

PRIVATIZATION: THE DOWNFALL OF THE BRITISH NATIONAL HEALTH SERVICE

Author:

Amit Manjunath

Faculty Sponsor:

Lucia Najšlová,

Department of Social Sciences, Charles University, Prague

ABSTRACT

Whether Andrew Lansley wrote the 2011 Health and Social Care Bill in an effort to bring patients to the center of the NHS and empower health professionals such as GPs, or in an effort to promote private motives is yet to be determined. What is for certain, however, is that the new reforms are not in the best interest of England. The inclusion of a market system promotes the profits of private businesses while reducing what the NHS provides in terms of frontline patient care.

INTRODUCTION

Barely making it through two World Wars, the Spanish Flu, and the Great Slump, the United Kingdom was in a state of economic crisis and its people, feeble. Many hospitals that were used as war infirmaries incurred major financial debts due to a poor allocation and planning of funds in regional governments for healthcare.¹ On the other hand, the implementation of an emergency medical service in 1939, which gave central government a right of direction over both voluntary and municipal hospitals in a time of war, gave the UK citizens a glimpse of the efficiencies and benefits of a nationally controlled healthcare service.² Post-WW2, thoughts of reform began to surface: people realized that healthcare was a right, rather than a commodity that was unreliably and sparsely provided by charity. The emergence of a welfare state was the only way to protect the majority of individuals in the nation who were not able to afford basic health needs; the only foreseeable solution to efficiently providing medical management for these masses was through nationalization. Being freed from the grips of war, Europe was experiencing a major transitioning phase that would allow the UK to carry out immediate radical changes from its old policies rather than slow, incremental modifications. This provided the perfect opportunity for politicians William Beveridge, Clement Attlee, and Aneurin Bevan to launch their long-discussed National Health Care Act in 1948.³ The new health administration consisted of three major components: hospital services, primary care, and community health services. Hospital services brought together municipal and voluntary hospitals into one system in which the staff was salaried. They oversaw local hospital management committees and emphasized the fact that these hospitals are responsible to serve their nation, not their locality. The primary care branch concerned itself with getting all physicians under a contract for services with an executive council. Furthermore, general practitioners (GPs) were deemed the “gate keepers” of the NHS as they were responsible for referring patients to specific hospitals and specialists based on their needs.¹ Finally, the community health services were accountable for the public health aspects of delivering healthcare (staffing community nurses, handling immunizations and infection diseases, building community health centers, etc.).¹ Under this new act, nearly 100% of healthcare costs were covered through taxation. This was possible because the rich paid more than the poor for analogous benefits.¹ An additional benefit of the NHS was that everyone, regardless of residential status in the nation, had access to free healthcare services and free referrals. Some of the outcomes of implementing NHS have been the following: child mortality has fallen from 86 (per 100,000) to just 6.2; the average number of vaccines administered have risen from two to seven; and the portion of the population that smokes has dropped significantly from 65 percent to 25 percent.⁴

HIGH PATIENT SATISFACTION

According to a 2010 statistic, the NHS has had the highest ratings in terms of patient satisfaction and average patient wait-time since its conception.⁵ As the old American adage goes, “if it ain’t broke, don’t fix it.” So with the onset of the 2011 Health and Social Care Bill, a question in need of an immediate answer is: Why change the healthcare system now in spite of all its recent successes? The answer given by

Andrew Lansley, former Secretary of State of Health and pioneer of the controversial NHS reforms, was that in the face of increasing costs of healthcare delivery and a rising size in the population of retired individuals, changes needed to be implemented in order to prepare for the future.¹¹ His reforms put GPs in the “driver’s seat” of the NHS, created a market system in which private and public services can compete to offer their services to local commissioning groups, allowed the proliferation of “foundation trusts” without their old regulations, and required a progressive budget cut over the course of four years.³ There is one word that can be used to describe this entire process: privatization. Whether Lansley’s motives for pushing these reforms were for the greater good or for the betterment of the private sector is highly debated. What is not as debated however, is the general consensus that the privatization of the NHS is not in the best interest of England. Its overall restructuring lowers the efficiency of the system while simultaneously reducing the overall amount of healthcare provided to patients in a timely manner.

One of the primary issues that Andrew Lansley said he would tackle with his NHS reforms was “empowering health professionals such as GPs.”⁶ According to Lansley, the older NHS structure was set up in such a way that general practitioners, those at the frontline of administering patient care, did not have enough of an impact in determining the allocation of funds and resources. While it is true that physicians should have a greater say in how the NHS should distribute its funds, as they are the ones that experience the burdens on a day-to-day basis, the new reforms do not hold up to their words in practice. Under the new structure, GPs will now be a part of groups called “GP Consortia,” and will collectively be responsible for a large portion of the NHS budget, £80 billion to be exact.⁷ GP consortia are groups of GP practices within a local area such as a community that have joined together for the purpose of forming statutory public bodies.⁸ These groups are responsible for commissioning services from any willing providers such as hospitals, private consultants, 24-hour emergency clinics, etc. on behalf of the patients in their community. In theory, it seems as though this structure gives GPs the freedom to tailor the services they commission to the needs of their patients. Much to the contrary, the only real responsibility that GPs have been given from the NHS is deciding where budget cuts should be administered. In an effort to mitigating the recent increases in healthcare costs and the increase in patients over the age of 65 (known to be the more costly demographic), the new reforms have actually mandated GPs to reduce the required budget by 20% by the year 2016.⁹ These budget constraints are the primary hindering factor for why GPs will remain just as powerless, if not more so than in the original NHS structure. Moreover, the fact that the nation’s budget is distributed evenly amongst the thousands of GP consortias means that each group will only be responsible for a small share of the budget, which can only be used for their respective communities. The issue with this is two fold: various consortia groups from different communities (in close proximity of one another) do not necessarily coordinate their finances, and each consortia group’s budget is not enough to commission every service that their respective community needs. In such a situation, there will be overlaps of services between neighboring communities along with disappearances of services that cater to more rare medical situations. Although section 19 of the new bill states that it is the job of the new NHS Commissioning Board to “ensure that...commissioning consortia – (a) together cover the whole of England, and (b) do not coincide or overlap,” the secretary of state has minimum influence over regulating this matter; he simply only exercises this regulation through an annual “mandate” that will set out the objectives of the independent NHS Commissioning Board.⁵ In a matter of two years following the reforms, 80% of the districts in England are already seeing deficits in their budgets ranging from £0.8 million (Merseyside) to £110 million (London).¹⁰ GP consortias simply will not be able to sustain their budget cuts in the long run and such a downward slope will be incredibly difficult to recover from in the future.

WHO BENEFITS?

Many proponents of the new reforms mention how the new Health and Social Care Bill makes a point to “bring patients to the center focus of the NHS” by addressing their needs⁹. To begin with, this generic statement is stated in a very ambiguous fashion and does not seem to have any viable support in the bill itself. Looking at the changes in levels of patient trust with the onset of the new reforms, it becomes simple to address one of the many aspects of why patients have not become the center of the new bill. If a patient became sick in the original system, their course of action would be to go to their GP, get a referral

from said GP regarding to which hospital and/or specialist to go, and then go to said hospital and/or specialist.¹¹ As the GP was not responsible for an annual budget (as in the new system) that would be deducted from with each referral that he or she prescribed, patients had a sense of security that their interests were the sole influences of the GPs referrals. The new system however presents a conflict of interests. Each referral administered from a GP consortia costs them a certain fixed amount (based on the type of referral). For example, the average cost of a GP referring a diabetic patient to a pharmacist for annual medication is £600.¹² This number may seem insignificant, but taken in terms of the restricted budget allocated to each GP consortia, the fact that roughly one in every twenty people are affected by diabetes in England (with a population of 53.5 million), and the fact that this statistic is for drug costs alone, it quickly becomes evident that even the smallest of treatments are heavily accounted for in GP budgeting.¹² An additional conflict that would affect the patient-GP trust relationship arises when looking at the private interests of the GPs themselves. Many of the GPs that are part of the newly formed consortias also work for private hospitals and clinics.⁹ As a result, GPs may begin to direct patients to certain services based on their own financial interests with their private firms. As an added bonus, a patient may not even be able to decipher which private institutions their GPs are associated with as under the new market system, many private services operate under the NHS logo; patients will find it very difficult to determine whether or not the service that they are being referred to is for-profit. Ultimately, patient trust under the new reforms is heavily hindered by the cloud that encapsulates their GPs interest: it will be impossible to know whether their referrals are in the interest of the patient, the consortia's budget, or the GP's private life.

A term previously mentioned, "postcode lottery," was a driving force of the NHS reforms. The general premise of postcode lottery is as follows: under the old system, it was not possible for each community, or "postcode", to have access to every single service within their community.⁹ For example, a person living in Birmingham may have access to basic emergency care but not heart disease care, as the latter only affects a small portion of England's population. As a result, a person in Birmingham with a heart-related issue may have had to travel all the way to Essex or London in order to receive proper treatment. The new NHS system states that with the incorporation of consortia groups along with more bottom-up advising (as opposed to completely nationalized policies), "there will be greater variation in treatments provided in all communities."¹³ This claim could not be farther from the truth. The fact that the new system allows more decisions to be made from the bottom up, and the idea that all communities are now given their own individual budgets simply indicates that the system will only further propagate the postcode lottery phenomenon. As mentioned before, it is a valiant theoretical ideal to allow GP committees to make the decisions regarding which services to provide for their community; after all, they are closest to their patients so they can make more informed decisions regarding what services to commission. However, due to the diminutive size of the national budget apportioned to each community, it becomes very difficult for a group of GPs to reasonably divide the funds for all the services required for their given community (regardless of how efficient they may be with their finances). For example, imagine a community primarily consisting of old-aged people under the new Health and Social Care bill. It is obvious that the GP consortia of this community would focus a large amount of their funding on geriatrics (branch of medicine dealing with the health and care of old people). Now imagine if a younger family in that community was to give birth to twins that were both autistic. In order to support these children, this community would now need to commission a mental health service, which would put great strain on the consortias already tight budget. In reality, the parents of these children would have to travel to another region of England specialized in mental health issues since it is very unlikely that their community would have the capacity to change its budget. This scenario is very to how families move to certain cities for the sake of getting their children into decent schools. Although it is agreeable that the old nationalized system did little to solve the postcode lottery issue, the new system only further propagates the mess, if not, making it worse.

FOR PROFIT MEDICINE AND THE NHS

One of the great controversies incorporated into the new reforms is the creation of a market structure. Within this it is possible for private businesses, particularly those that are in the healthcare market primarily to make money rather than provide services, to compete with not-for-profit sectors of the

NHS.¹⁴ The issue with allowing these firms to compete is that due to their vastly larger financial reservoirs, they have the ability to “cherry pick” the easy and cheap healthcare services to provide in the NHS; after all, these are the services that allow for the greatest profits.⁹ Examples of the easy and cheap healthcare services include general check-ups, dental services, and gynecology. Since private firms take over these low-cost markets, the NHS is left with the more complicated and costly procedures (i.e. maternity care, mental health care, surgery, etc.).¹⁵ This situation nullifies the “cross-subsidizing” scheme that NHS hospitals used to use. Under this, NHS hospitals were in charge of both the easy *and* complicated procedures. As a result, they were able to use the profits made from the former services to subsidize the deficits sustained from the latter.⁹ Not being able to utilize such a scheme will negatively impact the nation in the near future, especially in terms of budget constraints. This may force the government to cut certain procedures from the list of ones that they currently cover, thus ultimately costing the patient significantly more out-of-pocket. In addition to introducing the cherry-picking phenomenon, the creation of a market structure is quite a financial burden to the NHS in terms of maintenance. According to a statistic posted by the Center for Health and Public Interest, the annual cost of maintaining the market structure is £4.5 billion.¹⁶ The same statistic posted by a different organization puts the price at roughly £10 billion.¹⁷ Another factor that should be considered in markets is the cost of advertising. The new NHS structure is set up in such a way that NHS and private firms must advertise themselves to GP consortias in order to convince them to commission their respective services. It is evident that the market structure is taking away from the NHS funds that could be used towards frontline patient care. In the words of Stephen Cragg, a specialist in public law and human rights, the new reforms are “replac[ing] a ‘duty to provide’ with a ‘duty to promote’.”¹⁸

A foreseeable future under the new NHS reforms is the creation of a “two-tier healthcare” system. This is a situation in which the government is responsible for providing basic healthcare and medical necessities whereas the second tier of care exists only for those who can purchase additional healthcare services.¹⁹ Although it may seem unreasonable at the moment to make such assumptions (considering that the majority of services provided by the NHS are still free), consider the subject of “foundation trusts.” Prior to the reforms, there were very few hospitals in England that fell under this category. These hospitals are separate from the NHS, and essentially act as independent businesses; they have the ability to gamble on the stock exchange, borrow money, and act independently of the Department of Health.²⁰ Post-reforms, effectively every hospital is acting as a foundation trust. Many of the smaller hospitals have merged, and some have even been forced to shut down due to an inability of producing necessary funds. It is clear that these foundations are required to create their own capital, and the easiest way for them to do this is by providing services to *private* patients. Although pre-reforms, there was a cap on how much money these foundation trusts could make from private patients, this limit has been removed by the new bill.⁹ Basically, hospitals now have the option to bring in as many private patients as they want in times of economic crisis (as they inevitably will be due to the progressive budget cuts). The consequence of the abolition of the limit is that hospitals will have longer lines and waiting times for patients under public care. Thus, patients in dire need of care will need to pay out of pocket if they want to join the private line.

Two main sources of opposition to the aforementioned arguments concern themselves with the economic theory of competition and the locality of the Clinical Commissioning Groups (CCGs). Economic theory states that creating competition in a market is beneficial for the market itself and for its consumers. This is because competition creates a greater turnover rate with firms, greater technological advancements, and the propagation of the “invisible hand.” Fundamentally, the theory suggests that a competitive market system will help bring services to patients at the cheapest rates in the most efficient manner. The reality of the situation contradicts this theory. The healthcare market is divided into several sub-markets of service provision, ranging from the cheapest (simple check-ups, gynecology, etc.) to more expensive markets (cancer treatment, mental health services, etc.).¹⁵ Although it is true that the creation of competition will in fact provide the driving force for innovation and the lowering of prices, it is often forgotten that big businesses that are competing in the system get to cherry pick which sub-market they wish to enter. It is only logical that they will take over all of the cheaper markets because these will be the ones that will yield the most profit.¹⁷ This implies that all the expensive markets will be left at their high

prices due to a lack of competition. In addition, this lack of rivalry will also provide little incentive for improvement and innovation in these expensive markets. As previously mentioned, the cost of maintaining the market structure costs anywhere from £4.5 billion to £10 billion, which is money that could have been going to frontline healthcare provision in a non-privatized system. This clearly is not in the best interest of the future of the NHS as the benefits of sustaining a market structure definitely do not outweigh its costs. The argument regarding the locality of CCG groups has already been outlined. Theory holds that because GPs now run consortia groups in their communities, they are better able to provide for their communities. Their jobs are to commission services from any providers that they see fit for their community. However, the fact that each of these groups is only responsible for a small portion of the overall NHS fund, that there is a lack of coordination between adjacent groups, and that GPs are expected to implement drastic budget "efficiencies" over the next four years invalidates the advantages of the bottom-up control.

CONCLUSION

Whether Andrew Lansley wrote the 2011 Health and Social Care Bill in an effort to bring patients to the center of the NHS and empower health professionals such as GPs, or in an effort to promote private motives is yet to be determined. What is for certain, however, is that the new reforms are not in the best interest of England. The inclusion of a market system promotes the profits of private businesses while reducing what the NHS provides in terms of frontline patient care. Healthcare costs will only rise from here onwards since under the new system, patients will be less likely to obtain regular check ups due to its associated out-of-pocket costs; this will ultimately shift the nation's original emphasis from preventative care to curative care (use of healthcare system only in times of sickness). Quite simply, privatization of healthcare in England is toxic for its people. In 1990, former prime minister Margaret Thatcher was removed from power (i.e. not reelected) due to her strong beliefs in neoliberal ideals and the fact that she tried privatizing fundamental systems in Britain such as education and healthcare. Looking at Lansley's widespread reforms, it seems as though history has repeated itself, only this time, for the worse.

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