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Book Reviews

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The Plot Against the NHS by Colin Leys and Stewart Player

Merlin Press Ltd. 2011
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Reviewed by
Nadine Edwards

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Dr Jacky Davis's forward puts the central thesis of this book thus: 'how politicians and private interests have worked patiently together behind closed doors to try to transform the NHS from an integrated public service into a mere "kitemark" attached to a system of competing private providers. The NHS one of the most cost effective and equitable health services in the world now stands on the brink of extinction, and many will be waking up and wondering how we arrived at this point without an outcry from the public and the media.'

This powerful warning was published in 2011 and still many seem unaware that the intention for a long time has been the full privatisation of health health as a commodity for those who can afford it, rather than a social good for all. This book is part of a very long story of plans to privatise health which was made plain in Margaret Thatcher's 1979 election manifesto (www.margaretthatcher.org/document/110858). It contributes to a body of literature which charts a much bigger story about the commercialisation of most of our public services. Health was somewhat lower down the list of Government priorities, as it was unlikely to find widespread support but has nonetheless been worked on, often behind closed doors since the 1980s. Allyson Pollock's important book, NHS plc published in 2006, spelled out much of what had been happening and where this would lead. The Plot Against the NHS takes up the story prior to the Health and Social Care Bill being passed in 2012.

The secrecy, deception, spin and departure from any form of democratic engagement and dialogue ensured that the background to and implications of the Health and Social Care Bill were obscure, while many who knew better hoped that it would simply not be passed. We have been hoodwinked again and

again by 'reforms' disguised by rhetoric about patient-centred, patient choice, but which have relentlessly moved towards the privatisation of health care Ã l'Americaine. The authors provide evidence of a Government steeped in commercial interests (conflicts of interest par excellence). The book describes an ever busier, but largely invisible revolving door between Government, private health care and the private health insurance industry amongst other associated businesses, where MPs and civil servants stand to earn vast sums of money at the expense of our health. The book lays out just how Andrew Lansley and others have continued the plan to turn 'healthcare back into a commodity and a source of profit' (p5), against the reported wishes of the public. That the NHS needed reforming is not disputed. What is at issue here is what 'reform' means and how this could best be done in the public's interest.

Some politicians mistakenly believed that introducing limited private care could be done and that it would improve the NHS overall. But market models, when evaluated, have been shown not to work: the lessons learned by this were 'don't evaluate', or better still, abandon data collection and make more and more data commercially sensitive, so that any evaluation is impossible. For example, it has not been possible to discover what the runaway costs of a huge IT project, Connecting for Health, actually were, nor the vast and ongoing costs of PFI contracts, and there has been a deliberate failure 'to collect data that would allow the results of operations done on NHS patients by private treatment centres to be compared with NHS outcome data' (p111).

In any case, the plan was never to stop at part privatisation and introducing a market model paved the way for full privatisation which has been relentlessly pursued, despite evidence: 'that privatisation makes health care more costly and worse. The evidence from the US confirms what economic theory says, that markets will not produce good health care for all, as the NHS is pledged to do' (p9). In fact, a survey for the US Commonwealth Fund found that out of 11 industrialised countries the NHS was almost the least costly, most accessible and fairest of all healthcare systems, while the US model, dominated by HMOs (Health Maintenance Organisation) see box opposite is the most expensive and unequal.

The authors describe in detail the process by which the NHS continued to be made ready for privatisation. For example, Alan Milburn set in motion the move from Trusts to Foundation Trusts (competitive businesses) which were given 'managerial independence' (ready for private companies to take over). The 'private sector-like freedom' of these new businesses meant that they could 'go bust', thus *'every policy decision must be judged first and foremost on its impact on financial viability, rather than on whether, for example, it would meet the needs of this or that category of patient'*(p23). 'Payment by results' was introduced, making possible price competition (initially ruled out, but ruled in, in 2010). Having driven privatisation forward, Alan Milburn left the Government to become*'a paid advisor to a clutch of private companies interested in cashing in on the marketization of the NHS'*(p25). Doctors were also prepared for privatisation: hospital doctors were enabled to carry out more private practice and encouraged to consider forming their own companies or working for other private companies. GPs were offered a pay rise and the option to stop providing out of hours care which 90% did. This created an opening for private companies such as Serco and Take Care Now mostly with poor results (www.theguardian.com/society/2013/jul/11/serco-gp-outof- hours-substandard

, www.theguardian.com/business/2013/dec/13/serco-losecontract- gp-services-nhs-outsourcing).

Importantly, while no insurance is needed within a nationalised health service free at the point of access, as there is nothing to insure against, private care and 'top up' care make insurance vital (for those who can afford it) to be able to access anything more than a very basic, under resourced public services. But it is also restrictive, as it dictates what can be treated and how. Profits must be made for shareholders and thus providing healthcare for the good of people is of secondary concern. The authors ask: 'How will the conflict between choice and rationing be resolved?' (p122) under these new conditions?

The authors examine the various documents produced, from the NHS Plan of 2000 onwards and suggest that: *'It took a close reading and an awareness of the increasingly close relationship between the Department of Health and the private health industry to see that each of these documents concealed a new entry point for privatization' (p107). For example, Creating a patient-led NHS in 2005 said that Primary Care Trusts must offer choice of provider, including an independent one, and that organisations would have to learn to live with risk and that failed services would be allowed to 'exit'. 'This was a veiled description of how a health care market works',* but as the document was aimed at NHS managers it was easy to avoid public and media attention.

As bids were invited, for GP services for example, it became apparent that large healthcare businesses had experience of preparing these as well as deep pockets (preparing bids can cost upward of Â£40,000) and that popular, existing local providers, who have served their communities well and have better outcomes, have little chance of competing. For example, In Camden, London, United Health won three contracts against local GPs *'who scored higher on all the criteria listed in the invitation to tender, except cost'* (p110).

The focus on profit necessarily drives down quality and safety and health care will be no exception - we need only look at the railway services, and in the health services - cleaning, nursing and care homes, GP practices, health centres etc: *'business models of healthcare provision, depending on maximizing revenue and minimizing staff costs, is sufficient in itself to destroy quality'*(p126). Indeed the 'key mandate' of the new regulatory body, Monitor, *'includes promoting competition in healthcare, drawing upon precedents from the utilities, rail and telecoms industries'* (p120). Other downward pressures on quality include *'the high cost of operating a competitive market compared to a system based on collaboration and planning'*(p127), including dividends to shareholders, high salaries commanded by senior management, and insurance against overspending. Fraud is another significant and costly problem with a long history among some of the US healthcare businesses hovering to take on business in England. For example, the same UnitedHealth as mentioned above paid $2.9 million to settle accusations that it had charged the US Government for care to patients it falsely claimed were in nursing homes and has been involved in numbers of other scandals (p131). McKesson had to repay *'insurers and patients $350 million which it had overcharged them by manipulating the wholesale price of drugs (including drugs for cancer and other major illnesses)'*(p130-131). The authors point out that malpractice not only adds to the cost of health care, and thus lowers quality by reducing resources but also changes the culture of health care and licenses the kind of unethical behaviour displayed by Kaiser Permanente, an American HMO *'when it settled criminal charges for discharging a 63-year old patient and then dumping her on the street in a hospital gown and socks in a run-down area of Los Angeles'*

(p131). Officials were said to be investigating a further 50 charges. The authorscomment that while we might want to think it could not happen here, we have no factual basis to think otherwise*'If we accept the conversion of the NHS into a market we should expect fraud and unethical behaviour to become as usual here as it is in the US. It could actually be worse, because England lacks a political and legal culture which could offer any serious check to it. Presumably health care providers are well aware of this.'*(p132).

Once healthcare providers can dictate what and how much healthcare is on offer (which they already do in parts of England), they can restrict it for example, in the US,*'one doctor testified before the US Congress, HMSOs pay doctors doing this work a bonus related to the proportion of treatments denied.'*(p135) Not only this, but GPs themselves are being encouraged to become 'doctorpreneurs' through training by consultancies such as 'Diagnosis', which has several McKinsey-connected staff (www.theguardian.com/society/2011/nov/05/nhs-reformsmckinsey- conflict-interest), and a quarter of GPs already had interests in health care companies at the time this book was being written. Under corporate interests, what chance is there that you will not be over or under treated (depending on your financial status), and that you will be referred for the best care for you, and that your doctor will be able to provide it?

The authors describe a three tier system for the future - a very basic service, a service requiring top ups from individuals at the point of care, and private services for the wealthy.*'In the long run it will give us something close to the most expensive and worst health system in the developed world, that of the USA ... For the private sector it will be the bonanza that its spokesmen have openly campaigned for.'*(p143).

The authors suggested that it will be up to us (the public) to fight for the NHS, but the public remains confused and divided. What needs to be understood is that:*'The choice is not between change or no change. It is between handing over a public service to be developed by private enterprise in the interests of shareholders, and ensuring that it develops in the interests of the public...'*(p149). The authors also claim that there is no evidence that a properly resourced NHS cannot change and finally, that*'good health care for all means excluding profit-making.'* (p154).

NHS SOS - How the NHS was betrayed - and how we can save it by Jacky Davis and Raymond Tallis

Oneworld Publications 2013
ISBN: 978-1780743288
£8.99



Reviewed by
Virginia Hatton

Find this book on Amazon

The final stage of the transition to privatise the NHS began on 27 March 2012 when the Health and

Social Care Act passed into law. The book NHS SOS documents the evolution of the Health and Social Care Act 2012 and the process of privatisation of the NHS which began in the 1980s and culminated in the legislative and administrative means to destroy the right to universal tax funded healthcare in England. Its chapters include essays on the failure of the British Medical Association to successfully challenge the bill, politicians' close relationships with medical corporations and consultancy firms, the failure of the media to draw attention to the devastating effects of the bill, and sociological and political analysis of the wider context in which the bill was created and succeeded in becoming law. The two chapters I found most readable and informative are Allyson Pollock's 'From Cradle to Grave' which documents the creation and death of the NHS; and 'A Failure of Politics' by Charles West which provides a retired GPs story of campaigning against the bill from the inside of the Liberal Democrat party.

Why is this bill so important? First of all, it means that universal access and equality in healthcare are no longer required by law in England (p183). The Health and Social Care Act 2012 is pivotal in the privatisation of the NHS because it only requires the Secretary of State to promote a comprehensive health service. The Secretary of State now has no legal responsibility to *'provide or secure provision of services' or to 'ensure that the health service should be free of charge except as expressly provided by legislation',* as was stated in previous Acts (p146). These requirements were intentionally left out of the 2012 Act in order to change the NHS from a provider of services into a commissioner of health care from independent providers (including the private sector)(p133). Of particular interest to AIMS members should be that the Act also abolished the rule that required services and facilities for pregnant women, women who breastfeed, and services for children to be mandatory and provided free of charge. (p194).

The Health and Social Care Act 2012 was motivated primarily by commercial and corporate interests and did not have the support of health workers, royal colleges, or a party voted in by the majority or the public. How did this bill which bypassed legitimate government, was steeped in government corruption and collusion with private US healthcare companies and was drafted by politicians with huge conflicts of interest in private consultancy firms become reality? On 24 January 2012, twenty royal colleges (including the Royal College of Midwives) met with the BMA and RCN to draft a statement which declared, *'The Academy and medical royal colleges are not able to support the bill as it currently stands.'*(p105) However, when a draft of the joint statement was leaked, ministers warned colleges that *'they might lose their cherished charitable status if opposition became official.'* The result was that the colleges made no further public statement of opposition to the bill. Similar to the corruption seen in the government, colleges and professional organisations such as the British Medical Association were let down by their leadership who also had vested interests in the bill.

Disadvantages of private healthcare - increased patient choice? Or choice of patient?

'In the US, where the private sector delivers health care to the general population, the poor and those made poor by chronic illness, especially in old age, have been left to the government to care for, via the Medicaid programme - because they are not profitable patients. For this reason, the private sector could never be the solution to our country's health needs.' (p36)

In addition to explaining how the Health and Social Care Act 2012 came into being, NHS SOS also illustrates why private healthcare is not the answer to existing problems in the NHS. The NHS was founded on the principle that 'the poor, the chronically sick and the frail elderly would receive the best available care only if the rich received the same service' (p175). The Health and Social Care Act 2012 is in direct opposition to this principle since it 'repeals the law ensuring everyone, rich or poor, wherever they live, receives the same health care' (p175). *'Markets and universal provision of care conflict because the private providers can choose the services they wish to provide and the patients for whom they provide them. A free market for health care does not result in "increased patient choice", but in "increased choice of patient".'* (p194) 'When political parties have promoted "patient choice" they have really been promoting "competition", in order to promote market over government control.' (p183).

Economic theory says that the markets will keep things in check, but this is not reality, as illustrated in the American insurance industry which comes at a higher cost and creates more inequalities than a tax funded system. The comparison with the US health care system is particularly relevant because it is American health companies and consultancy firms which shaped the 2012 Health and Social Care Act to be favourable for these US companies. The bottom line is that private health care is more expensive to consumers and that the level and quality of care is driven by profits, not on individuals' needs. Instead, we need a system which is legally accountable and driven by administrative controls rather than market forces and competition. (p179).

Already the Clinical Commissioning Groups (CCGs) who commission health care have been shown to be unaccountable either to Monitor, NHS England, or the Secretary of State. CCGs were intended as a way to increase GP involvement in decision making for local services. However this is not the reality either as soon CCGs will be required to be put to tender and therefore there is no guarantee that local people will be involved in decision making (p25). Individual members of CCGs not only have conflicts of interests and connections to private health care companies, they have the authority to decide what services patients can be charged for and to drop patients. Clinical Commissioning Groups are also not obligated to commission care based on geographic areas. Now legally, local authorities alone have a duty to provide for geographic populations and they also have the authority to charge for care. (p190,194)

When the market dictated incentive is on increased profits rather than patient needs, care providers start to 'cherry pick' healthy, profitable patients in order to minimise their financial risks. In 2011 Charles Alessi, a GP in south London, removed 48 elderly and disabled patients from his practice list 'primarily for financial reasons'. (p130) In addition, where US health companies are currently involved in private GP practices in the UK, GPs have to refer to a higher authority for referrals, and this higher authority has the power to reject the GP's referrals based on costs of care to the company. (p192) That private health care

results in 'cherry picking' healthy patients is further illustrated in that *'nowhere in the world does the private sector voluntarily undertake services... which are not profit making such as emergency care, care for the chronic sick, health care for the elderly, unless they are generously rewarded for accepting those risks as part of a lucrative contract.'* (p35-36).

Other disadvantages to private health care include *'conflicts of interest, fragmentation of care, the challenge of collaboration between competing providers, the destabilising of established services by competition from new providers, and the need for teaching, training and education.'* (p133) All of these issues are already familiar to those who campaign to improve NHS maternity services and privatisation of services will exacerbate these problems. In addition, the private sector has *'no obligation to supply or even collect information about their patient numbers or outcomes.'* (p138) Private providers or companies are not covered by the Freedom of Information Act and can block Freedom of Information Requests because of 'commercial sensitivity' of data (p143). This means information will become more difficult to obtain, including financial dealings and patient outcomes. It is already unclear where money is directed within the health care system and who is accountable to ensure government initiatives (such as increasing the number of midwives), and this will only get worse.

The next step - What you can do to change it

The Health and Social Care Act 2012 is currently law, but it can be over turned. Here is a list of ways you can take a stand to ensure that future generations in England have access to a universally accessible, tax funded health service.

Inform yourself about the changes to the NHS

Keep Our NHS Public - information about the campaign against privatisation: www.keepournhspublic.com.

NHS Support Federation - tracking changes in local services and finding out if tendering processes are transparent, reporting cuts and closures: www.nhscampaign.org

38 Degrees - a site which connects those campaigning for change: http://www.38degrees.org.uk.

Local Level

Write to MPs - a sample letter is available here: www.keepournhspublic.com/wycd-MPhelp.html.

Join your local Healthwatch and CCG consultation networks.

Draw the attention of Health Scrutiny and Oversight committees and Local Authority Health Overviews to cut backs and privatisation.

National Level

Spread the word - The Health and Social Care Act 2012 can be repealed without expensive or disruptive

reorganisation.

Vote in the next election.

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