

We must go our own way on NHS reforms

Privatisation of health care does not need to happen here, indeed we could take a lead by sticking to principles
 By Allyson Pollock



CAN it be true that we can no longer afford an NHS? The service was created when the country and its citizens were broke, bankrupted by the Second World War. But, since its inception, the UK Treasury has attempted to curb its costs and its scope, telling the people the country cannot afford the NHS, that costs must be brought down, care rationed, and patients charged for services.

The NHS is the most loved of all the welfare institutions. And yet, year after year, we are told its costs are rising exponentially, patient demand is out of control and the country cannot meet the claims of an ageing population especially in this new age of austerity. Coupled with the refrain that the NHS is wasteful and inefficient, this provides the platform for advocates of commercialisation and privatisation.

But does the message stand up? Is it really the case that a finite population has infinite health care needs that will lead to ruin under the NHS? And will England's

proposals to privatise services and provide scope for user charges and private health insurance contain costs, and cure the NHS?

Let us start close to home. In recent evidence to the Scottish Parliament's finance committee Professor David Bell of Stirling University proposed that the NHS might wish to follow Sweden's policy and levy charges on patients for hospital costs or for visits to their GP. Fundamentally, this would mark a radical departure from an NHS free at the point of delivery provided on the basis of need and not the ability to pay. Over the decades the UK Treasury has repeatedly reviewed the option of charges for care, only to come down heavily against them as regressive and unfair. To avoid introducing conflict between doctor and patient, the Treasury recommends there should be maximum separation between the way in which funds are raised.

It is well established that central taxation is the cheapest and fairest way. Research evidence shows user charges of any sort are regressive and penalise the poor and sick; they act as a barrier to care and are also expensive to administer since

they necessitate means-testing and decisions about eligibility.

And the justifications for user charges are equally flimsy. Take for example the refrain that costs are rising because of an ageing population sometimes called "the demographic timebomb". The myth is easily exploded; improvements in life expectancy need not generate more disease and illness, and financial survival does not depend on ending the universal, comprehensive system of health care that we have enjoyed for more than 60 years.

Ten years ago, the UK royal commission on long-term care estimated the added costs of an ageing population would be no more than an extra 0.3 per cent of UK national wealth by 2051. Numbers like these were one of the factors that rightly persuaded the Scottish Government to reverse Westminster's policy of charging for long-term care. The health select committee at Westminster too has found no evidence to support the claim and research in the European Union has reached a similar conclusion. "Contrary to popular belief," writes Professor Josep Figueras, director of the World



Health Organisation's (WHO) European branch, "ageing is not an inevitable and unmanageable drain on health care resources."

Moving from the detail and the debate over charging north of the Border, another argument used against a free, comprehensive NHS in the UK is the additional cost of medical advances and new technologies. This needs closer scrutiny. One of the biggest claims on NHS funds is spending on medicines or pharmaceuticals, which accounts for between 15-20 per cent of advanced country health budgets. For most of the past 20 years the growth in the drugs bill has outstripped inflation and the annual growth in public health budgets making more demands on scarce resources.

This is not because of the public's insatiable appetite for new drugs. Rather, as the health select committee has highlighted, countries with large pharmaceutical industries, like the US, UK and Germany, keep profits deliberately high and allow generous profit margins to drug companies selling to the NHS to protect export prices.

The committee notes how the Department of Health allows trade interests to override public health; pharmaceutical companies are protected by a patent system that allows them to charge monopoly prices to the NHS for at least 20 years after the introduction of a new drug. The consequence is that the industry's profit rates are estimated to be more than triple those of all industries. These profits are met from the patient care budget and there is insufficient scrutiny of the real worth of new drugs in terms of efficacy; many give very little additional benefit.

And what of the argument that the NHS is wasteful and inefficient? On the contrary, the NHS is an extraordinarily economical project. In the US the 15 per cent of GDP spent on health is almost double that of the UK and, at the same time, some 60 million people lack proper access to health care and another 100m are underinsured. Unlike the US, no-one in the UK is greeted at the reception of accident

and emergency or their GP surgery by a request for a credit card and their insurance certificate to show entitlement before they can be seen. No-one here need fear the debt collectors. In the US half of all bankruptcies and insolvencies are due to health bills; in the UK no woman need fear having to choose between her treatment for breast cancer or her family and children's home being repossessed. That is everyday reality in the lives of Americans where every decision is influenced by eligibility for health care. That is the system England is about to import.

The question is not can we afford to have an NHS but: can we afford not to have one?

To use the argument of financial necessity to overturn the fundamental principles of the NHS, which call for the best attainable health care for everyone, free at the point of need, is both careless and untruthful. For generations the pursuit of this has contributed to raising health status and life expectancy. Nye Bevan's postwar dream that the NHS would be there when you need it, provide dignity and security and, above all, freedom from fear is now our daily reality.

South of the Border there is careless talk, with the coalition calling time on the NHS, bringing in commercial health care providers. Its new White Paper substitutes commercial management and private-for-profit provision for public administration, ownership and control. For the first time in NHS history its services will be orientated towards business interests and inevitably, as services are reduced, user charges and private insurance will expand.

The US companies now advising the coalition running the English system have been fined hundreds of millions of dollars for fraud and embezzlement of government funds and for actively pursuing denial of health care to patients by excluding high risk, unprofitable patients especially those with chronic diseases and older people. They are also advocating the use of "Milliman guidelines", commercial care plans used by for-profit health maintenance organisations in the US

to overrule doctors' decisions and protect shareholder interests.

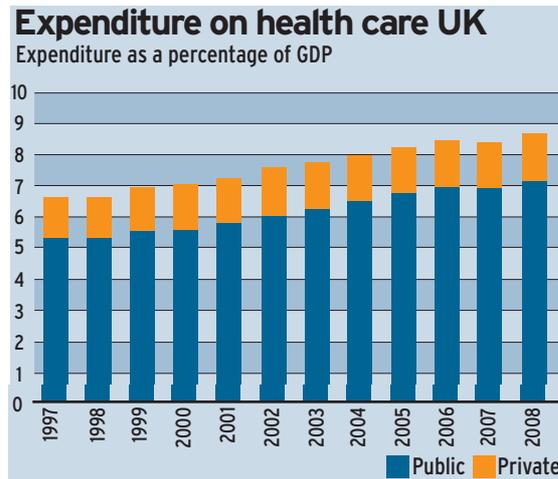
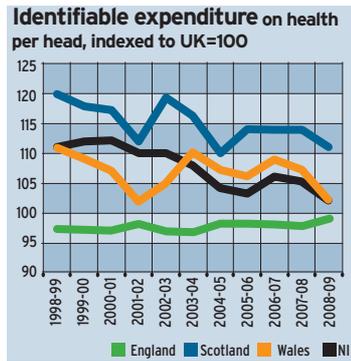
In the US, a 1997 survey of 5,160 primary care physicians found 36 per cent could not obtain non-emergency hospitalisations for their patients, and 18 per cent could not refer patients to an appropriate high-quality specialist consultant because of company policies and corporate control. One in four physicians said they could not provide high-quality care to all their patients or make decisions in their best interests. This is the future for England. Parliamentary opposition is non-existent because the Liberal Democrats are tied to the coalition and New Labour put in place the machinery for privatisation. For Scotland and Wales, which have rejected the market, England's road introduces new challenges. How can market and non-market systems co-exist within the UK?

But there are new opportunities too. Scotland and Wales are rapidly becoming the standard bearers for a system of universal health care that is being advocated by the World Health Organisation and other international health care communities. The financial crisis has shaken the belief that international corporations can be tamed for the good of society.

Dr Margaret Chan, director-general of WHO, reflected this when she said: "Great waste occurs when health is treated as a commercial commodity, to be bought and sold, assuming that market forces will somehow self-adjust to iron out any problems. This seldom happens. What you see instead is unnecessary tests and procedures, more and longer hospital stays, higher costs, and the exclusion of people who cannot pay."

Scotland has had a long tradition of public accountability through common ownership, public administration and control. The NHS is an important democratising element. Scotland has an international role to play in pressing home the message, resisting market forces and shareholder presence. We must not lose our NHS to discover what we already know. A return to the market will be a return to fear.





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Contrary to popular belief, ageing is not an inevitable and unmanageable drain on health care resources

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Ref: 39840592





| Identifiable expenditure on health £ per head | | | | | | |
|--|---------------|---------------|-------------------------|--------------------------|--------------------------|--------------------------|
| | Year 07-09 | Year 08-09 | Diff vs Eng 07-08 | Diff vs. Eng 07-08 | Diff vs. Eng 08-09 | Diff vs. Eng 08-09 |
| England | 1,626 | 1,774 | - | - | - | - |
| Scotland | 1,893 | 1,986 | +267 | +16.4% | +212 | +12% |
| Wales | 1,780 | 1,834 | +154 | +9.5% | +60 | +3.4% |
| N.Ireland | 1,744 | 1,835 | +118 | +7.3% | +61 | +3.4% |

Sources: HM Treasury, PESA 2009

Emergency services could follow America's bad example, and put cash concerns before care

Picture: Jane Barlow

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