as profits to shareholders.

New Labour has become increasingly fixated on handing over large sections of community health services to social enterprises – and a succession of ministers since Patricia Hewitt in 2006 have somehow convinced themselves that this is a policy which health workers support, despite the absence of any evidence to support the case.

Lord Darzi’s report ‘High Quality Care for All’ incorporates an incredible section on community services which effectively spells out a commitment to extend to staff the right to be privatised.

Recognising that one of the key obstacles to transferring NHS staff to so called “social enterprises” is the issue of pension rights, Darzi offers weasel words, extending NHS pensions to staff who transfer, but no equivalent guarantee for staff who subsequently join the staff of the social enterprise.

“Where PCTs and staff choose to set up social enterprise organisations, transferred staff can continue to benefit from the NHS Pension Scheme, while they work on wholly NHS funded work.”

This makes a two-tier workforce inevitable. Note also the cynical use of the word “choose”, suggesting that maybe staff are yearning to leave the security of NHS terms and conditions of employment and work for a “social enterprise”.

Of course there is no evidence staff wish to leave the NHS for these alternative organisations which offer them less security, fewer rights at work, less prospect of training and promotion, no guarantee of pay increments comparable to Agenda for Change, and may well be taken over by an outright private provider or by another social enterprise.

There is evidence that many who did not want to get involved have in the past been ignored by dictatorial managers and (as with community nurses in Central Surrey) effectively press-ganged into a new set-up, on pain of losing their jobs.

Darzi dresses the whole proposal up as if it flows from staff themselves, pressing the case for innovative social enterprises against stick in the mud NHS management:

“We will also encourage and enable staff to set up social enterprises by introducing a staff “right to request” to set up social enterprises to deliver services. PCTs will be obliged to consider such requests, and if the PCT approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years.”

The wording is deliberately vague on which grades of staff, how many of them, and what proportion of staff involved, would need to support a social enterprise for this to be granted by the PCT: past experience would suggest that a hard core of a few gung-ho managers, or a handful of disgruntled professionals would probably be seen as giving sufficient pretext for the process to get under way.

It is clear that behind the scenes the Department of Health is wedded to the model of social enterprises, and applying pressure on key staff to exercise this “right of request”. Behind the velvet glove of Darzi’s encouragement is the iron fist threatening that services which do not request may be outsourced in some other way.

Interestingly this whole process of driving towards a fragmentation of the NHS appears to run directly counter to some of the “key principles that guide the NHS” in the NHS Constitution drawn up by the government. Point 7 argues that **“The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to public, patients and staff”**.

The silence on these issues in the press and mass media shows that journalists, the public, patients and staff are all largely unaware of the scale of the changes being forced through in local services, and the extent to which the NHS itself as a coherent organisation, is under threat.

Some of the PCTs have produced baffling publicity on ‘World Class Commissioning’, larded with almost unreadable jargon and buzz-words that mean nothing to the wider public – but there is little or no substantial public engagement with the process taking place.

And as we will see in the final article, the most far-reaching changes of all, revolving round the role of the Cooperation and Competition Panel, have barely been reported even in the specialist health press.

Only through this type of sneak attack can ministers hope to ambush the general public and impose a policy that nobody had called for, and next to nobody supports.

3. A blatantly biased panel

The third, and most draconian measure to force the pace of privatisation across the whole of the NHS is the establishment of a new “Cooperation and Competition Panel” chaired by former private healthcare and nursing home boss Lord Carter of Coles, whose appointment was eagerly welcomed by the private sector.

The Panel was set up last year to allow private sector providers to raise complaints that they have been unfairly treated, and that a local area is not sufficiently opened up to competition between would-be providers – whether this be in community services, primary care, mental health or acute hospitals.

In other words the Panel is a bent umpire, with the task of shifting the goalposts to ensure that the private sector gets what it wants.

The Panel sees its role as responding to any private sector complaints against potential mergers of NHS providers, and against what they see as unfair procurement policies, “collusion”, or “price fixing”. As such, despite its misleading title, the Panel is transparently biased against cooperation, collaboration or planning between different sections of the NHS.

The draft policy guidance for this obscure body has in theory been out to public consultation since January 30, although it has barely been reported even in the health service press. It

has been subject to virtually no debate, and few health workers, MPs or members of the public will have any idea what is being proposed. The consultation ends on April 30.

One person who has flagged up the importance of this Panel is Professor Chris Ham, a former advisor to Tony Blair's government, who recently branded the guidelines as "written by a neo-liberal economist on speed", and criticised its "one-eyed" focus which undermines integration of services and regards almost any collaboration between providers as "collusion".

The Panel's total opposition to any form of "price fixing" might even question the Department of Health's policy of establishing a national tariff for treatment costs, warns Prof Ham.

Although the word "cooperation" is included in its title, there is no sign of any commitment to cooperate: the Panel is single-mindedly focused on driving through a competitive system. Its policy documents endlessly reiterate claims for the benefits of competition, despite the total absence of any evidence to support them:

"In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients."

None of these alleged benefits is supported by even a shred of evidence, anywhere in the world. But the Panel goes on to make even more extravagant and absurd claims for the merits of competition against planning:

"As set out in the Framework for Managing Choice and Competition, choice and competition in the NHS can be expected to:

- improve quality and safety in service provision;**
- improve health and wellbeing;**
- improve standards and reduce inequalities in access and outcomes;**
- lead to better informed patients;**
- generate greater confidence in the NHS; and**
- provide better value for money."**

This list is pure fantasy: indeed not even the most fundamentalist of free-market ideologists would dare to claim that markets "improve health" or "reduce inequalities" – that's not what markets are supposed to do.

Having spelled out its clear, fundamentalist, completely biased free-market approach, the Panel's guidelines go on to claim that

"The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients (i.e. service contestability). Where the process of competition is dampened, or otherwise hindered, by a merger, the benefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost."

Of course all this, too, is a deception; empty words. The private sector does not want genuine competition, because there is no way private medicine is viable in a free market. The inequalities of capitalism mean that the people most likely to need health care tend to be

the very young, the very old and the very poor – who are least likely to be able to pay a market price for their care. That's why even in the private sector-led USA almost 60% of health spending comes from government.

The only way New Labour has been able to build up the previously marginal private healthcare sector of 1997 into a slightly less marginal one in 2009 has been through state sponsorship and blatant favouritism: preferential allocation of ring-fenced contracts to private providers, paying above NHS rates for Independent Sector Treatment Centres (ISTCs), paying out sweeteners, start-up subsidies, and guaranteed long-term contracts.

Even now private contracts with the NHS are exempt from the "Payment by Results" system that applies to all NHS and Foundation Trusts, while public sector providers are excluded from even bidding for ISTC contracts.

Genuine competition would kill off the private sector, which delivers marginal minor treatment at higher cost, while leaving all of the more complex and demanding treatment, all emergencies and chronic care, and almost all mental health care, to the NHS. Private providers don't want competition: they want to split up and carve up the NHS, to slice off (cherry-pick) the bits they find profitable and leave the rest – and the Panel is being set up to help them do it.

The NHS is viewed by the Panel as a business like any other, with no recognition that certain services have to be maintained and made available to meet local health needs. Any attempt to stabilise NHS Trusts and their services through mergers is seen simply as an obstacle to private sector involvement, and therefore "anti-competitive": so any planned mergers of NHS organisations with a combined turnover of more than £15m a year in primary care, £35m in community services or £70m in acute and mental health care (i.e. virtually any NHS providers) could be referred by the Panel to the Office of Fair Trading, or even the Competition Commission, and potentially blocked..

Any attempt between two or more NHS providers to cooperate and divide responsibility for services between them – or to agree NOT to provide the same services or to compete with each other for the same pool of patients – could also be branded as collusion.

And the Panel could even intervene in cases where – even without any collusion – an NHS provider is seen as having too large a share of a local market without sufficient competitive pressure.

With this new team of hanging judges positioned to mete out brutal retribution to any NHS organisations which seek to collaborate, plan or integrate services, ministers are setting an accelerated course to hiving off large sections of the NHS by the time of the next election, after which of course David Cameron's team of privatisers could happily pick up and use the same apparatus to complete the process of picking bare the NHS carcass to benefit the profiteers.

Health unions, campaigners, MPs, councillors still have a few weeks to register concerns over the Panel's role and its proposed policies. But time is running out on World Class Commissioning: it is important that PCT direct service staff are not bullied or stamped into "social enterprises" which then raise long-term problems in terms of employment rights, terms and conditions.

Nobody has asked Labour ministers to smash up our NHS, fragment it, or wheel in grasping private companies and “social enterprises” to take over local services. There are no votes to be won in carrying out these changes: if there is a loud enough roar of protest, there must be a chance that the process can be halted and rolled back.

It's desperately late in the day: but let's start the shouting now.