The NHS Dismantled

The Americanisation of the NHS is not something waiting for us in a post-Brexit future. It is already in full swing. Since 2017 Integrated Care Systems (ICSs) have been taking over the purchasing as well as the provision of NHS services, deciding who gets which services, which are free and which – as with the dentist and prescriptions – we have to pay for. Known in the US as Accountable Care Organisations (ACOs), ICSs are partnerships between hospitals, clinicians and private sector providers designed – and incentivised – to limit and reduce public healthcare costs, and in particular to lessen the demand on hospitals. Health Maintenance Organisations (HMOs), the forerunners of ACOs, were pioneered by the US health insurance provider Kaiser Permanente in 1953. President Nixon's adviser John Ehrlichman explained to his boss the basic concept before the passage of the 1973 HMO Act: 'The less care they give them the more money they make.' In May 2016 Jeremy Hunt, then health minister, admitted at a Commons Health Committee hearing that Kaiser was a model for his planned NHS reforms. When a trial of ACOs was announced in the UK in 2017, it caused an outcry from campaigners and NHS England quickly rebranded them ICSs. But the Kaiser model isn't new to healthcare policy in the UK: it has been the inspiration for the long and discreet process of the dismantling and reformation of the NHS since the 1980s.

In his report to the Conservative Party's Economic Reconstruction Group in 1977, Nicholas Ridley wrote that

> denationalisation should not be attempted by frontal attack but by preparation for return to the private sector by stealth. We should first pass legislation to destroy the public sector monopolies. We might also need to take power to sell assets. Secondly, we should fragment the industries as far as possible and set up the units as separate profit centres.

After coming to power two years later, Thatcher was able openly to denationalise many industries, but the NHS, with its huge number of staff and institutions, its largely effective and equitable provision of healthcare and its great popularity, was a far more difficult proposition. In 1986 hospital cleaning services were privatised. In 1988 Oliver Letwin and John Redwood published *Britain's Biggest Enterprise: Ideas for Radical Reform of the NHS*, which proposed turning the NHS into an independent trust and advocated joint ventures with the private sector and the introduction of fees.

The first major legislative step was the creation of the internal market. Kenneth Clarke's 1990 NHS and Community Care Act split the NHS into 'service purchasers' and 'service providers': hospitals and GPs would compete for custom and the successful parties would be rewarded with greater funding. The influence of the HMO model and of the Kaiser consultant Alain Enthoven was acknowledged in Parliament

by the then Tory MP Quentin Davies. 'The fund-holding practice concept owes something to the system of HMOs in the United States . . . Elements of the Bill reflect some of the thinking of Professor Enthoven in his famous report and reflect his concept of an internal market.' Enthoven was seen as an expert on 'unsustainable growth' in health expenditure and in 1985 his report 'Reflections on the Management of the National Health Service' had advised the Thatcher administration that 'in competition doctors impose on themselves controls they would never dream of accepting if the government tried to impose them.' 'The system needed to be reconfigured,' he later explained, 'in such a way as to give incentives to motivate the self-interest.'

Letwin and Redwood's ideas also had traction in Tony Blair's 1997 National Health Service Act. Together, the 1990 and 1997 Acts turned NHS hospitals into trusts able to operate as commercial businesses. Many formed Private Finance Initiative partnerships to build and maintain hospitals – these deals, originally worth £11.4 billion, have lumbered the NHS with more than £80 billion of debt. Under New Labour a number of hospital trusts commissioned Kaiser and United Health, the largest US private health insurer, to run pilot programmes. 'Consumer choice' had been the mantra of the Thatcher era; under New Labour NHS patients became consumers and the goal 'patient choice'.

These changes were minor compared to those introduced by the 2012 Health and Social Care Act (Letwin was by then a senior figure in Tory policy-making), which enabled hospital trusts to raise 49 per cent of their budgets from private patients and other sources, and to use NHS 'brand loyalty' to attract patients to their private services. In 2017 Swindon's Great Western NHS Hospital advertised its private service saying: 'Our patients benefit from a premium environment while having immediate access to specialist services often only available in large NHS hospitals.'

The Act gave more than 60 per cent of the NHS budget to local Clinical Commissioning Groups (CCGs), comprised of GPs and other clinicians, to be used to commission services from the private sector as well as from the NHS. Writing anonymously, one GP described the change as 'how to get turkeys not only voting for Christmas but also plucking, basting and putting themselves in the oven'. Given their lack of business expertise, CCGs were provided with Commissioning Support Units run by private companies including KPMG, Price Waterhouse Cooper, McKinsey and Optum, the UK subsidiary of United Health. In practice, these companies now run the franchising of NHS services.

A key part of the 2012 Act, to which McKinsey was a significant contributor, was the abolition of the health minister's responsibility for national healthcare provision. This was left to NHS England under its new director, Simon Stevens, a former health policy adviser to the Blair govenment appointed by David Cameron because 'he knows more about NHS problems and market solutions than any man alive.' In his previous role as a CEO of

United Health, Stevens had led corporate opposition to the introduction of Obamacare. His 'Five-Year Forward View', launched in 2015, became the basis for NHS England's Sustainability and Transformation Plans (STPs), drawn up with Optum and McKinsey. The STPs were supposed to create savings of almost £5 billion a year by 2020. As in the Kaiser model, costs are cut by reducing access to care. (Meanwhile, the revolving door continued to turn: senior government and NHS England figures who took prominent positions at Optum include Cameron's health adviser Nick Seddon, NHS England's commissioner David Sharp and its mental health director Martin McShane.)

The STPs divided England into 44 CCG-run 'footprint' areas, all of which were put under pressure to amalgamate hospitals and shrink specialist units. Hospital beds have been progressively cut: the UK's bed-to-patient ratio is now one of the lowest in any developed country. Accident and emergency departments, which not only require expensive equipment and high numbers of staff but also take the brunt of social care failings, are in the process of being cut from 144 to about fifty. GP care is increasingly provided by 'physician associates', nurse practitioners and pharmacists, while patients are exhorted to use privately owned, profit-making online and app consultancies such as Doctaly, GP at Hand and myGP. Opening up new markets for US tech giants is a key factor in the reconfiguration of the NHS.

Enforced centralisation has resulted in 'hub' hospitals and fewer, larger GP practices: at least a thousand have closed since 2014 and the number with more than twenty thousand patients has tripled. With funding incentives from NHS England, GPs are merging their practices into competing, largescale organisations with names like Primary Care Networks and Super-Practices, or becoming partners in commercially driven Multi-Speciality Community Provider centres. These reduced and restructured services are open to takeovers by private companies. NHS hospitals now lease space on their own premises to private companies. Guy's Hospital, in the absence of the funding it needed to develop adequate cancer facilities, rented space to the Hospital Corporation of America for private cancer suites that were given access to the hospital's facilities. The merging of public and private provision in the same space usefully blurs the distinction between them. And the rationing of non-urgent operations such as hip replacements and restrictions on follow-up therapies – as well as increased waiting times – encourage patients to seek private treatment.

A recent report by the Strategy Unit, an NHS consultancy, acknowledges that ICSs are designed to 'moderate' demand and reduce spending, while their partners keep the savings they make if they run below budget. It cautions that, as with ACOs, there is 'only limited assurance that providers will not game the system and that quality will not suffer . . . large financial rewards may flow out of the NHS.' At the 2012 World Economic Forum, Stevens (then working for United Health) led proposals to replace public healthcare sys-

tems around the world with accountable care systems. His collaborators included Medtronic, the world's largest producer of medical devices (a US company based in Ireland for tax purposes), Qualcomm Life, which designs medical technology, and Kaiser. Since his arrival at NHS England, the influence of such companies has grown: IBM is now a lead supplier of IT; Optum runs GP referrals services and is in a partnership with the second largest GP federation, Modality. The UK's largest GP network, the Practice Group, is owned by the American company Centene. Similar companies, such as the Priory Group, are major players in mental healthcare provision and are involved in mental health ICSs.

Private companies, with their increased overheads, higher rates of borrowing and shareholder dividends, are inherently more costly to the public than state-funded services. Less obvious are the high costs of management and administration involved in franchising and marketing services. In the US these are estimated to account for more than 30 per cent of the $3.6 trillion spent on healthcare. A 2010 report commissioned by the Department of Health estimated management and administration costs at 14 per cent of total NHS spending, more than twice the figure in 1990. Commercial confidentiality laws and opaque NHS accounting make the costs of privatisation hard to quantify but privatisation is probably adding at least £9 billion a year to the NHS budget.

Stevens was recently praised by politicians and the media when he called for the repeal of Section 75 of the 2012 Health and Social Care Act, which requires competitive market tendering for the provision of services – ostensibly a move away from privatisation. But the real reason lies in the small print. Section 75 subjects private contractors to the Competition and Markets Authority. Its repeal will deregulate the sector and make ICSs more attractive to companies. Andrew Taylor, the founding director of the Co-operation and Competition Panel for NHS Funded Services, told a Commons committee hearing in May: 'I don't think anyone's realistically talking about removing the private sector from the NHS. What the proposals do in effect is deregulate NHS markets. They don't actually remove markets from the NHS.'

The Ridley Report's proposals for denationalisation are being hurried to fulfilment. NHS property and land assets worth £10 billion are being sold to private developers. The fragmentation of a once fully integrated service into competing and commercially-driven units is well advanced and has been accomplished without proper public scrutiny, knowledge, consent or appropriate Parliamentary legislation. Successive governments have been assisted by the failure of the media to recognise the overall shape of the project and sufficiently analyse the disparate changes. The contracting of ICSs by NHS England will be concluded within 18 months.

John Furse