
The Medico-Legal Society

A meeting of the Society was held at the Royal Society of Medicine, 1 Wimpole Street, London W1, on Thursday, 8 May 2008. The President, Mr Bertie Leigh, was in the Chair.

Public Health Meets Law: Are There Sufficient Legal Safeguards to Ensure Access to Public Health Care for All?

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The President: Good evening everybody. It gives me enormous pleasure to welcome Professor Pollock this evening to lecture to us. I imagine most people in this room are thoroughly familiar with her writings and her valued polemics on behalf of the NHS and I sometimes think she is the only person who seems to understand what is happening to the health service and to be capable of articulating what we all feel and, as it were, to unzip the disasters that are being brought upon us by PFI, which is in my view damaging our great British institution. Her most prominent work is *NHS plc*, which I think is one of the most brilliant political polemics published within the last 15 years, and she has with her one or two copies which she will be signing afterwards. Professor Pollock. (Applause.)

Professor Pollock: Thank you very much for inviting me today. I really know nothing about the law, so in some ways being here today is partly an appeal for help, either directly or indirectly. Increasingly services are being transferred from the public sector to the private sector and so it is imperative that we consider the implications for universal health care. Are there any remedies left in law to protect public health care?

I first started thinking about this topic three years ago when I had a phone call from a Dr Beth Barratt in Derby who said that her GP contract had instead been awarded to United Health, a large American health maintenance organisation. I put her in touch

with Richard Stein, of Leigh Day who brilliantly helped take this case to judicial review (which failed initially but succeeded in the Court of Appeal). The process was long and very traumatic for the local patients and GP and although the Court of Appeal found for the public side, the action only delayed the privatisation process.

Today, general practice is being taken over from local doctors and being operated by health care organisations. Despite protests and a recent BMA petition signed by 1.3 million people the process goes on with judicial review the only legal procedure available to protestors and this has proved ineffective. The Government is intent on privatising the NHS and in my view this removes fundamental rights and entitlements we have enjoyed to date. NHS funds are flowing out of the NHS into commercial providers who have commercial contracts. This is a major departure which the public sector has never had to deal with before. It has very big implications for access, for entitlement and for the basic values of universal health care free at the point of delivery. For example, there is no moratorium on the commercial sector when they are running NHS services from charging top-up fees or co-insurance policies. As soon as you introduce charges you introduce unfairness and penalise the poor and the sick who can't afford to pay; means testing doesn't work.

The old system was based on hierarchical planning with services delivered on the basis of need with

no market mechanisms so there was no cherry picking and no winners and losers. But now we are moving to the model of patient as consumer, with the idea that consumers exercise their voices through exit and entry and also through choice; that is the big issue says the Government – but as soon as you introduce choice it implies an uneven and unequal quality of services from which you can pick.

Introduction

These are crucial times for the future of the United Kingdom's National Health Service. The current changes extend market-oriented changes introduced by Margaret Thatcher back in 1990 which are rooted in the US health care system – the most unfair system in the Western World.

The Values of the NHS

The UK NHS was the model maker for the rest of the world. Our European neighbours modelled their own systems on our values of universality, fairness and social justice which underpinned the UK NHS from its inception and made it the model-maker for the rest of the world in 1948. The key goals of a universal health service are:

- services for everybody;
- comprehensive; no services would be excluded or treatments or conditions or individuals;
- equal access for equal need and not ability to pay;
- free at the point of delivery.

These values have stood the test of time and contribute to the social fabric of our countries, society and culture.

Does It Matter Who Delivers Health Care?

Government today claims that it does not matter how services are provided so long as they are publicly funded. Government will tell you: “We are bringing in market oriented changes but it doesn't matter *how* we are going to provide them or *who* provides them, so long as they are publicly funded.” It doesn't matter whether it is a for-profit company or a public hospital – people don't care.

First point: there is no evidence in support of these

claims. There is no country in the world that delivers universal health care through a market and for-profit providers. Indeed all the evidence shows that markets cannot deliver universal health care because market logic works against the core principles of national health systems.

Second, across Europe universal health care systems have evolved in different ways. Some countries have more market elements both in the insurance arrangements and ways in which doctors and service providers are reimbursed with the result that some systems are more cost inefficient and fragmented than others. All vary in scope and coverage. However, until recently all countries in Europe with universal health care systems have safeguarded against the entry of multinational corporations and for-profit enterprise.

How the Principles of Universal Health Care Are Safeguarded in the Design

The architects of your health services paid careful attention to the design both of funding and delivery. In particular they integrated two core mechanisms: fairness of funding and equity in delivery into the design. The belief is that no patient and their family should be disadvantaged by the catastrophic costs of care, the fear of health care bills or debts. This is in marked contrast to the US where health care results in a half of all personal bankruptcies and no one has freedom from fear of health care bills.

Fairness of funding and delivery or social solidarity are not mere aspirations and require technical solutions. The two key mechanisms are risk pooling and redistribution.

i) Risk pooling allows the risks to be shared across the whole population. It is efficient and fair. Pooling risk prevents the selecting out of favourable populations or exclusion of unfavourable groups of people. In a universal system no one can be excluded by virtue of age, or illness; individual hospitals or services should not be able to exclude you because you are ill or too poor to pay. In the USA by contrast, excluding unprofitable patients and treatments is the logic of the market. Every action of the private insurer and provider is aimed at reducing their risks which means selecting the profitable risk pools and leaving unhealthy and poor and sick groups behind.

ii) Redistribution: the basis of equality or equity is

equal access for equal need and not ability to pay. If funding is raised fairly the healthy and wealthy contribute more than, and share the risks and costs with, the sick and the poor. The old and the poor need and use services more than the healthy and wealthy therefore any form of user charge is regressive and this is why user charges are so problematic. User charges punish the sick, the old and the poor. But fairness of funding has also to be built into the delivery system so that money flows according to need by the whole population and not the ability to pay.

How Redistribution and Risk Pooling Is Built into the Raising of Funds for Public Health Care

All the evidence shows that central taxation and income tax is the fairest and most progressive and cost efficient way of raising finance for health care so in a national system funds should be collected at national level and not at a local level. Thus, regionalisation and decentralisation of funds and administration should not be confused with decentralisation of funding responsibility, so that poor regions are left having to raise funds. User charges act as major barriers to care; user fees are regressive because the burden falls on the poor and the sick and the old. They act against social solidarity. User charges ultimately pass the risk and cost down to the level of the individual and their family and work against the risk pool. In their extreme forms, charges are catastrophic for patients and families. The best examples of this are evident in very poor countries and the US, but other examples include the funding of long term care or pharmaceutical treatments, where often the costs are born by the patients and their families. The other advantage of central taxation over social insurance and private insurance is that it is cheap and efficient to administer and it is comprehensive, it does not allow the population to be divided into multiple risk pools, nor does it allow segmentation of the risk pool, which is how private insurance works.

How Redistribution and Risk Pooling Is Designed into the Public Delivery System

In universal health care systems the unit of administration is a geographic area and often this is a local municipality. The reason for this is that geographic

areas ensure coterminosity and population coverage. The area of administration cannot exclude groups by virtue of their cost, namely, the old, poor and sick. The administrative body must plan services to meet the needs of all residents in their area. In contrast, a market oriented system has as its unit of administration the firm or the provider/insurer, the population covered are the members and not the residents. However firms have an inbuilt incentive to compete for healthy patients and the logic of the market is to select out the profitable patients and treatments excluding those who are high risk or cannot afford to pay. In a public health system the service are planned on the basis of the whole population living in an area. This population tends to be relatively stable. In contrast, a system designed around membership or enrollees is unstable as high numbers of people may enrol and leave each year. HMOs may have high turnover with up to half their members changing each year because of the selection procedures they adopt. For example, when they are recruiting new members, HMOs will deliberately screen out those who are sick or poor making it difficult to plan for and to provide continuity of care. Indeed the incentive is not to plan for long term needs.

When designing the delivery system, careful attention has to be paid to risk pooling and redistribution, the population that is covered, the planning structures and public accountability.

Second, services should be integrated and funded in such a way as they have no incentive to select out patients or treatments or externalise costs, pass costs back to patients, carers or other services. There should be no incentive to deny people care or restrict eligibility or entitlement.

How the Money Flows Through the System

Patients should be able to obtain the services that they need, but money should be separated from the clinical encounter. There should be a maximum separation of the money from the clinician providing the care and the patient, ability to pay should not cloud clinical judgment.

Money should also flow into the system on the basis of need, i.e. fair resource-allocation. Previously in the UK it was allocated by the regional tier through block grants to hospitals and services irrespective of the patients they treat. Now the govern-

ment is introducing tariffs or prices. It is inappropriate that money should follow patients, because the logic of that is that you're moving into a market-pricing system, with winners and losers and the act of tying money to patients undermines the principle of risk pooling. So, pricing is a completely irrational, illogical system.

The third question: where is the money going? We know from the international studies that the cost of pharmaceuticals is rising three or four times faster than average health expenditure. It is an area government could look into. Where does the money go? Why are the prices of pharmaceuticals products so high? Attention is focused on NICE but not on the prices charged by the industry. The same is true with accounting for PFI and other services. We must be able to follow the money – this is an indispensable function of a democracy.

The Market Oriented Changes in the UK Health Care System

In the UK the government changed the integrated NHS into a system of buyers and sellers with commissioning agencies (PCTs) which have the freedom to buy care in from external providers, many of whom will be new multinational companies. Government is also introducing changes to the flow of funds in the system so that money will follow the patients rather than flow into services on the basis of planned needs, sometimes called “payment by results” or “tariff”. In effect this allows government to shift large amounts of funding from the current providers to the for-profit providers. So instead of public hospitals and services receiving block grants on the basis of patient needs, they have to earn money for each patient under a pricing system known as (diagnosis-related groups) DRG. This is the system that is used by the US health care industry.

Government claims that market competition offers more choice and diversity of provision. They argue it does not matter who delivers health care so long it is funded by the government, that there will be greater professional autonomy and control by doctors and nurses and more cost efficiency.

The Limits of Choice and Competition in a Market

The first thing to note is that it is quite possible to have both competition and choice in a public system – the amount of choice will depend on the willingness of the public authority to pay to leave some surplus capacity in the system but of course this affects efficiency. Research demonstrates that what most patients really want is good high quality services close to home when they need them. They do not want choice, save for second opinions for specialist services.

Second, choice is often confused and conflated with diversity. Diversity is not the same as choice. Diversity implies different types of services and treatments for the same condition. However for most technical procedures patients do not want diversity they want the same high quality and standard of care. What government really means when it substitutes “diversity” for “choice” is a desire to bring in private for-profit providers. However, in practice, far from being diverse these new providers usually offer a much more limited list of services and procedures because for-profit providers are keen to minimise their risks.

In a market it is left to the individual provider, or company, or firm to decide what services they will provide and who they will provide them for. Under market competition instead of planning services for needs and allocating resources, the idea is that money will follow patients and the patients will exercise their voice in the markets by either deciding to go to a service or exiting or not taking up the service. The idea behind choice in a market is that consumers will select the service not on the basis of price but of quality. But if all patients want high quality care and not all services are of an equally high quality inevitably some consumers will be better able to pick than others. It is not hard to imagine which groups these will be.

Choice in a market which is judged on the basis of quality means that not all care will be of an equally high quality. But quality means different things to patients and to doctors and to citizens. For example a shiny new facility may offer good food and a comfortable bed, but terrible clinical care. Quality is difficult to measure and difficult to judge as patients

are not technical experts. And here we arrive at the four key problems of the market

i) **Asymmetric information:** anybody who has used the health system knows choice is not simple because of imperfect information. As a patient you are very vulnerable, you don't have good knowledge, and you can't make good decisions if you are critically ill. What you need and want is not choice but trust in the system that it will provide only the best for you and the doctors will be motivated to do their best. So, choice is not a very good mechanism in a health care system and it certainly doesn't replace needs-based planning. The government also argues that if patients don't like the service they will use their "voice" and exit the service. But how can you do that when you are vulnerable and sick? You are in a supplicant position and dependent on experts to make decisions for you. The Icelandic government, for example, wants to bring into its health system a mechanism that will allow money to follow patients as in a marketplace with the idea that patients will pick and choose providers on the basis of quality.

Given there is already quite a lot of choice within the public system, why would you want to pick and choose within a market? Choice in the marketplace implies that there will be winners and losers. It implies that not all services will be equal and some consumers will be better able to choose better services than others. That's the way the market works. It also implies that patients can exit but it is not easy to leave if the quality of care is bad.

ii) **Inefficiencies:** choice requires that there is surplus capacity including beds and staff and services. But if you want to run an efficient system you don't want hospitals and beds and staff lying idle. So, how can choice be compatible with maximum efficiency?

iii) **Cream skimming and cherry picking:** competition creates winners and losers and some will go to the wall. If money flows out of the public system it weakens and destabilises the financial viability of the public system. There will be a lot less cash in the public system. So "the patient as consumer with voice and choice" is a problematic concept. The other problem with competition is the danger of cream skimming and cherry picking with providers focusing on the more profitable end of treatments and care.

iv) **Incomplete contracts:** in a market situation

professional expertise and trust is replaced by a commercial contractual relationship. Everything, including quality, has to be negotiated through a commercial contract in return for payment. Once again the research evidence shows that health care is highly complex and technical and not every eventuality can be contracted for. This means that user and purchaser are vulnerable. Suppose a patient gets pneumonia in hospital. The relatives feel there was neglect. Do they blame the company who employed the cleaner who opened the window? The doctor who failed to diagnose the illness, the side effects of the drugs given, the infectious patient in the next bed or the company that made the food that may have carried the organisms? How do we cost and monitor risk, uncertainty and blame?

There are real problems with the ways in which "voice and choice and diversity" are used. How can patients who are often frail and elderly pick and choose? They don't need choice – they need the same high quality care everywhere for all and trust in the system. Trust is not what markets are built on. However, trust underpins the public system and the interaction between patients and professionals in a public health care system.

The English Experiment in Markets

The English experiment in privatising health care is drawn from a school of thought called New Public Management. The idea is to create markets in public services by decentralising management and breaking up the administration into buyers and sellers. The sellers become the hospitals and services while the buyers are the government agencies, or agents acting on behalf of government or insurers. Markets need a price mechanism because only in that way can for-profit providers enter into commercial contracts. Price also allows risk to be devolved down to the level of the provider and then to the individual patient.

What happened to the NHS in England is as follows. First, in 1991 using the purchaser provider split the government decentralised administration moving away from the geographic area-based planning to an internal market of purchasers and providers where all NHS services were created as "firms". The government in England then used incremental legislation to set up a full commercial market.

Now the health services are increasingly privatised under commercial contracts and under commercial ownership where the accountability is to shareholders, and no longer to government and citizens. The government has brought in an independent regulator who now bypasses parliament. So, just as the government sold off railways, water, telecoms and utilities in the UK, it is now privatising health and education. The UK NHS is a laboratory for privatisation. And the UK government had a lot of help and advice from the Americans, from the American health care industry, and from management consultants like Price Waterhouse Coopers. It has taken nearly 20 years to destroy and dismantle the English NHS and it was done without any democratic mandate or discussion, because every piece of legislation – and there have been nearly 30 bits of legislation over 20 years – was presented as a technical change, a minor change to improve the cost efficiency, to improve the choice for patients and the public. But there was never at any time a proper, democratic discussion, nor was it in the government's election manifestos and pledges.

As we describe in our book *NHS plc* in the UK NHS there have been six phases of privatisation or marketisation over the last 25 years all of which have involved technical changes and some legislation.

i) Introduction of new management tiers. Margaret Thatcher brought in her supermarket guru Lord Griffiths who said why can't health care be more like Sainsbury's and so he advocated management reforms which involved taking control away from the health professionals and bringing in a new technocratic management. So, government opens new schools of management and business and trains up a new generation of managers in the principles of the market. Mrs Thatcher's model was to develop supermarket managers for the NHS. These new technocrats are apparatchiks for the government.

ii) Contracting out. Throughout the 1980s the early privatisation took the form of contracting out catering and cleaning and laundry staff. They were poorly unionised, low-paid and mainly women. The companies operating these services are now global giants – e.g. SERCO, Sodexo and Tarmac – and have become increasingly powerful over time. The companies over time are extending their reach to infrastructure and clinical services and of course European markets.

iii) Structural changes: internal markets and purchaser provider split. In 1991, the NHS was broken up and the integrated health system replaced by commissioning agencies and competing providers – services were established as public corporations or firms. Government later put in place a new regulatory system independent of the Health Minister (2003), known as Monitor. United Health in America, Mercury from South Africa, Canadian companies like Intra Health – all of these companies are new entrants into the British NHS.

iv) Direct privatisations – from within. Public hospitals now have power to become private companies, or not for-profit firms, known as foundation trusts. They also have new powers to go into the marketplace, to bring in new investment with venture capitalists and to bring shareholders onboard. That is privatisation from within. These new bodies are no longer regulated directly by the government, but by an independent regulator. The foundation trusts can also subcontract to private for-profit operators bringing in corporations to run health care and shareholders to profit from care.

v) Contracting out clinical care. Whereas formerly public bodies were governed by public contracts and public law, the government has moved to bring in commercial providers under commercial contract, but funded by the NHS. Privatisation began with non-urgent elective surgery such as hip operations and cataract surgery. Government decided to take the low-risk, easy, profitable services out of the hospitals and give them to the private entrepreneurs. The same is happening with general practitioner services. These services too are being commodified and broken up and parcelled out to the for profit sector. Radiology, pathology, blood services, health promotion, information and data – everything is being broken up and taken out of the public system and handed through commercial contracts to the private sector.

vi) Privatising the land and buildings. Even the land and buildings are being sold and leased back under something called "P3" or "Private Finance Initiative". The Private Finance Initiative has allowed every part of the public system to be privatised. And this is how it works: The government, instead of raising the money for new capital investment, goes to the banks and the venture capitalists and asks them to raise it creating a 30-year debt for

us and our children and grandchildren to pay off. PPPs are being exported by the UK government, not just to Europe, but to Africa, to Canada, to America, to Latin America. The profits are immense for the private sector. The costs are exorbitant. There are 600 or 700 contracts that have been signed but nobody, apart from the lawyers who have been negotiating them, has seen them; they have not been open to proper public scrutiny, and even more worrying is that the National Audit Office hasn't done much scrutiny either. One of the first questions you might want to ask is how much is the cost of the finance and what are the returns on equity? The FOI commissioner in Scotland has ordered the publication of the ERI contract and researchers have shown that the public will be paying out £1.4 billion over the 30-year life of the contract; the equity stake was half a million pounds and the projected dividends are £170 million. Hairmyres Hospital in Lanarkshire, the equity stake was £100 and the projected dividends are £89 million. Edward Leigh, who is the Conservative Chairman of the Public Accounts Committee, actually called PFI "the unacceptable face of capitalism" because the rates of return are extraordinarily high.

vii) Privatising the administration and management. The final phase is the privatisation of public administration, government standards and data collection. In other words the functions of the commissioning agency are being privatised to enable the total transfer of responsibility from the state to the private sector enabling the flow of government funds to the private sector which in turn will decide who is eligible for care and what services will be provided, to whom and how they will be paid for. Of course the market too will render invisible and voiceless those that do not get access to care as the data just won't be there. This last phase creates a US HMO where the HMO is given the public "dollar"/pound and acts as an intermediary purchasing care on behalf of members.

In England, privatisation could not have happened without the 1990 legislation which brought in the structural changes establishing this internal market, the purchaser/provider-split and pricing. There then followed a whole lot of new regulations and mechanisms which would enable privatisation. They weren't always in the primary legislation, some were secondary regulations drawn up by the civil servants.

They were invariably presented as technical changes to improve efficiency and access and accounting.

How the Market Has Increased the Fragmentation of Care and Is Eroding Entitlement to Care in England

Since 1948 NHS clinicians have had an open ended duty of care, they could not limit their risks and costs of care or openly deny care. However, in a marketplace providers must limit risk and this means that they will not accept the open ended duty for providing care. In England the government is trying to persuade its people that health care is no longer a universal entitlement. Professionals are being trained to accept that care need not be integrated and holistic but can be broken up and commodified as units of output that can be packaged and priced. Take GP services.

Every patient in the country has, since 1948, had entitlement to a GP twenty four hours a day. No longer. The new GP contract changed the whole basis of primary care. First it allowed GP services to be broken up and it also allowed those services to be tendered in the market place. For example cervical cancer screening or childhood immunisation and out of hour services are being packaged and priced and tendered out in the marketplace. But so too are lab tests and scans and x-rays and elective surgery. Just as pharmaceuticals are packaged and priced so too are other tests and treatments. The advantage of breaking care into discrete packets is that the new corporate providers can limit their risks and say what they will provide and to whom. But the disadvantage for patients is they must now navigate dozens of competing providers for care. For example GP services have been replaced with a myriad of alternative providers of care offering a range and variety of services. How will they get redress when things go wrong?

The government is spending a long time persuading the public to want health care as a commodity. So services have to stop being available at no cost at the point of use and appear to be rationed – take for example expensive drug treatments and debates over co-payments and charges for cancer treatment etc. But user charges are regressive and unfair, they penalise the poor and the sick and

they work against the risk pooling principles which underpin social solidarity.

The workforce has to be re-motivated to deny people care and work for the new shareholders and to minimise risk hence the importance of league tables and quality measures. Cardiac surgeons won't operate on very sick old people because of what they might do to their figures. At the same time the work force is being proletarianised, working hours and terms are being redefined and more work is being deregulated and removed from professional control e.g. GP work is shifting to high street pharmacists without qualifications or training and against the evidence.

Deregulation – Lowering of Quality and Standards and Entitlement

A public service is built and driven by *trust*. Trust between the nurses, the doctor and patients and trust between the government and its citizen. That trust is also built on professional standards, and professional training. It is not to say that everything goes perfectly in the public sector, but professional standards and trust underpin it and drive it and it is integral to the organisation. When you bring services into a marketplace, the doctors and nurses are now accountable to the shareholders, not the patients, and you have a loss of trust. So, the regulator now has to come in with external monitoring and regulation which is very expensive. The providers play games to try to conceal their activities and to maximise their income and some of these are fraudulent, such as claiming for services that are not provided. Fraud abounds in the US. The move away from public trust and professionalism to private, commercial standards and regulation is subtle, but important.

All market providers are risk-averse. The shareholders *must* maximise their investment, which means the providers have to carefully select the treatments and patients that will be most profitable to them. Or, they have to make their profits by changing the way the work force responds to patient needs, which may mean excluding or time-limiting care. In England we have a time-limit of six weeks for older people on entitlement to health care and some groups such as asylum seekers and refugees are being refused access to care. So, commodifying care is subtle, but it is very important to understand why it

happens and what the consequences of turning care into outputs or packages means.

Public and Parliamentary Accountability – the Case Study of ISTCs

Increasingly private bodies and government are preventing access to data which would allow the scrutiny and audit of public funds. Take the ISTC (Independent Sector Treatment Centre) programme, where the English government claimed that they wanted to bring in a new diverse-provider system, because it would bring new capacity, higher quality care and innovation, value for money and much greater efficiency. It dedicated £5 billion to taking elective surgery (eye operations, hip operations) out of the public hospitals and, through the new commissioning agencies, put the services out to commercial providers from South Africa and America. Government claimed it would provide high quality health care and value for money. However, the parliamentary health select committee could find no data or evidence to support government claims of the advantages of the private sector. It was very concerned that money was now being taken out of the public hospitals, to support new private institutions, destabilising services and introducing new costs and that there were no systems to review quality and training and continuity of care. It was also concerned about the private sector cherry-picking the healthy, profitable patients and treatments and being paid very generously for it, which means that there is less money for the public sector, which is left with the high-risk, unprofitable patients and treatments. It raised serious questions over training and education of the workforce.

When the Parliamentary committee had its year-long inquiry, the government refused to give them the value for money-analysis and even the methods saying it was bound by “commercial confidence”. So, the public was unable to scrutinise the “value for money” case. Government and the commercial sector hide behind “commercial confidence” and government told the Parliamentary Health Select Committee that the public interest in withholding the information outweighs the public interest in disclosing it.

Among the claims made for the private sector were that it would bring in additional services, beds

and staff. However two years into the programme the DoH was still not collecting data on beds and staff required from the Independent Sector Treatment Centre. So how can you look at whether there is additional capacity if you don't know how many new beds there are? How can you look at productivity, length of stay, throughput, all the performance measures if you don't know how many beds there are? What we do know is that there has been a huge decrease in NHS beds; from 300,000 in 1987 to less than 180,000 in 2006/7, so we actually have half the number of beds; and the rate of closure has been particularly dramatic again in the last ten years under this Labour Government. When Labour came in it had just over 200,000 beds; it has now cut 26,000 beds. 10,000 beds have been taken out of the NHS. So small wonder there was huge pressure in the hospital system or that waiting lists were rising, because the bed occupancy rates were often over 100%. So how was it that the Government said that they needed additional capacity from the private sector when at the same time they were busy closing more and more and more beds?

The private sector also claimed it would bring in additional staff. But the DoH response to our query on staff was "we don't collect any data on workforce in ISTCs". Some of you will have children or grandchildren or friends' children who can't get jobs now in medicine or in nursing in the NHS. The pool of labour has grown enormously in ten years, for two reasons: opening up the EU borders, which is partly a trade issue, and secondly, a deliberate expansion of all the medical and nursing schools and therapy schools. The Government has a huge pool of flexible labour, plus a plan to make more than 30,000 staff and 3,000 consultants redundant in the NHS, so you can begin to see that the private sector will have its pool of labour, and they will be flexible, non-unionised and happy to take whatever they get.

And what of the additional patients treated? The government claims it is paying out £5 billion for 170,000 patients a year but the Government's own department, the National Centre for Health Outcomes, commented that late delivery of data, poor quality and variation in data collection completeness rendered any attempt to look at trends or comparisons futile.

The Government claims that no ISTC deal is signed unless it is value for money. However, the

Health Select Committee again found that they couldn't do any assessment of value for money because of commercial confidentiality; the DoH refused to provide even the methodology because "the public interest in withholding the information outweighs the public interest of disclosing it".

What about risk transfer? The private sector now is being underwritten by the NHS Litigation Authority, after a lot of confusion early on. Moreover, the private sector is managing to cherry-pick, because they actually work by clinical protocol, so increasingly they are eliminating high risk patients, who are excluded because the private sector may not have intensive care units, etc, etc, all the support and backup.

But the other risk that is really interesting is demand risk, because these were three-year and five-year take or pay contracts, so the Government is paying regardless of how many patients were treated. I have already shown you that the Government doesn't know how many patients are treated, it didn't do its proper monitoring, and yet it is paying up regardless.

And what of NHS training and support? If the private sector is doing the easy stuff, the low risk stuff, your junior doctors, nurses, theatre technicians are not being trained but of course it may only be a matter of time before the government moves training and support budgets into the private sector. This hasn't stopped the Confederation of British Industry publishing its report "Sticking Plaster or Real Reform" in which they make ten claims and say "We have got in excess of 170,000 operations a year, increased efficiency and productivity, lower complication rates, value for money". But where is the evidence to verify all these claims? I believe nine out of those ten statements cannot be properly verified. The one claim for which there was evidence was patient experience: that 97% of the patients in the private sector had a better experience compared with only 88% who had a good experience in the NHS. I do not consider that patient experience is a measure of quality of clinical care.

And still the government continues to roll out the ISTC programme; American corporations, South African corporations and Canadian corporations have moved in, along with small start-ups.

The Government likes to say that GPs were private: they were not in that sense of the word, they

were independent but they were actually not under commercial contracts and they were very heavily regulated through the “The Red Book”, but what the Government did when it renegotiated the GP Contract was to bring in the new commercial form, which means that all their services can now be put out into the marketplace. Branson is very interested in polyclinics because he likes the whole issue of sale and lease back; he wants to have the property portfolio; and franchise out services. The Government is beginning to move services, like audiology, dermatology, ophthalmology, out of hospitals and into the high street, and this is really worrying because these are operators who are operating there for profit under very different rules and standards. The ENT surgeons were mobilising this week because they were really unhappy that audiology services were now going out to the high street but they got almost no press coverage.

So, what we see is that the public sphere is being redefined as private and new walls are being created to keep the public out. The Freedom of Information Act, combined with commercialisation, is proving very problematic in that it prevents public access to data and information.

Privatisation hides, conceals and confuses the public record with claims which cannot be substantiated leading to information asymmetry. Because the private sector is risk-averse, it does not want to take on responsibility for open-ended care; the real risks and costs are born by the citizen, the patient, and the staff. There is not a town in England that has not been holding public campaigns and protests, all as a result of the leakage of money and public funds to private bodies at higher costs which means fewer services for staff and patients and major service closure.

Transactions Costs

Finally, we also know that the market brings new inefficiencies, new costs that the National Health public systems don't have. These costs include administration or transaction costs, the costs of marketing, billing and invoicing. Now, in the NHS administration costs were 6% prior to the internal market in 1991, they doubled when the internal market was introduced. In the US 30–50% of funds go to transaction costs, there is no reason to suppose

the NHS is different. The other costs that the public sector does not have are shareholders' profits. Every penny spent on market bureaucracy and profit means less for health care. Something has to give. In the NHS, staff costs account for around 60–70% of the budget of hospitals and services. Staff is the most important variable in terms of quality of care but managers have no choice but to balance the books by cutting staff and services and quality.

Finally the loss of trust and government oversight and control means that the government has had to draw up complex regulatory systems which also have costs. We know from the English experience that privatisation involves deregulation of quality and standards with the default position being a minimum standard rather than standards built and developed over time with professionals on the basis of experience and trust and evidence. Trust has gone and this brings new costs of monitoring and inspection and enforcement and in turn providers may play the system, lying, cheating and engaging in fraudulent activity. This is well documented by the Department of Justice in the US where the health care industry has been fined billions of dollars for fraud and embezzlement of government funds and for denying patients care. The lessons from markets is that they create winners and losers among patients, staff and services “externalising” the risks and costs of care, i.e. displacing the costs to patients and families.

So, a market oriented system will not save money. If anything, government may have to put more money in and get less value for it.

Loss of Government Control Over Domestic Health Care Policy

When government allows public services to be privatised using commercial contracts it moves away from public law to trade law and competition policy. So, government can now be challenged if it doesn't continue to place contracts in the private sector or if it puts the private sector out of business. EU case law has moved the dividing line between what is state responsibility and what is EU responsibility. But actually, domestic government, of its own volition, is moving that dividing line into trade. One of the big downsides of the EU is that it has no social welfare mandate – it only has a trade mandate. So, while in

some ways we should be warmly embracing the idea of social solidarity and redistribution across all countries, if you have no social welfare mandate, it's difficult to see what function the EU has other than as a trading bloc.

In Whose Interests Is the NHS in England Being Remodelled?

The English health service is being remodelled along American HMO-lines. The American advisors came in very early on in the 1990s and have played a big role in designing this system. In the UK, Prime Minister Blair's key health policy advisor Simon Stevens had previously been policy adviser to each Health Minister from 1997. Simon Stevens and Blair told the people it doesn't matter who provides health care so long it is publicly funded. Having designed and put in place the plan for privatising the NHS, Stevens left the Labour administration to become president of the European subsidiary United Health. United Health is a large American health care corporation; a health maintenance organisation which now has hundreds of millions of pounds of NHS contracts: contracts for primary care, contracts for elective surgery, and it is seeking to hold the whole budget for NHS care. Yet American health care costs 16% of GDP – nearly two trillion dollars. It denies 50 million people, 15% of the population access to care. This includes 10 million children who have no access to health care. The UK NHS is known as a socialised health care system, the model maker for Europe. If the UK NHS can be broken up then the model may be implemented elsewhere.

Health care in Europe accounts for 6–10% of GDP, funding which is largely protected from the market. According to the US trade lobby, "Historically, health care services in many foreign countries have largely been in the responsibility of the public sector. This public ownership has made it difficult for US private sector health care providers to market in foreign countries."

In my view the US Republican government and industry and their management consultants want social protections to be torn down and dismantled and new mechanisms put in, which will make it easier for the commercial sector to access public funds.

It is the US trade lobby view that "commercial

opportunities exist along the entire spectrum of health and social care. Hospitals, out patients, nursing homes, assisted living, service provided in the home and ambulance services – they are all up for sale. The US health care industry is in crisis; it has to find new markets. It has been targeting Latin America but it sees the welfare states of Europe as a big, unopened oyster.

Restoring the English NHS

Scotland and Wales have their own Parliaments but limited control over mainly domestic matters as fiscal and foreign policy is determined by the English government. However during the election of the Scottish government last May, the single most important thing for the public was public ownership and public control over public services. And that is why the citizens voted in a minority Nationalist government. Scotland reversed its market in 2003, it was the very first thing it did in 2003, under a Labour government. The minority coalition government is moving to dismantle the market in Scotland while in Wales they are bringing new legislation forward to abolish the internal market.

One should not underestimate the enormous opposition in England. Many doctors and nurses mobilised against many of these changes. But the British Medical Association and leadership have not. It was particularly the general practitioners who allowed the commercialisation – have created their own companies with the British Medical Association lawyers and are buying up general practice and community health centres. The British Medical Association has played a big role in the commercialisation but recently it took a petition signed by 1.3 million patients opposing commercialisation to Downing Street. There is a big rebellion going on there at the moment and Labour will likely lose the next election.

In England government is in the thrall of private capital and commercial industry. The English NHS is a useful case study – it is a laboratory for market changes that are being proposed in Italy. However there is *no evidence* to support a purchaser/provider split of markets in health care. On the contrary, all the evidence is of increased costs to citizens, patients and staff and of new costs, transaction costs, profits,

marketing and loss of public accountability and parliamentary scrutiny and control.

Thank you. (Applause.)

DISCUSSION

The President: Well, I am sure people have got some questions.

Dr Richards: My name is Natalie Richards and I work as an Emergency Department Consultant, and I am a GP as well. I went to a recent conference; it was a pan-London debate on the Darzi Report; and a lot of the GPs were there, who were actually horrified at privatisation, because it is actually happening now. GPs who have been in practice for 20 years have been trying to prepare a document to submit against the PPPs and despite their experience and the time they will always be outbid by the private companies. United Healthcare have recently bought out three local GPs at a hospital where I work, so the other issue now that we are facing is an Urgent Care Centre and who is going to win the bid for that. Will that remain with the hospital or will it be provided by United HealthCare? It really is happening now; I think plans are actually in place now for the next 9 to 18 months or so. My question really is do you have anything that can help us in this situation now we are actually going to be competing actively with the private sector?

Professor Pollock: The first thing to say is that the Government doesn't need to go down the commercial route, there are alternative forms of contracting. The BMA was absolutely mad to ever think that GPs could compete in a commercial setting because, as you well know, the commercial sector will set the terms. GPs need to mobilise the public. In Scotland, public opposition prevented Lanarkshire Health Board bringing in Serco, a large facilities management PFI company, to run the GP practice, the public came out and said "We don't want you to use this contract form, use one of the other three". So I think the first thing is to say you are not going to bid under that commercial contract, there are other contract forms, and I would say the same for Urgent Care Centres: do not get into a commercial bidding process, because you can't win. The government might award a few commercial contracts to keep you sweet, but you can't win overall and it is not part of the bigger plan. If you

want a universal healthcare system it has to be planned and you have to have Government control over the distribution of resources and planning and all the rest of it. BMA negotiators Childers McCrae – the doctors who negotiated, then got together with the BMA lawyers and created their own company – is now currently also buying up new funded companies. As a natural logic as you get into the commercial sector you become imbued with it and then you are left managing the risks or passing them down to patients.

Dr Louth: Dr Louth; I am a GP in Islington. I am more interested in the role of the media. I believe that they are there to inform the public, and yet there doesn't seem to be any public debate in the newspaper. Even the *Guardian* journalists, who will say they are independent types and are not for shareholders, don't seem to have any ongoing debate about health care in this country. I would like your views on this.

Professor Pollock: Well, you are quite right. Mainstream journalists seem to be just taking everything as a drip-feed from the Department of Health, not questioning it or challenging it at all, so I feel they are complicit in this.

Dr Josse: Eddie Josse, medicine. I have been on more committees than I have had hot dinners, from the Department all the way down, fortunately not during the time of all this happening in the last five years. I think you have hit the nail on the head when you say that the clamour has to come from the public to politically influence Government. They don't like losing elections because they want to stay in power and this will in a sense be one way of trying to do things. Nye Bevan gave one power to the Royal Colleges back in 1948 and that was the approval of hospital posts. Whilst that still stands it means the Royal Colleges can have an enormous influence on the employment structure in the private hospitals if they are not going to be approved educationally, because there is nothing that the training doctors are going to gain from going into the private sector. The other point I would just mention is that with these huge profits, because that is what the private people will be out for, what is to stop Government doing as they did with the oil companies and saying "We will extract revenue from you..." because they have got a power in Parliament so to do, "...and respond, "If you don't like it, don't come into the league"?"

Professor Pollock: Well, there is another bit to the story, which is that the Treasury is actually taking Corporation Tax back from these PFI schemes, but we haven't gone into that. But it is not nearly enough. The money that is lost from the NHS isn't returning to it. I am not sure now about these powers of the Royal Colleges, modernising medical careers and deaneries mean a reduction in powers.

The President: I don't think that really helps. The college rep is simply there to see that the candidate who is appointed is appointed according to certain criteria. But can you come back on Dr Josse's question, which I think is very interesting. He has raised the idea that the remedy for all of this is to frighten the electorate and get a Tory Government in, and then we will have a more socialist NHS. (Laughter.) Can you explain to us how it is that the largest Labour majority in history has driven this forward?

Professor Pollock: You can only think that this wasn't a Labour Government that we have had in. The Labour party that I understood was one where socialism was committed to redistribution through the tax system and through benefits and the NHS was redistributive, so it doesn't make sense. Perhaps they have a different constituency which isn't the public.

The President: At some point in some way people like you have lost the intellectual argument for the heart and mind of a Labour Government and I don't understand how it has happened.

Professor Pollock: It happened very early on because actually before Labour came to power the Treasury mandarins were writing, contrary to all our expectations "Labour is on board for PFI", so they had already been captured, even before they came to power, by the idea that somehow this was going to be in the interests of the country.

The President: PFI is a different argument, isn't it? PFI is simply the Treasury not being willing to raise from taxation this year what it wants to spend this year. It is exactly like the raid on pension funds. It is saying it doesn't care about anything that happens beyond the next election. But what you are talking about is a more sinister destruction of the National Health Service; that is what the ISTCs are about.

Professor Pollock: Well, it is happening in education as well.

The President: Yes.

Professor Pollock: It is happening in every sphere, in roads and everything.

Professor Vincent Marks: It happens in the university sphere as well as in the NHS. My name is Vincent Marks and I date the problem from when the medical fraternity was disenfranchised. The original NHS for the first 35 years was in a way clinically orientated. There were statutory medical advisory groups at every one of those tiers that you have shown us at departmental level and nothing could be done which did not have the approval of the clinical advisory group. Mrs Thatcher abolished statutory medical advisory machinery and from then on it became a managed service as opposed to an administered service and that is, I think, a similar problem. Griffiths took over the idea that if you could run Sainsbury's you could run the NHS, but in effect what the NHS had managed to do was to have a clinical orientation that had statutory medical advisors. Once you abolished that, then the doctors were downgraded and, as you say, the CEO of a Foundation Hospital, which was the final blow, can do more or less what he likes within the law, because the law gives him the same authority as a Public Health Officer.

The President: Do you agree with that?

Professor Pollock: Well, I do in part because of the professional input, but you are asking a different question, which is about the political processes that were going on in No. 10 and in the Department of Health. I think that is a really important area of work and research. We know that within days of coming to power the Government was following in Thatcher's footsteps; it was basically bringing into the Civil Service private sector methods; so they had somehow bought into that belief that the private sector was more efficient. I haven't done any of the research around it. Maybe people in this room know much more.

Dr Dale: Peter Dale, Orthopaedic Surgeon. There is a very strong influence from the management consultants from across the water in America. They have infiltrated the Labour ministerial network and committees of the Civil Service too, and their attitude is to take money out of the cash cow. They are in positions of power. Occasionally they fall down because they can't make political decisions, they are rather indecisive at times.

The President: Dr Bewley.

Dr Bewley: Thank you very much for a very good talk. It struck me it is nothing to do with medicine and your much wider questions around the loss of social solidarity, which I think came with Mrs Thatcher's "There is no such thing as society". Power corrupts absolutely and a massive Labour majority of people like most are lured by money, lured by contacts, lured by cronies; this is the way the world works and it is much wider; as you said, it is health, education, so on and so forth. To come back to your original question, what are the remedies from the consumerisation of all parts of life? Today at the National Council of Bioethics they were talking about consumerisation of the body itself and, you know, the buying and selling of parts and pieces and cells, and so forth, but this is something much, much wider that affects the way young people think and operate and the way we think and operate. I don't know whether it will be doctors or lawyers that are going to help you. Lawyers are very, very clever people and they should be able to help more than mere people like doctors on how to regain social solidarity and political competence, you know, and surely lawyers can say to David Cameron when he comes in just to say "Well, the people who negotiate these contracts are so utterly stupid and incompetent we are just not going to take them". I don't know if that will work.

The President: I think the lawyers were completely bamboozled by one medical person saying that the whole system worked properly when it was run by doctors and another one saying that it ought to be run by lawyers. (Laughter.) ... Did you see Chris Ham's statement today in which he said that the purchaser-provider split intrinsically demands a much higher investment in management than we have made so far and we would have to spend far more on NHS management to make this work?

Professor Pollock: If you look at the American data we know that when you bring in a market you are looking at transaction costs, billing and invoicing, of around between 30 and 40%. Now, in the old NHS the transaction costs were 6% for the internal market. So these are entirely new costs that the NHS is now having to absorb, let alone having all the other costs of commercialisation, and I guess I am going to come back to the lawyers here and ask, you know, how are you going to help? We are seeing

that universal access is being eroded by the process of commercialisation and commodification and the Government increasingly is going to be able to introduce user charges; you have seen it for long-term care; you have got a six-week entitlement criterion now for long-term care. How can we challenge this, how do we go about it?

The President: You have got to realise that the lawyers are there to see that the law is enforced. If the law is made by Parliament all the lawyers can do is run round and snap at the legs of the legislative process as it is going on and spot where they are making mistakes with things like the Judicial Review, but you can't expect lawyers to upend the law which is made by the Queen in Parliament carried by Labour MPs.

Professor Pollock: This is important. Freedom of information is constantly being refused on the grounds that it is "Commercial in Confidence", but there is a possibility to go back in under the public interest. Who is working on that? Who is going to give us help on that one? I mean, that is the practical thing to do and public interest, as you know, is so contested, so difficult, but that is the area of the law that we need you to be engaging in and with.

The President: Yes, but you would have to demonstrate that the Secretary of State had taken a decision which no reasonable Secretary State would take when he decided that the "Commercial in Confidence" issue was not trumped by the public interest.

Professor Pollock: No, that is not the point, because public interest is itself highly and keenly contested.

The President: But he has to balance it.

Professor Pollock: It is the interpretation. At the end of the day it is the Information Commissioner who will be interpreting it. Now, is that not worthy of actually taking that and saying let's start to work with this and to challenge it and open it up?

The President: Well, it may help and you may produce some more embarrassing statistics, but you seem to have done that.

Professor Pollock: No, we have not started FOI. This is where I lack the legal competence and I need legal help. Maybe your firm will come and see us.

Mrs Brahams: Diana Brahams, barrister. I haven't got any brilliant solutions for you, but of course it would have been open, and is still open, to the Government, which is awarding these contracts,

to say “These are contracts for the public, funded by the public with public money, and therefore we will dispense with commercial confidentiality in its interest and if you want to bid for it you have to understand that the contract will be transparent”. The Minister is absolutely able to do it and there are so many people who would want the contracts that I am sure there would be takers with transparency clauses.

Professor Pollock: That is a solution then. It is something that we should advocate.

The President: Yes.

Mrs Brahams: Well, I am just speaking off the top of my head, but it seems to me to be pretty obvious. The Government could impose whatever conditions it liked, but it seems they don’t want to.

The President: The theme of the lecture we have heard this evening has demonstrated with enormous

lucidity that the Government actually doesn’t want this to be revealed and therefore the last thing it is going to say is that you have got to agree to your data shared out, because it doesn’t want to share out the data.

Mrs Brahams: Okay. But a new Government that perhaps had toppled the old regime might have a great interest in showing how incompetent the last regime had been. If I were you I would approach David Cameron.

The President: I really do think we are going to vote Tory for a more socialist health service. It’s high time we had a drink. (Laughter.)

Thank you all very much. Professor Pollock, thank you for a marvellous lecture, we have all enjoyed it immensely.

(Applause.)