

The Plot Against the NHS **Colin Leys, 8 April 2011**

This lecture, given at Goldsmiths College, is based on the book *The Plot Against the NHS*, by Colin Leys and Stewart Player, published on April 14th.

The common view of the changes proposed in the government's Health and Social Care Bill is that they would be the most radical changes ever made to the NHS. In one way this is correct: the changes do mean replacing a comprehensive, universal system of care with a US-style healthcare market, consisting of providers, all governed by the bottom line. There will be a limited, 'basic' package of services for everybody, funded by the state; and better-quality treatments, on payment of a fee or co-payment, for those who can afford to pay.

But in another way the common view is wrong: the changes that were made under New Labour were more radical. A simple consideration makes this clear. If Mr Lansley had taken office last year facing an NHS as it still was in 2000 his project would be unthinkable. In 2000 there were no foundation trusts; no payment by results for hospital treatments; no private health companies already providing NHS acute care and GP services; no independent regulator of a healthcare market (Monitor). Without all these changes, and many others, what Lansley's Bill now proposes would be unthinkable.

All of these changes were major. Yet most people were largely unaware of them, and certainly unaware of where they were leading – and that includes many MPs and even many clinicians. And not just because the NHS is complex, and organisational changes don't make sexy headlines. It is above all because the changes were made covertly, using government powers that did not require primary legislation. The true purpose of a series of so-called reforms was deliberately concealed. It is because of this that what has happened deserves to be called a plot.

The story begins for me in July 2000. Alan Milburn was Secretary of State for Health and was in the middle of negotiating a so-called concordat with the Independent Healthcare Association. The concordat said that from now on the NHS would take advantage of private sector healthcare providers on a regular basis, not just exceptionally, as for example in the annual winter beds crisis. The Independent Healthcare Association's chief negotiator was Dr Tim Evans. I interviewed Tim Evans at the time. He told me that his vision was that the NHS would be just 'a kitemark attached to the institutions and activities of a system of purely private providers'.

In my innocence, I dismissed this as a far-right fantasy. What I didn't realise was that his vision was shared, to a greater or lesser extent, by a small number of people at the heart of government, especially Blair's senior health policy adviser, Simon Stevens,

Milburn's adviser Paul Corrigan, and a significant number of senior staff in the Department of Health including, critically, its young director of strategy and planning, Dr Penny Dash, and Milburn himself. They all thought that to make the NHS efficient it should be reformed into a kind of healthcare market.

The NHS Plan, which was published in the same month, July 2000, was written by a team that included Stevens, Dash, Corrigan and Milburn. It mentioned the main elements of the shift to a market, but it disguised them as mere improvements in the existing system.

Three major changes in the NHS were required. First, the taboo on private provision of NHS clinical services had to be overcome, and a bridgehead created for the private sector in the NHS. Second, NHS organisations had to be converted into real businesses, not the make-believe businesses of the so-called internal market. Third, the ties between the NHS workforce and the NHS had to be weakened, so that enough NHS staff would be ready to transfer to private sector employment as private providers took over more and more NHS work. Milburn initiated all three of these changes.

Creating a bridgehead for the private sector

Creating significant openings for the private sector in acute or hospital care faced a basic problem: the NHS was highly efficient, while the existing UK private health sector was tiny, with very high costs, and wholly dependent on the part-time work of NHS consultants. There were no British companies that could perform any procedure as cheaply as an NHS hospital, let alone compete across the board with a full District General Hospital. To overcome this was the real aim of the Independent Sector Treatment Centre (ISTC) programme. ISTCs are small stand-alone clinics specialising in standard low-risk procedures, chiefly cataract removal and hip and knee replacements. The programme was set in hand in 2002 by a new Commercial Directorate in the Department of Health led by Ken Anderson, a Texan businessman.

The real aim of the programme was to put pressure on the existing British private health companies – chiefly BMI, Nuffield Hospitals and BUPA's hospitals – to restructure themselves into high-volume lower-cost businesses. This was done by giving very lucrative and risk-free contracts to a set of newcomers from overseas such as Netcare from South Africa and Capio from Sweden. The incumbent firms were, officially at least, disconcerted, and set about restructuring. The BMI hospital chain started separating its private patient work from its NHS work, aiming to make its NHS work cheap and fast, and was then sold to Netcare in 2006. BUPA sold all its hospitals to a private equity company, Cinven, which set about the same task. At the same time, because the new private centres were spread all over England the idea of private provision of clinical services was normalised everywhere. The ISTCs were also allowed to use the NHS logo (or kitemark), so that many if not most patients still don't know they are privately owned and profit-making.

The official aim of the ISTC programme was to add to the NHS's capacity to do elective surgery, and so reduce waiting times, which in 2002 were still very long. Since then there has been a dramatic reduction in waiting times, but it owes nothing to the ISTCs. They have never done more than 2 per cent of NHS elective surgery, and

that has only been achieved by allowing them to use a growing proportion of NHS consultants and other staff – in other words they didn't bring additional capacity. A good case can be made for saying that their extremely generous financial terms took capacity away from the NHS.

But by 2007 the ISTC programme had morphed into a wider system of private providers. As the incumbent companies adapted, they joined the ISTCs in a so-called Extended Choice Network of – at the last count - 149 private hospitals and clinics that are eligible to treat NHS patients and can theoretically do so profitably at NHS prices – at least for the lower-risk, least complicated procedures.

NHS work now accounts for about 25 per cent of the private sector's total revenues (for some firms the proportion is much higher). But this still accounts for only about 2 per cent of total NHS spending on acute or hospital care. It might seem that Tim Evans' dream of a healthcare system consisting only of private providers is still a distant fantasy. But that would be to underestimate the potential for transforming NHS trusts into businesses, which was the second change initiated by Alan Milburn – foundation trusts.

Corporatizing the NHS

The model for foundation trusts was the so-called health foundations – fundaciones sanitarias - set up by the People's Party in Spain. These were publicly-built hospitals that were handed over to private companies to run for a fee. They had freedom from the health ministry and could set their own terms of service for their staff. They were said to be more efficient than the regular state-run hospitals, although subsequent studies don't support this.

But Milburn liked the idea and decided to implement a version of it in England, and even took over the name, 'foundation'. There was a key difference: when NHS hospital trusts got foundation status they were not handed over to private management. But they were freed from Department of Health supervision and could operate in many respects like private companies, including setting their own terms of service for their staff.

But the central point about foundation trusts is that the contracts they make are legally enforceable, and if they run up unsustainable debts they won't be bailed out by the Department of Health. This means that they become fully exposed to the risk of bankruptcy. The independent regulator, Monitor, can step in and impose new management on a foundation trust that is heading for bankruptcy, or let it close and get its work taken over by other providers. This means that the crux of all policy decisions in the hospital becomes financial. Foundation trusts don't have to pay dividends to shareholders but in all other respects they have to behave like private companies. Milburn's aim was that all NHS trusts should become foundation trusts by 2008.

But they couldn't behave like companies unless their income was related to their performance. So Milburn also introduced payment by results. Each completed treatment was to be accounted and paid for individually. This involved putting a price on every procedure, a price that varies according to the different level of cost and risk

posed by each category of patient. These prices were fixed. For the time being competition was to be on quality alone. But once a system of payment based on price per treatment was in place, price competition could then be quite easily introduced.

The target date of 2008 was too soon, but the job is now being completed by Mr Lansley. All NHS trusts are now required to become foundation trusts, or merge with a foundation trust, by 2014, and all community health staff have to be part of a foundation trust or a social enterprise by this coming April. By 2014 all NHS services – acute hospitals, mental health hospitals and clinics, ambulance services, community health services and, of course, GP practices – will be run as independent businesses competing for patient income in a healthcare market.

All this makes Tim Evans' dream look a lot less distant. There will be great scope for the private sector to pick off weak NHS foundation trusts once the new market is fully operational. Two years ago the Department of Health was already expecting up to 90 trusts to disappear over the next 20 years.

Detaching the clinical workforce from the NHS

But for this to happen smoothly, a good part of the NHS clinical workforce also had to be made available to the private sector. Accordingly, the NHS Plan of 2000 called for new contracts of employment for NHS consultants and GPs, and new contracts were signed and came into force in 2003 and 2004.

On the face of it the new contracts gave consultants and GPs large increases in pay for very little if any additional work. But their real significance was different.

In the case of the consultants, a show was made of trying to make them accept much closer supervision by hospital managers, and cut back on their private work. But it soon came to seem that the real aim of doing this was to make them feel more disenchanted with working as salaried NHS employees and readier to go into business – to form doctors chambers, on the model of barristers, or other kinds of business, and sell their services to any employer, public or private, that offered them the best terms. A significant number began to plan to do so and some have begun to. And as the cuts begin to bite there will be unemployment among hospital doctors. As you will have read, consultants are among those scheduled to be laid off by St George's hospital in Tooting, and elsewhere. Working for private providers will become normal again in a way it hasn't been since 1948.

In the case of GPs, the new contract gave most GPs a huge pay rise; it also allowed them to give up out of hours provision for a very modest cut in income. It is not clear how far the size of the pay rise was intended, but almost as soon as it was introduced GPs started to be vilified as overpaid and lazy; and they had also lost their monopoly of primary care. Private companies were invited not just to take over out of hours care, but also to set up a large number of new GP practices, employing GPs on salary. By mid-2010 227 GP practices were being run by for-profit companies and all GP practices are now increasingly based on fixed-term contracts, which have to be competed for again at the end of each contract.

That left the third main component of the NHS workforce in England – 250,000 community health staff. After the 2005 election Patricia Hewitt became Secretary of State for health. In 2006 she tried to get the community health workforce shifted out of Primary Care Trust employment, into self-employment or employment by commercial employers. The aim was clear; staff should only be employed by organisations capable of competing in a market. There was a huge backlash, and Hewitt retreated. But what Hewitt failed to do Andrew Lansley has now accomplished. All community care staff have to be out of PCTs by this April 2011. Most of them have been taken on by foundation trusts.

The last major change initiated by the marketizers was the attempt from 2007 onwards to set up some 500 polyclinics, or GP-led health centres, throughout England. The official aim was to achieve more ‘integrated care’ – meaning, especially, dissolving the boundary between primary and secondary care. The idea was to shift non-urgent work out of hospitals into more numerous, smaller organisations, with at most day surgery facilities and few if any inpatient beds, but offering relatively sophisticated diagnostics and other treatment services. Care would be provided by specialists as well as GPs, especially for the growing population of older patients with long term chronic conditions, but most GP practices would be expected to relocate into the new centres.

There was and is a lot to be said for the polyclinic model. But the key idea underlying it in 2006 was to use it to solve the persisting difficulty of building up a private healthcare industry. The Department of Health Health estimated that about 60 per cent of hospital work – all outpatient clinics, much diagnostics, most minor surgery – could be unbundled from the rest of hospital activity and shifted to these new centres, which would be built and operated by the private sector. This aspect was not mentioned by ministers in public. The official view was that the shift was aimed at improving patient care. But in private meetings held with the private sector every six weeks throughout 2007 and 2008 it was made clear that the new centres were to be an opportunity for private investors.

The front man chosen for the public exercise was Sir Ara Darzi, who was often pictured in his operating theatre scrubs, lending the project an aura of high-tech professional dedication. No one of any consequence was impolite enough to ask what qualifications a specialist in minimally invasive surgery had for making health policy. In reality his three reports all followed closely a script prepared for the Department by a team under the leadership of the same Dr Penny Dash who had been director of strategy in the Department of Health at the time of the NHS Plan, and who was by now a partner in the London office of McKinsey and Company.

Towards the end of 2007 all 152 PCTs in England were ordered to have a one GP-led centre up and running by April 2009. In practice, by the end of last year 140 had been opened. About a third are run by corporations, such as Virgin Assura, but many more are run by GP-owned businesses.

But this way of expanding the role for the private sector in NHS-funded health care has not gone according to plan. One reason why it didn’t was the financial crisis, which meant that private investors couldn’t borrow the necessary funds. A more important one – especially for Lansley, given that his market project hinges on GP

commissioning – was that GPs were reluctant to move into the new centres. By the end of last year several centres had closed and more were facing closure for lack of business. None of them was a centre of integrated care, with high tech diagnostics and facilities for day surgery, involving specialists as well as GPs, in the way Lord Darzi had envisaged.

Last month Mr Lansley quietly shelved the whole initiative.

The shift to an unmanaged market

In my opinion this decision is very significant. Under New Labour, the marketizers envisaged a managed market. The private sector would have a growing share of it – but in structures prescribed by the government. The next major advance for the private sector was to be into Darzi centres.

But the private sector didn't rush to do it, and not only because of lack of credit. It was even more because it wasn't clear how much money there would be in it. Too many aspects of it were unknown: such as, for example, how easy it would be to get hospital consultants to come and work in the centres in places outside London. And there were many unknown unknowns, as Donald Rumsfeld would say. They were also waiting for the election.

The point here, which I think Lansley understands, and few Labour ministers did, is that businessmen want to work out their own opportunities, where they can calculate the risks and the returns. Opportunities selected by the government are only interesting to them if the government assumes all the risk, as it did with the ISTCs – and that is too expensive for governments to repeat very often. And this is what is really new about Lansley's Bill: it promises an unmanaged healthcare market, in which how health care is delivered will be decided by what businesses see as profitable, controlled only by minimum health quality standards (set by the Care Quality Commission) and Monitor, the regulator.

How the market will be regulated is something the experts are still trying to work out, so I am not going to attempt it here. Huge discretion is being handed to the independent regulator, Monitor, to decide what is 'appropriate' or 'necessary', as those who have drafted the Bill put it.

But I think a few things are clear. Over half of all NHS-funded activity - everything that is not paid for on the basis of the fixed-price tariff – is already subject to price competition. We are already seeing it in the way contracts for GP practices and community health services are now being awarded (for example Camden PCT awarded GP practices to UnitedHealth purely on the basis of cost, and replaced the physio services of the Royal Free by those the Newcastle-based company Connect Physical Health). And the interim chief executive of Monitor, David Bennett, has made it clear that price competition will gradually replace the fixed tariff for other activities, including hospital treatments.

Once this starts to happen corporate bidders will undercut NHS hospitals for various bundles of hospital work, using loss-leading pricing if necessary to get started as they already have in primary and community care. The NHS hospital services affected will

close, and clinical staff will move to where the work then is, either as employees of the new corporate providers, or as members of doctors chambers or social enterprises under contract to them.

Many entire hospitals will close, especially in London and other big cities. When a hospital cannot be allowed to close Monitor will move in and franchise its management to corporate management teams. This has already happened to the Hinchingsbrooke Hospital near Cambridge (Circle Health), and experts expect it to happen to 20-30 more in the next few years.

Prices will rise. On the one hand, the cross-subsidisation that is practised inside NHS hospitals will come to an end as the less costly activities are taken out of them, forcing them to charge more for what remains. On the other hand, Monitor will have to ensure that prices are set so that all providers make a profit. To keep the NHS budget down, what is covered by the NHS will decrease. More and more treatments will be 'decommissioned' and will become 'extras', which you can have if pay for them. This is already happening in one particular way, thanks to another New Labour measure – personal budgets, or lump sums given to patients with chronic illnesses to buy their own care with. If you want more care than the lump sum will cover you can pay for more, if you can afford it. Inequality in health care will be restored.

And while prices rise, quality will fall, because quality is hard to measure, and costly to police (the Care Quality Commission is only really mandated to detect cases of gross neglect or abuse, and is grossly under resourced). In other words the NHS will consist of a limited set of treatments of basic quality – and a kitemark.

How was it done?

This very condensed account omits several major issues that are covered in the book Stewart Player and I have been working on. Among other things it omits the way the shift to a market has already been anticipated by the Department of Health, in dozens of initiatives and 'pilots'. It omits the development of the private health industry, which is now on the verge of a dramatic expansion at the expense of the NHS budget. It omits fraud, which is so much part of the history of many of the companies involved, and which seems bound to become as endemic here as it is in the US and other healthcare markets.

But one question can't be entirely omitted from even this brief account: how could the NHS be abolished as a public service without a debate and without the public knowing? The answer is really the story of what has become of democracy in the neoliberal age, condensed into a single case. Spin, of course, has played a big part – secrecy, misrepresentation, manipulation of statistics, lies and the suppression of criticism. But even more important has been a radical change in the nature of government: in effect, the state itself has been privatised.

First, in terms of personnel, the boundary between the Department of Health and the health industry has become so permeable as to be almost non-existent. By 2006 only one career higher civil servant was left in the Department's senior management team. The rest came chiefly from backgrounds in NHS management or the private sector. In addition, senior positions in the department were filled with personnel recruited

directly from the private sector, while former department personnel (including two Secretaries of State) moved out to firms in the private sector. The revolving door has revolved faster in the Department of Health than in any other part of government except perhaps the Department of Defence. Conflict of interest has become so routine as to be almost unremarked. The idea of a boundary between the public and private sectors, which civil servants and ministers police in the public interest, has gone out of fashion.

Second, policy-making has been outsourced. This is an oversimplification, but not much. A so-called health policy community developed, structured especially around two main think tanks, the Kings Fund and the Nuffield Trust. The current Chief Executive of the Kings Fund was formerly director of strategy at the Department of Health, and so was the current vice chair of the board. Their governing bodies also have strong private sector representation and their seminars and conferences are where the market plans have been developed and disseminated. And this has been done partly at public expense, as these and many other think tanks, some of them militantly neoliberal, are charities, and so tax-funded.

Third, and particularly important in the run-up to the 2010 election, is the health industry lobby. Tamasin Cave and David Miller at Spinwatch have made a remarkable short film on the health lobby, called 'The Health Industry Lobbying Tour' which you can watch online at Spinwatch.org. When you have seen it you understand a lot more about Andrew Lansley and where his ideas are coming from.

I'll leave it there. But just in case you are not convinced of the design behind this, and don't think it is fair to call it a plot, let me add just one more item. In January there was a discussion on Radio 4 between Matthew Taylor, who was once Blair's chief of staff, and Eamonn Butler, the Director of the Adam Smith Institute, where Tim Evans also works – same Tim Evans who negotiated the concordat with Milburn and looked forward to the NHS becoming just a kitemark. They were asked if they thought the NHS was really going to become 'a mere franchise'. Butler replied, quite casually, 'It's been 20 years in the planning. I think they'll do it.'
