

60 years on from the National Health Service Bill

The 21st March 2006 is the 60th anniversary of the post-war labour government's white paper National Health Service Bill (Cmd 6761).

Its most radical features were the transfer of funding to general taxation and that there should be no fees or charges to patients; the proposed nationalisation of all hospitals; and the proposal to locate all family practitioners and community health services in health centres.

For the next fifty years the citizens of the UK enjoyed entitlements to health care as a right, and the NHS has endured despite the last thirty years of continuous sniping and assaults. It is true that not all that was proposed in the legislation that established it materialised – for example the plans for salaried GPs and for integrating GP and community services were never properly implemented – but the mechanisms for integration and fairness in resource allocation were crucial in protecting the NHS's founding principles. But critical weaknesses in the original structure remained – above all lack of capital investment, the retention of private practice, the independent practitioner status of GPs and dentists, the separation of responsibility for health and social care between central and local government, and weak public accountability. In the end these weaknesses would provide fertile soil for market predators, assisted over the last two decades by both Conservative and Labour government policy.

Since 2000, with the launch of the NHS Plan and the 'Concordat' with the private sector, government legislation has been intent upon tearing down the very structures and mechanisms which protected the NHS from market predators and on opening up clinical services to large for-profit corporations. Following the management reforms and outsourcing of non-clinical services to the private sector by the Thatcher and Major governments, came the 'internal market', breaking up the NHS into hundreds of competing operating companies (culminating in the creation of the almost fully autonomous foundation trusts) and the transfer of political accountability from the secretary of state to a regulator, known as Monitor. The PFI, loading individual NHS hospitals with the costs of private sector borrowing, was followed by the uncoupling of resource allocation from a basis in the needs of local communities and a switch to 'payment by results', involving the costing and payment for every individual patient treatment. The idea was that a market is more efficient, and a market in clinical services needs price signals.

Then there began the privatisation of the easy bits of clinical services, elective surgery, diagnostics and pathology, and the giving of new powers to foundation trusts to enter into joint ventures with companies like the US-based UnitedHealth, the Swedish-based Capio, the South African-based Netcare, and our own BUPA, for the provision of clinical services. And so across the country the results are unfolding. Moving services out of the NHS into private hospitals and 'Treatment Centres' destabilises the NHS hospitals' budgets creating financial difficulties, while those with PFI schemes are stuck with unaffordable leases that are even more unaffordable now that revenues they counted on are being diverted to private providers, while still more revenue may go elsewhere as a result of 'patient choice' – a kind of choice ('any hospital in the country') which surveys consistently show patients do not really want. So far from 'price signals' becoming a mechanism for allocating resources, central

government fiat are channelling funds to what are in effect private semi-monopolies, with ring-fenced tax revenues and 3-5 year guaranteed patient numbers at well above-NHS rates. Many of the contracts are not being fulfilled leaving the NHS paying twice for care. Instead of 'price signals' we have bureaucratic decisions leading directly to the closure of NHS services, and in many cases to the closure of whole hospitals on which local communities have been able to rely for three generations. Across the country we are seeing the closures of services for the mentally ill, the chronically sick, those in need of palliative care services and rehabilitation; patients are now going without care and suffering on a scale which has not been seen since before the inception and creation of the NHS in 1948 – all for the sake of the alleged gains to be had from 'market efficiency'. Across the country the public is protesting, but their voices go unheard and unanswered in Westminster.

What would a new White Paper for the NHS today look like? We do not need to reinvent the wheel. The weaknesses of the original NHS were serious, and they have been skilfully exploited in the drive to privatise it, but the basic design was good; it deserved to be improved, not surrendered to the ideologues of private enterprise. As in 1948, a new White Paper would set out the key principles: service on the basis of need and not ability to pay, for everyone wherever they live – i.e. a comprehensive and universal service. It would pay close attention to funding and delivery. As Derek Wanless, the banker and then advisor to the Treasury, found after exhaustive examination – and as other European countries are also finding now – central taxation is the most efficient and cheapest, as well as the fairest way to pay for health care; the idea of 'top-up' fees for 'superior' levels of service are transparent attempts to reintroduce unequal health care and should be anathema to us all. That pregnant women going into labour at the NHS Queen Charlotte's and Chelsea Hospital in London should pay a top-up fee of £4,000 for NHS care to guarantee the presence of a named midwife and a superior birthing package will simply accelerate the cycle of deprivation that babies born to poor mothers will experience.

As for the design of the delivery system, what is critical is the flow of resources through the system to ensure equity. Resource allocation must be on the basis of need and disbursed to geographic planning tiers with budgets for hospitals and community services which require integrated service planning; the lines that Scotland and Wales are working towards would be good start. Integrated budgets and service integration are key: without it providers can cherry-pick profitable patients, treatments and services, to the neglect of others. Equity also needs good data and monitoring systems, on the basis of geographic populations and integrated service planning.

Finally there needs to be strong public accountability, both at the population level and at the level of the individual patients. Valuable mechanisms that were in place have been eroded or even abolished (for example the Community Health Councils). There is room for important creative action here.

Market mechanisms must be abolished. These include purchaser-provider split, payment by results, and practice-based commissioning. US studies show that transaction costs of operating a market in health care provision are in the order of 20-30% of annual income. These costs are the costs of operating a market. In England, the savings that would accrue would include the appallingly large portion of the NHS budget – estimated at not less than 15 per cent, or some £12 billion a year – that is

currently spent simply on trying to operate the NHS as a market – on invoicing, accounting for and auditing the accounts of millions of individual patient treatments, on making and monitoring thousands of contracts, on management consultants and financial ‘rescue’ teams from the private sector at £2,000+ per consultant per day, on marketing and advertising, on lawyers and communications, etc, as hundreds of competing NHS trusts each try to survive in the new market-place.

If this does not happen the NHS in England is destined to become no more than a logo attached to a group of corporate chains, while all the old health inequalities and fears return.