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Statistics and the Privatisation of the National Health Service and Social Services

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Using statistics to investigate the hidden privatisation of health and social care services

Government policy has been to:

- reduce the size of the public sector through privatisation and contracting out;
- involve the private sector in providing existing and new services through the private finance initiative and challenge funding.

Financial Statement and Budget Report, HM Treasury, 1996

Background

While other parts of the public sector have been privatised with a single high-profile sell-off, privatisation has been taking place piecemeal in the UK's National Health Service (NHS) and social services. In some sectors, such as long-term care, the process is well advanced, while in others, such as acute hospital care, it is less well advanced but catching up fast. Many of the methods used to further private-sector involvement in the NHS are well known. They include tax relief on private health insurance for elderly people, compulsory competitive tendering for cleaning, catering and laundry services, the transformation of NHS beds into pay-beds, and charges to users of services. Others, such as capital charges, the private finance initiative and the subsidy of private nursing and residential care homes through the social security budget, are less well known.

These policies were brought together with the introduction of the NHS internal market in 1991 and the changes made in social services in 1993. Under these, health and local authorities have purchased care for their resident population from NHS trusts providing hospital and community services and also from private hospitals and private and voluntary organisations providing residential care and community services. This contrasted with the previous situation in which health and local authorities planned and provided the services themselves. The changes also offered scope for the private sector to use any spare capacity to sell services to the NHS.

This chapter uses the statistics which are available to describe the impact of these changes, while pointing to gaps in the data available. It is concerned first and foremost with the effects of the policies, rather than the mechanics by which they are implemented. It starts by describing changes made in long-term residential and community care before going on to discuss acute hospital care and charges to users of services.

Privatisation of long-term care

Before the 1980s, responsibility for funding and providing care was shared by two public-sector agencies. The NHS funded and provided care in long-stay hospitals, acute hospitals and community health services, while local authorities funded, and through their social services departments provided, residential care and community-based home care services such as 'meals on wheels' and home helps. All services provided by the NHS were free at the point of delivery but local authorities had discretionary powers to make charges for services and means-test their users. Until the 1980s few chose to do so (Association of Metropolitan Authorities, 1994).

Since the 1960s, the policies of community care and deinstitutionalisation had been leading to the rundown and closure of NHS and local authority institutions, as Figure 29.1 shows, with the transfer of people with learning difficulties and mental illness into what was described, often euphemistically, as 'the community'. For some people this may in reality mean homelessness, as Chapter 23 shows. These trends continued into the 1980s, and were extended to elderly people including those described as 'elderly mentally infirm'.

Up to 1981, the private and charitable sectors played a relatively minor though slowly increasing role in provision for long-term care. This changed when the Conservative government used an amendment of the Social Security Act to allow residents entering private-sector homes to claim board and lodging allowance

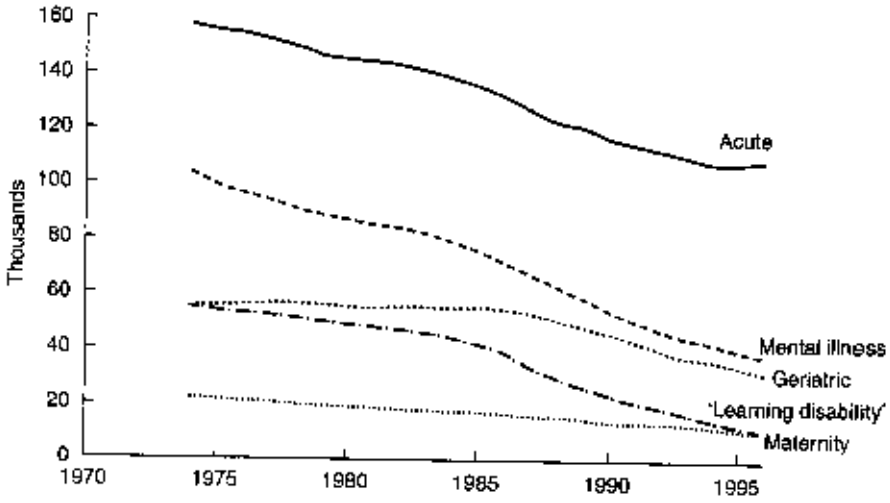

Figure 29.1 Average number of beds available daily, England 1974–96/97
Source: DHSS and DoH *Statistical Bulletins* 5/85, 1995/29 and 1997/20

from the social security budget to pay for their care. This option was not available for residents in local authority or NHS facilities or for community services for people in their own homes. It led local and health authorities to encourage their residents to opt for private care subsidised through social security payments. These changes had a dramatic effect on the pattern of residential and nursing home care provision, calling into question the stated policy of moving towards 'care in the community' (Audit Commission, 1986; Department of Health, 1988). In England, the overall number of places in homes for elderly and disabled people rose from 179 502 in 1979 to 233 587 in 1985 (Radical Statistics Health Group, 1987). The proportion of these places which were in private homes rose from 18 per cent in 1979 to 34 per cent in 1985.

These trends continued through the late 1980s and into the 1990s, with increasing numbers of places in private and voluntary homes for people with learning difficulties, and in private homes and hospitals for mentally ill people. Although the move to the private sector was the most outstanding feature, changes in methods of data collection in England made it difficult to measure changes precisely, let alone compare trends with other countries of the UK, each of which collected the data slightly differently. In 1987–88, a new category, 'elderly mentally infirm', was introduced to categorise people who had previously been described as either 'elderly' or 'mentally ill'.

Greater changes in data collection accompanied the much more widespread changes made in 1993 when the NHS and Community Care Act of 1990 was finally implemented. The key features of the Act were to devolve responsibility for funding long-term care to local authorities and to restrict the extent to which long-term care was funded through the social security budget (Pollock, 1995). The NHS' role in long-term care was reduced to caring only for the people who are most dependent on health care, thus requiring local authorities to provide care for increasingly dependent groups of people. Local authorities began to fund people in private nursing homes registered with the NHS as well as those in various types of residential care registered with local authorities. From 1994 onwards, the Department of Health began to collect data about places and residents in nursing homes. Small homes with four or fewer residents were required to register with local authorities from 1 April 1993 and they began to appear in the statistics from 1994 onwards.

The number of homes registering dually as both residential and nursing homes rose in the mid-1990s, from 602 in 1993 to 1537 in 1997 (Department of Health, 1997c). To counter the likelihood of double counting, from 1997 onwards data about residential and nursing care in these were explicitly subdivided. In the same year, data collection about places in unstaffed homes run by local authorities was stopped on the grounds that much of this accommodation was now being provided by housing associations, from which the Department of Health does not collect data. All these changes make it difficult to assess whether the rundown of NHS inpatient facilities has been offset by facilities provided elsewhere. As a result of these difficulties, data for 1997 have not been added to the graphs in this chapter.

In England, the overall number of places in staffed residential homes of all types rose from 283 800 in 1987 to 307 896 in 1997 (Department of Health, 1996, 1997c). The proportion of these which were in local authority homes fell from 45 per cent in 1987 to 20 per cent in 1997 and most of the growth was in the private sector. In addition, the numbers of residential places in dual-registered homes

providing both residential and nursing care rose from 11 308 in 1993, the first year for which data were collected, to 24 954 in 1997. The numbers of places in nursing homes rose from 124 369 in 1994 to 143 834 in 1995, then fell to 131 674 in 1997, while the numbers of nursing places in dual-registered homes rose from 13 831 in 1993 to 48 633 in 1997 (Department of Health, 1997c).

As can be seen from Figure 29.1, the rundown of 'mental handicap' hospitals has taken place over a long period. The process speeded up from the mid-1980s onwards, with the average number of beds available daily falling by 36 000 from 46 000 in 1983 to 10 000 in 1996–97 (Department of Health, 1997d). In contrast, the number of places for people with learning difficulties in staffed local authority, voluntary and private accommodation rose by only 28 896 from 17 328 in 1983 to 46 224 in 1997, as Figure 29.2 shows. The numbers of places available in local authority unstaffed homes apparently rose by only about 1250 from 1453 in 1983 to 2700 in 1995, but by 1997 there were 3389 people with learning difficulties living with local authority support in unstaffed homes, which could be owned by local authorities, housing associations or other organisations.

For people with mental illness, the average number of hospital beds available daily fell by 44 000 from 82 000 in 1983 to 38 000 in 1996 while the numbers of places in residential accommodation outside long-stay hospitals increased to a much lesser extent from 6500 in 1983 to 13 100 in 1996. The picture here is much less clear, as Figure 29.3 shows. People categorised as 'elderly mentally infirm' were not counted before 1987–88. Although the overall picture shows a major shift to the private sector, private mental hospitals are very different from the long-stay institutions which have been run down. They cater largely for people with less severe illness who are funded by private health insurance, although this may be changing.

The NHS and Community Care Act 1990 also requires local authorities to assess people's needs and financial eligibility for long-stay residential and nursing home care. While they continue to have discretionary powers to impose charges on

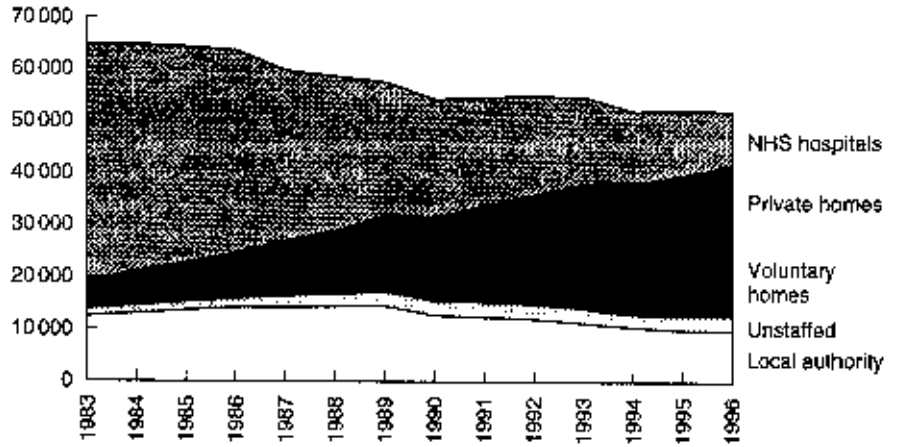

Figure 29.2 Places in homes and hospitals for people with learning difficulties, England, 1983–96

Source: Department of Health Local Authority Statistics A/F 91/11A and Statistical Bulletins 1994/13 and 1996/25

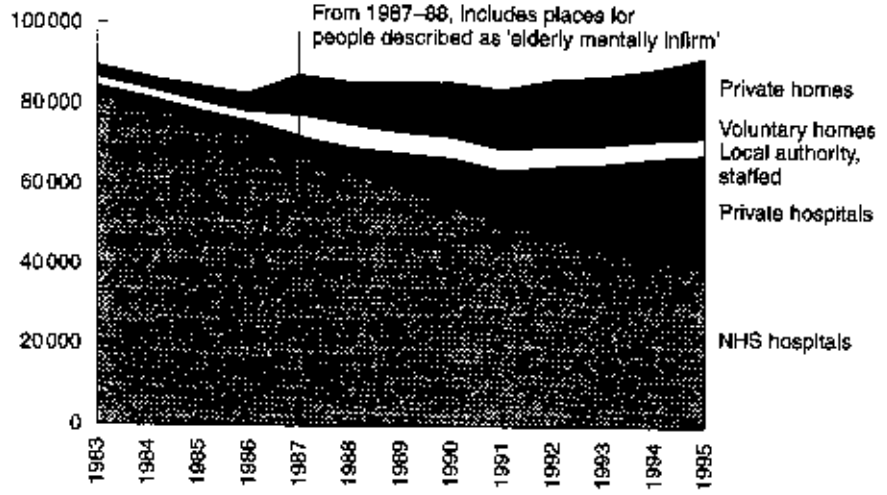

Figure 29.3 Residential places and hospital and nursing home beds for mentally ill people, England, 1983–95
Source: Department of Health Local Authority Statistics A/F 91/11A and Statistical Returns KN03, KO36, RAC5, RAC(5)S and RAU1

community-based services, means testing for residential and nursing home care follows national criteria. As a result, in the financial year 1994/95, £559 million was collected by local authorities from charges for residential and domiciliary care (House of Commons Health Committee, 1996a).

In 1996, the total expenditure on residential care for elderly, chronically ill and physically disabled people was just over £8.2 billion, of which 61 per cent was publicly financed, while the rest came from user charges, means testing and individual payments. Another £3.7 billion was spent on non-residential and domiciliary care including that provided by the NHS, social services and private and voluntary organisations (House of Commons Health Committee, 1996a). In 1995 over half of the long-term care expenditure in England, £4.9 billion, was spent on care in private residential and nursing homes and 49 per cent of the costs were met from public funds. There are no data available so far on the amount spent on community-based private care because this sector is fragmented and a national survey has yet to be done. In 1997, the average cost per person per year of nursing home care and residential care was estimated at £17 472 and £12 844 respectively in England (Laing, 1997). There are no national data on the number of people who have had to sell their homes to pay for care (Hamnett, 1992).

As a condition of central funding, social services departments increasingly use private organisations to provide community-based services such as 'meals on wheels' and home care. In 1996, the private sector provided 32 per cent of the total contract hours of home help and home care in England, compared with just 2 per cent in 1992 (Department of Health, 1997e). Although the numbers of hours of care had increased, the numbers of households receiving it had declined from 528 500 in 1992 to 491 000 in 1996.

These changes have yet to be thoroughly evaluated but the immediate impact of decentralisation has been to introduce wide differences in approaches to needs assessment, in both financial and other criteria for service eligibility (Leicester and Pollock, 1996; National Consumer Council, 1995). These differences create wide geographical and other inequities in access to long-term care services.

It is worth noting that many of the large health care corporations providing care in the USA have also set up operations in the UK. US experience shows little evidence that the shift to private-sector financing and ownership of long-term care will save money, especially if the corporations operating in the UK have similar patterns of spending on administration, similar capital and similar profit levels (Harrington and Pollock, 1998). At present, there are few data about the position in the United Kingdom.

Acute hospital care

The removal of restrictions on private practice led to a growth in the numbers of private acute hospitals in the early 1980s. The actual size of this growth is not so easy to assess, however. Data collected by the Independent Healthcare Association, shown in Figure 29.4, relate to the UK as a whole and do not tally exactly with the data collected separately by the health ministries for each of the four countries, because of the differences in definitions.

Data collected by the Independent Healthcare Association show that the numbers of private acute hospital beds in the United Kingdom rose from 6614 beds in 150 hospitals in 1979 to 10 155 beds in 201 hospitals in 1985 (Radical Statistics Health Group, 1987). After that, numbers of beds levelled off for a year or two before increasing more gradually to 11 681 beds in 227 hospitals in 1995 (Independent Healthcare Association, 1995). The percentage increases have been highest in the regions and countries, such as Scotland and the former Northern, North Western, East Anglian, Wessex and Oxford regions of England, which had the fewest private beds in the past. Nevertheless, private acute hospitals are very

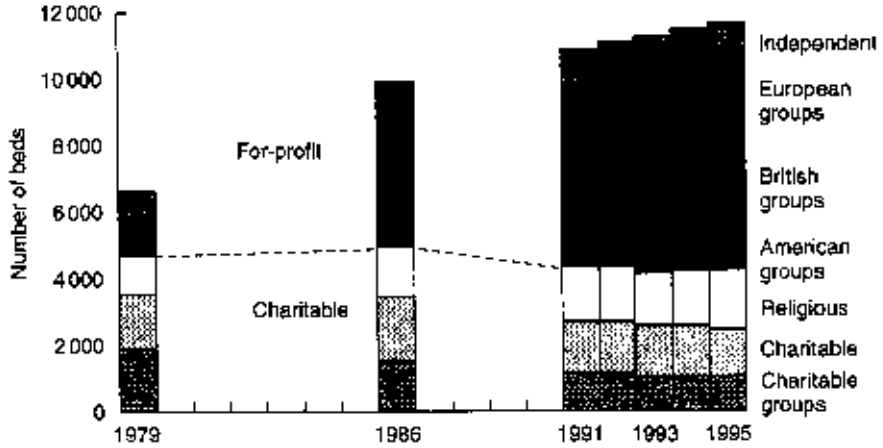

Figure 29.4 Numbers of beds in private acute hospitals by ownership, UK, 1979–95
Source: Independent Healthcare Association

unevenly distributed geographically. In 1995, 44 per cent of the beds in the UK were in the Thames regions and many of them were concentrated in London.

The increase has largely been in hospitals run by for-profit organisations, with a slight decline in hospitals owned by religious and voluntary groups. For-profit groups owned 63 per cent of private acute hospital beds in 1995, compared with 29 per cent in 1979. The early 1980s was a time of major expansion for British groups, such as the British United Provident Association (BUPA), and US companies expanded into the UK market. Since then European groups have entered the market and largely replaced the US companies.

The numbers of pay beds in NHS hospitals also rose in the early 1980s. In England, the authorised quota rose from 2405 in 1979 to 2919 in 1982, after which numbers levelled off to 2967 in 1985 and 2956 in 1991, the last year for which the data were collected in England. Revenues from NHS pay beds rose from £94 million in 1991 to £240 million in 1996. Over the same period, the NHS's share of the total private health care market rose from 10.9 per cent to 16.7 per cent and was predicted to rise to 20 per cent over the following three years (Fitzhugh Directory, 1997). Data from the Hospital Episode System for the financial year 1989/90 onwards show an increase in the use of private beds from 83 478 in-patient and day case episodes in 1988–89 to 99 399 in 1994–95 (Williams, 1997).

The increase in the provision of facilities in the private sector came at a time when facilities for acute in-patient care in the NHS were decreasing, in response to the move to day case surgery and shorter lengths of in-patient stay. In England, the average numbers of acute beds available daily decreased from 147 000 in 1979 to 108 008 in 1994/95 but have shown a slight increase in the past two years, reaching 108 895 in 1996/97 (Department of Health, 1997d). The decreases over earlier years were also associated with hospital closures, in many cases, meaning that people are having to travel longer distances for in-patient care. It is difficult to assess the extent of this inconvenience, as the Department of Health no longer records the location of hospitals in the published statistics and simply identifies trusts by the type of care they provide.

No data are collected routinely about the numbers of in-patient and day case admissions to private hospitals, but a series of three surveys estimated that numbers of admissions to short-stay private hospitals in England and Wales rose from approximately 275 752 in 1981 to over 655 350 in 1992/93 (Williams and Nicholl, 1994). In 1992/93 about 5 per cent of these were paid for by the NHS. As part of waiting-list initiatives in the late 1980s the first steps were taken to buy NHS services from the private sector. The introduction of the internal market in general, and general practitioner fundholding in particular, have accelerated this trend. In 1994 Virginia Bottomley stated that it did not matter who provided the services so long as they were paid for by the public purse.

Further developments increased private-sector interests in public hospitals. These were the introduction of capital charges in 1992 as part of the internal market, the extension of competitive tendering, which had been introduced in the 1980s for catering, cleaning and laundry, to other services such as computing and laboratory services, and the launch by the Treasury in 1992 of the Private Finance Initiative (Pollock and Gaffney, 1998).

When replying to a parliamentary question about the backlog of maintenance costs, the Department of Health admitted that a substantial reduction in the size of

the NHS estate was anticipated over coming years along with a continuing ambitious programme of capital investment by the private sector as part of the private finance initiative (PFI) (Pollock *et al.*, 1997). The object of PFI is to bring private finance into large capital projects for the NHS, but the buildings will be built and largely owned by private companies and consortia, which will lease them and their services back to the NHS. The NHS, using its revenue funds, will pay for both the capital and the running costs but will not 'own' the facilities built under the initiative. A recent report has shown that the NHS and the Treasury are using public funds to subsidise the expansion of the private sector. The report also draws attention to the reduction in overall capacity and service provision as a result of the increased cost of the PFI hospital building programme compared with publicly funded alternatives (Gaffney and Pollock, 1997). It is likely that the rundown of NHS acute and community service provision will mirror the recent trends in long-term care.

Privatisation and the employment of NHS staff

Because so many NHS staff work part time, statistics about them are expressed as whole-time equivalents. Each employee is counted according to the proportion of whole-time hours she or he works. The numbers of whole-time equivalent ancillary staff in the hospital and community health services in England decreased from 124 270 to 66 760 between 1986 and 1995, after which a change in the way jobs are classified made trends difficult to monitor (Department of Health, 1997f). Many of these were replaced by staff employed by private contractors. There are no data about the number of staff these firms employ on NHS work nor about the extent to which nursing and other staff may have to take on some of the tasks previously carried out by ancillary staff.

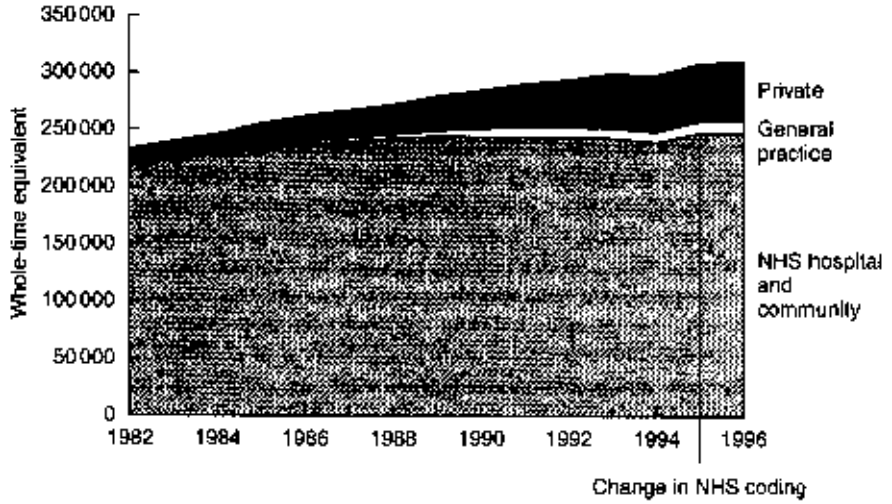

Figure 29.5 Whole-time-equivalent qualified nurses by sector, England, 1982–96
Source: Department of Health non-medical workforce census, bi-annual census of general medical practitioners and annual return KO36

The numbers of whole-time-equivalent qualified nurses working in NHS hospital and community services declined from a peak of 244 220 in 1989 to 238 780 in 1994. After that, the numbers appeared to increase slightly as a result of a change in the way nurses are classified. Senior nurses, who had been counted as managers, are now counted as nurses. The numbers of whole-time-equivalent nurses working in general practice rose from 1449 in 1982 to 9820 in 1996 (Department of Health, 1997f). Nevertheless, the most marked feature of Figure 29.5 is the increase in the number of qualified nurses working in private homes and hospitals from 12 208 whole-time-equivalents in 1982 to 50 810 in 1996.

Private sources of funding

As well as being funded by general taxation, health and social services and private care can be funded by charges to users. These may be met wholly or partly from private health care insurance. The trend since 1979 has been to increase charges and to introduce more charging policies for health and social care. The proportion of NHS income coming from charges for prescriptions, dental fees, private health care and other sources has always risen under Conservative governments and fallen under previous Labour governments (Webster, 1997). It rose from 2.0 per cent of total NHS expenditure in the UK in 1978/79 to 2.9 per cent in 1984/85 (Radical Statistics Health Group, 1987). After reaching a peak of 4.3 per cent in 1990/91, the proportion started to fall, reaching 2.0 per cent in 1996/97 (Office for National Statistics, 1998b). The main reason for this fall is that NHS trusts, as autonomous public corporations, no longer report income from charges.

There are other reasons why income from charges appears to have fallen. First, some drugs which could formerly be obtained only on prescription became available without prescription. This transfers the cost of the drug to the person paying and removes its cost from the NHS. Second, where drugs cost less than the NHS prescription charge, many general practitioners are prescribing them on private prescriptions. Third, eye tests and the provision of spectacles have been completely privatised and dentistry has been partially privatised. Finally, some other private charges, such as local charges for screening and management of subfertility, are not declared nationally and so do not appear in statistics.

The creeping privatisation of prescribing is particularly important. From 1979 onwards, prescription charges rose every year, usually well ahead of inflation. It has been estimated, using Department of Health Prescription Cost Analysis data for 1995/6, that over half of prescribed items cost less than the prescription charge (Department of Health, unpublished data from Prescription Cost Analysis). If the use of private prescriptions increases, this will have a number of effects. First, prescribing analysis and cost (PACT) data will no longer accurately reflect general practice prescribing patterns, reducing the value of indicators of prescribing derived from PACT data. Second, the net costs of drugs will rise because of 'cream skimming' of cheaper drugs. Third, private prescribing will act to increase inequalities in practice funding. Costs of drugs prescribed privately will not appear in practice prescribing budgets. This will favour practices in affluent areas where the demand for private prescriptions will be greater, as fewer people are exempt from charges. Such practices will therefore have lower NHS prescribing costs than practices in more deprived areas. Fundholders have been able to use savings on their prescribing budgets for other purposes (Heath, 1994).

Social services departments' income from charges was poorly documented throughout the 1980s. Charges accounted for 9.6 per cent of total social services expenditure in 1991/92 rising to 12.4 per cent in 1995/96 (Department of Health, 1996). These data may not reflect the extent to which charges were actually recovered, which is thought to be much lower. The potential to raise income from charges for residential care is taken into account in the central government allocation to local authorities. Social services charges are particularly regressive because they require payment from users of services. These are often the people with the highest need for health and social care. For many services, such as home care and domiciliary care, people increasingly have to pay from their Income Support for the domiciliary care provided.

Private health care insurance

Although in the original NHS Act, the then Minister of Health, Aneurin Bevan, allowed doctors to offer private health care in NHS pay beds, the private sector remained small, with only 120 000 people holding private insurance in 1950. The number had increased to over 2 million by 1972 and by 1992 approximately 6.4 million people – that is, 10.8 per cent of the population – were covered. These data are compiled in a variety of ways, from either surveys or returns made by third-party insurers, and their accuracy has not been evaluated (Laing, 1997). Insurance coverage can be measured as the numbers of subscriptions taken out each year, or in terms of the numbers enrolled at one point in time.

The uptake of private medical insurance is known to vary geographically, although data have not been published for some time. The most recent published data are from the 1987 General Household Survey. This estimated that 16 per cent of people in the Outer Metropolitan Area around Greater London and 15 per cent in the Outer South East were covered, compared with only 3 per cent in the North and 4 per cent in Scotland and Wales (Office of Population Censuses and Surveys, 1989). Uptake of private health insurance also varies strongly by socio-economic group. As might be expected, policy holding and coverage are highest among professional and managerial groups. In 1995, policy holding ranged from 21 per cent of men in professional occupations to 1 per cent of men in manual occupations (Office for National Statistics, 1997c).

What conclusions can we draw?

The patchy data available show that the privatisation of the NHS and social services has reduced the availability of care to most people in England. Similar forces were at work in the other three countries of the UK. Given the extent to which public funds have been used to subsidise investment in the private sector, better data should be available about how they have been spent. Better data are also required on the needs for health and social care and how they are met, together with the impact of changes in funding and charging policies on access to care. Compiling good data is no easy task. It is difficult to collect data in a

way which reflects policy changes and anticipates their impact, while also allowing consistent time series to be compiled. We suspect that such data would seriously call into question the way in which these policies of privatisation are still being pursued under a Labour government.

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Industrial Injury Statistics

Theo Nichols

Official statistics on industrial injury are not a valid measure of safety performance

In late 1997 when Frank Davies, Chairman of the UK's Health and Safety Commission (HSC) presented the 1996/97 Annual Report, he reflected that the increases in fatalities at work provisionally estimated for that year had to be taken seriously, even though at that point it was too early to judge whether the new statistics indicated a 'brief rise in this country's previously improving safety record or the start of an upward drift' (Health and Safety Commission, 1997, p. xi). The key purpose of this chapter is to critically assess the assumption that the British safety record had been improving from the mid-1980s. It is argued that it is doubtful it had improved, if by this is meant that a reduction in the Health and Safety Executive (HSE) statistics had come about as a consequence of improved attention to safety matters in British industry.

What is safety?

It is an important feature of the history of advanced capitalist societies that they have generally evidenced rises both in the level of productivity and in safety. As far as safety, rather than safety and health, is concerned – for safety and health may move in contradictory ways and it is safety alone which is the focus here – the contribution of several different factors has to be reckoned. One of these is the role of increased investment and, especially important in manufacturing where machinery is a more common immediate cause of injury, increased mechanisation and automation. As far as fatality rates are concerned, long-term improvements in medical facilities, both on site and by way of general public provision, can make for improvement. Also – and generally this is the more so the longer the time period that is considered – a part is played by increased expectations about how people should be treated at work and, just as important, increased expectations about the rights and confidence they have outside it. However, whatever the importance of each of these possible contributory factors, the emergence of Thatcherism as a short-termist, anti-labour political regime at the start of the 1980s should be sufficient warning that there is