2001 Health Care Conference: Keeping Health on Track.

Plenary 2a

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The NHS: the View from Above and the Way Forward.

Introduction

Since, submitting this plenary title to the Conference Planning Group, two significant policy changes have taken place. First, the June Election has committed the government to introducing further 'diversity' in the NHS, i.e. more private and non-governmental involvement in the investment, management and running of the NHS and other public services. Secondly, following the collapse of Railtrack, the private for-profits company established by the government ten years ago to manage the running stock of the UK railway network, the government is proposing to establish a new not-for-profits central body to run the network. If these two developments are taken as indications of government thinking on Public Private Partnerships (PPP) in the NHS, they both augur different approaches to the future. One adopts an open-ended approach in extending greater diversity; the other a more singular approach that narrows the options for partnership. What can we say about the opportunities for and limits faced in developing new partnerships in the NHS between the public and private sectors?

It is clear that the Government is bent forming new relationships with the public sector. The Labour Party Manifesto 2001 announced two new policy proposals:

- Child Endowments (or 'baby bonds') and Adult Savings Gateways in the HM Treasury consultation *Savings and Assets for All* published in May 2001

- New and extended Public Private Partnerships for the NHS.

Both proposals suggest opportunities for greater involvement from private financial services and investment. Yet they both came as a surprise as they appeared to come out of the blue – that is, to come from no where; but also they came tinged with the political colour of previous *Tory* policies. What direction was the government heading in? This was also surprising in view of Labour's continuing opposition during the 1990s to Tory policies promoting an internal market in the NHS. However, these proposals have attracted the opposition of the Trade Union movement and public opinion as registered in public opinion polls.

Since 1997 the Labour Government has extended the Tory government's PFI investment programme for new building in NHS hospitals, schools and prisons. Indeed, in 1999 Labour could boast that it had the largest hospital

building programme in the history of the NHS with over half the rebuilds financed by PFIs.

This was followed by the publication of the IPPR's final Report of the Commission on Public Private Partnerships, *Building Better Partnerships*, chaired by Martin Taylor chair of WH Smith, International Adviser to Goldman Sachs, and author of a HM Treasury working paper on tax credits. Postponed until after the 2001 election to avoid embarrassing the government, the Report advocates greater 'diversity' in the provision of public services, with more involvement from the private and voluntary sectors with the public sector.

The government has justified these moves as necessary to its programme of modernising the public services and as the only way to raise new investment in the public sector. These new forms of partnership are underpinned by an undertaking that private investment will not affect the provision of free and universally available public services. In a more philosophical vein, the government has proclaimed in all its White Papers on modernising different public services, that this approach is part of a distinctive *Third Way* approach that is neither public nor private but something else.

These developments pose a challenge to the public, private and voluntary sectors in how to make sense of the changing landscape of social policy and more specifically health policy. What are the opportunities posed by the Government's new policies for greater involvement of the private and voluntary sector in a more diversified system of public services. At the same time what limits is the government's programme of partnership reforms likely to face. We will examine the changing landscape of health policy at three levels: global, regional (European) and national. The emergence of a global economy means that national social policy must be examined in this global context. It is no longer possible to study social policy as if it were simply the product of the national government acting on behalf of the democratic will of the nation. The global context cannot be ignored.

However, notwithstanding these requirements, time only allows us to examine selective aspects of global and regional landscape of social policy. We will look at the opportunities first and then consider the limits faced by public private partnerships in healthcare.

Global Perspective: the General Agreement on Trade in Services

GATS is an important example of global governance - an international agreement, set up by the WTO at its launch in Uruguay in 1994, to promote global trade and investment. It sets up a regulatory framework affecting all 140 members countries and covering all service sectors. It commits its member states to the progressive liberalisation of trade in services (Ruane 2001). This could include the private provision of healthcare, but not services supplied 'in the exercise of government authority'. The issue is whether GATS provisions could affect the NHS. This is in part a legal question, that would require a test case defining what 'the exercise of government authority' in the

area of healthcare means, and which services are covered by this remit and which are immune to GATS.

However, this question has joined several letters-writers in debate in the letter pages of *The Lancet, The Guardian* and *The Observer*, including Clare Short, Minister for Oversees Development, Richard Caborn, Minister for Trade, and Rudolf Adlung, of WTO Secretariat, arguing against members of the World Development Movement and academics who claim that GATS will undermine the undermine the provision of universal healthcare free at the point of delivery (Ruane 2001).

Whilst the British NHS remains a pubic service provided by government and paid for out of general taxation, it constitutes a service supplied 'in the exercise of government authority'. However, the NHS is no longer the state service monopoly it once was. Many individual services that form part of health provision have been out-sourced; over half of the hospital rebuilds since 1997 have been financed by PFIs. The 2001 Manifesto proposes introducing commercial, for-profits management into failing hospitals. These developments mean that the NHS is no longer a totally public service in the way it was 20 years or so ago. Competition and commercial considerations are already facts of life shaping many aspects of health services.

The defenders of GATS say there has been no attempt by a member country to challenge another country's provision of public healthcare, even where private providers are involved. They stress that

> 'GATS commitments have a real value in providing secure and predictable conditions of access to markets, which benefit traders, investors and, ultimately, al of us as consumers.'

However, the World Development Movement claims that its provisions once established will be 'irreversible' and that GATS negotiations:

> 'threaten to fundamentally change the way services are organised by permanently limiting governments' ability to intervene in service delivery in order that basic needs are met and electoral promises fulfilled' (both quoted in Ruane 2001)

Regional Factors

As pat of the EU, the UK government benefits from the reciprocity agreements between EU countries. As part of this arrangement, the government has promoted moves by local authorities and health authorities to outsource NHS clinical treatment and social care to nearby neighbours in Europe.

OPPORTUNITIES AND LIMITS TO FUTURE PARTNERSHIPS IN THE UK

The Third Way

The Third Way is neither the way of the market nor the state. This negative description makes it difficult to determine what The Third Way is. *The New NHS* (1997) says that

> In paving the way for the new NHS the Government is committed to building on what has worked, but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s. That approach stifled innovation and put the needs of institutions ahead of the needs of patients. But nor will there be a continuation of the divisive internal market system of the 1990s. That approach which was intended to make the NHS more efficient ended up fragmenting decision-making and distorting incentives to such an extent that unfairness and bureaucracy became its defining features. (Para2.1)

This type of argument is found in all the White Papers where the Labour government sets out its agenda for modernising public services: *Modernising Social Services* (DH 1998), *Modern Local Government* (DETR), *Modernising Government (Cabinet Office1999)*, etc.

Whatever new departures are signalled by the Third Way, the government repeatedly assures the public that the NHS will remain universal and free to the public.

At base, the government is following a pragmatic approach. *The NHS Plan* (2000) says that 'ideological barriers should not stand in the way of better care for NHS patients' (2000: 96). The language of *co-operation* replaces *competition* in the government's description of its Primary Care Trusts, which replace the purchaser-provider split.

Policy options for the Third Way in the NHS

1. Structural changes to NHS

In theory, the Labour government has scrapped the purchaser-provider split and introduced the new principle of 'integrated care'. In practice, this pulls together purchasers and providers into new NHS trusts, such as local Primary Care Trusts and Community Care Trusts, and allows for a degree of joint planning between the two sides rather than competition. However, the interests of purchasers and of providers remain distinct with the expectation that pursuing their different interests will promote efficiency.

This is Labour's major innovation in replacing the internal market. PCTs unite 'under one roof' providers and purchasers; general practice and community services. In some cases, social services and health services are being combined into new Care Trusts. By 2004, PCTs will control 75% of NHS budget. PCTs will commission social as well as health care. They will have resources to purchase private as well as public provision.

As part of this restructuring, new Transitional Care Beds for elderly – 5000 beds by 2004 costing extra £900K – are being introduced to unblock the flow of patients between hospital care and social care. In her critical assessment, Pollock suggests that the first episode of intermediate care – up to 6 weeks - will be free at the point of use; but subsequent stays will involve means tested charges for housing, living costs and 'personal care'. This raises issues about how 'personal care' is defined. This is in line with the Government's partial acceptance of the proposals of the Royal Commission on Long Term Care to pay for nursing care, but to charge patients for (i.e. means test) accommodation costs and, *pace* the Royal Commission, to charge for personal care.

2. NHS-private health sector concordat

The Corcordat: The NHS-private health sector concordat was announced in the 2000 *NHS Plan* and formalised by government and the Independent Health Association in the autumn**.** There is now a national framework for partnerships between the private and voluntary sector and the NHS, which includes a set of national guidelines to help primary care groups and trusts when they commission services.

The *Health and Social Care Act 2001* allows NHS Trusts to be shareholders in companies manufacturing new health products. It further puts in place a framework within which NHS Trusts can introduce charges for personal care. These developments redraw the boundaries between public and private healthcare and redefine free public healthcare.

3. Public Private Partnerships

According to the IPPR:

> 'A PPP is a risk-sharing relationship between the public and private sectors based upon a shared aspiration to bring about a desired public policy outcome.'

But Note:

- By private sector, the IPPR means voluntary, not-for-profit bodies (e.g. the new RailTrack, housing associations, hospital services) as well as for-profits bodies. *Diversity* is the key word now used. One public service can involve all three bodies.
- Risk-sharing is important.
- The stress on outcomes that are compatible with the public sector. Does this allow individual partners to make profits?

But:

- Fragmentation
- Safeguarding democratic accountability of NHS as public service

ECONOMIC OPPORTUNITIES

1. Labour is using a new argument to justify changing the ownership of the means of production from public to mixed ownership. Ownership of the means is not important; whilst securing the ends of providing high quality, free and universal services is. A modernised public service needs a more diversified system of provision and investment. Introducing new private sector talent in to management and private capital into public services will secure this end. Building Better Partnerships say, for example,

> 'The enduring goals of public policy must be distinguished from the particular means through which they are pursued at different times and in different circumstances'. (IPPR2001: 15)

Here arguments about means are being separated from arguments about ends. The ends remain the same, but the means are redefined. This argument was first used when the Labour Party rewrote Clause IV.

2. Private Finance Initiatives in NHS

PFIs are a form of borrowing, not funding, public provision that shift the burden onto future generations. The public sector repays the full cost of the infrastructure and services to the private sector in annual payments over periods of 20 to 30 years. This is like buying a house on a mortgage in that it spreads the costs of repayment over a long period. Because of interest payments, the cost involved is higher than paying upfront (Pollock et al 2001). One example given in the letter pages of *The Guardian* states that the original PFI costing for the rebuilding of the University College London Hospital was £160m, for which UCLH would pay £20m a year for 30 years, as well as £10m a year for providing services – a toal of £900m (Cullinan).

There has been a substantial shift in the proportion of services carried out in the private sector. Pollock et al (2001) uses government figures to show that the proportion of annually managed public expenditure going to private suppliers has risen since 1977:

	Percentage of public expenditure going to private suppliers
1977	28
1991	38
1999	57

Now over half of public expenditure goes to private suppliers, and this proportion will increase with PFI. Opponents of PFI fear that this will take the control of public expenditure in the hands of private corporations.

The NHS Plan lists some interesting areas of innovation in healthcare which will depended on PFI/PPPs:

1. PFI is being used extensively to finance the bulk of new NHS hospital building schemes (38 in all), half of which, *The NHS Plan* claims, will be open by 2003/4.

2. PPPs involved in developing new generation of Diagnostic and Treatment Centres for elective operations completed overnight or in the same day. They will separate routine hospital; work from emergency work. 20 DTCs by 2004.

3. NHS Local Improvement Finance Trusts.

ECONOMIC LIMITS

1. Standards

Support for post-operative problems. NHS hospitals have highly qualified back-up staff on stand-by if post-operative problems occur. Private hospitals normally have only Resident Medical Doctors (usually junior doctors with little expertise) on stand-by; few have round the clock emergency cover. Consequently, in 2000 there were 142,000 admissions from private hospitals to the NHS – out of a total of 800K elective surgical procedures (Pollock 2001).

Hospital Cleanliness. The government's revelation of the 'dirtiest hospitals' in Britain showed that 4 out of 5 trusts that run the 10 dirtiest hospitals employ private contractors to clean their wards (Pollock 2001).

2. Transaction Costs and Efficiency

Transaction costs - the cost of managing, marketing and contracting a new product - rise as the provision becomes more complex: compare refuse collection with NHS (Pollock 2001). The NHS generated low transaction costs – monitoring services, contracting. For example, administration cost NHS about 5% of total costs until 1990s. After 1990 the introduction of internal market led to increased admin costs from 5% to 12%; and the ratio between nurses and admin staff fell from 3.5:1 in 1981 to 2:5.1 in 1996. In the USA - where there is a mix of public hospitals, non-for-profit charity hospitals and for-profit hospitals – 26% of the budget is spent on admin costs. In for-profit hospitals 34% of budget is spent on admin costs (Pollock 2001).

3. Limits to Market Opportunity

Further limits to market opportunities may follow in the wake of the government's decision to 're-nationalise' Railtrack with no compensation. This could affect future initiatives where private sector partners are sought for the purposes of investing in new public assets.

4. Labour Costs

PFIs have been attractive to companies because of the affect of greater competition on the costs of labour. Put more directly, scarce labour employed in a public sector monopoly is protected from the competitive pressures of the open market. Whilst greater competition can push labour costs up or down, depending on the level of labour demand, the 2001 Labour Manifesto promise to protect the conditions of work for NHS employers who are outsourced. This will provide more of a level playing field for groups of workers, a policy based on social justice rather than economic efficiency.

Conclusion: Implications of PPPs in the NHS for Private Healthcare

The endorsement of PPPs cuts three ways.

The private sector would have to accept its part in fulfilling broader social goals beyond the normal goal of profit maximisation.

The government would have to keep its pledge to provide public services universally and free of charge. Critics fear that the loss of social care and residential care to the private market over the last 20 years, resulting in the extension of means tested charges and the loss of universal access to social care, provides a picture of the future of the NHS if subject to increased private sector involvement.

Individuals would have to be willing to bear more welfare costs privately – pensions, long term care, certain health costs such as hotel charges and personal care – and to support a degree of redistribution that finances public care for the poorest. Could this be done in a way that did not make NHS a means-tested services on the same basis as social care? The extension of means testing under recent Tory and Labour governments suggests that the NHS could succumb. The debate on means testing is part of the wider debate on privatisation.

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