The Twilight of the British Public Health System?

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Less than two years after the fall of Nazi Germany, a bankrupt Britain—reeling from the most destructive war in history and living under conditions of stark austerity—elected to create an extraordinary system of universal health care, the National Health Service (NHS). Aneurin Bevan, the Labour Party minister of health who played a crucial role in its creation, famously remarked that the NHS would "last as long as there are folk left with the faith to fight for it." Subsequent developments, it seems, have put his challenge to the test.

In 2012 David Cameron's Conservative-led government passed the Health and Social Care Act, legislation that opens the NHS to privatization like never before. Building on a series of neoliberal health care "reforms" dating back to the Thatcher era and coinciding with the dictates of our age of austerity, Cameron's law could very well mark the beginning of a slow end for the English NHS (the largely autonomous Scottish NHS has been going in a much different direction). To be clear, the law is not meant to privatize the system entirely; after all, caring for a whole population—including its poor, elderly, and chronically ill—is messy, complex, and frequently unprofitable, and so historically uninteresting from a commercial perspective. Instead, the law will allow—indeed, it will require—the competitive "tendering" of health care services to corporate providers, which can then pick off the profitable parts, bit by bit. Its provisions end the fundamental legal requirement that the secretary of state ensure comprehensive care throughout the country. The law encourages NHS facilities to provide uncovered services for cash, while at the same time reductions in funding force cuts in covered services. The law may even ultimately open new opportunities for fees to be charged at the point of service, in direct contradiction of the service's founding principles.

The Health and Social Care Act, in other words, will not end the NHS. It will fragment and commercialize it, while the demands of austerity will continue to stretch it thin. At some point, though the NHS will continue to exist, we may no longer be able to recognize it.

I. 1948–1980: "It Is Not a Charity"

Shortly after the NHS went into effect in 1948, a leaflet was distributed to all homes to explain the function and purpose of the new system:

> It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in times of illness.

Though its organizational structure may have been considerably complex, such a simple and straightforward summary spoke to the truly radical—and fundamentally universal—nature of the new service.

Its first few years in action revealed the great, unmet medical needs of the country, with the sudden surge in the use of health care resulting in substantial initial overspending. This precipitated, in the early

1950s, the introduction of fees for medications, eyeglasses, dentures, and eventually all dental treatment. Still, other care remained free at the point of service, and the NHS's general structure remained largely intact over the next few decades, protected by strong public support and by a consensus between Labour and Conservatives on the importance of the welfare state. Yet at the same time, the NHS was often starved of resources.

The NHS is frequently touted for its success at keeping the cost of health care low, easily beating not only the United States but also most of its continental peers with respect to efficiency. (In 2008, for instance—after a period of historically high spending—the UK was still only spending $3,129 annually per capita on health care, compared with $3,737 in Germany, $4,079 in Canada, and $7,539 in the United States.) Yet its frugality has time and time again gone too far, and the end of the 1970s—when the United Kingdom was facing anemic growth, marked inflation, and persistent deficits—was one such time.

II. 1980–1997: "Safe with Us"

By the time Margaret Thatcher came to power, therefore, the NHS was in a state of neglect. What was needed was more attention and more money, on par with that of other industrialized nations. But the modern neoliberal era was just beginning, both in Britain and in the United States; the Thatcherite prescription was, unsurprisingly, a dose of austere market medicine.

Still, she moved slowly on the NHS. In 1982, for instance, Thatcher distanced herself from a leaked internal cabinet think tank report that all but called for gutting the NHS (and the welfare state with it). "It is . . . worth considering," an early version of the report read, "aiming over a period to end the state provision of healthcare for the bulk of the population, so that medical facilities would be privately owned and run, and those seeking healthcare would be required to pay for it." The public was outraged by the leaked report, and in response Thatcher declared in her 1982 Conservative Party conference speech that the NHS was "safe with us," an assurance repeated by Conservatives ever since.

It appears, however, that Thatcher and her cabinet may not have been quite as horrified by such bold proposals as they claimed. Indeed, as the *Guardian* reported on the basis of cabinet documents released last year, Thatcher and her chancellor Sir Geoffrey Howe had actually commissioned and encouraged the report and discussed its recommendations at a special cabinet meeting. Howe, meanwhile, continued to defend the report even after the rest of the cabinet went the other way.

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But Thatcher understood that the Conservative stance on the NHS remained an ongoing political liability, so over the decade her administration moved slowly, but surely, in changing the service. Non-clinical hospital activities (like laundry and cleaning) were outsourced to private companies. Fees for dentistry, eye care, and prescriptions were raised again and again. Spending on new facilities was kept low. NHS long-term nursing care facilities were mostly closed, progressively replaced by private facilities. Hospital management was corporatized, with new "chief executives" replacing consensus management and the number (and pay) of business-trained managers throughout the system rising dramatically.

However, Thatcher's administration is best known for endeavoring to create an "internal market" within the NHS. Based in part on recommendations from the American managed care advocate Alain Enthoven, the reforms were meant to create a pseudo-marketplace within the NHS by splitting the system into "purchasers" and "providers." The former, composed of health authorities and some general practitioners (GPs), were to "buy" health services "sold" by newly created "trusts" (composed of hospitals and specialists). The system was costly, didn't produce much in terms of efficiency gains, and was rather unpopular. The GPs, some of whom now functioned as "fundholders"

charged with "buying" services for their patients, didn't seem to particularly like the additional job, while the split between GPs who became fundholders and those who didn't risked establishing a two-tier system.

The move was, in any event, politically ill-advised, and Labour was quick to capitalize on this. In the 1997 elections they ran directly against the "internal market": "Our fundamental purpose," read their manifesto from that year, "is simple but hugely important: to restore the NHS as a public service working cooperatively for patients, not a commercial business driven by competition."

III. 1997–2010: "To Restore the NHS"

On this platform, Labour won the 1997 elections by a landslide, gaining the biggest majority held by any government since 1935. Its health care mandate, therefore, could hardly have been clearer. Yet Blair's "Third Way" would prove in most respects—save one—a continuation of Conservative neoliberal health care policy.

Despite Labour's fierce election-time criticism of the "internal market," for example, the division into buyers and sellers was more or less maintained. Labour also passed legislation in 2003 that allowed NHS hospitals and care groups to apply for "foundation" status, whereby they would no longer be under the direction of the department of health and could essentially function as nonprofit organizations. These "foundation trusts" could then borrow on financial markets, enter into ventures with private companies, and go bankrupt like other corporations. Along similar lines, in 2000 the government signed a "Concordat" with the private sector, promising a closer relationship between the NHS and private providers. Such reforms are evidence of the "essential continuity," as the historian Charles Webster put it, between Conservative and Labour health care policy.

But with the so-called Private-Finance Initiative (PFI), Labour outdid the market zeal of Conservatives. Under this system, the government allowed consortia of banks, construction companies, and management companies to build and manage public service buildings like hospitals; the "trusts" would then sign long-term leases of these buildings from the private sector. PFIs never really took off under the Conservatives given a lack of investor enthusiasm, and like the "internal market," PFIs were sharply criticized by Labour during the election year. Once in power, however, the party abruptly reversed course: Blair passed legislation protecting investors from financial risk in hospital PFI deals, and a rush of profitable NHS PFI contracts followed in short order.

The PFI experience ended up proving much more expensive in the long term than traditional hospital construction through public financing. PFIs allowed the rapid construction of new capital stock at low initial cost, presenting a veneer of improvement while funneling NHS dollars into the private sector. By pushing costs decades down the road, however, they left hospital trusts with poisonous obligations, later resulting in cuts in services and requiring government bailouts. In February 2012, for instance, the government bailed out some seven PFI-encumbered NHS trusts to the tune of £1.5 billion. "Labour left some parts of the NHS with a dismal legacy of PFI," the Conservative health secretary Andrew Lansley rightly (if hypocritically) put it.

One thing, however, that Labour did right was to begin to adequately fund the NHS. Though Labour came into office with a tight budget plan for the NHS, toward the end of the 1990s it began promising a new course. Indeed, the government all but agreed that it would need to lessen the spending gap between it and other industrialized nations: by 2000 NHS spending was growing at nearly twice its historic average rate.

With this increased funding, the NHS was able to make substantial improvements in the quality of care. Polling data from 2010, for instance, revealed that 70 percent of the public was either "very" or "quite" satisfied with the NHS, up from 35 percent when Labour took power in 1997. Cameron's 2010 Conservative-led coalition government, on the other hand, was less content: two decades of neoliberal reform had not, apparently, gone far enough.

IV. 2010–2012: "Putting Patients First"

Needless to say, the Conservative-led coalition didn't come to power on an anti-NHS platform. "We will stop the top-down reorganisations of the NHS," the coalition government blandly promised, "that have got in the way of patient care." When the new health secretary Andrew Lansley released his important NHS White Paper in July 2010, many of his declarations—"[making] the NHS more accountable to patients" and "putting patients first"—sounded pretty unobjectionable.

Yet this was no ordinary year. The global financial crisis was in full swing, and anti-Keynesian macroeconomic policy had become the reigning paradigm in Europe. Austerity was the order of the day in the United Kingdom, and the NHS was not spared. In part on the basis of a 2009 McKinsey report that claimed the NHS in England could save between 15 and 22 percent in spending over three to five years through improved efficiency alone, hospitals and other health trusts had their funding frozen or cut. Reductions in spending, the government argued, were to come through improved productivity, but in light of the reality of health care inflation and ever-rising demand, such a mandate has been tantamount to a spending squeeze unprecedented in NHS history.

However, it wasn't until January 19, 2011 that Lansley's Health and Social Care bill hit Parliament. Totaling some 354 pages, it laid out a radical reconfiguring of the entire NHS and quickly precipitated widespread alarm. The government responded with an unusual "listening pause" so as to (it claimed) hear out the concerns of the public. The honesty of this exercise was called into question by a leaked confidential memo that revealed that the government "drew a red line" under most of the fundamental parts of the bill. The pause ended in June, and the bill returned to Parliament, made its way through the Lords and the Commons, and became law in March 2012. Although there were pockets of resistance, they were insufficiently powerful, united, headstrong, and prompt to derail the law, which was pushed forward by far more powerful political and corporate interests.

V. 2012–present: "A Convenient Logistical Base"

The implications of the law took some time to work out, its dense legalese obscuring (for some) what would be its inevitable consequences. And in truth—as the Conservative-led government frequently and fairly argued—many of its provisions were extensions of what had already been initiated (or continued) under Labour governments. A case in point is the new Clinical Commissioning Groups (CCGs) that the law created. The CCGs are led by GPs and are required to "commission" tax-funded health services, a task that dates back to the "internal market." More novel is the fact that—under new regulations issued under Section 75 of the act—the CCGs will not have the option of preferentially commissioning services from the NHS: they are now legally required to put all services up for competitive tender, including to corporate providers.

There are several reasons to predict that commercial entities could take over more and more of the provision of care as a result. First, GPs are busy enough with the task of taking care of patients; the complex process of commissioning was, from the outset, going to rely on assistance from outside corporate consulting groups. Second, the motives of some of the GPs involved in commissioning have been called into question. An investigation performed by the *British Medical Journal* recently revealed that more than a third of GPs on the boards of the CCGs have conflicts of interest arising from involvement in private companies, ranging from directorships of local for-profit health care service companies to stock ownership in large national health care corporations. Third, by exposing the CCGs to the influence of corporate lawyers and to the rules of European Union competition law, the law will further limit the GPs' ability to slow privatization. CCGs "will think twice before invoking the wrath of one of the large corporations now moving into healthcare," as an editorial in the *BMJ* put it. "With legal and contracting teams many times larger than those available to the commissioners, it is they who will be the ultimate arbiters of the shape of healthcare."

And no doubt, health care corporations—both national and international—are chomping at the bit. A variety of U.S. corporations have, for instance, been buying up international health care services for years. "There has been what seems like blockbuster deal after blockbuster deal," the UK industry magazine *Health Investor* reported last year. For these U.S. corporations, the magazine gushed, "the UK also provides a convenient logistical base from which to expand. Setting up offices in a country that speaks the same language, has a respected legal system and isn't far from mainland Europe provides the . . . ideal platform [for expansion]."

Last July the NHS announced that it was embarking on the single largest outsourcing deal in its history, inviting bids for a billion-pound contract to provide health care for the elderly, including end-of-life care. Leading corporate contenders were said to include the Virgin, Circle, and Serco corporations, though the latter was still embroiled in a fiasco relating to data manipulation on the quality of care at one of the general practices it runs.

The point is not that corporate interests can, will, or even want to privatize most or much of the NHS; the concern is that they will poach the choice cuts—the self-contained, profitable services—and then leave the unprofitable care, the catastrophes, the poor patients, and the complications to the nearby NHS. As an article in *Health Investor* frankly admits, "there are many obvious benefits for patients, consultants and providers of a unit co-located with a major NHS hospital. . . . Proximity to Level 2 Intensive Care Units gives greater peace of mind should something go seriously wrong." It's hard to imagine a better arrangement—for the company, of course.

The NHS has had significant issues with care quality at times. But under austerity and with the resultant service cuts and hospital closures, the quality of the NHS may very well deteriorate—a situation that commercial interests will be ready to exploit. One private insurer, for instance, recently blamed some 13,000 deaths on the "tragic consequence of negligence" by the NHS, which it contrasted with its own private health insurance that provides patients with "the peace-of-mind they need for their health." Private insurers also received a boost by way of another provision of the law: in addition to enabling the creeping commercialization of health care through "competitive tendering," the law also weakens restrictions on how much private medical treatment can be provided in NHS facilities, allowing "foundation trusts" to make up to 49 percent of their annual revenue in private, non-NHS care. As an analysis by the *BMJ* revealed last year, NHS hospitals are already offering and marketing more and more private medical services to patients for cash, at the same time that cost cutting has forced them to reduce the availability of NHS services. The emergence of a two-tier system seems almost preordained under such circumstances.

Replacing the NHS with a semi-privatized, commercialized, corporatized, and fragmented body will only exacerbate its weaknesses, while hollowing out its universal, moral core.

Yet do these changes truly constitute a revolution, or are they simply part of an evolutionary process of privatization that began during the Thatcher years? Allyson Pollock, professor of public health at the University of London, has made a persuasive case for the former. Though the law may further the siphoning of NHS funds into the private sector, she has argued that its largest impact may be elsewhere. By repealing sections 1 and 3 of the NHS Act, the 2012 law ended the duty of the secretary of state to provide comprehensive and equitable health services, allocated on the basis of need, throughout the country. Pollock and her colleagues have concluded that this could endanger one of the most essential, and most treasured, elements of the NHS—free care. Now, it will be up to the individual CCGs to determine which health services will be provided and free, and which will not. "NHS hospitals, built with public money, [are] charging people for treatments that used to be free," the Labour

shadow health secretary Andy Burnham railed at his party's annual conference, "and [are] still free to people living elsewhere."

The law, in sum, is both something old and something new. Developments over three decades have moved the NHS—if ever so slowly, unevenly, incompletely, and at times ambiguously—away from the "comprehensive health service" called for by the 1946 act and toward the vision of the 1982 policy memo that even Thatcher had disowned. In the case of undocumented immigrants, in fact, this change has already occurred: in 2011 charges were introduced for prenatal care for immigrants, and in late 2013 charges were instituted for all emergency care. Whether such measures actually succeed in saving money—or whether the revenues are consumed by the administrative apparatus needed to collect and process the fees—remains to be determined. Either way, some of the most vulnerable individuals in English society will now be discouraged from seeking health care.

This transformation must be understood not only in the context of British history, but also against the background of parallel developments occurring internationally. From this perspective, it seems that the travails of the NHS are but one more instance of a global neoliberal phenomenon (if uneven and incomplete) in health care. The demands of austerity in continental Europe are, for instance, limiting the scope of universal health care in countries ranging from Spain to Greece, raising "user fees" for care at a time when people are less able to pay than ever, while simultaneously furthering the privatization of the health care sector. Spain, just like England, has also moved to restrict the ability of undocumented immigrants to access the health care system. In the United States, meanwhile, the largest health care reform in a generation has critically subsidized the private insurance industry in an effort to stem rising uninsurance, while abetting historic rises in "cost sharing" that may eventually make this nation a "copay country." The transformation of the NHS, therefore, though in some ways a local problem, is also a part of a much larger dynamic in the global political economy of health care. The challenge of maintaining, improving, and expanding universal health care, it is becoming increasingly clear, must therefore be met on both the national and the international stage.

The NHS—like all health care systems—is, and always has been, imperfect. Yet replacing it with a semi-privatized, commercialized, corporatized, and fragmented body—still funded by general taxation but otherwise a pale reflection of its former self—will only exacerbate its weaknesses, while hollowing out its universal, moral core.

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