

Protecting our NHS - An introduction for campaigners

This guide was written for Keep Our NHS Public by Caroline Molloy. Our thanks are owed to her and to individual members of KONP who commented on drafts

This guide is aimed at both new and experienced NHS campaigners. It gives an introduction to the main challenges facing the NHS - where we are now, how we got here, and where we might be going. It aims to help give you confidence in your health campaigning, when talking to local health bosses, the media, fellow campaigners, patients and the general public about what is going on.

For ideas on *practical* action you can take, please see Keep Our NHS Public's other recent guides including "CCG Guide - Resisting Privatisation", "Working with Health & Wellbeing Boards" and "Working with Councillors and Scrutiny Committees", all available from www.keepournhspublic.com

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1. What did the Health & Social Care Act actually do?

The Health and Social Care Act 2012¹ did 3 main things:

- removed the responsibility of the Secretary of State to secure comprehensive and universal healthcare provision. This means government can blame local decision makers (Clinical Commissioning Groups and NHS hospitals), and that these

¹ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

organisations will find it easier to start to withdraw care from patients and/or start charging for it².

- lifted the cap on private patient income from Foundation Trusts³, ⁴ (and laid down a legal requirement for all NHS Trusts to become Foundation Trusts), so that they can earn up to half their income from patients who can afford to pay (meaning those of us who can't, will be increasingly pushed to the back of the queue).
- replaced the old bureaucracy with a new, more complicated one (at a cost of £3bn), in particular replacing Primary Care Trusts with Clinical Commissioning Groups (CCGs). CCGs have less responsibility to treat all patients in their areas. They have a few doctors on the board (this is why the Act was presented as 'giving power to doctors', even though most doctors are not involved and want to spend their time being doctors, not contract administrators).

Just before the Act went fully 'live' in April 2012, a regulation (under Section 75) was inserted doing one more, crucial thing:

- requiring all commissioning decisions to be open to competition from private providers, unless there is only 'one capable provider' (something that is very hard to prove, particularly when there is continual talk of the need to 'do things differently').

The effect of all of this will be to hasten privatisation of the NHS⁵. In the longer term, there are also fears about the impact of a forthcoming EU/US Free Trade Agreement making it more difficult to regulate private providers or undo privatisation⁶.

2. How did we get to this point?

Since 1990, the English NHS has been divided into two parts:

- The 'providers' - for example NHS Hospital, Ambulance or Mental Health Trust, a Foundation Trust -or, increasingly, a private company or charity/social enterprise.
- The 'purchasers' - the organisations that spend the NHS budget on buying (also called 'commissioning') healthcare, from the provider(s). The local 'purchaser' used to be the Primary Care Trust⁷ but from 1 April 2013, they have been replaced by 211 'Clinical Commissioning Groups' (CCGs) which include a few GPs on their boards. A national body, NHS England, commissions highly specialised services across the whole country

This divide is called the 'purchaser/provider split', which has created a market for health care.

At first, this 'market' was mostly an internal market, where local NHS bosses (the 'purchaser') bought clinical services from other parts of the NHS (the 'provider'), including

² <http://www.qmul.ac.uk/media/news/items/smd/62717.html>

³ <http://www.nhscampaign.org/NHS-reforms/ppi.html>

⁴ <http://nhsprivate.wordpress.com/>

⁵ <http://www.guardian.co.uk/business/2012/sep/16/health-firms-nhs>

⁶ <http://opendemocracy.net/freeform-tags/euus-free-trade>

⁷ Until recently, Primary Care Trusts also provided a wide range of healthcare (what are known as Community Services, see px) but this was stopped by the last government who wanted a total separation between purchaser and provider.

Hospital Trusts, Mental Health Trusts, Ambulance Trusts, and Community Services Trusts (district hospitals, district nurses and specialists like physiotherapists).

Meanwhile, patchwork privatisation took place.

‘Support services’ have been being steadily privatised since the 1980s

In the 80s many NHS hospitals ‘contracted out’ their support services like cleaning and catering. From the 90s, some of took place as part of expensive Private Finance Initiative (PFI) deals. With PFI, support and maintenance services were bundled with building contracts, the hospital was built and owned by consortia of private companies (with expensively borrowed private debt) and leased back to the NHS. The contracts were often [over-priced](#) and inflexible. In the 90s and 2000s, other support services were contracted out, including much diagnostic testing, logistics/supplies, and back office work.

Some (limited) NHS clinical treatment started being privately provided in 2000

Most clinical services remained, *until now*, provided by NHS hospitals, clinics and employees. However there were some exceptions. In 2000 then health secretary Alan Milburn signed a ‘Concordat’ with the Independent Healthcare Association. This stipulated that the private sector would be considered as an alternative provider. It was presented as a way of rapidly reducing waiting lists.

Over the next 10 years the private sector encroached into clinical provision:

- routine elective operations (like cataracts and hip operations). The ‘choose and book’ scheme allowed patients to choose to be treated at a private hospital / clinic at the NHS’s expense. Some of these clinics were new ‘independent treatment centres’ which were pump-primed with very favourable contracts and lots of money even if they didn’t treat many patients.
- doctors surgeries (through a scheme called ‘APMS’⁸).
- GP out of hours services.

Problems occurred:

- In elective operations, clinics without intensive care units and with insufficient staff were closed down after patient deaths - but the NHS had to pay tens of millions to escape the contract⁹.
- In out of hours, some private providers have been found to be cutting corners, employing insufficient qualified staff, and falsifying inspection data¹⁰.
- Some GP surgeries were closed when the private providers simply moved on, leaving patients without a doctor¹¹.

⁸ Who Runs Our GP Services? <http://www.nhscampaign.org/uploads/documents/NHS%20Unlimited.pdf>

⁹ <http://www.opendemocracy.net/ournhs/caroline-molloy/paying-for-private-failure-in-englands-nhs-again>

¹⁰ <http://www.guardian.co.uk/society/2012/may/25/serco-investigated-claims-unsafe-hours-gp>

¹¹ <http://www.camdennewjournal.com/news/2012/feb/gp-surgery-was-sold-us-health-company-set-close>

Privatisation is now accelerating fast, with many clinical services contracts now being awarded to private [providers](#) who are often better able to put in glossy 'bids' in the 'tendering' process.

3. How exactly is the NHS being privatised?

Unlike past privatisations like water and rail, there won't be a big bang, share offering-style privatisation, complete with 'Tell Sid' adverts. Instead, privatisation is happening piecemeal, through thousands of decisions made mostly at local level by 'purchasers' (the CCG). There are three key ways these decisions can let in the private providers:

- By putting a contract 'out to tender' so that private companies can bid (a cumbersome process that they can afford teams of experts to undertake)
- By using the new 'Any Qualified Provider' (AQP¹²) model which means private companies get onto a 'shopping list' of providers which the patient then chooses from. This model is a development of the earlier 'choose and book' scheme, but CCGs can now use it for a much wider range of healthcare services, particularly 'community services'¹³. This model gives CCGs very little control - but it is cheaper than tendering. Meanwhile patients need to negotiate the unhelpful marketing spiel of private providers on the NHS Choices website.
- By the use of direct payments and/or 'personal budgets'¹⁴ for an increasing range of conditions - patients are given a fixed sum to buy their healthcare themselves, from either the NHS or private providers. Personal budgets have been trialed since 2009 and are now being rapidly extended. By 2014 they will be rolled out to all patients receiving NHS continuing care. The experience from social care personal budgets here and healthcare in other countries is that risk is passed down to the patient, and state health providers can go under¹⁵. Budgets often get progressively cut, leaving the individual to top up from their own pocket, or via insurance, if they can afford it¹⁶.

Meanwhile services that are commissioned centrally by NHS England - including specialist services - are also being offered in large tenders to private providers¹⁷. The government is also consulting currently on increasing 'competition' amongst GP practices¹⁸.

4. But none of this is really happening in my area, is it?

The public is often unaware how much of the NHS has already been privatised¹⁹, because private providers often operate under an NHS logo. The vision of some politicians is that the NHS will be reduced to nothing more than a 'kitemark' applied to private providers²⁰.

There has also been a muddying of the water by the use of '3rd sector' organisations (charities and 'social enterprises'²¹). Whilst there has always been an active third sector in a

¹² <http://www.nhscampaign.org/NHS-reforms/privatisation/community-healthcare-privatisation.html>

¹³ <http://nhsforsale.info/privatisation-list/community-health-services.html>

¹⁴ <http://www.opendemocracy.net/freeform-tags/personal-budgets>

¹⁵ <http://www.keepournhspublic.com/pdf/ReynoldsPHB.pdf>

¹⁶ <http://www.opendemocracy.net/ournhs/colin-leys/personal-care-budgets-could-further-fragment-nhs>

¹⁷ <http://www.mirror.co.uk/news/uk-news/nhs-hospital-corporation-america-donates-2246513>

¹⁸ <http://www.opendemocracy.net/ournhs/deborah-colvin/more-competition-medicine-now-its-your-gps-turn>

¹⁹ <http://nhsforsale.info/privatisation-list.html>

²⁰ <http://www.opendemocracy.net/ourkingdom/colin-leys/plot-against-nhs>

²¹ <http://www.guardian.co.uk/politics/2011/nov/12/care-private-company-nhs-hospital>

few specific areas of the NHS (notably, mental health and hospice care), it is now a useful 'Big Society' figleaf²², giving the impression that NHS services are being given to friendly local organisations, at least (though these friendly local organisations are usually gobbled up by the big fish²³). Charities are being sucked in by the idea of 'partnership' and some are lobbying hard for more privatisation²⁴.

5. How do private companies make money from the NHS if we don't (currently) pay?

At present, basically, they get our tax money instead. NHS hospitals and providers used to get a grant from government based on the needs of the local population. But now the NHS operates a system called 'Payment by Results'. It isn't really anything to do with results! What it means is that the 'providers' (whether NHS or private) get **paid per treatment**, procedure, or 'episode of care'. Providers have an incentive to compete against each other - and to discharge patients quickly - to treat more patients. The payment - or 'tariff' - is set low, starving NHS providers of funds, though private companies can afford to run 'loss leaders' or just cut corners and run services on the cheap.

6. Why does it matter if services are privatised? Maybe it might help make things 'efficient'?

Cherry picking - Private providers are happy to leave the most costly aspects of our healthcare - A&E, Intensive Care, patients with complex needs, emergencies, and training staff - to the NHS. By picking off the cheaper to run bits, they suck money from NHS providers that is normally used to 'cross-subsidise' more expensive bits, leaving NHS providers struggling.

Transaction costs - The costs of administering this 'market' are huge. Admin costs were 5% in 1979, but by 2010 research commissioned (though not published) by the Department of Health showed that it had risen to 14%²⁵. It is likely to be substantially higher now.

The myth of choice - evidence tends to show that patients do want some say in *how* they are treated, but most don't want to have to choose between competing providers. They just want to be treated quickly and looked after well. 'Choice' tends to be of most benefit to the better off and more articulate.

The myth of higher standards - There is little evidence to support the argument that competition drives up standards in healthcare. Consumer competition just doesn't work in healthcare^{26, 27, 28}, which is not like choosing your clothes or groceries. In healthcare it is far more important - and far harder - to assess quality. The current obsession with data and statistics is unlikely to ever address this - particularly for the elderly and vulnerable people who are the greatest users of the NHS.

²² <http://www.bbc.co.uk/news/uk-politics-13273932>

²³ <http://www.theguardian.com/society/patrick-butler-cuts-blog/2011/sep/19/social-enterprise-big-society-gets-reality-check>

²⁴ <http://www.opendemocracy.net/ournhhs/andrew-robertson/english-charity-sector-lobbied-hunt-to-keep-controversial-nhs-privatisation->

²⁵ House of Commons Health Committee Fourth Report 2009-10

²⁶ http://www.keepournhspublic.com/pdf/MARKET_FAILURE.pdf

²⁷ <http://www.nhscampaign.org/NHS-reforms/tracking-privatisation/companies-run-hospitals.html>

²⁸ <http://abetternhs.wordpress.com/2011/06/29/competition/>

The failure of insurance models - The best known example of 'market failure' in healthcare is the US, where the average citizen pays twice as much (in insurance and taxes) as we do in the UK, for a system that delivers far worse outcomes. Their system of competing providers is hugely bureaucratic (\$1 in every \$3 is spent on administration, billing and marketing) and private providers extract substantial profits, taking money away from patient care. There is substantial fraud²⁹. Patients who can't pay are undertreated, and just as dangerously, those who can, are over-treated. In the US 62% of all personal bankruptcies (900,000 a year) are due to medical expenses, even though 78% of those bankruptcies were of patients who actually had "insurance" (Michael Moore's film, Sicko, lays this out well).

The NHS is one of the most efficient in the world - A peer-reviewed study for the Royal Society of Medicine found that the NHS system (pre-2012) was the 2nd most cost efficient in the developed world³⁰. A 2010 Commonwealth Fund study of a smaller number of countries found the NHS was the most efficient system of all of them³¹.

Competition + cuts = lower standards - In an environment of substantial (20%) cuts^{32, 33} to the NHS budget over 5 years, 'market competition' tends to mean competition on price. The provider that can put in the cheapest 'bid' for the contract to provide a service, may well win it, even if they score lower on quality of care. The government claims this doesn't happen, but it does³⁴.

Fewer skilled staff - The easiest way to cut costs is to reduce staff costs. In the NHS, healthcare workers are somewhat protected by centralised negotiations and trade union recognition, but when services are outsourced, it is far easier to make staff redundant³⁵, to downgrade them, or to replace them with lower skilled staff (as we have seen with the NHS 111 service³⁶) - all of which have an impact on patient care.

Experience of other privatisations - The idea that private providers provide better value, ie 'do more for less', is not one borne out by the history of privatisation - from rail to water³⁷.

Privatisation leads to lower quality and extra costs for our NHS. Patients are inconvenienced as services fragment - and may even be endangered if they are treated in private centres that don't have the expertise and equipment to cope if problems arise³⁸. As a result, patient satisfaction last year showed a record decline³⁹, some services are becoming rationed⁴⁰, waiting lists and hospital wait times are increasing⁴¹ - and charges are being threatened^{42, 43}. Already, health care insurance companies are trying to use these impacts in their advertising, to encourage patients to take out private healthcare insurance.

²⁹ <http://chpi.org.uk/511/>

³⁰ <http://www.guardian.co.uk/society/2011/aug/07/nhs-among-most-efficient-health-services>

³¹ <http://www.bbc.co.uk/news/10375877>

³² <http://www.nhscampaign.org/NHS-reforms/cuts-don-t-cure.html>

³³ <http://drdavidwrigley.blogspot.co.uk/2012/12/the-madness-of-king-nicholson.html>

³⁴ <http://manchestermule.com/article/patient-transport-privatised-as-nhs-hit-by-budget-pressures>

³⁵ <http://www.bbc.co.uk/news/uk-england-suffolk-20395749>

³⁶ <http://www.mirror.co.uk/news/uk-news/new-nhs-111-helpline-crisis-1780745>

³⁷ <http://weownit.org.uk/privatisation>

³⁸ <http://www.guardian.co.uk/society/2013/jan/05/nhs-clinic-closure-patient-death>

³⁹ <http://www.telegraph.co.uk/health/healthnews/9324019/Biggest-drop-in-satisfaction-with-NHS-in-30-years-survey.html>

⁴⁰ <http://falseeconomy.org.uk/blog/nhs-efficiency-savings-are-being-achieved-by-rationing-patient-healthcare>

⁴¹ <http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-leaders-half-of-all-aes-will-fail-to-hit-waitinglist-targets-this-winter-8803424.html>

⁴² <http://www.guardian.co.uk/commentisfree/2013/apr/17/nhs-charges-next-government>

⁴³ <http://www.nhsforsale.info/what-s-the-impact/database/more-charges-for-care.html>

7. If privatisation isn't better value, why are they doing it?

Vested interests and ideology.

Healthcare is a huge opportunity for wealthy investors. Our basic needs, such as health, are one of the few reliable sources of demand and income for them, now that consumer spending has dried up due to the financial crisis, declining wages and benefits. A large government contract is a far easier way of making money than having to be entrepreneurial and attract new consumers all the time.

Gordon Brown spelled it out when he told financiers in 2000 (describing the Private Finance Initiative) that they would be investing in "core services which the government is statutorily bound to provide and for which demand is virtually insatiable. Your revenue stream is ultimately backed by government. Where else can you get a business opportunity like that?"⁴⁴

Many of the big healthcare companies are owned by secretive private equity investors, hedge funds, and offshore companies - often with links to politicians⁴⁵.

Investors are also eyeing up the vast opportunities of transferring our state funded system to an insurance based model where we all have to buy insurance.

This won't happen overnight. But as NHS 'purchasers' and 'providers' are both starved of funds, insurers are already beginning to offer 'top up' insurance so that those who can afford it can buy more services. There are other reasons to believe the insurance model is the one we are rapidly heading towards - see below.

Ideologically, the exploding number of managers in the NHS (they've doubled in recent years) are, at senior level at least, often trained in 'new public management' - an approach which focuses on putting a 'cost' against every activity, so it can be run as a business. This doesn't really lend itself to a joined up, holistic, patient-focused healthcare system.

Privatised, fragmented services are easier to weaken as they are far less accountable to the population, and they also lack a 'public service ethos'. It is easier to make cuts secretly, and for politicians (both locally and nationally) to wash their hands - especially politicians who are ideologically committed to a 'smaller state'.

8. But it they've promised it will be free at the point of need - so I won't have to pay, at least?

"Free at the point of need" doesn't mean "all the care you need free at the point of need", necessarily. The NHS may not charge but may simply withdraw the service. This is much easier since the Act scrapped the Secretary of State's legal responsibility to secure a comprehensive health service.

There is already evidence that this is increasing⁴⁶ - for example that in some areas people are no longer having two cataracts on the NHS, one good eye being judged enough⁴⁷. For

⁴⁴ File on Four 2004, quoted in The Politics of English NHS Reform <http://www.keepournhspublic.com/pdf/Peedell-IAHPEpaper-2009.pdf>

⁴⁵ <http://socialinvestigations.blogspot.co.uk/2012/02/nhs-privatisation-compilation-of.html>

⁴⁶ <http://www.nhscampaign.org/NHS-reforms/rationing.html>

the last few years some services have been redefined as 'extras' or 'non core' which the NHS will not pay for, for example some ante-natal services, midwifery, some dermatology, physiotherapy... things are being chipped away. For these services that used to be free, people are now having to pay.

This charging for 'non-core' services is a model that is already used in social care, alongside extensive means-testing - which is a worry if health and social care are increasingly to become integrated. (See 'integration' section).

Even more widespread is that as cuts bite and waiting lists increase, people are being pushed towards paying (or getting insurance) to go private if they want or need prompt treatment that they used to be able to get on the NHS. Sometimes, they are even being encouraged to pay to jump the queue, to get exactly the same treatment in an NHS hospital⁴⁸.

The crisis in A&E with [rising wait times](#) is obviously part of this concern too - already, UKIP are even suggesting that people should be allowed to pay to [jump A&E queues](#).

So reassurance from politicians that the NHS will be 'free at the point of need' does *not* mean you won't have to pay extra in future.

And 'free at the point of need' could be used even more sneakily than that. After all, in an insurance model, you don't pay at the door of the hospital, but when your direct debit comes out, or your extra deduction is taken from pay.

Lastly, the government's plans to charge immigrants for GP services raises concerns that this sets a dangerous precedent for the rest of us⁴⁹. Leaving aside the morality of such a move, there are such obvious public health risks, and the government admits itself there isn't the evidence that setting up such a scheme to facilitate charging, would actually save any money. So what's it really about?

Few politicians - yet - are prepared to openly advocate charging for NHS services for the general population. But various senior NHS management figures have begun to suggest it's 'inevitable' and Liberal Democrat peer Shirley Williams - a key figure in getting the bill through parliament - recently suggested the introduction of charges to visit a GP⁵⁰, along with the ending of free prescriptions to better off pensioners.

If we want our politicians to publicly commit to a health service that's "free, universal, and funded through progressive taxation" then we need to listen out for *exactly* these words in their statements and pledges.

9. Why is privatised healthcare less accountable?

It is more difficult for patients to hold privatised services to account in lots of ways:

⁴⁷ <http://falseeconomy.org.uk/blog/nhs-efficiency-savings-are-being-achieved-by-rationing-patient-healthcare>

⁴⁸ <http://www.opendemocracy.net/ournhs/caroline-molloy/more-nhs-hospitals-turning-to-private-patients>

⁴⁹ <http://www.opendemocracy.net/ournhs/juan-camilo/migrants-fairness-and-nhs>

⁵⁰ <http://www.opendemocracy.net/ournhs/caroline-molloy/shirley-williams-suggests-new-nhs-charges>

- The NHS, as a public organisation, is accountable to the public, through our elected representatives. Private companies are accountable to their shareholders, not to the public.
- Many of the recommendations of the Francis report into the mid-Staffs scandal - such as the ban on the future employment of failed managers - will not apply to the private sector⁵¹.
- Private providers are not subject to Freedom of Information requests themselves. You can try to get information on them from the 'purchaser' (the CCG) but it is very difficult in most cases. See the KONP CCG guide for more on submitting FOI.
- Unlike NHS Trusts, private providers do not have to hold their board meetings in public.
- Private providers often respond to criticism by saying that they are meeting the terms of the contract. But contracts are negotiated secretly and terms often too vague. The contract may well not bind the provider to specifics that local people might think are important, for example, minimum staffing requirements, or even keeping the service open!⁵²
- Private providers can sue critics for libel - something the NHS generally cannot. Even if the criticism is true, our strict libel laws have a chilling effect on freedom of speech - something that critics of privatised care homes have already discovered⁵³.
- The public often doesn't even know who is providing their services underneath the NHS 'kite-mark'.
- Whatever politicians may claim, regulators can't provide the same kind of accountability as public ownership. You only need to look at the toothless utilities regulators, or the underfunded Care Quality Commission to see that.

10. Why is the government so obsessed with IT and data?

Many suspect that facilitating a 'market', with costs against every activity and patient, was the main purpose of the disastrous £20bn Connecting for Health IT project. Despite delivering virtually nothing, it spent a sum equivalent to the entire NHS budget cuts⁵⁴!

[Some](#) have also speculated that the move towards ever more **data collection** (sometimes talked about as 'a paperless NHS' or 'electronic records' may be largely about facilitating both charging and large profits for data companies. Our medical data is already being made increasingly available to private medical insurers⁵⁵.

Finally there is some evidence that data is being collected in a way that can be used to criticise existing NHS providers^{56, 57} and hence justify the use of more privatisation and cuts.

11. What is the relationship between privatisation and cuts?

NHS hospitals, clinics and Trusts are finding it more difficult to make ends meet, because

⁵¹ <http://www.opendemocracy.net/ournhhs/roger-kline/never-again-jeremy-hunt%E2%80%99s-response-to-francis-report-is-inadequate>

⁵² <http://www.guardian.co.uk/society/2012/dec/19/when-privitisation-gp-practices-wrong?intcmp=239>

⁵³ <http://www.opendemocracy.net/ournhhs/robert-sharp/enclosures-act-of-mind>

⁵⁴ House of Commons. Public Accounts – Twentieth report. 26th March 2007

⁵⁵ <http://www.opendemocracy.net/ournhhs/phil-booth/your-medical-data-on-sale-for-pound>

⁵⁶ <http://www.theguardian.com/healthcare-network/2013/apr/09/friends-family-test-unfit-for-purpose>

⁵⁷ <http://www.theguardian.com/society/2013/aug/07/nhs-health>

- they are losing many of their 'easy' procedures to the private sector already 'cherry picking'⁵⁸ these profitable patients and the funding that follows them.
- they are having to compete against private providers who promise the 'commissioner' (CCG) that they will provide services more cheaply. They may well do this by either putting in a loss-leader bid, or by cutting the number of skilled staff (which they can do more easily because there is less accountability in private companies). In hospitals, providers often find a way round 'fixed tariffs' that are supposed to prevent competition on price happening.
- when commissioners run a tender, the cost to the NHS provider of submitting a bid to can itself be up to £1/2million or more.
- they are being crippled by expensive Private Finance Initiative debts⁵⁹.
- to get Foundation Trust status (compulsory, under the Health & Social Care Act) they have to show the regulator, Monitor, that they have balanced their books and are financially sustainable - in other words, that they operate like a business.

On top of all this, the impact of the 'Nicholson challenge' of £20bn cuts required over 5 years, is having a devastating impact. These are badged as 'efficiency savings' or 'QIPP savings'. The government has repeatedly said that these savings are not supposed to require cuts to front line services. But that is exactly what is being cut, as cash-strapped commissioners try and hammer down the money they pay to NHS hospitals. Nurses have dropped by 4,500 over the last 2 years⁶⁰ and 17 hospitals have 'dangerously low' levels of nurses, according to the CQC⁶¹. The source of the £20billion projected savings was a McKinsey report⁶² which recommended a reduction in what they termed 'low value added healthcare interventions' - but commissioners are now deciding is 'low value' isn't the kind of things you would expect (see 'Rationing', below).

Even whilst budgets were cut, top NHS managers were so keen to underspend that last year the NHS returned a *further* £2billion to the Treasury.

⁵⁸ <http://www.nhscampaign.org/NHS-reforms/cherry-picking.html>

⁵⁹ <http://www.telegraph.co.uk/health/healthnews/9357679/PFI-hospital-crisis-20-more-NHS-trusts-at-risk.html>

⁶⁰ <http://www.telegraph.co.uk/health/healthnews/9423559/Thousands-of-nurses-cut-from-the-NHS-official-figures.html>

⁶¹ <http://www.bbc.co.uk/news/health-21002205>

⁶² <http://nhsvault.blogspot.co.uk/2012/09/qipp.html>

12. What's the impact of all this on my local hospital?

NHS providers struggling for all the above reasons are threatened with being put into the 'failure regime' - taken into administration, broken up and closed down. Even providers that are doing well, like Lewisham, are being threatened with cuts to bail out neighbouring Trusts. The government was defeated on its appeal against a high Court decision that it did not have the power to force a successful Trust to cut its services to bail out a neighbouring failing Trust, but it is now introducing new legislation to give itself exactly that power across the country.

These financial pressures are leading to closures of wards, departments - such as A&E, or specialist departments⁶³ - and whole hospitals⁶⁴. This is although even prior to the latest cuts, beds had already reduced substantially (by 10% in the 3 years from 2005-8). The UK already has amongst the lowest number of hospital beds of any developed country.

Politicians try to blame the local decision makers and argue that the closures are not for a lack of cash, but for 'clinical reasons' of 'quality' and 'safety'.

Campaigners should not allow their local MPs to get away with such claims. Local NHS providers are being forced to cut costs (as outlined above) to the point that they cannot afford enough frontline staff to provide 'quality' and 'safety'.

Both Lord Darzi and more recently Andrew Lansley made commitments that service changes should not take place without clinical evidence of benefit. Campaigners should demand such evidence and seek out supportive clinicians (either through local contacts or via national organisations like KONP) to help them scrutinise it - an example used by Lewisham to great effect.

13. Why do they keep talking about 'Care closer to home'?

The other line that both senior managers and politicians use is that it is 'better' to move care **out of hospitals and 'closer to home'**. Many think tanks have advocated such an approach even though the evidence of benefit, cost-efficiency and public demand is extremely lacking.

'Care closer to home' means different things to different people. Whilst patients might like the idea of care closer to home if it were provided by specialists in a District General Hospital, GP surgery, or a District Nurse visiting them at home, these models are not cheap, and they seem to be on the decline - the number of District Nurses dropped 40% over the last 10 years for example, though there was a growth in the number of less specialist staff replacing them.

Models of 'care closer to home' that rely on fewer skilled staff are being pursued vigorously instead, including:

⁶³ <http://www.opendemocracy.net/ournhs/steve-walker/leeds-childrens-heart-surgery-twisted-statistics-conflicts-of-interest-and-hidde>

⁶⁴ <http://www.dailymail.co.uk/news/article-2207274/A-E-closures-Secret-report-reveals-lives-risk-sweeping-plans-close-25-casualty-units.html>

- Healthcare in high street stores (for example, more ophthalmic procedures being transferred to high street opticians) - meaning less skilled staff and problems for patients with more complex needs
- Healthcare *in* the home, including:
 - the replacement of staff with technology such as digital monitors, telephone advice lines, and telehealth monitoring - with the ambition to roll the latter out to 3 million people by 2017⁶⁵ - even though these models have been found to be problematic^{66, 67}.
 - the replacement of staff with patients, or their carers, looking after their own needs more. This is often labelled as ‘empowerment’, ‘responsibility’, ‘self-care’, ‘co-production’ or an ‘asset-based’ approach. Of course it is good for patients to be able to look after themselves. But only when appropriate - not as an excuse for cuts.
 - care by home-based staff - often provided by private companies.

As the new director of strategy for NHS England has pointed out recently:

“[there is a] widely held myth [that] by shifting services into the community we can address the NHS’s financial woes. This myth depends on the assumption that services provided “in the community” are cheaper. Yet since labour is the most important driver of costs, this would only be true if very different working practices accompanied the move.”⁶⁸

In other words, if cheaper, less skilled staff were providing the services.

As the NHS England strategy director says, “Achieving substantial savings also depends on decommissioning hospitals.”

In other words, such models only save money if significant parts of local hospitals are closed down - and maybe not even then. It is expensive to provide properly rewarded, skilled staff and equipment visiting a patient’s home or community. A reliance on technology or even self-care can also be surprisingly expensive in the short or long term, too. And recent scandals in home social care also show the problems of providing care in an environment that isn’t supervised.

Some patients may want care at home, but much depends on their home and their needs. Patients have concerns - especially given the experience of ‘care in the community’ mental health provision in the 80s - that a greater burden will ultimately fall on them, or their carers, or that they won’t get the standard of care they need.

So if it’s not necessarily cheaper, nor particularly wanted, nor superior, why is *this* model of ‘care closer to home’ being pushed?

14. What’s all this talk about ‘integration’?

Integration *sounds* like common sense. But it is important for campaigners to realise that the way it is used by influential figures often doesn’t mean the common sense understanding –

⁶⁵ <http://cno.dh.gov.uk/2012/11/14/telehealth-to-benefit-100000-people-with-long-term-conditions/>

⁶⁶ <http://www.gponline.com/News/article/1175670/Telehealth-not-good-use-NHS-money-finds-DH-backed-study/>

⁶⁷ <http://www.pulsetoday.co.uk/telemedicine-trebles-death-rate-in-elderly-patients/13803303.article#.UcFwUPIKtw0>

⁶⁸ “NHS England’s new vision will be radical”, Health Services Journal, 14/6/13

i.e. an end to the divisions between competing parts of the NHS, which fragment services and cause patients to be pushed from pillar to post as different parts of the NHS compete to meet their discharge targets.

Instead 'integration' in the mouths of some influential figures is turning out to mean other things - which have considerable risks attached.

Integration can mean the 'integration' of health and social care

The Health & Social Care Act 2012 included a 'duty to promote integration' of health and social care (both home care and care homes). There are 10 'pioneer' projects. Both main parties are advocating merging health and social care.

If done properly, this could make sense. It was only over the last 20 years that some of what we now consider 'social care' was redefined as such - previously much of it had been defined as long term healthcare and provided free by the NHS.

But even if integration delivers some savings, in itself it will not solve the huge crisis in social care, which is facing a black hole in its budget.

There are **two big risks**.

Firstly, **funding**. As yet, Labour has not said how its proposed 'integrated national health and social care service' would be funded. Would it be free, universally provided and funded by universal taxation (like health care)? Or would it be based on means-tested and increasingly restricted personal budgets, provided by a range of mostly private organisations, and topped up by the individual e.g. via sale of homes and / or insurance (like social care). Labour currently has a commission chaired by Sir John Oldham⁶⁹ to look at these questions, though the terms of reference to the commission say that 'more money' is not an option.

As for what the government is planning - there is a Care Bill currently going through parliament. Their solution appears to be a 'cap' of costs after the first £70k (in other words, continuing the model where people need to sell their homes to pay for social care unless they are very rich or very poor). What this could mean for *healthcare* funding when it's merged in, one can only speculate.

Secondly, **privatisation**. The risk with health and social care integration is healthcare could follow the model of social care provision - largely privately provided (since the 80s), expensive, and low quality.

As we've just seen in a massive £1billion contract of integrated health and social care, in Cambridgeshire, this 'integration' has made it more difficult for the NHS to argue that it is the only 'capable' provider. Therefore, under the controversial Section 75 Regulations of the Health & Social Care Act, it has had to go out to tender. Cambridgeshire services - currently provided by NHS Trusts and a mixture of social care providers - could be taken over entirely by the private sector. Most of the bidders are from the private sector, including all the big players (Care UK, Circle, Virgin, Serco, Capita, United Health).

⁶⁹ <http://www.labour.org.uk/need-swift-integration-of-care-to-safeguard-nhs>

Even those without health expertise can bid, as a 'prime contractor' which then sub-contracts. This is a model that the head of NHS Commissioning is pushing strongly.

Integration can mean the integration of 'purchaser' and 'provider' - but not necessarily under a publicly owned and comprehensive NHS

David Nicholson, head of NHS England recently suggested integrating 'purchaser' and 'provider'. Whilst this has long been the goal of campaigners, Nicholson's suggestion met with concern amongst campaigners. Nicholson's model of integration⁷⁰ is the Accountable Care Organisation / Kaiser Permanente model, where a health insurer is integrated with, or tied to, a particular health provider, who give discounts to the insurer if the patient chooses that provider. Provision isn't universal but based on membership of an insurance-based scheme with managed care pathways - though such a scheme could become compulsory through some form of additional payment.

To many observers, such a model bears an alarming resemblance to that put forward by Thatcher's advisors 30 years ago, of 'Health Management Organisations'. One of those advisers, Oliver Letwin, is now David Cameron's policy guru, thought to have had more to do with the Health & Social Care Act than Health Secretary Andrew Lansley himself. Observers have noted that many elements of the 30 years old plan are already in place⁷¹.

Now that the Health & Social Care Act has removed the government's duty to secure a comprehensive healthcare system on behalf of its citizens, and alongside other changes, the new CCGs are now free to be selective about what patients they accept. They are far freer to deny NHS services apart from a shrinking pool of what are deemed 'core' services.

In this context, the otherwise pretty pointless £3billion Health & Social Care Act reorganisation could be seen⁷² as establishing at the taxpayer's expense - a move to a far more expensive and unequal insurance based system, with (as in America) a mixture of state and private funding.

In this model, the NHS is reduced to the role of a state owned insurer competing alongside private insurers. Private health insurers are already starting to offer an expanding range of price plans, including top of the range provision for those who can afford it.

Many - including former Department of Health director of strategy Professor Chris Ham, now at highly influential think tank, the Kings Fund - said the last few years have set us on the route to seeing the NHS "increasingly become a health insurer" not a provider, picking from a "mixed economy" of private, public and 3rd sector providers⁷³.

The Impact Assessment⁷⁴ for the Health & Social Care Act acknowledges that CCGs are structured as state-owned insurance schemes. This direction (ultimately leading to inadequate free healthcare and the need for a private insurance top-up payment, as in the US) has been laid out by many of the think tanks advising the government. Nick Seddon,

⁷⁰ <http://www.opendemocracy.net/ournhs/alex-nunns/sir-david-nicholsons-latest-bright-idea-for-english-nhs>

⁷¹ <http://www.sohealth.co.uk/2013/03/15/dr-lucy-reynolds-with-a-very-clearly-evidenced-explanation-of-uk-nhs-privatisation/>

⁷² <http://falseeconomy.org.uk/blog/choosing-to-profit-how-private-providers-can-select-and-reject-patients>

⁷³ FT, 19/4/05, quoted in Clive Peedell's article

⁷⁴ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf

recently appointed⁷⁵ as the health policy advisor in the Downing Street policy unit, has been a strong advocate of the insurance model.

Some in Labour - including Burnham⁷⁶ - have expressed an interest in CCGs morphing into some kind of Accountable Care Organisation, working with NHS providers. But such a model is not shown to be cost-effective at scale. There are other problems. Without a radical reversal of privatisation, the CCG will continue to have funds sucked out by cuts and privatisation. They are likely to end up competing with private insurers for the cheap, healthy / less risky patients, and coming under increasing pressure to reduce state-funded provision. This is already happening - see 'Rationing'.

KONP activist Alex Nunns describes the Kaiser Permanente model thus: "companies would decide if the NHS will fund a treatment for their customers, and then perform it too. Patients would get a balkanised health system and taxpayers would get to subsidise private shareholders."

Meanwhile, CCGs are already shifting towards privatising their decision making about our healthcare in other ways. Since 2007 there has been an increasing reliance on 'external commissioning support', where private companies have been running 'referral units' that vet - and sometimes refuse, or redirect to private providers - GP patient referrals for treatment⁷⁷.

CCGs are under increasing pressure to hand more decision making over to Commissioning Support Units (CSUs). These are completely unaccountable bodies - and they are to be offered up for private sector takeover in 2014. Labour has not yet said it would scrap CSUs.

15. Why does everyone seem to be criticising the NHS and saying it needs to change radically?

In fact, whilst government and right-wing media sources are constantly criticising the NHS, the satisfaction of the general public with the NHS was at a record high in 2010 - and satisfaction amongst those who actually used it, even higher.

That is not to say things are perfect.

We all want to see improvements to healthcare.

But where there is a 'problem', there are people queuing up to offer 'solutions' - and these days, these 'solutions' often turn out to be, more private involvement in healthcare.

So-called radical 'innovations' all offer considerable opportunity for further private sector involvement. Whenever something could be said to be a big departure from the way things have been done before, it is more likely that the service will be commissioned afresh, with the private sector insisting on its right to bid to provide the services. It will be difficult for the NHS to argue that it is the only 'capable provider'. It is also easier to introduce charges for these 'new' services.

16. What can we do?

⁷⁵ <http://www.opendemocracy.net/ournhs/andrew-robertson/this-cant-go-on-cameron-hires-private-health-lobbyist-into-heart-of-governme>

⁷⁶ <http://www.guardian.co.uk/healthcare-network/2013/jan/31/andy-burnham-american-import-nhs>

⁷⁷ <http://www.bmj.com/cgi/content/short/333/7557/9-a?etoc>

We need to ask tough questions - and be prepared to challenge the answers, dig around for our own, and publicise them. The main weapon of those who would cut and privatise our NHS, is secrecy and confusion.

If people properly understand the threats, they are likely to be very angry indeed, and to demand that politicians do something about it - restore the duty of government to secure a comprehensive health system⁷⁸, funded through general taxation not charging, and end the wasteful market⁷⁹ and Private Finance Initiative rip-offs.

The 'reforms' and 'policy prescriptions' are designed to be confusing, to avoid this anger until it's too late.

Many think Clinical Commissioning Groups have been given a poisoned chalice by government. But will they sup from it in secret, or will they speak out and expose what is happening?

If not, campaigners will have to do it themselves.

Privatisation is not the solution for problems in the NHS - it is a huge part of the problem, as this guide shows. Privatisation is often sold as a solution to financial pressures - it is the job of campaigners to point out that in fact privatisation is an [ideological](#) project and the evidence suggests it's more expensive - though the money goes to private hands, often friends of those in power.

We need to ask tough questions about what has happened to healthcare where services have been privatised or cut. Has anyone checked?

We also need to ask tough questions about what the problems are that health bosses 'solutions' are supposed to address. What is the evidence is that this 'solution' will actually improve matters? Does the 'solution' involve inviting bids from private providers? Have other solutions which keep healthcare provision in the NHS been explored? If not, why not?

Many of the concerns about the damage being done to our health service, particularly rationing and inadequate care, would be helped if there was a legal change to restore the **duty on the Secretary of State to secure a comprehensive health service** which the Health & Social Care Act removed. Campaigners and academics are pushing for this hard and there are recent indications Labour may be considering it in their current policy reviews.

See the 'KONP CCG Campaign guide' for more detailed, practical guidance on the questions to ask, how to ask them, and how to campaign to protect the NHS, in your community and beyond.

⁷⁸ <http://www.opendemocracy.net/ournh/allyson-pollock-david-price-louisa-harding-edgar/briefing-paper-nhs-reinstatement-bill>

⁷⁹ <http://www.guardian.co.uk/commentisfree/2013/jul/11/funding-the-nhs-coalition-services>