



Foundation Hospitals and the NHS Plan

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Foundation Hospitals and the NHS Plan

Introduction

Foundation Hospitals are part of the UK Labour government's ten-year programme of reform known as the NHS Plan for England, under which the market oriented and pro-business policies begun under previous Conservative administrations continue to be implemented. Health is a devolved function and so Foundation Hospital Trusts (FHTs) do not apply in Scotland, Wales, and Northern Ireland.

Under the NHS Plan for England, patients are treated by a diversity of providers, including the private sector, overseas corporations, and the voluntary sector, as well as by new forms of NHS bodies, Care Trusts and Foundation Trusts. The changes also make it possible for alternative sources of revenue from charges and private insurance to supplement tax funding for health care. The UK NHS, a publicly provided system of public health care in the UK, will increasingly become the funder, but not the provider, of health care services, enabling private companies to have a much larger role in running health services. An independent regulator will determine which services will be provided by which hospital and whether private for-profit or public sector.

1. Money follows patients as in a market: from planning to commissioning

The government, far from abolishing the internal market, is now bringing in a real market in health care through the greater use of private providers.

In April 2002 new purchasing bodies known as primary care trusts (PCTs) were established to replace district health authorities and GP fundholding. The 304 PCT trusts cover the entire English population and have responsibility for 75% of the NHS' three-year budget allocations for the patients in their care. From this they must cover the cost of running the general practice surgeries, including doctors' and practice nurses' salaries, clinics, and drugs as well as the cost of commissioning hospital and other medical services on behalf of their residents.

While PCTs eliminate the inefficiencies of GP fundholding, the system which accompanies the new structure is based on market principles of competition and contracting. As in the 1991 internal market, commissioners will purchase Hospital and Community Health Services for their local populations. With 'money following the patient' competition between providers is intended to improve efficiency and the quality of care, and lead to a distribution of services and providers more responsive to their needs. However, two changes are taking place. First, the government intends that patient choice will 'drive' the system, with patients able to choose both the provider and the individual clinical team by 2005, and second, the NHS is to be opened up to health care corporations. The idea is that with 'money following the patient', competition between providers will lead to a distribution of services and providers more responsive to people's needs.

2. Operationalising the market through contracts and pricing systems

As part of its plans for greater private sector involvement, the government is refining the contract and pricing system which was established as part of the internal market. Under the new system, set out in the Department of Health's *Reforming NHS financial flows: introducing payment by results* (October 2002)¹, the commissioners, predominantly the PCTs, will pay the hospitals and other providers on the basis of the number of treatments they carry out. National tariffs will be introduced for almost every non-emergency procedure and weighted to take into account higher costs in the London area as well as the costs of capital. Fees will also be weighted to encourage greater 'efficiency' - the use of day case surgery for example - or to reduce waiting lists for certain specialties. However the system of national tariffs will not apply to commissioning of NHS care from the private sector, which will set its own prices.

The prices charged by NHS providers will be based upon the total cost of each case (plus a 6% return) rather than on the average cost. These will be standardised for NHS providers. Extra activity will be rewarded, and under-activity penalised, on a quarterly basis. As an incentive to efficiency, providers will now be able to retain any surplus they generate. They will also be able to charge social services and other providers of non-acute services for delayed discharges and emergency re-admissions.

The introduction of national tariffs which will eventually be adjusted for individual patient risk constitutes a major change from the present system whereby hospitals are paid a fixed amount regardless of the number of patients they treat and their morbidity. Once the fee per service is in place providers will have a strong incentive to select carefully the groups of patients and conditions they offer treatment for in order to maximise their income. They will have a strong incentive to reduce the length of NHS stay and to displace the risks and costs of care to social services and patients. The system of contracting and pricing is modelled on the US health care system. There, the use of competition and contracting has seen a trend towards 'drive-by mastectomies', the inappropriate discharge of patients with serious conditions, over-billing by private hospitals, the careful selection of low risk patients, and the shifting of costs and risks of care to the patient and their family. This has resulted in enormous public discontent with the system of US care. The problem is that fee-for-service creates opposing incentives among commissioners and providers - one seeking cost containment, the other income maximisation through competition, careful selection of patients, and cost shifting to patients.

Having established a contracting and pricing system under which money can follow individual patients, the government is now in a position to bring in a real market in health care through the greater use of private providers under the new commissioning arrangements.

¹ Department of Health. *Reforming NHS financial flows: introducing payment by results*. London: Department of Health 2002. <http://www.doh.gov.uk/nhsfinancialreforms/>

3. *From public provision to a mixed economy of care*

A. Hospital and community health services

The public provision of hospital and community health services has always been one of the key features of the NHS. With the introduction of the internal market in 1991 NHS providers (hospitals, community care centres, etc) were set up as semi-autonomous business units called NHS Trusts, although they remained under public ownership. Structured along business lines, NHS Trusts' sole statutory duties were financial, with a requirement to break even, to stay within limits on access to capital funding, and to pay capital charges.² However, they remained heavily regulated from the centre, constrained in their ability to retain any surpluses they generated, in their ability to borrow from the private sector, in their access to capital, and in their ability to set their own terms and conditions of service.

Central to the current reform process is the move away from public provision of health care services. The Secretary of State for Health describes the current reforms as

*“about redefining what we mean by the National Health Service. Changing it from a monolithic centrally run monopoly provider to a system where different health care providers – public, private, voluntary and not for profit – work to a common ethos, common standards and a common system of inspection... This is the modern definition of the NHS”.*³

The introduction of the private sector is being achieved in four ways:

- First, through the privatisation of the infrastructure, assets, and elements of the workforce using the highly controversial Private Finance Initiative (PFI) (now called Public Private Partnerships (PPPs)).
- Second, by using the ‘concordat’ with the private sector to bring private hospitals and nursing homes into the main stream of NHS service provision.
- Third, by making some NHS Trusts into Foundation Trusts, giving them the ability to vary the pay and conditions package for staff, and privatisation through the contracting out of clinical and non-clinical services and the use of private finance.
- Fourth, through the establishment of new regulatory regimes. We describe how each of these in turn leads to greater privatisation of provision.

i. The privatisation and downsizing of the NHS using PFI

In 1992 the Conservative government introduced the PFI as an alternative to direct funding from central taxation for new investment. Under the PFI the private sector raises the finance for capital investment in return for which it receives a contract or lease to design, build, and operate services. The contract is usually for 30 years. The PFI has been highly controversial because of its high costs and the way in which the introduction of shareholder returns and profits results in reductions in the services provided to local communities. The high costs of

² Capital charges consisted of depreciation (charged annually to the accounts) and an annual payment to the DoH equivalent to 6% of their net assets. They were intended to make NHS managers aware of the costs of capital and provide an incentive for its efficient use. Being passed on to purchasers in the prices charged for services, they were also intended to put the pricing of NHS services on a par with private sector providers to enable fair competition.

³ Alan Milburn. Secretary of State for Health. Empowering Front Line Staff. Speech to the BAMMS conference. 12 June 2002.

PFI drain hospital revenue budgets, leaving less for direct patient care - the high costs of the first wave PFI hospital schemes resulted in a 30% reduction in beds and a 25% reduction in budgets for clinical staff. The use of PFI has the effect of reducing both NHS services and the level of services available to patients and at the same time privatising NHS assets. This model is now being propagated abroad by the UK government.⁴

ii. The concordat with the private sector

In 2000 the Secretary of State signed a concordat between the NHS and the private sector as part of the NHS Plan. This marked a sea change in government policy. Described as “a permanent feature of the new NHS landscape” the roles of the private sector include:

- providing spare hospital capacity, with up to 150,000 procedures purchased per year
- providing management to run ‘failing’ NHS Trusts
- forming joint ventures with NHS organisations
- providing overseas clinical teams for existing NHS providers or new NHS-managed developments
- providing intermediate care in nursing homes and the community.

The private companies involved may be foreign-based, and overseas companies will be able to finance, build, and operate services with the NHS as public payer.

DTCs and ACADs

The government is establishing a network of 51 clinics which will carry out fast track diagnostic tests and routine surgical treatments such as hip replacements and cataract surgery for NHS patients. Known as diagnostic and treatment centres (DTCs) and ambulatory care centres (ACADs), the clinics will be built and run by the private sector, and British and overseas firms are to be invited to bid to set them up. The private operators will be guaranteed a minimum volume of patients, and encouraged to run a chain of clinics rather than just single units and to use overseas staff. These clinics are expected to handle more than 250,000 patients by 2005.

In a move that has run into opposition from both the private sector hospital operators and workers alike, the government has done a U-turn and said that the clinics will also be allowed to treat private patients.

Management contracts for ‘failing’ hospitals

Three of the eight acute NHS hospitals that failed to achieve any ‘stars’ in the government’s review of hospital performance in July 2002 are to be taken out of normal NHS management and run under three-year management contracts. The Royal United Hospital in Bath, United Bristol Healthcare, and the Good Hope Hospital in Birmingham are the first hospitals to be franchised out, under a scheme announced by Alan Milburn last May for approved NHS hospitals and private sector corporations to take over ‘failing’ NHS hospitals.

⁴ Pollock AM, Shaoul J, Vickers N. Private finance and “value for money” in NHS hospitals: a policy in search of a rationale? *BMJ* 2002;324:1205–9. See also Gaffney D, Pollock AM, Price D, Shaoul J. NHS capital expenditure and the private finance initiative - expansion or contraction? *BMJ* 1999;319:48-51; Gaffney D, Pollock A.M., Price D, Shaoul J. PFI in the NHS - is there an economic case? *BMJ* 319:116-9, 1999; Pollock AM, Dunnigan M, Gaffney D, Price D, Shaoul J. Planning the ‘new’ NHS: downsizing for the 21st century. *BMJ* 1999;319:179-184; Gaffney D, Pollock AM, Price D, Shaoul J. The politics of the private finance initiative and the new NHS. *BMJ*,1999;319:249-53.

The minister cited the hospitals' poor performance in reducing waiting lists and meeting their financial targets as justification for the decision. The other five failing hospitals would be given more time to improve their performance. But should they fail to improve their performance, they too will be subject to new management. Milburn has given eight private sector corporations the right to bid: BUPA and BMI, Britain's largest hospital groups, the Swedish owned Capio, Interhealth Canada, Hospitalia Active Health from Germany, the British owned facilities management company Serco, Secta Group, and the consultancy firm Quo Health.⁵ This is despite the fact that some of these corporations have never run hospitals before. Of those that have, most have never run hospitals the size and complexity of NHS hospitals which are at least 10 times the size of a typical private hospital specialising in elective surgery.

Companies who can bid for management of zero star trusts

BMI Healthcare Ltd
 BUPA Hospitals Ltd
 Capio healthcare UK Ltd
 Hospitalia ActivHealth gmbh
 Interhealth Canada Ltd
 Quo Health
 Secta Group Ltd
 Serco Health

Contracts for elective care

The government is now contracting for NHS services both here and overseas. In 2002, 190 patients from three NHS sites in southern England (East Kent, Portsmouth & Isle of Wight, and West Sussex & East Surrey) were sent on pilot schemes for elective care at a hospital in Lille, France, and at eight hospitals and a day care centre in northern Germany.⁶ Following this, lead commissioners have been established for London (commissioning treatment in Germany, Belgium, and northern Europe) and for the south (commissioning treatment in Italy, Spain, and southern Europe). Patients who are at risk of breaching waiting times guarantees for cardiac surgery, for example, could be offered treatment abroad in Belgium, France, or Italy.

In another example, for ophthalmology:

“the Department of Health has identified a ‘capacity gap’ in the provision of ophthalmology services (e.g. cataracts) in the National Health Service (NHS) in England. It is therefore seeking offers from private sector bidders for the provision of such services to supplement NHS provision in England. ... Expressions of interest are therefore sought to provide services ... over a 5 year contract period. It is further anticipated that the successful private sector bidder will establish mobile diagnostic and treatment centre(s) in order to provide the required ophthalmology services. However, consideration would be given to permanent centre(s).”

⁵ Department of Health press release: reference 2002/0525
<http://www.info.doh.gov.uk/doh/IntPress.nsf/page/2002-0525?OpenDocument>

⁶ <http://www.doh.gov.uk/emergencycare/emergencycarereportchap2.htm>

iii. Foundation Trusts and Foundation Hospital Trusts

The third and most controversial element is the commitment to increase the scope and range of private sector activity within NHS services by creating independent public interest corporations under Foundation status. The proposals were drawn up by the UK government and its policy advisors. These include the chief executive of the Californian health maintenance organisation (HMO) Kaiser Permanente, and representatives of health care corporations such as the Institute of Directors, which is known for its reports advocating the break up of the NHS monopoly and switching provision to private and voluntary sectors.

Foundation status organisations will have NHS assets transferred to their ownership and control. Granted a licence to operate by an Independent Regulator, they will be freed from NHS controls and will be accountable not to the Secretary of State for Health but to a board comprising employers, staff and local residents, some of whom will be locally elected. They will have greater freedoms to set their own terms and conditions of service, the freedom to borrow for capital investment, the freedom to generate income, and greater control over the retention of the proceeds of land sales.

The Secretary of State has emphasised the idea of community ownership and staff involvement on the boards, in addition to local residents and employers. Ian McCartney, chair of the Labour Party's National Policy Forum, wrote in praise of Foundation hospitals in *The Guardian* on 2 December 2002, stating that Foundation Hospitals "are a new form of public ownership", adding that this has moved "the debate about who should own public assets away from Thatcher's popular capitalism". "These hospitals", he says, "cannot be described as 'elitist' in any real sense of the word ... They lock the public resources of the hospital into ownership by the citizen in the community: owned by the community, for the community, serving the community. ... This is public ownership which means exactly that: owned by the public."

However, the new powers which are to be conferred on Foundation Hospital Trusts (FHTs) make it clear that while there may be a greater role for the local community in fund raising, FHTs will simply accelerate the trend towards the privatisation of services with all the inequities that follow.

According to the Department of Health's Guide to NHS Foundation Trusts published in December 2002 and to be enacted during the 2002-03 parliamentary session, the top performing hospitals and PCTs will be allowed to apply for Foundation status. FHTs will be independent hospitals, free from NHS control and run nominally by a board of local 'stakeholders' on a not-for-profit basis. While they will not be allowed to sell their core assets, they will be allowed to raise finance for new facilities from the capital markets, subject to the government's overall borrowing limits, and to set up joint ventures with the private sector.

All such NHS bodies are being established along business lines and although there will be no shareholders, initially their sole statutory duty will be to break even. Foundation Trusts faced with cash-limited budgets and insufficient NHS revenue will have to use their new powers, which include the freedom to borrow for capital investment, the freedom to generate income, and the freedom to dispose of what were formerly NHS assets. Each of these measures will inevitably lead to greater inequity for communities, patients, and the workforce.

How FHTs will lead to inequities in distribution of health care supply

Until 1991 it was generally accepted that the assets the NHS inherited in 1948 belonged to the whole community and not any individual institution. Since 1991 hospitals have increasingly retained the receipts from land sales rather than ploughing them back into the priorities of the community as a whole. This has meant that primary care, community-based service, and hospitals without the legacy of a generous asset base find it difficult to invest, increasing the inequalities in provision. Three-star hospitals are currently restricted to selling off NHS estate in £10m chunks. However, such restrictions will be relaxed for FHTs. Similarly the private sector will be introduced only in areas where there are profitable patients. FHTs and private providers will begin to compete not only for staff but also for patients, while insurers will compete for members.

How FHTs could lead to greater privatisation of infrastructure and services through the use of PFI or by direct contracting out of clinical services

The Foundation Hospital could, in order to access finance for new equipment or wards, subcontract the entire running of the hospital or various parts of it to the private sector. Far from providing an alternative to the government's deeply unpopular PFI, whereby the private sector provides the hospital and the non-clinical services, this would in effect extend it to clinical services as well. A model for this is provided by the unbundling of Welsh Water into a not for profit stakeholders' trust that owns the infrastructure but contracts out the supply of water services to another water company, United Utilities. The FHT could eventually sell and lease back its assets and contract out core clinical services.

How FHTs could lead to damaging labour market distortions, greater privatisation of the workforce, and greater disparities in pay between and within staff

Foundation hospitals *have* greater autonomy than other NHS Trusts to vary the terms and conditions package of staff. This will result in harmful competition between NHS Trusts and could lead to damaging labour market distortions. A particular target is likely to be hospital consultants who are currently paid on the basis of the number of sessions they work irrespective of the number of patients they treat, as the FHTs will seek to link extra pay to extra work.

How FHTs could lead to increased exploitation of patients

FHTs will be encouraged to generate new sources of income especially since their statutory financial duties are to break even. Hospitals currently do this by opening private beds, leasing out parts of their estate or allowing private sector companies to operate services on their premises. For example, National Car Parks run hospital car parking, Capita and Serco provide visitor and staff catering, retail outlets such as McDonalds or WHSmith operate on the hospital forecourts, and Patient Line supplies telephones and televisions at astronomical rates. This will now be expanded.

There is concern that hospitals might be able to create spin-off companies in order to exploit tissue samples taken from patients during surgery for research. With ownership of tissues unclear under UK law, it is possible that patient data could become a valuable commodity those many genetic and biotech companies would like to own and exploit.

How FHTs could undermine access to care and services free at the point of delivery

Foundation Hospitals will only be required to meet a 'reasonable' level of demand - commensurate with their business plans and contractual commitments. As more and more hospitals move to Foundation status, any conception of a planned service, the hallmark of the NHS thus far - at least in principle - to meet the needs of all on a regional basis would go. Each hospital will be able to carry out those activities that meet its own financial needs, regardless of the health care needs in its area.

1. Generating income through 'intermediate' care by redefining NHS care

Access will be further undermined by the potential of NHS trusts to generate non-NHS revenue streams. PCTs and FHTs will be constrained by the bottom line and their duty to break even, and under such circumstances they will use their new powers to generate new streams of income. For example, NHS bodies have access to means-tested local authority funding both as a result of structural changes, which will merge NHS and local authority funding in a new body known as a Social Care Trust, and as a result of new guidance which time-limits NHS care to a maximum of six weeks for most conditions. Many episodes of this 'intermediate' care will in fact be much shorter than this, for example, one to two weeks following acute treatment for pneumonia or two to three weeks following treatment for hip fracture.⁷ Once a patient enters hospital the clock will start ticking. After a set period the individual will find that their eligibility for care is being reassessed and some elements of care, namely personal care once delivered free under the NHS, could be redefined as non-NHS care and charged for. This measure will affect all patients but particularly the old, the frail and the chronically ill.

2. Charging for 'social' care by redefining NHS care

At the same time the government is introducing legislation to allow NHS bodies to charge social services departments for delayed discharges and intermediate care elements. Thus if a patient is deemed fit for discharge from any setting even if they have ongoing health and social care needs they will become the responsibility of local authorities. If local authorities fail to place them at home or in another setting the local authority will become liable for the costs of their care. However, since patients may be charged for all local authority care, this means in effect that the costs and risks of continued care will pass to the individual. Again, those particularly affected will be the elderly, who account for around 50% of all admissions to hospital.

3. General income from top-up fees and private health care

Joint ventures with the independent sector open up commercial and fee-paying revenue through top up fees and the sale of private health care. The incentive will be for FHTs to redefine what treatments are provided and which categories of patients are covered by the NHS. If this happens, the fundamental principles of universal services free at the point of delivery will be undermined.

⁷ Health Service Circular / Local Authority Circular HSC 2001/01 : LAC (2001)1. 19 January 2001

How FHTs could undermine the geographic population focus and lead to inequities and the US model of care. The hallmark of the UK NHS has been its coverage of the entire population on a geographic basis. PCTs will still retain responsibility for the population within a given geographic area and the government provides resources on that basis. However, consideration is being given to a move away from resource allocation on the basis of populations within areas to resource allocation on the basis of ‘membership’ of a PCT. The consequences of this are far reaching.

If a PCT has to enrol members then what is to prevent FHTs, private insurers, and the private sector lobbying government to be allowed to compete for members by offering a similar range of services and benefits to those offered by PCTs? The effect of this will be two-fold: firstly, a diminishing role for PCTs and the disappearance of needs based planning; and secondly, a new insurance-based system modelled on pools of insured patients where the provider competes for members and carries both the risks and the costs of care. A membership system of this kind builds in an incentive to exclude high-risk patients and treatments. This practice is common in the US and is known as cherry picking or cream skimming. The results of this system are greater inequities, the loss of universality and a lottery for care. NHS bodies such as PCTs could become rump services carrying high-risk patients but with insufficient funding. In the US such bodies are known as ‘the providers of last resort’ and are notorious for their overcrowded, underfunded conditions.

iv The new regulatory bodies - a force for greater privatisation

Central to the reform process are the new regulatory structures to which the Department of Health devolves political and parliamentary power and responsibility. Made up of arms-length quangos and non-governmental bodies, their role is chiefly to operationalise the market system envisaged by the NHS Plan by ensuring that there are no barriers to the entry of the private sector in terms of price, subsidies, or NHS monopolies.

The government has established three regulatory bodies, the Independent Regulator which issues the licences to provide services to NHS providers, the Commission for Healthcare Audit and Inspection (CHAI), which licenses the independent sector and monitors and enforces the inspection regime of all establishments providing NHS care, and the National Institute for Clinical Excellence (NICE), which determines which new treatments will be provided by the NHS.

The Independent Regulator

The Independent Regulator for the NHS will issue the licences and has the power to determine the range of services and treatments to be provided by the NHS and what assets it can retain and those it needs to dispose of. As with telecoms, energy, and postal services, the ‘market’ for certain treatments may be opened up to the private sector and key public services and obligations excluded.

In the NHS the regulator could withdraw the licence to provide various services. For example, as Diagnostic & Treatment Centres siphon more elective care into the private sector the regulator could intervene to prevent NHS hospitals from operating and providing elective services, thus protecting the income of the private sector. Similarly over time it could withdraw the treatments and services provided under the NHS. The regulator could decide

that elective surgery and out of hours primary care will no longer be provided by an NHS provider but only by the private sector. Similarly it could decide that assets currently used by the NHS are surplus to requirements and should be sold to the private sector. The future of the NHS will no longer be a state responsibility.

CHAI

Key to the work of CHAI is the NHS performance framework which governs NHS providers and which is the direct route to private sector control. The performance framework does not measure quality. It is, rather, a measure of individual providers' ability to manage political risks such as lack of NHS funding, waiting lists and setting prices. CHAI does also undertake largely 'qualitative' reports, which also largely focus on whether hospitals have procedures in place for measuring quality.

Quality measures are linked to a star system where success or failure is rewarded or punished by greater private sector involvement. Successful trusts deemed to have managed their financial position and waiting lists well are allocated three stars and granted access to performance fund monies and the "earned autonomies" of a Foundation Trust. As described above these new autonomies are entrepreneurial freedoms, which uncouple the hospital from the NHS in order to allow it to voluntarily increase the role and scope and size of the private sector in the infrastructure, delivery, and funding of health care. The failing trust with a zero star status is forcibly subjected to new management and franchised to the private sector. The end result will be a multi-tier health service with greater inequities of distribution and resources and distribution of services.

Earned autonomy freedoms for three-star and two-star hospitals

- Freedom 1** Direct allocation of additional capital
- Freedom 2** Higher delegated limits for the approval of capital investments
- Freedom 3** Retention of more of the proceeds of local land sales for re-investment in local services
- Freedom 4** Additional funds from the 2003/04 Local Capital Modernisation Fund
- Freedom 5** Opportunity to shape national policy
- Freedom 6** Less frequent monitoring from the centre
- Freedom 7** Removal of management cost limits
- Freedom 8** Fewer and better co-ordinated inspections
- Freedom 9** Automatic entry on to the NHS Franchising Register of Expertise
- Freedom 10** Direct access to 'fair shares' of 2003/04 central budgets without the need to bid
- Freedom 11** Additional freedom when establishing 'spin-out' companies
- Freedom 12** Additional funding for sabbaticals to support the Trust in contributing to the work of the Department of Health and the Modernisation Agency
- Freedom 13** Eligibility to apply for NHS Foundation Trust status

Department of Health. *Raising standards across the NHS. A programme of rewards and support for all NHS Trusts.* London Department of Health 2002

B. Accountability to patients and community

Community Health Councils (CHCs), the patient watchdogs with statutory redress through the Secretary of State, are being abolished. Instead, patient and public involvement in the health care system is to be achieved by Patients' Forums which will provide patient and public input into how local services are run and be represented on the boards of all NHS organisations. Greater public accountability is also an aim of Foundation status. Local residents and employers will be eligible for 'membership', with board structures intended to ensure greater community and stakeholder involvement. Local Council Overview and Scrutiny Committees' powers also now extend to the scrutiny of local health services. However, the Foundation Trust boards themselves will be severely restricted by their own legal duties, which are financial, and by the frequency by which they meet, and it is likely that political effort could be misdirected at a board's structure and composition rather than its statutory duties.

It is likely that the changes described above will bring about extensive NHS service closures and transfers of assets to the private sector. This has proved politically controversial in the past as CHCs have used their power of appeal to the Secretary of State. As part of the distancing of health care decisions from government, the government has created a national body, the Independent Reconfiguration Panel, to deal with controversial decisions.

C. The break up of primary care

Primary care, too, is undergoing major change. Primary care has always been the anomaly in the UK health system. Unlike the rest of the NHS where doctors are salaried, GPs remain independent practitioners operating as small businesses owning their own premises and employing their own staff, albeit almost totally dependent on NHS funding. The government abolished GP fundholding only to bring in the market and now it is currently breaking the GPs' monopoly on primary care, using current negotiations on the GP contract. Whereas the contract was formerly between each GP and the Secretary of State, the new contract is between a practice of GPs and the PCT, distanced from government. Central to the contract is the issue of which services will continue to be provided by GPs.

The government has recommended a basic or core package of primary care services, for which all GPs will be remunerated. However, all other services provided by GPs will be subject to contract and negotiation. Thus out of hours services, vaccination and immunisation, specialist GP services for diabetes and coronary heart disease, etc, will be contracted for. In this way the GP monopoly and control over the service will be broken up and it will be made easier for the government, through the regulator, to contract out large chunks of primary care to new private sector providers. Under this system the government will gain greater control over general practice by linking pay to work. The Secretary of State has estimated that by 2005 a majority of GPs will be salaried.

Control and ownership of practice premises is also being passed to corporations through the increasing use of private finance and government subsidies to the private sector. The private health care industry and insurance companies are increasingly taking stakes in the ownership of premises, which eventually they will manage, giving them more and more control over the health care services taking place within them. The increasing proportion of female and part-

time GPs and the rising costs and risks of owning premises make this policy easier to implement.⁸

Lastly the government is also bringing to an end national negotiations and terms and conditions of service and payment. The break up of the GP monopoly over services and the switch to local contracts between PCTs and practices means that increasingly GPs will be subject to local pay bargaining and control over primary care services will pass to corporations. The implicit model is that ultimately health care corporations will own and manage the service, employing GPs and staff directly on locally negotiated terms and conditions.

4. How the UK NHS is being remodelled along American lines

The position of the UK government is and continues to be that it does not matter who provides the services so long as they remain funded by government. Thus the changes and reforms described here are presented to the public as about improving efficiency and choice through competition and changing the delivery system. The government maintains that the system will continue to be funded through taxation and endorses central taxation for the NHS. Hence the changes made are to the delivery system with no overt undermining of the funding base. However, the system that is being created is built on market principles and engineered along US lines.

The argument in the US is that the problem with their system is that the government is not the universal payer. But the supporters of the US system fail to understand the way in which a delivery system based on profits and returns to shareholders fragments the risk pool and introduces new inefficiencies and transaction costs making universal health care unsustainable. The inherent but unstated logic of Foundation Hospital status is that the private sector ‘partners’ and finance providers will take over the running of the hospital in all but name and that there will be a gradual reduction in NHS services paid for out of taxation and largely free at the point of use. Profits will compete with needs and as the experience with railway privatisation and long term care shows, universal care, equity of access to services, and high quality care will be sacrificed. Health care will be a lottery decided at local level and there will be a return to the fear and uncertainty that were part and parcel of life before the NHS.

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⁸ Pollock AM, Player S, Godden S. How private finance is moving primary care into corporate ownership. *BMJ* 2001;322:960-3; Pollock AM. Will primary care trusts lead to US-style health care? *BMJ* 2001;322:964-7; Pollock AM, Godden S, Player S. Capital investment in primary care: the funding and ownership of primary care premises. *Public Money and Management* October 2001:43-9.

Glossary

- ACAD** **Ambulatory Care & Diagnostic Unit.** Outpatient facilities, like a polyclinic, covering specialities such as dermatology, ophthalmology, dentistry, ENT, gynaecology, psychiatry, orthopaedics, radiology, paediatrics, and physiotherapy. They may have basic laboratory facilities, as well as a theatre for minor operations.
- CHAI** **Commission for Healthcare Audit and Inspection.** The Government has announced its intention to establish a new, single healthcare inspectorate, the Commission for Healthcare Audit and Inspection, which will bring together the functions of CHI, the private health care related functions of the National Care Standards Commission, and the Audit Commission's national value for money studies in health.
- CHC** **Community Health Council.** Independent health watchdog, established in 1974, to be abolished and replaced under the NHS Plan.
- CHI** **Commission for Health Improvement.** The Commission for Health Improvement was established in 1999 as an executive Non-Departmental Public Body. It was set up to provide independent scrutiny of local efforts to assure and improve the quality of care provided by the NHS in England and Wales.
- Concordat** The agreement signed in 2000 by the DoH with the private and voluntary sectors to enable private health providers to be brought into the planning of local health care on a more systematic, proactive, and long-term basis. It includes such things as the use of private operating theatres and facilities to carry out elective surgery (non-emergency surgery) and the use of facilities in private and voluntary organisations to provide rehabilitative care for the elderly.
- DoH** **Department of Health.**
- DTC** **Diagnostic & Treatment Centre.** DTCs were announced in the NHS Plan, and are modelled on ACADs. Centres will provide elective or scheduled care separated from emergency care, with both diagnosis and treatment provided. Most (but not all) of these units will be on the same site as emergency and complex or critical care services but their elective work will not be vulnerable to disruption by them.
- FHT** **Foundation Hospital Trust.** Independent or semi-autonomous hospital free from NHS control, run by locally elected stakeholders on a not-for-profit basis.
- HMO** **Health Maintenance Organisation.** US health care organisation, not restricted in size, combining insurance and provider functions. They are free to select patients.
- Independent Reconfiguration Panel** This will advise the Secretary of State for Health on locally or nationally contested proposals for reconfiguration of NHS services in England.
- Local Capital Modernisation Fund** Provides funding for investment projects initiated by clinical teams at acute trusts. Trusts receive between £100,000 and £1m.
- Modernisation Agency** Established as a 'centre of excellence', the Agency's two main roles are to modernise services, ensuring they meet the needs and convenience of patients as outlined in the NHS Plan, and to develop current and future NHS leaders and managers at all levels in the NHS.
- NHS Plan** Published in July 2000, the NHS Plan outlines major changes in the structure and funding of the NHS, in particular setting out ways in which the private sector will be involved.
- PCT** **Primary Care Trust.** Established in April 2002, PCTs replace district health authorities and GP fundholding. They pay for general practice surgeries, clinics, drugs, and hospital and other services on behalf of their patients.
- PFI** **Private Finance Initiative** **PPP** **Public Private Partnership**

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