NHS REFORMS

Further privatisation is inevitable

Repeated government denials about NHS privatisation don't stand up to scrutiny. In response to widespread criticism of the proposed reforms of the NHS in England, the health secretary, Andrew Lansley, the prime minister, David Cameron, the deputy prime minister, Nick Clegg, and the chancellor of the exchequer, George Osborne, have repeatedly claimed that there will be no privatisation of the NHS in England. The Department of Health website even states that "Health Minsters have said they will never privatise the NHS" (http://bit.ly/mtd8iF). However, these claims and promises fail to acknowledge the evidence that privatisation is an inevitable consequence of many of the policies contained in the Health and Social Care Bill.

The meaning of privatisation is complex, covering a range of ideas in law, politics, economics, and philosophy. However, the World Health Organization has defined privatisation in healthcare as "a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services" (J Muschell, *Technical Briefing Note on Privatization in Health*, 1995, WHO/TFHE/TBN/95.1).

So the government's attempt to deny privatisation of the NHS by claiming that NHS services will remain publicly funded and free at the point of delivery does not escape the WHO definition if services are delivered by non-governmental actors, such as private and third sector (voluntary and community) organisations. This is clearly a stated objective of the reforms.

Some authors have tried to create a coherent taxonomy of the act of privatisation. S Commander and T Killick's classification of privatisation in five main types is widely quoted and listed below ("Privatisation in developing countries: a survey of the issues," in P Cook and C Kirkpatrick, eds, *Privatisation in Less Developed Countries*, 1988, Wheatsheaf Books). A more detailed typology of privatisation described by E S Savas concurs with all of these mechanisms ("A taxonomy of privatization strategies," *Policy Studies Journal*, 1989;18:343-55).

(a) Divestiture or outright sale of public sector assets in which the state divests itself of public assets to private owners

(b) Franchising or contracting out to private, for profit, or not for profit providers

(c) Self management, wherein providers are given autonomy to generate and spend resources

(d) Market liberalisation or deregulation to actively promote growth of the private health sector through various incentive mechanisms, and

(e) Withdrawal from state provision, wherein the private sector grows rapidly as a result of the failure on the part of the government to meet the healthcare demands of the people.

The proposals in the Health and Social Care Bill fulfil all these criteria for privatisation in the following ways.

(a) The proposed legislation for all foundation trusts to become social enterprises is a form of "divestment by donation to employees," which represents a mutualisation process. This policy places hospitals outside state control and out of the public sector. Kingsley Manning, business director of Tribal Consulting, which provides commissioning support to the NHS, has stated that this policy would result in "denationalisation through mutualisation," which "could see the transfer of billions of taxpayers' assets to employee controlled businesses" (*Liberating the NHS: The Next Turn in the Corkscrew*, Tribal Consulting, 2010).

(b) A key part of the bill involves the use of "any willing provider," which will ensure contracting out to private and third sector providers. In addition there will also be contracting out of the management of commissioning to the private sector through the framework for external support for commissioning. This was initially introduced by New Labour and prompted the former health secretary Frank Dobson to state, "If this is not privatisation of the NHS, I don't know what is. It is about putting multinational companies in the driving seat of the NHS."

(c) Self management is consistent with the foundation trust model, which gives trusts greater autonomy in generating and spending resources. The abolition of the cap on the amount that trusts can earn from private income will stimulate a drive to increase income by treating more private patients. Foundation trusts will also be allowed to borrow money from the financial markets to invest.

(d) The bill is clearly a blueprint for creating an open market in healthcare. Monitor, as the new economic regulator of the NHS, has been tasked with actively promoting market competition by encouraging a plurality of providers from the private and third sectors. Mr Lansley has stated that "maximising competition is the first guiding principle" for his reforms, and he initially tried to introduce "price competition," in a move to replace the current quasi-market of fixed pricing, but has since been forced to backtrack on this (www.andrewlansley.co.uk/newsevent.php?newseventid=21). Moreover, if the NHS is opened up to European Union competition law, as suggested in a recent analysis published in the *BMJ* (2011;342:d2071), the government could be rendered powerless to prevent services going out to tender in the European healthcare market.

(e) Section 9 of the bill removes the duty of the health secretary to provide comprehensive healthcare and is a classic example of removing state provision. In addition, section 10 of the bill states that a consortium doesn't have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate." This withdrawal of state provision for many services will be accelerated by the quality, innovation, productivity, and prevention (QIPP) initiative of £20bn (€23bn; $32bn) worth of efficiency savings (advocated by the private management consultants McKinseys under the previous Labour government). Waiting lists and waiting times are rising, which is associated with increased uptake of private healthcare insurance and the use of private providers.

The Health and Social Care Bill will therefore result in increasing privatisation of the English NHS according to all five of these criteria. In fact, this is in keeping with the "supply side" economic policies of this government, which promote privatisation throughout the entire public sector, as the prime minister promised in February this year ahead of the delayed white paper on reform of the public sector (*Daily Telegraph*, 20 Feb, "David Cameron promises public sector revolution," www.telegraph.co.uk).

The coalition government's denials of NHS privatisation do not stand up to scrutiny. The public is being misinformed and misled about the objectives and consequences of the Health and Social Care Bill.

Clive Peedell argues that the government's health reforms fulfil commonly accepted criteria for privatisation

"The public is being misinformed and misled about the objectives and consequences of the Health and Social Care Bill"

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NHS REFORMS

How to lose friends and alienate people

Although the current English NHS reforms have been developing over two decades, their direction has been remarkably consistent. Three basic elements have emerged: the separation of provision from procurement (to try to reduce the acute sector's supply-side pressures on demand); the introduction of some contestability to further reduce complacency among providers; and the devolution of decision making more closely to the patient interface to increase clinicians' personal involvement in these decisions.

The mechanisms have changed and evolved, but the underlying principles have weathered changes in government, health secretaries, and financial circumstances. Indeed, similar principles have underpinned health service reform internationally. So it may seem surprising that the current reforms are causing enough unrest to threaten complete paralysis or even reverse the established direction of travel. Why has this happened, and does it matter?

The two key issues of contention regarding the substance of the changes are:

- How much competition can the NHS encompass without risking destabilisation?
- What kind of accountability is appropriate when procurement is led by clinicians who are themselves providers (especially when viewed by other, less involved clinicians)?

There is no definitive answer to the first question, but common sense suggests that it would be foolish to endanger any service whose consequent failure would threaten the viability of the whole organisation. Few developed countries would privatise their entire education system, but most include significant aspects of competition and market forces. The trick is to outsource services only where there are enough alternatives to allow seamless replacement should failure occur (say in catering or payroll) or where the risk of failure doesn't raise the possibility of political blackmail (as happened when banks were "too big to fail").

In the NHS such conditions already exist, and many "marginal" services are now contracted from the private sector. Such conditions also pertain in many clinical areas; as long as the expertise and technology are not so unusual or expensive that they cannot be replaced, there are no operational reasons why an effective commissioner should not keep providers and potential providers on their toes without risking the failure of any service. Individual trusts should be able themselves to select areas to subcontract externally; physiotherapy, orthopaedic surgery, and cardiac rehabilitation (among many others) could all be put out to tender while maintaining the "golden rule" of ensured continuity and viability.

As long as trust boards understand that they remain accountable for clinical and financial outcomes, how these operational transactions are managed should concern external commissioners only in terms of their legality and safety.

And if that holds true for the acute sector, shouldn't it apply to primary care too? Ultimately, the putative GP consortiums are no more than providers under contract to some form of NHS commissioning board (whatever the eventual arrangements) responsible for the healthcare of their registered populations. In that role, they should be free to choose which services they provide themselves (where expertise, technology, and quality markers allow) and which are commissioned (for which read "subcontracted") from other agencies, likely to include NHS trusts, non-NHS providers, and internally provided alternatives too. As long as consortiums remain accountable for acceptable outcomes, effective finances, and positive patient feedback, and the "golden rules" of procurement risk are applied, does it matter whether money is withheld from traditional hospital providers?

Without the freedom to enact this role, consortiums will lose clinicians' involvement completely. Expectations have been raised and dashed so often that there is much cynicism among GPs (remember the problems with implementing practice based commissioning?), and so promises made will have to be kept or else further initiatives of this kind precluded for a generation.

Introduced as radical and perceived as revolutionary in a way that belied its uncontentious principles, the 2010 white paper *Equity and Excellence: Liberating the NHS* has certainly created resistance (but then so have previous attempts at NHS reform). The recently introduced "pause" will not increase anyone's sense of ownership but may dilute its principles so far that the well established and generally agreed direction of travel could be lost completely.

One lesson here is that both politics and Politics should formally be taken into account at the start of any change process and a campaign planned to minimise resistance, not the opposite. Imperfect though it was, there may be lessons here from the Darzi consultation process.

Another lesson is the link between professional ownership and responsibility. Individual autonomy has long been part of medical training and is seen as important for successful doctor-patient relationships; the problem it raises is how also to inculcate wider, NHS responsibility among doctors without asking them to surrender their individual independence.

We all spend "our" money more carefully than we might use someone else's cash, and the challenge in health reforms is to find ways of allowing clinicians feel that it is "their" resources that they are spending, not "just" Treasury funds. All the moves towards clinical engagement in management over the past two decades have tried to achieve this, whether through GP fundholding, primary care groups and primary care trusts, or the new GP commissioning consortiums.

Despite the financial climate getting steadily colder, the current reforms emphasise financial "ownership" being given to GPs, but this is often perceived by GPs as government trying to pass rationing over to them. Power and responsibility need to be seen to be aligned, along with the ability to benefit in some way (which needn't be financial) from accepting them.

The final lesson about the process of change concerns the general perception of public services and the NHS in particular. British society still has a surprisingly strong sense of egalitarianism. The term "private sector" is inextricably linked in the public mind to ideas of elitism and advantage, thereby invoking the private sector as the putative saviour of public services needs to be handled with sensitivity, especially by a largely Conservative government. It is no accident that most NHS "marketisation" has happened when Labour was in power: they could take for granted support for such action among Tory voters and so only had to persuade their own (relatively) friendly followers to support their approach.

The current government is attempting to persuade the country to welcome a notion that more than half the population believes will undermine all its values in terms of public sector, equity, profits, and elitism. To achieve this requires inspired and informed political, managerial, and clinical leadership with a human touch, all of which currently seem to be in short supply.

Why are the NHS reforms causing so much unrest as to threaten complete paralysis?

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MEDICINE AND THE MEDIA

What GPs know about asthma

Recent headlines about general practitioners' poor knowledge of asthma reflect flawed surveys, writes **Margaret McCartney**

Are general practitioners no good at treating asthma? "GPs' poor asthma training 'risks lives,'" said the *Independent* recently, sternly warning that "Asthma UK says a survey found that 47% of GPs admit that their own knowledge about the condition could be better . . . it estimates at least 45 million could be saved if GPs were better informed and care was better managed" (3 May 2011, www.independent.co.uk).

The free *Metro* newspaper went with "Asthma deaths 'could be cut with GP training,'" saying that doctors' "education on the chronic condition is not a priority despite more than half of GPs agreeing that the number of deaths could be reduced with better care. Just under two thirds said that they felt that public awareness of asthma could be improved, while 47% admitted their own knowledge was lacking. This reflects a Primary Care Respiratory Society survey in which more than half of the GPs questioned gave incorrect answers on clinical guidelines for asthma" (2 May 2011, www.metro.co.uk).

JIM VARNEY/SPL

Asthma UK's criticisms of doctors are baseless

Neil Churchill, chief executive of Asthma UK, said on BBC Radio 5 Live, "Unfortunately, the majority of GPs got questions wrong, in fact over half of GPs answered incorrectly in eight out of 10 questions they were asked about asthma clinical guidelines. So it's probably not surprising therefore that the majority of GPs—nearly two thirds—said that education for healthcare professions could be improved."

The interviewer, taken aback, asked, "Asthma's not an uncommon condition, so it seems surprising to suggest that there is this lack of knowledge?" "We think that standards in asthma have probably slipped in recent years," Mr Churchill replied, saying that asthma admissions and deaths were now static. "We can't afford to have someone end up admitted to hospital every seven minutes with an asthma attack, for what is pretty much a treatable condition with modern medicine" (www.bbc.co.uk/news/health-13270027).

These are serious allegations about doctors' knowledge, so what's Asthma UK's evidence? The press release that the charity released (on "world asthma day") cited two surveys (www.asthma.org.uk/news_media/media_releases/gps_agree_that_asthm.html). The first had results from 1001 general practitioners, was funded by Asthma UK, and completed by GfK Healthcare, a market research company. This questionnaire asked general practitioners their views about their knowledge and training concerning asthma. The second survey was performed by the Primary Care Respiratory Society. It involved asking people who were visiting their website looking for asthma guidelines to defer reading the guidelines and answer a set of multiple choice questions. People were asked for their job title and told, "We'd like you to take the short survey on this page before you look at the guide" (www.pcrs-uk.org/asthmaguide).

It would therefore seem that this was a select group of people who had wanted to look at the guide and who might therefore have had questions they wanted to ask. The participants were not told that their results would be formally reported or indeed that campaigning groups would use their results as evidence of their knowledge (or lack thereof).

Writing up their findings as a "short report" in the *Primary Care Respiratory Journal*, the authors noted that out of 3560 hits on this part of the website, 413 went on to fill in the questionnaire (2010;19:180-4). Of these, 96 described themselves as general practitioners. Despite being in the minority of respondents, general practitioners were the only group mentioned by Mr Churchill on both the BBC and, the same day, by him on a *Guardian* web debate. Here he repeated that the study by the Primary Care Respiratory Society showed that "half of GPs answered incorrectly in eight out of ten questions about clinical guidelines for asthma" (www.guardian.co.uk/society/blog/2011/may/03/nhs-reforms-live-blog?commentpage=all#start-of-comments).

Not only was the use of the results withheld from participants, but when the results were publicised, it was not equally clear that the website was sponsored by an "educational grant" from the drug company GlaxoSmithKline. Hilary Pinnock, lead author, described the published report to me as a "quick and dirty" paper of which the authors were aware of many flaws that are listed in the paper.

Indeed, it was not clear which respondents even completed all of the questions; some people may have only filled in one or two and scored zero on the remainder. The questions themselves were so guideline based as to be confusing—for example, the first question asked, "In which group of children should clinicians take the following approach? Watchful waiting with review: (a) Those with a high probability of asthma; (b) Those with a low probability of asthma; (c) Those with an intermediate probability of asthma." The correct answer was (b) because the guidelines class children already with symptoms that could suggest asthma into these three probability groups. But it was not clear from this question that it was about children with symptoms. And each of the four authors declared sponsorship, honorariums, travel, or consultancy fees from a total of 16 drug companies.

Asthma UK declined to say how much it spent on its survey, and it was only on questioning for this article that GfK Healthcare said that 9200 general practitioners were initially contacted, giving a response rate of only 10.9%. Mr Churchill has told national radio that general practitioners don't know enough about asthma. Doctors have a professional obligation to keep well informed and up to date. Is it fair that they also have mistrust in them engendered by surveys that do not have the strength to justify them? If healthcare charities want to be taken seriously they should not be in the business of using weak research to satisfy their aims.

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