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**OBSERVATIONS**

**Health and Social Care Act**  
**The future of the NHS—irreversible privatisation?**

BMJ (BMJ) 2013; 346 doi: <http://dx.doi.org/10.1136/bmj.f1848> (Published 20 March 2013)  
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Please see: [The future of the NHS—irreversible privatisation?](#)  
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*This is the edited transcript of a video interview carried out on 3 March 2013 by Jill Mountford with Dr Lucy Reynolds, research fellow at London School of Hygiene and Tropical Medicine. Dr Reynolds has studied the background of the NHS in detail, and in the interview she shares her view of the consequences of the NHS reforms and possible privatisation of the NHS*

JILL MOUNTFORD: Lucy, can you explain to us what is going on right now? The Health and Social Care Act has been law now for almost a year, and we thought surely that's all going to go ahead. All of a sudden there is a lot of movement, a lot of anxiety and a lot of agitation around something that's happening in parliament that's going to have a big effect on the National Health Service. What is it and why?

LUCY REYNOLDS: The health and social care bill was passed in the form as if it were an aeroplane with no engines. The structure was all there. Its significance was not very plain to many people unfortunately. They looked at it and couldn't really understand what they were looking at. They couldn't find the thing in it that was actually going to accomplish the privatisation because really the only marker of it was a little clause explaining that regulations would be issued.

Now those regulations [section 75] are with us, and those regulations provide the jet engines to make that privatisation go ahead. So all of the rest of the plane was put in place last year, and now at the very last minute before this whole thing happens on 1 April 2013 the regulations are coming into place to show that everything has to be put out to competitive markets by CCGs [clinical commissioning groups] and the national commissioning board. That will create rights for private providers to supply which will not only allow them to take quite a lot of the share of the NHS budget for their business right now, it also potentially makes the privatisation irreversible in the future.

JILL MOUNTFORD: For somebody coming to this question fresh who is very concerned, what does this mean? From 1 April what will this mean for them accessing services, and how will it unfold over the next few years?

LUCY REYNOLDS: We're not going to have a big bang privatisation for the NHS. We're going to have a very quiet one.

What has happened is that all of the rules that control health financing have been gradually changed since the New Labour times. Overall, we now have the NHS reorganised in such a way that it can be relaunched as a mixed market, so not just the public health sector service, but also a healthcare industry. The rules are structured in such a way that there will be a gradual transition between those two groups. The public sector will shrink away, and the private sector will grow.

But because there will never be an announcement in parliament that the NHS is

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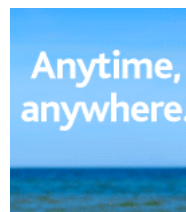
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privatised, and because the private providers will be allowed to use the NHS logo for anything that they are getting NHS funding for, it is very likely that the general public will not be aware that the private sector has in fact come in and taken over whatever bits of the NHS it finds profitable until probably service provision gets fairly bad.

JILL MOUNTFORD: Lucy, you made reference to a mixed market in the National Health Service in the near future. Why is this such a bad thing?

LUCY REYNOLDS: Well, it sounds like a good idea to have diversity and options and these kinds of things, and that would be fine if it weren't for the fact that the rules of the market are thoroughly stacked. We know for certain that organising [healthcare] as a public sector service is the cheapest and most effective way of providing healthcare. And that is broadly because the market model does not fit healthcare. The market model includes assumptions that both parties are in possession of all information about the subject of the transaction. In markets where the consumer has to rely upon the supplier for guidance, what you get isn't a market that clears down to a minimum price and is efficient. What you get is soaring inflation and abuse within that market.

Of course the US health system is the most salutary warning to us, but there are an awful lot of other countries which have had their health services privatised over the last couple of decades.

If you pay doctors only when they do work, then they over-treat people. If you make sure that medical facilities have no way of making any money other than by selling things, then they become salesmen, not advisers and advocates for the public. And actually in the world we have one of the very best public services, and compared to other developed countries it's also one of the most cost effective. There were several of these in Europe. Sweden's has been privatised. Spain's has been privatised. Ours is being privatised. In fact 1 April 2013 is also the day the Spanish government signs over control of its national health service into the competitive market.

JILL MOUNTFORD: So this is an ideological attack on the National Health Service. It's an attack on the founding principle of free healthcare at point of need.

LUCY REYNOLDS: There is certainly an ideology promoted around privatisation, but that is a rationalisation to convince people who otherwise wouldn't come on board. At the bottom of it it's about making money.

JILL MOUNTFORD: You made reference to CCGs and how they come into play from 1 April. Can you tell us a little bit about the size of the budget that they're going to be holding, the power, the massive power shift that's going to take place and what this means?

LUCY REYNOLDS: The health service is being restructured on to an insurance compatible footing, and the CCGs are technically state-owned insurance schemes. So they are going to be taking on around 80% of the NHS budget and they are going to be parcelling it out to providers. They have been told that they are going to have a lot of autonomy in that and that they will be able to represent the interests of their patients in the matter.

That bit doesn't appear to be able to be delivered when we have these regulations in place because what the regulations say is that commissioners will put out contracts according to competition law, and they will decide according to competition law. If anybody that didn't get the contract feels that they don't like the decision and that it could be faulted on failure to comply with competition law, they are permitted to complain to the sector regulator, Monitor, which is required to enforce competition law. So once everything gets put through the market, the CCGs won't actually have any autonomy in the matter.

And the reason we have been told about GP empowerment and patient empowerment is firstly to lure the doctors into complying with this. They are belatedly starting to understand that this has been a trick.

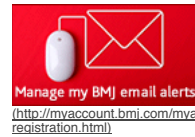
The second reason GPs have been told that in CCGs they would have the chance to advance the interests of patients is because it's very important for our politicians that nobody blames them. The public has been induced to believe that the GPs are taking over and will be in control so in five years when the whole thing is complete chaos and you can't get decent care, it won't be the politicians' fault.

JILL MOUNTFORD: What is the experience of the last 15 years, 13 years under the Labour government though? Is there anything that the Labour government did whilst it was in power to give people the confidence to feel they can rely on Labour to sort out the NHS?

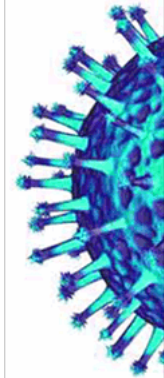
LUCY REYNOLDS: All of the stuff about the purchaser-provider split, the creation of commissioning within the NHS, the first bringing in of these competition regulations direct from Brussels in 2006-2007 by the Labour government, all of this has been absolutely fundamental to setting the thing up. I think the Labour government has been absolutely critical to the success of NHS privatisation and continues to be so.

JILL MOUNTFORD: On 1 April people are talking about the NHS is now going to be in the thick of being a privatised service. What exactly does that mean?

LUCY REYNOLDS: It's not suddenly going to turn into a privatised service on 1 April.



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### THIS WEEK'S POLL

**Should GPs on the boards of clinical commissioning groups in England stand down if they have conflicts of interest?**

What happens on 1 April is a bunch of legal and operational changes that affect the way that the NHS functions internally. In general this reform is a health financing reform. So we're finishing the transition away from the original form of funding of the NHS and moving into a market system which is going to be full-on market.

JILL MOUNTFORD: So full-on market means people are going to be competing for contracts, profits are going to be made, and is profit going to be the driving force as opposed to patient care?

LUCY REYNOLDS: Profit is already the driving force as opposed to patient care, even within traditional NHS hospitals. There won't be a sudden change, but there will be a new set of legal arrangements which will cause certain things to happen more than others.

And the things that are going to happen include a lot of private providers coming into the health service and a lot of public providers going bust, because every time the public provider of a service does not get the contract to carry on providing that service because a private provider has got it instead, that service will be shut down permanently because there won't be any more money to pay the staff and keep the lights on.

So gradually this system will kill off all our traditional NHS providers apart from maybe some big names. I'm expecting Great Ormond Street to survive. I'm expecting the Royal Marsden to survive. There are a few other really high profile hospitals around the country where the brand name is so valuable that they might carry on.

It is intended that all NHS hospitals be pushed through the foundation trust pipeline, which is an arrangement organised by competition regulator Monitor to privatise all of our hospitals. So all of our hospitals that aren't yet foundation trusts are being turned into them, and the foundation trusts are being pushed out into the private sector. So there is an intention that within a few years there simply will not be any public sector health provision, either because it's been driven out of business by a stacked competition or because it's just been straight privatised by Monitor.

JILL MOUNTFORD: Rich people have forever used private healthcare and have benefited from it. Now we're going to have that. What's the big deal?

LUCY REYNOLDS: Well, actually, you see we don't really have a proper private health insurance scenario in this country at all because the private health insurance only offers certain kinds of transactions. They like to keep it simple and they like to keep it profitable. So if there is any kind of problem where somebody has got two illnesses at once maybe, or they don't react to drugs well so you have to find other solutions, or if there is any kind of complication, the private hospitals don't deal with those people any longer, so they just refer everybody back into the NHS.

People in this country seem to believe you can use private health insurance for everything. But the truth is they are not interested in anybody that's going to cost them money. So they will certainly make sure that if you are already ill, they charge you a lot, and usually they will exclude ongoing conditions. It is very, very partial and very skewed, and frankly no use whatsoever to anybody that actually needs a lot of medical care. It's a great way for the insurance companies to make money, but it's a terrible way to deliver medical care.

JILL MOUNTFORD: You talk of private providers coming in to take over services and public providers losing out in the new commissioning set-up post 1 April. Who are these private providers? Are they health experts?

LUCY REYNOLDS: Well, under the rules of competition law it's not permitted to really restrict your providers. But a lot of them are general outsourcing companies that can just see a useful income stream. They're not people who have any kind of commitment to public health or the individual welfare of patients.

And you know the government has been very careful to muddy the water and make out that a public healthcare provider is pretty equivalent to a private healthcare provider, but actually their goals are completely different. In the public sector doctors attempt to arrange to have enough money to treat the medical needs of the people that come to them for help. The purpose is treatment, and the money is a means to an end.

Once you move into the private sector, company law forces company staff to prioritise making money for the shareholders above everything else. The whole system is about making money. What we need to do is move back to a public service model in which things are arranged so doctors can help people who are ill. At the moment this reform is taking us in quite the opposite direction.

JILL MOUNTFORD: So once the rules have locked in from 1 April, is there anything that can be done to prevent the private market or the market from governing our health service from there on?

LUCY REYNOLDS: Those rules could be taken away again. The problem comes when the contracts are awarded to the private sector. So at the moment an awful lot of things are being done by traditional NHS providers. But we will now have a regime where everything has to go out to tender and the private contractors are considerably advantaged in winning those tenders.

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JILL MOUNTFORD: Why are they advantaged?

LUCY REYNOLDS: They designed the rules, and the tendering process [is] quite highly technical—legally, financially and operationally. Just having medical knowledge is not enough. You need people who are good on legal and financial stuff and are experts in bid preparation. Private companies have a dedicated bid team who do nothing but search for bids to apply for, prepare the bids, and pull in the external consultants to get exactly the right technical expertise in.

There are some other reasons why it's stacked, Tory MP Sarah Wollaston started asking questions [at the Health Select Committee] about cherry-picking to the economists in charge of Monitor, And they explained that in order to resolve the cherry-picking problem, which is that the private providers only take the bits they can make the most money out of and ignore everything else, a special mechanism has been put in place which uses what is called a local tariff facility, which is in the Health and Social Care Act.

The arrangement is that where a provider has been cherry-picking, the CCG [will] be able to say well, since you don't offer the full service, and the full standard tariff is set up to reflect a provider which does offer the full service, you need to drop your prices. If Monitor approves that, then the CCG and the private provider can make a deal to have a special lower tariff, allowing competition on price which the government said would be impossible. And that means that the private providers can systematically undercut all of the public providers on price.

And every time one of those contracts is lost for the first time into the private sector, it means that that the public sector capacity to deliver that service disappears because there is nobody to pay the ongoing salaries. So this is a very important mechanism, and it goes directly against the assurances that our politicians gave us.

JILL MOUNTFORD: I assume that it will be bigger organisations that are running bigger chunks of healthcare. Is that not likely to be a model or not?

LUCY REYNOLDS: The healthcare won't be run in the same way as presently. They'll do it all in the way that makes them the most money so it will look different. I mean I'm sure the actual physical infrastructure won't change very much to start with, and certainly the logo will be the same. But the entire ethos and way of doing things and likely outcomes and transparency—all of that's going to be different.

JILL MOUNTFORD: What does this mean—we've got lots of fragmented care, some privatised, the cherry-picked stuff privatised, the profit-making stuff privatised, the less profitable, the more nitty-gritty, the more needed stuff perhaps, more long-term stuff will be there in the public sector.

LUCY REYNOLDS: But with not enough budget to actually do it any longer. What is plain is that this has been a long-term plan with things set up in a predictable way such that the outcome is likely to be privatisation of the NHS.

## Notes

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## Footnotes

Jill Mountford is an activist for the Alliance for Workers' Liberty. The full interview can be viewed at [www.youtube.com/watch?gl=CO&hl=es-419&v=OkTnCtq\\_Omk](http://www.youtube.com/watch?gl=CO&hl=es-419&v=OkTnCtq_Omk) ([http://www.youtube.com/watch?gl=CO&hl=es-419&v=OkTnCtq\\_Omk](http://www.youtube.com/watch?gl=CO&hl=es-419&v=OkTnCtq_Omk)).

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