

## A History of the NHS

Pre-war: healthcare was provided by a patchwork of private providers, charities, and employment related insurance schemes. Many people, especially the families of the working poor had minimal or no care and there was gross inequity in terms access and quality.

1946: Legislation setting up the NHS passed by Atlee's post war Labour government.

1948: Start of the NHS on 5<sup>th</sup> July. Initially dental care, eye tests and glasses and prescriptions were all free but gradually as costs mounted these were lost from the NHS. Prescription charges for medications were introduced in 1951 and exist to this day in England - however they represent only a fraction of the cost of many drugs and as many groups of people are exempt from charges (over 60 or under 16, suffering certain long term conditions, in receipt of benefits) the vast majority of prescriptions (**88% in 2012**) are dispensed free.

### The purchaser-provider split (1989)

This was the beginning of internal markets. For many, the rot started in 1989 with the Thatcher government White paper '*Working for patients*' which introduced **the purchaser provider split** – an effort to introduce competition into healthcare.

There is, on the right, a fundamental belief that competition is the driving force of enterprise and hard work – without it we are doomed to stagnation and inefficiency.

**There are many good reasons why markets are not a good way to run healthcare.** These include inelasticity of supply, the absence of experienced users and problems with measurement of quality.

The market relies on people weighing up what they think it is worth paying for a service: in a practical sense this is really difficult as there is a lack of transparency and our measures of quality in health care are very imperfect.

There are also **moral and ethical objections** to the quality of healthcare you receive depending on your ability to pay

Returning to the purchaser provider split: historically district health authorities had worked out what the needs of the local population were likely to be and then set about providing those services.

Thatcher's 1989 legislation envisaged hospitals which were independent trusts and health authorities which would have a budget to purchase the care that was needed from these trusts, from private providers or from charities.

**In this way, hospitals would compete for business** on quality and price, improving the former while driving down the latter. That was the theory – but **in practice there was relatively little change**. There were **costs involved in the contracting and billing that ensued which offset any savings** that may have been made. And there was a fundamental problem with what to do with hospitals that didn't compete successfully – it was not morally acceptable in terms of equity or access to health care (or politically acceptable in terms of re-election prospects) for failing hospitals to close.

### New Labour (1997)

**The neo-liberal consensus that the market would deliver continued through the years of New Labour**. There was an attempt to introduce Independent Sector Treatment Centres – ISTCs which would do high volumes of surgery more efficiently than traditional NHS hospitals.

There were problems – the quality control was poor and there were poor clinical results. They disrupted training – **what you need for training surgeons is case mix** – straightforward cases for juniors to learn and gain experience with, while seniors tackle complicated cases. One of the main reason they didn't really gain ground may have been because there was not enough profit to be made, despite very generous terms being offered.

There also appeared to be, from decision makers, **a fundamental misunderstanding about the nature of healthcare**, where most need doesn't come neatly packaged as a single operative procedure with predictable costs (cataracts, hip replacements) but involves older people with more than one thing wrong with them – this is a level of variability and risk the private sector was not prepared or equipped to take on.

### New GP contract (2004)

In 2004, a new GP contract was introduced which took away from GPs their duty to provide 24 hour cover 365 days a year. Many saw this as a way to break the GPs monopoly and to get the corporate sector into primary care (which is still mostly run as small businesses with a single contract to the NHS). Again changes were very slow as the cost of providing the service was

underestimated.

Under the Blair and Brown governments there was an emphasis on patient choice, and every time a patient was referred to hospital they were offered a choice of providers, some of which would be from the private sector. This was a **rather London centric policy** – if you live in easy reach of several hospitals it might make some sense, but here my patients would look at me blankly and say why? Is there a problem with the John Radcliffe? The information available to patients on which to make their choices includes waiting time, car parking and sometimes patient ratings but lacks meaningful information about outcome measures.

### **Foundation status (2003)**

In 2003, under Blair, some hospitals were given Foundation Trust status which gave them yet more independence – to form partnerships with private sector partners and to borrow money on the financial markets without any intervention by the secretary of state.

### **End of New Labour (2010)**

Some negatives and some positives. **Despite these attempts to diversify the NHS and bring in the private sector, and leaving aside the disastrous Private Finance Initiative**, [The PFI deals financed £11.8 billion in building hospitals in England but will cost **£79 billion** to pay back over 31 years] which continues to waste billions, the NHS was in relatively good shape at the end of the last Labour Government, and this was mostly because funding kept pace with demand. **NHS spending increased from 5% of GDP in 1999 to over 8% in 2009.**

Waiting lists fell, I would refer patients and in only a few weeks receive clinic letters in response – it makes me quite nostalgic to think of it.

### **The Health and Social Care Act (2012)**

**In 2009 David Cameron promised that there would be ‘no more top-down reorganisations of the NHS’.** In 2013 Andrew Lansley’s Health and Social Care Act came into effect which was exactly that - another massive reorganisation, memorably described by David Nicholson, then head of NHS England as **‘so big you could see it from outer space’.**

Again it aimed to open up the NHS to competition and there were significant voices on the Tory right (Jeremy Hunt among them) who explicitly set out to replace the NHS as the main provider of healthcare.

### **CCGs and contracting out (2013)**

In this new structure the purse strings were mostly held by local Clinical Commissioning Groups, made up of General Practitioners with some input from hospital clinicians. One of the most damaging aspects of the Health and Social Care Act was the obligation to put all contracts out to tender, unless there was only a single provider with the necessary skills and capacity to do the job. The result was that many contracts for work previously done by the NHS now went to private sector, for-profit providers such as Circle, Serco, UnitedHealth and Virgin. These companies were very good at writing tenders (and often had whole departments dedicated to doing just that) but not always so good at service provision.

Unfortunately most of the competition was on price rather than on quality. **In the year 2013-14 a third of all the contracts offered were won by the private sector and in the last year this has increase to 70% of new contracts.** *This still adds up to a relatively small slice of the NHS overall spend but the rate of change has accelerated very quickly.*

### **Private sector hits problems (2015)**

Things have not gone entirely smoothly for the private sector companies and the efficiency savings needed to make these bids work have not materialised. **The most costly element of healthcare is staff, and there is a limit to how far you can cut staff or how much you can replace highly skilled with less skilled staff before the whole enterprise falls apart.** One of the biggest deals was a contract with Circle Health to run Hinchingsbrooke hospital in Cambridgeshire. Circle took over in February 2012 with a 10 year contract but pulled out in January 2015 having failed to balance its books.

The announcement that it was throwing in the towel came hours before the Care Quality Commission, which inspects healthcare providers recommended the Trust should be placed into special measures after it was rated 'inadequate' on the questions of whether it was caring, safe and well led.

**As well as opening the door to wholesale privatisation of the NHS the Health and Social Care Act also, crucially, removed the secretary of state for health's responsibility to provide healthcare.**

### **Five Year Forward View (2014)**

While many of us were still digesting the Health and Social Care Act, the next

major change was around the corner. In October 2014 Simon Stevens's Five Year Forward View was published.

*Some background:*

*Until 2004 Stevens was Tony Blair's health policy adviser, then moved into the private healthcare sector working for UnitedHealth, a US based multinational. In October 2013, the speaker biography of Stevens for a health networking conference read: "His responsibilities include leading UnitedHealth's strategy for, and engagement with, national health reform, ensuring its businesses are positioned for changes in the market and regulatory environment."*

Unsurprisingly, many health campaigners did not celebrate when he became chief executive of NHS England from April 2014 and were not convinced about his commitment to a publicly provided NHS.

The most recent changes in the NHS were prefigured in that 2014 document. Some of it – the good bits - have not been implemented, for example the sensible material on the need for increased investment in public health to reduce preventable harm and healthcare need. Instead, as responsibility for public health has been handed over to local authorities and they have had their funding cut by central government, **spending on public health has been declining rather than increasing with budgets over the next 5 years for smoking cessation, drug and alcohol misuse and sexual health services all dropping by between 5 and 15%.** (King's Fund <https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets>)

**The parts that are being enacted are, effectively, yet another huge reorganisation and the creation of, initially Sustainability and Transformation Plans, and ultimately, Accountable Care Systems or organisations.** Recently these have been renamed 'Integrated Care Systems'- I'll come back to this. If it all sounds very confusing, that is because it is.

NHS England divided the country up into 44 geographical 'footprints' and STP boards were created and tasked with coming up with a transformation plan which would save the NHS £22bn over the next 5 years. These boards include representatives of local authorities, clinical commissioning groups, hospital trusts, and other stakeholders – although it is not immediately clear who decides the membership of these boards. The task they have been given is to transform and improve local healthcare while saving significant funds.

**There are a number of aims of the 5YFV that the STPs are meant to be enacting, including:**

- Bringing care closer to home (which is shorthand for closing hospital beds)
- Integrating health and social care to provide joined up care and eliminate waste
- Breaking down costly and inefficient boundaries between community and hospital care provision.

Unfortunately it is difficult to see these plans as a serious attempt to provide better services when the overriding criterion on which they are judged is whether they will produce the savings required, and it is increasingly clear that this is unlikely to happen.

Providing care closer to home in cottage hospitals or by visiting nurses may be popular but beds have been cut (in Oxford at least) both centrally and at community hospitals before there are enough community nursing staff to plug the gaps. District Nurse numbers (Full time equivalents) fell 46.4% between 2010 and 2016 and, according to the Nursing Times last month, up to 50% of DN training courses are set to close this year.

**Plans to save money:**

- **Integration of health and social care** is fairly obviously a good idea but there are as yet no clear ideas about how the funding for this will work – we have a current situation where healthcare is still relatively comprehensive, mostly publicly provided and paid for out taxation whereas social care is limited, provided by private contractors and means tested. As far as I understand from people who should know, this square has not been circled.
- **Technology** is also widely touted as a route to saving money – with high tech self-monitoring patients with long term conditions will have less need to costly input from nurses and care staff. Research does not back this up, in fact the evidence that any of these changes will save money, or provide better care, is distressingly absent.
- **Across the country savings are being made by closing and downgrading hospitals, and attempts are being made to raise capital by selling of**

**NHS land and buildings.** In the original document it was envisaged that the 144 full Accident and Emergency departments would be reduced to around 70. Closures are politically costly and so much of the STP planning has been done behind closed doors with a marked lack of transparency. Some of the closures that have already happened, in some cases dressed up as patient safety measures in response to staffing gaps. In this county you will be aware of the loss of maternity services at the Horton in Banbury.

### **Accountable Care Organisations**

Possibly the most worrying aspect of the STP plans are the intention to form new structures – Accountable Care Organisations – which will take responsibility for providing care for a defined population. This will include primary care (GP services) community care and hospital services as well as, potentially, mental health services and preventative health care. They are based on an American model (similar to Health Maintenance Organisations such as Kaiser Permanente) and are seen by many as a route to further privatisation.

In Manchester, which is ‘leading the way’ a £6 billion contract to provide all community health services was on the brink of being signed in October when it was stopped by some tax technicalities.

**One more recent positive is the recognition that competition is not the route to efficient healthcare – that concept has been quietly dropped – and collaboration and integration are the flavour of the month (although the requirements for competitive tendering enshrined in the HSCA have not been withdrawn).**

However, we have moved from a situation under the Blair and Cameron governments where public sector commissioners (PCTs and CCGs) were obliged to go through expensive tendering processes to piece together a working system, which then included private health care companies and traditional NHS providers, to one in which very large, 10 year contracts to provide for all health needs may be handed over to private sector, for profit, health companies.

This last statement has neither been confirmed nor denied by the current Health Secretary – currently there does not appear to be anything to stop the

likes of UnitedHealth, Circle, Serco or Virgin from bidding for ACO contracts. **Once they have these contracts, the fear is that they will reduce what is provided.** Private companies will find that they are unable to fund the services that they are contracted to provide for the amount they have bid and therefore the 'NHS offer' will shrink. Top up charges will be levied for discretionary items of health care, top up insurance will appear, to pay for the bits that are missing.

Another aspect of ACOs is that, as they will have a registered population, similar to a GPs registered list although much larger, they will be ripe for a more comprehensive shift to an insurance model.

Currently anyone can turn up to any hospital in the UK, and (providing you don't have dark skin or a foreign accent) care is provided under the NHS. In one version of the ACO future, you will 'belong' to a particular ACO, much as you do in the Swiss system, and presumably your funding will follow you – which leaves a lot of scope for people falling through the gaps.

Is there a better answer? The ACOs, like many other American health imports, were a solution to a US problem which we arguably didn't have in the first place, as we started from a strong primary care and community service base which was, in comparison with our international peers, strikingly efficient. The 'American Import' tag has been so damaging (not surprisingly given the reputation of US healthcare) that Accountable Care Organisations have now been renamed Integrated Care Systems.

### **The state we're in now**

We cannot claim that all is rosy in the NHS garden – we have problems with too large a proportion of our health spend going into hospitals and not enough to public health and primary care. We currently waste in excess of £4billion a year on the mechanisms of the market, which has greatly increased as a result of the Lansley reforms.

We also need some hard conversations about eye-wateringly expensive medications which prolong life by very few months and the appropriateness of some of the invasive care inflicted on very frail patients.

**We have a workforce crisis**, largely of this governments making - there has been a lack of workforce planning, underinvestment in General Practice to the point at which huge numbers of GPs are jumping ship, dramatic declines in

recruitment to nursing following withdrawal of the nursing bursary, and because of Brexit, we are about to wave goodbye to a very significant number of our European colleagues. Current estimates are that the NHS is short of 100,000 staff, including 10,000 doctors and 40,000 nurses.

### **The NHS is underfunded**

But most of all we are underfunded. There are lots of different versions of the figures and it can be hard to get a clear picture. Sometimes spending out of taxation is considered and sometimes the combination of public and private health spending, which is a bit higher. (Office of National Statistics figures from 2014 show that just under 80% of all spending on health is government spending with 20% coming from prescription charges, eye care, dentistry and private cover).

**What is spent by NHS England (which has gone up a little bit) is sometimes quoted leaving out the massive fall in funding for public health.** In general the consensus is that the UK spends approx. 10% of GDP overall and figures have been flat-lining, with spend per capita going down. In comparison the EU average spend is 11% of GDP – that may not sound like a big difference but it would be enough billions to get out of our current catastrophic state.

In 2014 the European comparison looked like this

Beds	UK 2.7 per 1000	vs EU average 4.5
Doctors	UK 2.8	EU average 3.8
Nurses	UK 8.2	EU average 9.4
Health Spend per capita	UK \$3971	EU average \$4166 (Germany \$5119)

**The NHS is underfunded - about the only voice that disagrees with this statement comes from Jeremy Hunt, and not even his own party believe him now.**

**The only question remaining for some is how much of this is reckless incompetence and how much a deliberate strategy** to break the NHS so that it can be replaced with a system which will please his friends and colleagues who profit from private healthcare corporations.

Interestingly there are some voices within health campaigns who believe it is only lack of funding that is saving the health service from wholesale

privatisation now. Currently it runs on a shoestring and goodwill, and private investors don't see where the profit can be made.

### **What can be done?**

It is not clear that the ACOs are necessarily a done deal - there is a complete lack of legal basis for the authority of the STPs which are setting them up and a legal challenge is going through the courts now (orchestrated by Allyson Pollock and supported by Steven Hawking amongst others).

Sarah Wollaston, Conservative chair of the health select committee has managed to persuade Jeremy Hunt to 'pause' the rollout of ACO contracts while her committee considers the concerns raised by campaigners. However if you consider the similar pause in the passage of the HSCA, we should not be overoptimistic about this having any effect on the outcome.

**City and Hackney CCG** in London is refusing to cooperate with its local STPs demands that it merge with other CCGs under a single accountable officer and telling the STP board that it has no powers – which is a possible route for other CCGs.

**In Liverpool**, health activists have prevailed on their Mayor to put forward a motion stating that labour-run Liverpool city council will have nothing to do with STPs ACOs or ACSs

**More noise is needed from local people and local politicians to stop the NHS from being stolen from under our noses.**

People will say that the NHS is unaffordable – but repeatedly studies have shown that any other way of organising health care is more expensive.

In terms of funding, the choice is fairly simple – either we continue to fund health through general taxation, providing the most efficient and equitable system in the world or we abandon the founding principles of the NHS and all end up paying more, for less and watching the most vulnerable in our society suffer while profiteers hide their winnings in off shore tax havens.