The plot against the NHS

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Plot: a secret plan, esp. to achieve an unlawful end; a conspiracy; Conspiracy: combination of people for an unlawful or reprehensible purpose.

(Oxford English Dictionary)

In July 2000 the Independent Healthcare Association, representing Britain’s still very modest – by international standards – private healthcare industry, was in the middle of negotiating a ‘concordat’ with Tony Blair’s second Secretary of State for Health, Alan Milburn. The Association’s leading negotiator, Tim Evans, was very clear on the ultimate aim of the concordat. He looked forward, he said, ‘to a time when the “NHS” would simply be a “kitemark” attached to the institutions and activities of a system of purely private providers’ (1).

At the time this sounded like the kind of fantasy you might expect from a policy adviser to the far-right Adam Smith Institute, which Evans also was. The NHS was still a taken-for-granted fixture of British life and values. But less than three months later a concordat was reached to make private companies permanent providers of treatment to NHS patients. By 2009 149 private hospitals, ‘treatment centres’ and clinics were treating NHS patients ‘on the NHS’, and using the NHS logo.

By 2014, if Cameron’s and Lansley’s Health and Social Care Bill becomes law, the remaining NHS hospital trusts, mental health trusts, ambulance trusts and the rest will all have been converted into independent businesses, increasingly indistinguishable from private companies. They will be competing in a market, in which the penalty for financial failure will be either closing, or being taken over by a private company (2). A growing number of nominally NHS hospitals are also expected to be under private sector management. Indeed, under the new Bill there is nothing to stop all NHS services being taken over by private providers.

Of course the fact that the privatisers’ dream is so close to being realised, and so astonishingly soon, isn’t evidence of a plot or conspiracy. Breaking up the NHS and replacing it with a healthcare market was not an illegal aim, or even reprehensible, at least in the eyes of those involved. In a democracy everyone is free to pursue their own interests and preferences.

Yet it was a plot. What made it a plot was its covert nature. Neither parliament nor the public have ever been told honestly what was intended. Misrepresentation, obfuscation and deception have been involved at every stage. Opinion polls show that, any time since 2000, if the public had been asked whether they wanted to see the NHS broken up and replaced with a healthcare market on American lines, to be run for profit by a variety of multinational health companies, private equity funds and local businessmen, they would have overwhelmingly rejected it (3). If the idea had been openly put before parliament only
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a handful of Conservative MPs in very safe seats could have risked supporting it. Whatever its faults, the NHS remains the most popular institution in the country. So if the project was to succeed it was essential to minimise public attention to what was really intended – and when attention could not be avoided, to obscure it.

The year 2000 presented the marketisers with an unprecedented opportunity. By promising a massive one-third real-terms increase in NHS funding, to be achieved over the next five years, bringing it up to the EU average, Tony Blair made available money that could be spent on creating a market without seeming to be at the expense of urgently-needed services.

The increase was intended to remove the valid complaint by NHS staff and others that the service’s fundamental problem was chronic underfunding. Among other things, NHS staff received substantial pay rises – in the case of most GPs, a dramatic rise. In return Blair asked the leaders of the NHS to sign up to a new ‘NHS Plan’, which called for radical improvements in the way services should be run, patients treated, complaints handled, and so on (Department of Health, 2000). A long list of senior doctors, nurses, managers and others were happy to sign. Most of the aims made sense, and with new resources they thought they could be achieved.

The NHS Plan was packaged as being about ‘modernising’ the NHS, making it more efficient and more responsive to patients’ needs. It said nothing about a healthcare market. It did say that the time had now come ‘to engage more constructively with the private sector’ and end the ‘standoff’ which had existed between it and the NHS for decades. It said that ‘ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients’ and the NHS should ‘harness the capacity of private and voluntary (meaning private non-profit) providers to treat more NHS patients’. And a section towards the end announced the new concordat, which Milburn was in the process of finalising.

The concordat suggested that the private sector might provide the NHS with more services, such as pathology, imaging and dialysis, but as regards treating patients the only suggestion was that more regular use might be made of private hospitals to take advantage of their spare capacity. Nowhere did the NHS Plan even hint at the possibility of making the NHS into a mere kitemark applied to a system of for-profit companies.

Four years later the government published an ‘NHS Improvement Plan’ which focused on ‘patient choice’ and said that by 2008 there would be a ‘growing range of independent sector providers’ for NHS patients, providing up to 15 per cent of all ‘elective’, non-emergency procedures. But there was still no suggestion that this was meant to be a stage in the conversion of the NHS into a full healthcare market (Department of Health, 2004, 10).

Yet behind the scenes key policy-makers were working precisely towards that end, creating one opening for the private sector after another – in ways that had indeed been sketched in the NHS Plan, though without spelling out their real implications. By 2004, in fact, all the main elements of a market were in place – Primary Care Trusts (PCTs) acting as commissioners, Foundation Trusts competing with a gradually widening range of private providers, treatments priced and paid for patient by patient, and the beginnings of an IT-based system of patient choice.

Glimpses of what was intended did surface occasionally. John Reid, when he was
Secretary of State for Health, caused a brief commotion when he said NHS hospitals that failed to attract patients would close (BBC News Online, 2005); and his successor Patricia Hewitt did the same when she said that there was no upper limit to the percentage of NHS work that could be given to the private sector (Carvel, 2006).

But these public admissions, prompted by the need to keep the private sector sweet in face of what it saw as a far too sluggish rate of progress towards a market, were soon forgotten. As a result very few people understood what was really intended by the strategists inside the Department of Health. When Andrew Lansley’s White Paper of July 2010 revealed what was really in store many MPs, and even many doctors, struggled to comprehend it.

So in spite of its great popularity, Britain’s most famous post-war social achievement was unravelled through a series of step-by-step ‘reforms’, each creating the basis for the next one, and always presented as mere improvements to the NHS as a public service. They were billed as measures to reduce waiting times, to offer more ‘choice’, to achieve ‘world class’ standards, to make the NHS more ‘patient-centred’ – anything but the real underlying aim of the key strategists involved, to turn healthcare back into a commodity and a source of profit.

Each of the so-called reforms involved persistent, behind-the-scenes lobbying and fixing by a network of insiders – inside the Department of Health, above all, but also by a wider network, closely linked to the Department: corporate executives, management consultants, ministers’ ‘special advisers’, academics with free market sympathies and a taste for power, doctors with entrepreneurial ambitions – and the House of Commons Health Committee, packed with just enough compliant back-benchers and deliberately insulated from advice from expert critics of the market agenda. Not to mention a large and growing corporate lobby.

Each ‘reform’ needed its own quantum of dissimulation and occasionally downright lies. The culture of the Department of Health was radically transformed. In place of old-fashioned ideas of accountability and fidelity to facts the priority shifted to misrepresentation and spin. This was accelerated by the fact that from the late 1990s onwards more and more private sector personnel were active inside the Department, often in leading roles.

Many were initially involved as consultants on PFI (Private Finance Initiative) hospital contracts, which the government made clear was the only way a hospital could be rebuilt or replaced. By 2010 a total of 103 PFI hospital schemes, originally valued at £11.3 billion, but expected to cost £65 billion over their lifetimes, had been completed or were in progress (Percival, 2010). To get a PFI contract the PFI way of financing had to look better ‘value for money’ than using publicly borrowed finance, and this led to systematic manipulation of the figures. Even the Deputy Controller and Auditor-General admitted that this involved ‘pseudo-scientific mumbo-jumbo’ in which ‘if the answer comes out wrong you don’t get your project. So the answer doesn’t come out wrong very often’ (Jeremy Colman, quoted in the Financial Times, 5.06.2002). Civil servants had to unlearn some long-established principles of objectivity and honesty in order to sign off on PFI projects.

And after the year 2000 large numbers of private sector staff were directly employed by the Department. Departmental documents increasingly looked and read like business
promotional material. Divining their real meaning called for the skills of a cold war-era Kremlin-watcher.

What lay behind the marketisation drive? The interests of the corporate health industry – global as much as British – were obvious. The huge NHS budget, with its assured flow of tax revenues, was of intense interest not only to healthcare multinationals such as the American Health Maintenance Organisation (HMO) UnitedHealth and the South African hospital chain Netcare, but also to companies such as Atos Origin, a French software multinational, and to various private equity companies equally lacking in any healthcare background – as well as to dozens of smaller British firms, all keen to get in on the act. The interest was not all on one side. Several ministers and numerous civil servants left to take highly-paid jobs in the private healthcare sector. But not all ministers and civil servants saw a financial advantage for themselves. What motivated the rest to join in?

There is no doubt that in 2000 the NHS was in need of modernisation, and no one should underestimate the scale of the task, even when very substantial additional funding was made available. The NHS is a huge and complex system, consisting of 1.3 million people working in hundreds of national, regional and local organisations, with diverse job categories and subcultures and interrelationships. Millions of people depend on it to help them deal with some of the most troubling and even life-threatening problems they confront. It can’t be lightly tampered with and so it poses a huge challenge to anyone trying to change it.

One can understand how politicians and officials, impatient with the pace of wished-for improvements, could be tempted by the idea that the pressure of competition could achieve what they found so difficult to achieve with the financial and administrative levers at their disposal. The message they constantly heard from businessmen was that they could accomplish in a week, with one hand tied behind their backs, what NHS managers seemed unable to do in a year, or even five.

Many strategists within the Department of Health were attracted by the notion that they could import elements of market-based healthcare systems elsewhere which looked to them more efficient, and use them to ‘gee up’ the surrounding structures of the NHS, without going all the way to a full-scale market. Such policy-makers can be thought of as ‘marketisers’, in the sense that they wanted the NHS to operate more like a market, while remaining publicly funded and managed. Others can be better thought of as ‘privatisers’ like Tim Evans, who thought that only private companies competing in a full healthcare market would achieve the desired efficiencies.

Unfortunately the marketisers continued to advocate market models of care even when experiments showed that market-based imports were not efficient at all – as with UnitedHealth’s ‘Evercare’ programme, for example. Evercare, which the huge American HMO was paid a large sum to test in four regions of England, was supposed to reduce emergency hospital admissions for elderly patients by 50 per cent. But when it was evaluated it turned out to be unlikely to cut admissions by more than one per cent (see Pollock, 2005, 13-14, 249). The marketisers had evidently not reckoned with the fact that England’s system of primary care was already accomplishing what Evercare does in the US, where there is no free primary care. The main lesson the Department of Health seemed to draw from this experience was not to evaluate such experiments.

Besides being ready to ignore evidence, many of the marketisers in the Department,
and their academic and think-tank advisers, also imagined that the state would always set
limits on the role of market forces. They thought market forces would always operate
‘within a planned and managed system’, as Labour’s shadow health secretary, John
Healey, put it in the Commons in February 2011 (5). They assumed that ‘the power of the
markets’ could be ‘harnessed’ to drive needed improvements in the NHS, without market
forces becoming too strong to remain planned and managed. Perhaps they also imagined
that the Conservatives would never return to power and complete the conversion of
marketisation into privatisation.

Probably few of the strategists under Milburn and his New Labour successors were
committed privatisers from the start, although some undoubtedly were. But as the decade
progressed the distinction became less and less meaningful. Policy-makers abandoned
their critical role and talked in increasingly vague terms about ‘the direction of travel’,
avoiding the need to say what the destination was. As more and more NHS activities were
handed over to private enterprise the companies involved were described as part of ‘the
NHS family’. Among policy-makers the notion that the NHS might end up as no more than
a kitemark gradually ceased to be unthinkable.

By 2010 marketisation clearly entailed not just the possibility but the longer-run proba-
bility of privatisation. Yet the fact remains that all the evidence shows that privatisation
makes health care more costly – and worse. The evidence from the US confirms what
economic theory says, that markets will not produce good health care for all, as the NHS is
pledged to do. A Treasury document published in 2003 clearly outlined the reasons why
this is so: price signals don’t work in relation to health care; the consumer lacks the neces-
sary knowledge, creating a risk of overtreatment; there is a potential abuse of monopoly
power; it is hard to write and enforce contracts for medical treatment; and ‘it is difficult to
let failing hospitals go bust – individuals are entitled to expect continuous, high-quality
health care wherever they are’ (HM Treasury, 2003, 12-14) (6).

Why was all this ignored? If the strategists in the Department of Health thought they
had contrary evidence or superior theory they should have come out openly and said so.
But they were never called on to defend their ideas, precisely because they proceeded so
covertly.

A 2010 survey of 20,000 patients in eleven industrialised countries for the US
Commonwealth Fund found that the NHS was almost the least costly healthcare system of
them all, and at the same time gave one of the best levels of access to care. Other coun-
tries not only spent more per head but also charged patients directly, reducing equality of
access. Only Switzerland reported faster access to care, but Switzerland also spent some
35 per cent more per head than the UK. Only New Zealand spent less per head, but one in
seven New Zealanders said they skipped hospital visits because of cost. In the US, which
spent almost twice as much per head as the UK, one in three people avoided seeking care
because of cost (Schoen et al., 2010) (7).

To ignore all this evidence and embrace the idea of replacing one of the most cost-
efficient health systems in the world, as well as one of the fairest, with one modelled on the
most expensive and unequal system (the American), sets a new standard for ideologically-
driven (and interest-driven) policy-making.

But the NHS has not only worked well, providing high-quality, equal care for everyone,
free of charge, at low cost: it is also the historic achievement of millions of people – those
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who fought to establish it, those who have spent their lives working for it, and everyone who has paid their taxes to build it up over the more than sixty years since it was created. Its founding principles of comprehensiveness and equal access for all have been core values of modern British society. Working to marketise it, and finally privatising it, without any democratic mandate – without even explaining that aim to parliament or the public, is as close as it gets to being not just unscrupulous, but actually unconstitutional. The question is whether the English people – Scotland, Wales and Northern Ireland having escaped the plotters’ reach – will accept having this precious part of our heritage filched from under our noses.

Postscript: the Health and Social Care Bill 2011

Andrew Lansley’s Health and Social Care Bill is a huge and complicated affair. Even the Commons Health Committee couldn’t understand how it will work. For example, on the key question of whether patients can choose to be treated by ‘any willing provider’, rather than having providers chosen for them by GP Commissioning Consortia, the Committee said: ‘the Department [of Health] needs to explain how it will ensure that commissioners are not simply bill payers’ (Health Committee, 2011, Recommendations, para 47).

In other words, will patient choice drive change, or will patients have to conform to choices made for them by the Consortia? Enormous power to resolve this and other questions is placed in the hands of two new bodies, an NHS Commissioning Board, and Monitor, the healthcare market regulator. Both will be appointed by the Secretary of State for Health. The Commissioning Board will be loosely accountable to him, while Monitor, with David Bennett, a senior McKinsey staffer, now in the chair, is accountable to no one. The fate of our health services will in future rest with these politically-appointed, market-friendly placemen and women.

But certain things are clear. The Bill removes the existing obligation on the Secretary of State for Health to provide a comprehensive health service, and does not lay that obligation on anyone else. ‘GP Commissioning Consortia’ – accountable only to the Commissioning Board – will be free to decide what NHS services should be available for their patients, and even to set fees for some of these. Private companies will be able to bid to provide any service that they can make a profit from, leaving NHS hospitals with the unprofitable remainder and forcing many of them to close. Any attempt by Consortia to preserve local hospitals by giving them preference in making contracts will be open to challenge (one private company, Circle Health, has already challenged two PCTs for doing this); and Monitor is mandated to promote competition.

GPs are already free, as independent contractors, not to accept patients, and so presumably are companies such as The Practice which provide GP services, and patients who are not registered with a GP will not be entitled to the NHS services commissioned by the Consortia to which all GPs must belong. Patients who are costly or difficult and can’t find a GP to take them on, and people such as asylum seekers and undocumented immigrants, will be forced to rely on local authorities to get treatment, which will not be free.

What is implied are health services increasingly provided by private companies, or by surviving NHS foundation trusts, which will be forced by competition to act like private companies. Free services will be limited to what each local GP consortium decides to pay
for, with fees charged for what they consider extras. A raft of current policies is already pushing the NHS towards the US model of care (see further below). The Bill will complete the process.

*Cameron and Lansley’s ‘listening’ pause*

What Cameron, Clegg and Lansley’s ‘pause for listening’ signifies is that the Bill is in deep trouble. The pause was intended to give a noticeably isolated Lansley time to try to find compromise amendments which will allow Cameron and him to say they have responded to public opinion, allow the Liberal Democrat leadership to say they have secured concessions, and still allow Lansley and the private sector to replace the NHS as a comprehensive and universal service with a healthcare market.

Cameron now knows he has allowed a tunnel-vision privatiser, who is close, and deeply obligated, to the private health industry, to push ahead with a very ill-thought-out Bill that risks major electoral penalties. He has been waiting to see whether Lansley can buy off enough opposition. For Clegg the question is whether, after losing the AV referendum, Scotland, and a raft of local councils, he can survive as Liberal Democrat leader if he gives up the party’s position on the NHS as he has on so much else – student fees, immigration, the banks. A large number of Liberal Democrat rank and file see the defence of the NHS as a final sticking-point that must not be surrendered, and voted to this effect at their March conference in Sheffield. For Cameron the question is whether he can keep the Coalition in being if Clegg demands changes in the Bill that are too radical for Lansley to accept, or whether he can drop Lansley and the Bill without provoking the wrath of his own backbenchers.

There is a further possibility: the drastic, unprecedented – and so far remarkably under-explained – cuts being imposed throughout the NHS could produce so much financial chaos and unpopularity that the whole enterprise comes to a halt of its own accord. But so long as the pause game is being played we need to look at the options. Cameron has declared that ‘major’ changes will be considered. What might these be?

*Proposed amendments to the Bill*

At the Liberal Democrat conference in March the membership forced the adoption of an eight-point resolution which declared support for the aims of Lansley’s Bill, but actually expressed radical opposition to it. The eighth point expressed the real intent of all the others: it called for ‘an NHS, responsive to patients’ needs, based on co-operation rather than competition, and which promotes quality and equity not the market’. After the conference twenty-one ‘essential amendments required to implement the Conference Motion’ were prepared by the Social Liberal Forum under the leadership of the former Liberal Democrat shadow health secretary, Dr Evan Harris (Social Liberal Forum, 2011). Any of the main amendments in this list would be unacceptable to Lansley. Taken together they are completely incompatible with his Bill.

In sharp contrast with these, numerous amendments have been proposed by various groups sympathetic to the government with a view to improving it and winning support from the NHS workforce and the public. The Commons Health Committee made various proposals for making GP Commissioning Consortia more transparent and accountable. The NHS Confederation, representing NHS managers, also wants Consortia to be account-
able, and calls for rules to govern potential conflicts of interest between GPs in the Commissioning Consortia and private companies in which some GPs may have an interest (NHS Confederation, 2011). It thinks that the scope of competition should be better defined and the speed of change slowed down. Two academics close to the Department of Health and the Commons Health Committee urge similar improvements (Ham and Walshe, 2011). All these suggestions aim to make Lansley’s Bill work, not to preserve a universal free and comprehensive NHS. Lansley could accept most of them, and could easily present acceptance of even one or two as ‘substantive changes’.

The real field of political calculation was signalled in early April by the deliberately over-dramatised announcement by the Liberal Democrat MP Norman Lamb, a Coalition whip and senior parliamentary adviser to Nick Clegg, and an alleged expert on the NHS, that Liberal Democrat MPs will ‘be unable to support’ the Bill if their concerns were ignored, and that he would resign (Watt and Campbell, 2011). Yet all he demanded was that GPs should not be forced to join Consortia, and the transition process should be slowed down! Quite apart from the impracticality of the first idea, Lamb’s *démarche* suggested that the Liberal Democrat leadership was hoping that it could seem to be getting concessions while actually making no significant changes to the Bill at all. But would the Liberal Democrat rank and file accept being fobbed off with something so completely irrelevant to their concerns? If not, would Nick Clegg decide to tough it out, as he has over so many issues, and hope for long-term rewards?

*The elephant in the room*

But the Coalition partners are not the only parties to the behind-the-scenes negotiations that will determine the fate of Lansley’s Bill. Several other de facto cosignatories to the draft Bill can be identified, the most notable of course being the private healthcare companies which stand to gain the most from the opening up of the NHS to market forces, and their attendant ‘policy community’, including the well-heeled Kings Fund and Nuffield Trust think tanks.

This network of policy wonks has consistently endorsed the US ‘managed care’ (HMO) model, and while the terms of the Bill have necessitated a slight adjustment in their conceptualisation of how the market should proceed, the basic ingredients remain: new service delivery models (essentially services removed from hospitals and integrated with primary care), combined with insurance. Assisting them in expanding the range of such delivery models have been some surprising allies, including the Royal College of General Practitioners (RCGP), perhaps lured by the promise of clinical leadership within the evolving market.

Almost all of the structures required to make Lansley’s Bill possible were put in place by the previous government. Competition, choice, payment by results, transforming NHS hospitals into autonomous businesses, and the fracturing of the workforce’s allegiance to the NHS, not only created the necessary entry points for the private sector, they also served to reframe the NHS along managed care lines. New Labour also oversaw and subsidised a dramatic expansion of the share of the NHS budget made available to the private sector. These ranged from bloated PFI contracts and the almost risk-free Independent Sector Treatment Centre programme, to the guaranteed initial volumes of NHS work offered to the Extended Choice Network of private hospitals. The Department of
Health also gives companies providing GP services an average of three to four times more per patient than it gives to traditional GP partnership practices. Major health insurance companies from both sides of the Atlantic have been granted access to the NHS’ commissioning coffers, while private and ostensibly ‘GP-led’ companies have been expanding, increasingly backed by private equity. Outsourcing firms, out-of-hours companies, urgent care centres… the corporate presence in the NHS is already substantial (Leys and Player, 2011, chapter 6).

But more important for the future under Lansley’s Bill, if it passes, will be the guiding template which has informed the whole process of marketisation under New Labour. US ‘managed care’ involves a degree of both separation and interplay between hospital providers and physician groups, but with insurers playing the determining role as to which services should be offered.

Under New Labour this was to be achieved by Integrated Care Organisations (ICOs). Multidisciplinary teams of medics would be housed in a nation-wide infrastructure of polyclinics, providing primary and secondary care, in contractual relationships with foundation trust hospitals, and with decisions on commissioning undertaken by PCTs. The aim was that PCTs would increasingly outsource their commissioning to one or more of the fourteen health insurers and global consultancy firms listed in the Framework for Procuring External Support for Commissioners (FESC).

The debt crisis, however, put paid to the availability of capital required for a state-directed polyclinic building programme. PCTs were also demonstrating unwanted institutional allegiance to the NHS, and full outsourcing to the FESC companies was proving difficult to achieve. GPs were seen as more amenable agents of the market drive, through lack of expertise in commissioning, or from simply having to spend their time with patients. And sufficient numbers of entrepreneurial, market-oriented GPs could be found to head up the new Commissioning Consortia, creating the necessary alignment with the FESC corporations, while also giving the market a patient-friendly appearance.

But the end of Ara Darzi’s plan to cover England with polyclinics does not mean that Integrated Commissioning Organisations will disappear. Rather they are being pursued on more frankly profit-oriented lines, such as the project of the Surrey-based McKinsey spin-off, Integrated Health Partners, to turn a planned underspend in a Consortium’s annual budget – savings on patient care – into a corporate profit (Adetunji, 2011). It also appears that the Royal College of GPs, under the leadership of its previous chair Professor Steve Field, had already been developing an alternative form of service delivery model to fit the managed care template. GPs were unwilling to be corralled into polyclinics, but the College developed a model of GP federations – large groups of GPs which would act as service providers distinct from, but contractually aligned with, commissioning bodies, and would cover the requisite number of patients. Through a brief but evidently telling contract with the US health corporation Aetna and the consultancy giant PricewaterhouseCoopers (Royal College of General Practitioners, 2010), the College gained the necessary understanding of the relationship between delivery and commissioning, and the models of risk retention and risk transfer, that are involved in the US healthcare model. Not surprisingly it is now the same Professor Field whom Lansley has appointed to lead the ‘Future Forum’, the group of patient representatives, doctors and nurses and managers who are supposed to ‘listen’ and report back to Government on the changes needed in his Bill (West, 2011).
Meanwhile the private sector is licking its lips, metaphorically speaking, seeing the situation as a win-win one. Adrian Fawcett, the chief executive of the largest private healthcare provider, the General Healthcare Group, expects the private sector to expand both from competing for NHS work and from the fact that the NHS won’t be able to meet demand, thanks to the cuts, so that demand for private care will also increase. A majority of private sector health company chief executives think that the government will follow through on most of the promises made to the private sector in Lansley’s Bill (Dowler, 2011). This calculation will be based partly on their close links to Lansley and his supporters in the Conservative Party, but also on the fact that Primary Care Trusts are already being dismantled and replaced by ‘shadow’, or so-called ‘pathfinder’, GP Consortia.

To sum up: it is very important to understand that while the details of the Bill are being debated, the plans and models for achieving its aims are quietly going ahead, rarely mentioned, let alone analysed, in the mainstream media.

Can the Bill be defeated?

The letter sent out to the NHS in mid-April by the Chief Executive, Sir David Nicholson, calling for ‘momentum on the ground’ to be maintained, suggests that as the cuts begin to bite, PCTs unravel, waiting times lengthen and treatments are withheld, a degree of something like panic has begun to set in. The NHS Confederation’s submission to the ‘listening exercise’ says the reforms will provide neither the productivity gains nor the financial savings that are needed; the proposals need a ‘significant overhaul’ and can’t be made on the timetable Lansley envisages, while the BMA’s submission finally calls for the Bill to be withdrawn (Johnstone, 2011). At the Royal College of Nursing’s Liverpool conference on April 13 an unprecedented vote of no confidence in the Health Secretary was passed by 478 votes to 6.

On 19 April 2011 David Cameron, speaking on BBC Radio 4’s Today programme, assured us that he is committed to an NHS free at the point of use, that it is a ‘precious’ institution, and that he sincerely wants to see the Bill ‘improved’. Will whatever changes he accepts be sufficient to win the ‘more full-throated’ support which he said (apparently without irony) that he needed from the nurses and the rest of the NHS workforce? Will his and Lansley’s hastily stitched-together ‘Future Forum’ of forty handpicked medics and others, and its pro-market ‘listening panel’ of five, be able to convince the media, NHS managers, the BMA and the public, that the predictably limited amendments they will propose are really major changes?

Or can popular pressure prevent the media colluding with the government’s inevitable attempt to present as radical amendments that will actually ensure that the key aims of the Bill are still achieved? There are various straws in the wind. For example Nick Clegg has finally announced that the Liberal Democrats will insist on the Bill being recommitted to the Commons Bill Committee, when this had already been floated by Lansley, and has called for further delay, when Cameron had already hinted at that. He has also said that the NHS must be based on cooperation, not competition, and that hospital doctors and nurses, not just GPs, must be in charge of the new Consortia – prompting Conservative backbenchers to mount a campaign to insist that Lansley not to give way, but to draw ‘a red line in the sand’ to keep competition central to the Bill (Martin, 2011). Most dramatic of all, Steve
Field, the chair of the listening Forum, and in his previous role as chair of the Royal College of GPs, the covert anticipator of the Consortia as described above, has announced – before the Futures Forum had completed its work – that Lansley’s reforms are ‘unworkable’. He too wants Monitor’s mandate changed from promoting competition to promoting cooperation and integration of services, NHS hospitals’ ‘core services’ such as maternity and Accident and Emergency departments protected, a local hospital doctor and a nurse (just one of each, apparently) included on consortia boards, among other things (Campbell, 2011).

What is going on here? The Department of Health’s comment that ‘Steve Field is quite right to say we’re looking for changes to make the legislation more clear and effective’ is suggestive. What the government needs is a confused atmosphere in which apparently major changes are being apparently accepted, even in quarters judged sympathetic to Lansley, allowing the Coalition to say it is making big changes while assuring Conservative backbenchers it is not. From now on the devil really is in the detail, as Labour’s shadow health minister Liz Kendall has pointed out, saying that it will be ‘extremely difficult’ to amend the clauses in a way that will prevent ‘full blown competition’, and that ‘just inserting a few words about promoting collaboration will not change the heart of the Bill’. She put her finger on the issue by pointing out that 82 of its 282 clauses are about competition (Sell, 19 May 2011). The government is not in fact going to allow a few dedicated MPs to rewrite its Bill clause by clause to eliminate the threat to the NHS as a public service, even if such MPs existed.

And it is clear that the Labour Party is not going to oppose the Bill in Parliament in that sort of relentless fashion, let alone mobilise against it outside Parliament. Labour’s shadow Health Secretary has belatedly distanced himself minimally from New Labour’s NHS record, saying that ‘we may have pursued the involvement of private providers for its own sake’, and that that was wrong (Sparrow, 2011). But Miliband has declared that Labour’s record on the NHS is ‘excellent’ and that ‘change is essential’ (reported in The Independent 4.04.2011). Not much room for coherent opposition there.

Yet efforts by NHS staff (including the nurses, the NHS unions, and a near-majority of doctors at the BMA’s special representative conference in March) have combined with widespread action by concerned citizens to create sufficient evidence of strong public opposition to pose a serious political dilemma for the Coalition.

Whether, without national political organisation and leadership, the pause can be converted into a retreat, is the key question. Media collusion with government spin must somehow be exposed. Reasoned but uncompromising and sustained pressure on every kind of political representative, from local councillors to the Lords, will be crucial. The Coalition need to fear that if they allow the substance of the Bill to become law they will be forever tagged with responsibility for destroying the NHS, and will pay an enduring electoral price.

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References

Sell, S. ‘Forcing Monitor to promote integration won’t change “heart” of Health Bill’, GP 19.05.2011.

Notes

1. Interview with Colin Leys, 30.07.2000.
2. The implications of the Coalition’s Health and Social Care Bill 2011 are spelled out in Leys and Player, 2011, chapter 9.
3. Opinion polls can of course produce results tending to support a given view if the questions are designed to do so. The best evidence that people would reject an American-style
healthcare market is really the fact that the government have never asked for their opinion on it. But the basic finding of numerous polls is that most people want the NHS they have and are opposed to both competition and privatisation.

4. How other elements of the marketisation agenda were handled in successive documents following up the NHS Plan is discussed in Leys and Player, 2011, chapter 8.


6. The document did not apply solely to health care.

7. A government spokesperson could only comment sourly that ‘the UK lags behind many international healthcare systems on survival rates – for example, for diseases such as cancer or stroke – and the NHS must reform in order to achieve better outcomes’ (Guardian 19.11.2010) – as if that was quite sufficient to justify the government’s latest privatisation plans. It was later shown that the statistical basis for the government’s statement was fallacious – a point taken up briefly in Leys and Player, 2011, chapter 11.