

HEAD TO HEAD

Will expansion of the NHS abroad benefit UK patients? No

The new NHS mandate calls for hospitals to set up more profit making branches abroad. **Philip Leonard** (doi:10.1136/bmj.e8493) says this will bring new revenue to the cash strapped service, but **Allyson Pollock** says that promoting trade in healthcare over universal access benefits no one

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Generating income from private patients abroad to fund the hard pressed NHS and meet patients' needs at home sounds like a good idea. The problem is that the NHS's system is not being exported; the NHS logo is simply a front for global business corporations.

David Cameron's announcement in August this year that the NHS "brand" would be tied to commercial investors has become Healthcare UK, a commercial joint venture between the UK Trade and Investment department and the Department of Health. Spun as a plan to set up NHS clinics abroad, the scheme covers all aspects of international trade from e-health and cross border trade in patients, to the trade in medical staff, technology, drugs, and intellectual property.

Selling NHS branded care abroad is not new. New Labour plugged the idea from 2003 to 2010, calling it variously NHS Global, DH International, and British Healthcare. The Health Industry Task Force set up by the government and the healthcare products industry in 2004 identified the NHS, because of its size, as a key sector in the development of a globally competitive British economy.¹ As the new NHS mandate, published on 13 November makes clear, trade is at the centre of the export model: "It contributes to the growth of the economy: not only by addressing the health needs of the population . . . but also through . . . exporting innovation and expertise internationally."²

Putting NHS funds into private pockets

For 60 years the NHS was neither a brand nor a kitemark but a universal healthcare system. It proved to be more cost effective and inclusive than almost all other health systems because its administrators had sufficient power to allocate resources according to need and to keep overall costs, including administration, low. The gatekeeper role of general practitioners was crucial. As parts of it are floated off, either as foundation trusts with commercial joint ventures or simply as contracted private providers, that power of direction is reduced and so too are public accountability and equity of access.

Large teaching hospitals, including Moorfields, Imperial College, and Great Ormond Street, have set up services in the Middle East, and efforts are being made to penetrate Brazil, India, and China. These titans of the pre-NHS voluntary hospital system—with their large endowments, extensive private patient lists (generating 30% of Moorfields' income), and political clout—have always exercised disproportionate influence over allocation of resources and been able to put their own interests before those of rational planning.³ Foundation trusts now have the freedom to divert scarce clinical resources including beds and staff to private use. The freedom to generate up to half their income from private patients brings no benefits for publicly funded patients.

The government has reportedly said that investment in foreign trade could come only from the revenue these organisations make from private patients.⁴ But increased trade has meant that taxes intended for patient care now flow into myriad private contracts, where commercial secrecy disguises the scale of profits and offshore and tax avoidance schemes disguise returns from international trading.

Nor will the NHS necessarily benefit. Private finance initiatives (PFI) are an international trade, too, and the results have been catastrophic, with major cuts in NHS services and staff. Today, most of the hospitals in England are on "red alert" because they have no beds available to which to admit sick people.⁵ The government has stopped monitoring the problems, but emergency departments are overflowing and bed occupancy rates and staffing are at dangerous levels for many specialties.⁵ Further cuts are looming with several NHS hospitals on the brink of bankruptcy as PFI debt payments continually rise. Reductions in activity of 25-30% are predicted across south London alone.⁶ These past and projected closures are a result of the Treasury's siphoning off more than £2bn to itself and billions to private, for-profit companies.⁷

Damage to public health

In India and South East Asia, where there has been a heavy emphasis on “health tourism,” the planning of hospital infrastructure and the costs of care are in danger of being driven up by trade related investment, leaving more local people without basic care.⁸ The same is true of the US. Take the rich and the middle class out of the public system and you are left with an underfunded service that no one wants to use.

International trade rules further reduce the scope for public health as distinct from market based planning. The status of foundation trusts after the Health and Social Care Act 2012 is a source of controversy: will their new commercial freedoms put them beyond government and the reach of the public?

Whether presented as generating income from foreign patients to benefit the NHS or as an industrial strategy for export led growth, the policy that promotes trade and markets in healthcare over universal access and equity is equally catastrophic for patients and for citizens both at home and abroad.

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