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[WHO WILL RUN OUR HEALTH SERVICE? WHERE THE POWER LIES]

NHS Support Federation / UNITE

Who will run our health service? - where the power lies

Introduction

According to the government, the driving force in the new health service is the patient. The theory goes like this: the English NHS is becoming like a market, with different NHS and private organisations competing against each other for business. Patients can supposedly shop around for their care, in the same way that they can choose between Tesco and Sainsbury's for their food. This choice, it is argued, will mean GPs, hospitals and health workers will raise their game and become more responsive. The health service will be remoulded around patients' priorities.

In this vision, NHS staff are dismissed as 'producers' who are unwilling to change, while patients are the 'consumers' who are in the driving seat of NHS reform.

In reality, of course, all power is not with the patients. The key decisions are taken well above their heads – by ministers in Whitehall; by managers in Strategic Health Authority board meetings; by lawyers drafting contracts between the NHS and the private sector. A thousand decisions have been made, and millions of pounds spent, before the patient is presented with a limited choice of hospitals in which to have an operation.

The question then arises, who really runs our health service?

Choice

The governments of Tony Blair and Gordon Brown have said a lot about empowering the patient through 'choice'. And who could be against choice? Surely it's good for patients to be involved in making decisions on their healthcare, to shape their own 'personalised' service, as the politicians call it.

Supporters of choice make even grander claims for it. They think it will transform the health service. As Julian Le Grand, an architect of the policy and a former advisor to Tony Blair, has said: "If patients have choice between competing providers, they have power. For providers then have a powerful incentive to meet the needs and wants of their users; those that do so will succeed, and those that do not will fail."

Le Grand sees NHS staff as "knaves" who must be cajoled into improving their performance by the threat of their unit closing. It is assumed that patients and staff, consumers and producers, are somehow in conflict, and that the government should help patients to gain the upper hand in the struggle.

Another prominent proponent of NHS privatisation, Dr Karol Sikora, has even compared the NHS to a pizza restaurant, saying that if there were a queue for the salad bar at Pizza Hut then diners would simply move to Pizza Express instead.

So can healthcare really be compared to a pizza? The truth is they are very different. No one is against patients having a bigger say in their treatment, but choice is really a nice word used to describe the huge changes being made to the NHS to transform it into a market system. There are big problems with the pizza analogy:

1. Unlike with pizza restaurants, markets in healthcare don't work. This is for the simple reason that patients don't know as much as doctors and health workers about medicine. In Pizza Hut or Tesco, it is not necessary to have an expert advise you on what to buy. In the NHS we want guidance on what treatment we need, meaning we are not acting like simple consumers.

2. For the choice policy to work some hospitals or services must fail. As Julian Le Grand has said there must be "costs" for those that aren't chosen by patients. But do we really want our local hospital or GP surgery to shut down because a private healthcare corporation has driven it out of business? This would be unacceptable – we rely on these services.

3. The nature of medicine, with specialists and expensive equipment, means that monopolies in the NHS are useful. For example, A&E departments are very expensive to run. They need to be surrounded by a thriving hospital to be viable. If parts of the hospital close because of competition, then it may not be possible to keep the A&E open.

4. Strong financial motives encourage a preference for patients with conditions that are easy and cost effective to treat. Unprofitable and time-consuming treatments can be dropped, as is already happening in some Foundation Trust hospitals. But this leaves people desperate and in need. In contrast, a pizza restaurant can drop Margheritas and focus on the Cheese Feast, if it so chooses, because nobody truly *needs* Margheritas.

5. The NHS was designed as a cooperative system. Its defining feature is its ability to plan healthcare to meet the people's needs. Competition undermines this completely.

6. Whereas rivalry between pizza restaurants forces prices down, with healthcare it's the other way round. There are huge costs associated with running a market (i.e. lawyers, accountants, billing etc) that the collaborative NHS was designed to avoid. Indeed, the government has found it has to pay the private sector *more* than the NHS to get it involved. All those millions of pounds in profit have got to come from somewhere!

7. A huge majority of people would prefer good local services to choice. One survey by *Which* found that 89% favoured a good local hospital over a choice of places.

Limited choice

On top of all these considerations is the fact that the choice on offer to patients is limited. It is not as fundamental as the choice between supermarkets or restaurants. Instead, a patient is presented with a few options for their care once they are already deep into the system.

This kind of involvement is simply not powerful enough to live up to the claims made for it by its supporters. In fact the real choices have already been made well before the patient gets involved.

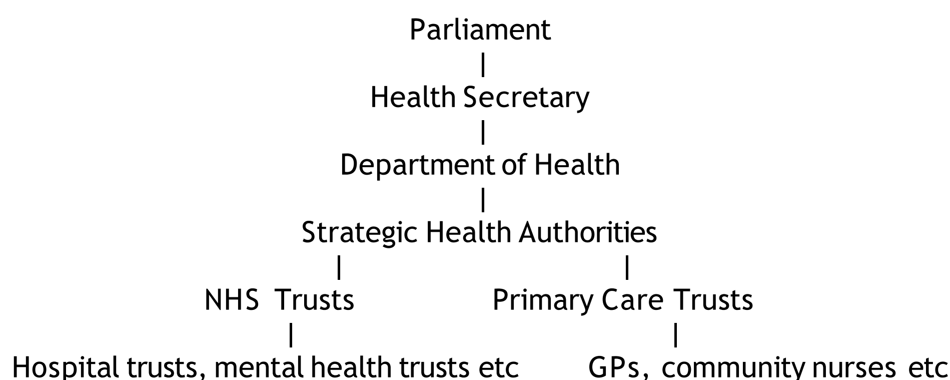
This can be seen by looking at the structure of the NHS and how it works, to find where the power really lies.

How does the NHS work?

Years of constant reform has seen the structure of the NHS change many times, meaning few of us now understand how it all works.

The NHS is a gigantic organisation with many layers of power – from the Department of Health down to local GPs.

A simplified diagram of the basic structure of the NHS



Parliament and the Department of Health

When Nye Bevan, the great Labour politician, founded the NHS in 1948, he was very keen that it should be democratically accountable to the people through Parliament. This means that the Health Secretary in the government has a great deal of power over the funding of the NHS and what the money is used for. He or she also gets the blame when things go wrong. This is where Bevan intended the power to lie – with a recognised figure who could set a clear direction for the health service, and who could be kicked out of the job if they messed it up.

The Health Secretary is in charge of the Department of Health. The Department, based in Whitehall, is ultimately responsible for running the NHS – it sets the priorities, allocates the money and oversees the management of the service.

Strategic Health Authorities

Below this, we start to get out into the country with Strategic Health Authorities, or SHAs (the NHS has a language all of its own). There are 10 SHAs covering different regions. In practice, they are management representatives of the Department of Health. They make sure that the policies of the government are implemented locally.

Recently, SHAs have played a key role in pushing through the government's market reforms, pressuring local NHS bodies to toe the line. They are led by specially appointed chief executives, who just happen to be keen supporters of government policy. An example is Mike Farrar, chief executive of North West SHA, an area that has been used as a test-bed for new private diagnostic schemes called CATS (see *The patchwork privatisation of our NHS – a users' guide*).

Beneath SHAs we have the front-line organisations providing our healthcare. Here, the NHS is broadly split into two spheres: primary care, which is the first point of contact for a patient (GPs for example), and secondary care, such as hospitals and services that require a referral.

Primary Care Trusts

Primary Care Trusts, or PCTs, are the most significant element of the local NHS. There are 152 PCTs in England and between them they are responsible for spending 80% of the NHS budget.

They 'buy' healthcare for their local population. This means that if you need an operation, your PCT effectively buys it from an NHS hospital. It didn't used to work like this before the Tories introduced the 'internal market' in the 1990s, and many people believe it is a very expensive and complicated way to run a health service.

Nevertheless, this role puts the media spotlight on PCTs. They are the classic 'NHS managers'. Your local PCT holds the budget for your healthcare. It decides what services and treatments are available and which are not. When funds are tight, it's the PCT that makes cuts and delays operations.

PCTs also provide care themselves, such as community health services and district nurses, although the government wants to stop them doing this – instead outsourcing these services to private companies or voluntary organisations (with little regard to the fate of the staff). GP cover is also the responsibility of PCTs, which either contract independent GPs, employ GPs directly (something which is becoming rarer), or sign deals with private companies for GP services (something which is becoming more common).

PCTs are not democratically accountable. Although they are responsible for the healthcare of their local population, there are no elections to PCT boards.

NHS Trusts

In secondary care, on the other side of the health service, there are NHS Trusts. This is where the majority of health workers are employed.

All hospitals are managed by a Hospital Trust. Trusts negotiate with PCTs over what services to offer depending on the funds available. There are also Mental Health Trusts, Ambulance Trusts and others. NHS Trusts provide care to the population, but much of their work is dependent on funding from PCTs. This means that a hospital, for example, has less power than people might think.

There are many more bodies and trusts not described above. One of the most noteworthy is the National Institute of Clinical Excellence, or NICE. This 'Arms Length Body' is responsible to the Health Secretary and decides which drugs and procedures the NHS should provide. For example, when a high profile cancer drug is not available on the NHS, it is usually because NICE has taken the view that it is too costly or unsafe.

New types of organisation

For all the recent changes, the structure of the health service outlined in the last section can be thought of as the traditional NHS. But lately the government has brought in new types of organisations and has gone out of its way to help the private sector do more NHS work (at a price, of course!). These innovations are part of the drive to make the NHS into a market system, where healthcare is bought and sold.

These new organisations respond to very strong financial motives. For example, private companies exist to make profits. The old notion of healthcare being a public service, a good thing in itself, has been eroded.

Foundation Trusts

Foundation Trusts were set up as a new way of managing hospitals and mental health services in 2004 after a controversial vote in Parliament. There are now over 70 of them, and the government wants every hospital to become a Foundation Trust in time.

Unlike normal NHS hospitals and mental health trusts, Foundation Trusts are not under the direct control of the Health Secretary. Instead, they are independent, and they are responsible for their own money.

The result: in 2007 Foundation Trusts were sitting on a one billion pound surplus. That's £1bn of taxpayers' money that has not gone into patient care.

Foundation Trusts have more power than a normal hospital over the services that are available to patients in their area. Their national regulator, Monitor, has advised Foundation Trusts to stop providing unprofitable treatments where possible and focus on the kind of work that will bring them the most money. This is a huge worry for the future of the NHS – it could easily lead to a situation where people can't get the operation they need at their local hospital because, as a Foundation Trust, it has decided not to offer that treatment.

Foundation Trusts have also started to set up separate profit-making ventures. They have been using various arrangements to get around the law, which stops them from carrying out too much private work. For example, the Moorfields Eye Hospital is running a franchise in Dubai, and University College London hospital has launched a joint venture with the Hospital Corporation of America, which has taken over a wing of the London hospital to treat private patients.

The government has talked of extending the Foundation Trust model still further in future, with local health services being turned into Community Foundation Trusts.

Private companies in secondary care

In addition to Foundation Trusts, the government is in the middle of the 'patchwork privatisation' of the NHS. It has bent over backwards to bring private companies into the heart of the health service, insisting despite all the evidence that they offer greater efficiency.

The most high profile example in secondary care is the Independent Sector Treatment Centre programme, or ISTCs. These are private sector clinics usually

specialising in straightforward treatments, like cataract operations. Patients choose or are sent to have their operations at the centres, which are paid for by the NHS.

In practice, patients have usually proved loyal to their local NHS hospitals, leaving ISTCs underused. But the private clinics have still received the full payment for the work they were *supposed* to do, meaning the NHS has been giving these companies millions of pounds for operations that never happened.

The government wants to use more private hospitals for NHS work, as long as they can do it at a set NHS price. This sounds like a good idea at first, but it ignores the fact that the NHS was designed to be a fully joined-up system based on cooperation. What the government reforms risk doing is helping private companies to establish their own spheres of influence, which will gradually increase as the NHS comes to rely on them.

Private companies in primary care

Perhaps an even bigger threat to the NHS is the involvement of the private sector in primary care, specifically GP surgeries. In 2006, huge multinational corporations started to take over GP services. This is the result of a new contract, negotiated by the government, which brought a dramatic shift towards a commercial business model in general practice. Already, the performance of some corporate GP surgeries has been poor. Companies have to make profits for their shareholders and that can lead to corners being cut, care being compromised and the doctor-patient relationship suffering.

The government's latest vision, set out in reports by health minister Lord Darzi, is for GPs to be grouped together in new 'polyclinics,' which will offer patients a range of treatments in one building. If the scheme goes ahead, the worry is that the government will favour private companies to build and run these polyclinics, as has been the case with Private Finance Initiative (PFI) hospitals. This method of building hospitals has proved astronomically expensive – taxpayers will have to fork out £53bn over 30 years for hospitals that only cost £8bn to build, and £23bn of that is profits and interest to the PFI companies and banks. We could end up with the same situation in primary care, again giving private companies a great deal of influence over how our local services are delivered.

Elsewhere in primary care, PCTs have begun to outsource the services that they provide directly, like district nursing and health visiting. The government has made clear that it wants PCTs to become organisations made up only of managers, concentrating on buying care from other organisations. But PCTs employ thousands of health-workers, whose futures are now uncertain. In some areas, like Central Surrey, community nurses have been encouraged to leave the NHS, form social enterprises (non-profit companies) and sell their services back to the PCT. Again, this takes responsibility away from a public body.

Commissioning

This is where the real power lies. Commissioning is the act of 'buying' healthcare for the population. This has been the role of PCTs, but government reforms are changing that in two ways.

In October 2007, the Department of Health produced a list of 14 companies that it wants to see take over commissioning for PCTs. On the list are some huge American corporations like United Health and Humana – names you may recognise from Michael Moore's film 'Sicko' – as well as UK companies like Bupa and accountancy firms KPMG and McKinsey.

When contracted by PCTs, these companies will gain control over which treatments patients receive and who provides them, and with it an unparalleled knowledge of which areas of healthcare are most profitable. This will open the door to conflicts of interest and undermine cooperation in the NHS.

Another similar government policy is 'practice-based commissioning'. Under the scheme, GPs are given the power to commission treatments for their patients. Instead of the money being held by a PCT with responsibility for the whole local population, it is handed to practices accountable only for their registered patients. Increasingly, these practices will be run by private companies, giving them huge power over what is on offer to patients.

The potential for conflicts of interest is obvious. In Liverpool it is already happening – a company that was awarded a contract for dermatology turns out to have among its shareholders 73 local GPs who are members of a consortium. They stand to make money as shareholders by referring their own patients to the company for treatment.

When it gets to the level of commissioning the healthcare we receive, it is clear that the private sector has penetrated right to the heart of the NHS. Private companies add yet another layer of power to the complicated NHS structure. What makes them so much more dangerous is the fact that whereas public service NHS managers can be expected to act in the interests of patients, private companies must put their shareholders first.

Who's accountable?

With all this reform the lines of accountability in the NHS have been blurred. It is no longer clear who is driving the changes that are happening, and who is to blame when they go wrong. The government says decisions are taken locally; local health managers claim they just follow national policies. The involvement of the private sector adds more confusion, as 'commercial confidentiality' makes matters of public concern a secret.

Consultation

Patients have the right to be consulted over changes to their health services. It is the responsibility of PCTs to make sure that people are involved in new plans and big decisions. This was enshrined in the Health and Social Care Act 2001.

However, since passing that legislation the government has had no end of headaches caused by patients brave enough to actually use the powers they have.

On a number of occasions, the Department of Health has sent its lawyers into court to argue against the consequences of its own laws – most notably when patients from Langwith, Derbyshire, successfully challenged the privatisation of their GP surgery.

PCTs have recently got savvy in their approach to consultation, realising that if they just go through the motions they can collect the views of the local community and then ignore them.

Democracy?

This shortcoming of consultation has raised the question of how to hold PCTs accountable if, as the government says, so much power in the NHS is to be moved to the local level. One solution might be for PCT boards to be democratically elected, or to combine their functions with local authorities.

When the government established Foundation Trusts, it attempted to add an element of pseudo-democracy by allowing local people to become 'members' of Trusts, eligible to stand and vote in elections for Governors. But this has failed to catch the public imagination. At other levels of the NHS, accountability mechanisms are hard to discern. Organisations like SHAs look up towards the Department of Health for their sanction rather than down to patients and staff. Of course, the Health Secretary is answerable to Parliament for the running of the NHS, but the shortfall in accountability has come when local NHS bodies have pushed through unpopular policies at the behest of the Health Secretary.

Accountability in the private sector

If the lines of accountability are unclear in the NHS, in the private sector they are non-existent. When health campaigners have tried to find out even basic information about the work private companies are doing, they have been met with the response that it is 'commercially confidential'.

For example, despite the fact that taxpayers' money is being spent on ISTCs, the precise cost of each contract is kept secret. What is more, details of their clinical performance are also under wraps. We know that many people have had hip operations botched in ISTCs, but we are not allowed to see the full figures for fear of harming the interests of the companies that run the centres.

The same secrecy surrounds private companies that run GP services. And not a single business case for a PFI hospital has ever been released to the public.

This is the big danger with the policy of outsourcing the commissioning role of PCTs. Private companies will be responsible for spending billions of pounds of taxpayers' money, with huge scope for conflicts of interest and corruption, yet what they do with it will be a commercial secret. The public will find it impossible to hold them accountable.

The essential problem is not one that can be overcome with better regulation or a bit of tinkering. The shift from a public service responsible to the people (at least nominally), to a service that has been outsourced to private companies for profit is a massive one. Instead of democratic accountability, we will have contract law, with all the obstacles, costs and legal shenanigans associated with it.

Trade unions

NHS staff, organised in trade unions, currently play a key role in holding the NHS to account. While the mechanisms for patients to get their message heard may be limited, staff have a much more direct bargaining card – after all, the NHS runs on their good will.

A large, public sector organisation like the NHS lends itself to powerful unions. This means Unite and the other unions can use their position to fight for better working conditions and pay, and can also influence national policy.

However, the government's market reforms could change this as the NHS becomes fragmented. Right-wing think tanks like Reform and some senior NHS managers have argued for an end to national pay bargaining. All NHS organisations are meant in time to become free-standing Foundation Trusts with the right to set their own pay rates. As more doctors and nurses leave the NHS to form social enterprises to sell their services back, and as the private sector plays a bigger role, these calls will only get stronger.

Not only could this mean a decline in working conditions and the end to nationally negotiated pension rights, but also a loss of influence over policy. We have seen how elsewhere union membership and power has decreased after privatisation.

This would be a disaster in the health service, where unions have often acted as the conscience of the NHS, true to its founding values.

Where is the real power?

If the picture painted in this pamphlet seems confusing, that's because it is. The sheer size and complexity of the NHS means it is not always clear who is pulling the strings.

The easy answer to where the power lies – that it is with the patient because of choice – is misleading. Power is dispersed at all levels of the NHS. The main player is still the Health Secretary, but increasingly the government is saying that decisions are taken at local level, forcing PCTs into the spotlight. The power PCTs have to commission healthcare for their population certainly puts them in a pivotal position. But here, as in many areas of the NHS, changes are afoot with private companies beginning to take on key roles.

Indeed, the newcomers to the NHS party – foundation trusts, social enterprises and private companies – have been granted more influence over the healthcare we receive than many traditional NHS organisations. These developments are shifting power to bodies that are motivated by strong financial considerations, and in the case of private companies have a very clear bottom line in profits for shareholders. There are very important questions about how these bodies can be held accountable if the services they offer decline, and worries about what the fragmentation of the NHS will mean for staff and their unions.

Whatever happened to the citizen?

What the emphasis on choice asks us to accept is that patients are no more than consumers and staff no more than producers.

It allows patients a limited choice over the venue of their treatment, which most of them never asked for and don't particularly want, while all the big decisions are taken above their heads. It presumes that staff are lazy and stuck in their ways and need to be threatened in order to raise their game.

What it doesn't allow for is the fact that both patients and staff are citizens who use and work for a proud public service that exists to care for people, not to compete, and certainly not to make profits out of pain. Patients *should* be more involved in their healthcare, but as citizens, not as consumers. Their views on what they want the NHS to deliver should be listened to, and they must be invited to take part in making it happen. Staff have an unrivalled knowledge of how to run a health service – their expertise should be valued and they must be at the centre of decisions.

Only then would power lie with those who care most about making the NHS a success.