Lewisham People's Commission of Inquiry

29 June 2013

WITNESS STATEMENT OF …Colin Leys…

I, Colin Leys, of (address removed)

retired professor, will say as follows:

1. I make this statement for the purposes of the Lewisham People's Commission of inquiry, which is to be held on 29 June 2013.

2. I am able to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.

3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible attach CV to statement

   I am an emeritus professor of politics at Queen's University Canada, and an honorary professor at Goldsmiths, University of London.

4. What is your connection/ interest/ background/ experience in NHS

   I have been reading and writing about the NHS since 1998 when I began collecting material for a chapter in my book, Market Driven Politics: Neoliberal Democracy and the Public Interest (Verso 2001). I subsequently collaborated with Professor Allyson Pollock on her book NHS plc (Verso 2004), and co-authored with Stewart Player The Plot Against the NHS (Merlin 2011).

5. What is your connection/ interest/ background/ experience in Lewisham and specifically, if applicable, with the hospital?
   ….None

6. Why do you want to assist the enquiry and/or see next question
   ……..
   ……

7. How are you able to assist the Inquiry – what is you expertise/ knowledge/ specialism?
   See (4) above

8. What in your view were the original vision and principles underpinning the NHS?

   See attached statement

9. To what extent, in your view, have these been eroded by the internal market and recent moves to open the NHS to external market forces?
   ……
   See attached statement

10. In your view to what extent have these changes been openly debated?

    See attached statement

11. In your view to what extent would this process culminate in the destruction of quality of healthcare for the community of Lewisham and South East London? ……

    What do the proposals mean to you and/or in your view to the community and/or to the NHS generally?
    See statement
12. Have you or someone close to you had any experiences of using Lewisham Hospital?
    No
    If so, can you describe what happened?
    In your view, how would your treatment or the treatment of those close to you differ if the changes go through?
    ……

13. Is there anything else you think the Inquiry should be made aware of or anything else you wish to tell the Inquiry or have on record?
    No

I, …Colin Leys……..., confirm that this statement is true to the best of my knowledge and belief:

16.06.13

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SIGNED DATE

Witness statement by Colin Leys on items 1a and 1b of the Commission's terms of reference.

1 a. <u>The original vision and principles underpinning the NHS, with particular reference to the community it serves and its accountability to that community.</u>

Vision and principles

1.The original vision and principles underpinning the NHS stemmed from the formation of a broad popular consensus during the second world war, crystallised by the Beveridge Report of 1942, which included the idea of a national health service combining hospital care, primary and community care, and public health services: this idea 'evoked spontaneous and passionate support from all sections of the community'.[1] And

> Consistent with the aspirations of the Beveridge Report, from the date of the earliest planning documents it had been assumed that the new service would be universal (available to all), comprehensive (including all services, both preventative and curative), and free (involving no payment at the point of delivery).[2]

On page 1 of *The New National Health Service*, the leaflet delivered to all homes at the inception of the NHS in 1948, Bevan wrote:

> 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 time of illness.

2. Although NHS planners and managers worked hard to realise this vision and these principles, practice fell somewhat short of them, in some respects from the beginning. Universal access was qualified: lack of funding and the resistance of doctors to government control over where they worked meant that there were wide discrepancies between the services actually available to different regions, although the differences were gradually reduced from the 1960s onwards. Comprehensiveness was curtailed from the 1980s onwards by the withdrawal of most long-term care for the elderly and disabled, the failure to fund NHS dental services on an adequate scale to ensure that they were available everywhere; the witdrawal of free spectacle frames for most patients after 1985. Hospice care has also never been provided by the NHS. The principle of free access was also broken by the imposition of charges for prescriptions and dentistry in 1951, and routine eye care in 1989. Although Bevan resigned in 1951over the imposition of charges, the reference to 'special items' in his 1948 pamphlet suggests that in other circumstances he might not necessarily have considered the charges that have been imposed as major infringements of the principle of free access.

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[1] Charles Webster (the official historian of the NHS), *The NHS: A political history*, Oxford University Press 1998, p.8.

[2] *The NHS*, p. 22.

Accountability to the community

3. The community to be served by the NHS was the population of the United Kingdom (no distinction was made between citizens and non-citizens). Accountability for the NHS was also national, through the responsibility of ministers to parliament, and parliament to voters. Bevan famously expected that the "the sound of a bedpan falling in Tredegar Hospital would resound in the Palace of Westminster".

4. Accountability for the NHS rested with the Secretary of State, whom the Health Act of 1946 made responsible for providing the NHS. Whereas NHS community health services, ambulance services and public health services initially remained the responsibility of local authorities, and hence were subject to some local accountability through council elections, neither hospital nor GP services were subject to any form of local accountability. Representatives of local authorities were appointed by ministers to the regional and district health authorities which planned and funded service provision; from 1974 a system of Community Health Councils was established to give local councils and voluntary organisations a role in commenting on local NHS services, with power to challenge proposed service changes by referring them to the Secretary of State; and in 1993 the Parliamentary and Health Service Ombudsman was created with powers to to investigate complaints of mismanagement in the NHS. But none of these institutions made the NHS hospital or GP services locally accountable. No powers were given to local communities to influence policy in respect of hospital or GP services.

<u>I b The extent to which changes to the NHS have eroded its original vision and principles, and the degree to which they have been openly debated</u>

Changes in the NHS since 1980

5. In 1999 responsibility for the NHS was devolved to the elected executives of Scotland, Wales and Northern Ireland. The rest of this statement refers to the NHS in England alone.

6. Since the early 1980s successive governments of all parties have progressively converted NHS hospitals and most other NHS service providers from elements of a centrally planned and administered single service into a set of increasingly independent 'public benefit companies', or non-profit businesses. The exceptions are GP practices, which remain independent contractors and are typically private partnerships, or (in a minority of cases) owned and operated by for-profit companies. The main stages in this transformation were:

> 1980-1990: 'Consensus management' of NHS hospitals by senior medical staff was replaced by management by chief executives, and hospitals were required to outsource their catering, cleaning and laundry services to private companies.
>
> 1990-2000: NHS hospitals were placed under the control of semi-independent local trusts, while local Department of Health staff were turned into 'purchasers' of hospital services (the 'purchaser-provider split'), creating an 'internal' quasi-market. Mental health and ambulance trusts were also subsequently created, and experiments were also made in giving the purchasing function to 'fundholding' GPs. Hospitals were required to pay the Treasury an

annual charge to cover the value of their capital assets (land, buildings and equipment); and virtually all new hospital building now had to be undertaken via the Private Finance Initiative (in which case the hospital trust concerned paid the capital charge for the new buildings to the PFI consortium, rather than the Treasury).

2000-2010: All NHS service-provider trusts were required to become Foundation Trusts by 2014; FTs are free from control by the Department of Health, free to borrow on the open financial markets and enter into joint ventures with for-profit companies, but no longer have access to Department of Health financial support if they run into financial difficulties. A new independent regulator of foundation trusts, Monitor, was created, with purely financial responsibilities. Community health service providers were required to either join an existing hospital foundation trust, or form free-standing 'social enterprises' to compete for their work with non-NHS providers. For-profit providers of clinical services were for the first time invited to provide services to NHS patients on a non-emergency, i.e. regular basis, beginning with Independent Sector Treatment Centres, Out of Hours GP services and a growing share of community health services.

2010-2013: The purchase (commissioning) of NHS hospital and community health services was transferred from Primary Care Trusts (which were in effect local branches of the Department of Health) to Clinical Commissioning Groups, composed of GP practices; all GP practices were required to belong to a CCG. From April 2014 Monitor's remit will cover the whole health care market.

These changes restructured the NHS into a system of independent businesses – hospitals or hospital groups, community service providers, ambulance services – ready to compete for patients in a full healthcare market. A wide variety of private providers of non-acute clinical services were authorised, from among which NHS patients have a right to choose for treatment; and since April 2013 competition for hospital patients has begun to be opened up by regulations under the Health and Social Care Act 2012(Section 75). The regulations effectively require CCGs to invite tenders for all services they commission, unless there is only one supplier which is capable of providing the service or services in question. Monitor is charged with ensuring that this is done.

The impact of these changes on the original vision and principles of the NHS

6. The single most important effect of the conversion of the NHS into a market is the replacement of patient needs by financial concerns as the dominant consideration at all levels of the service. This is not a matter of being cost-conscious, or of facing the reality of limited resources. That has been the norm in the NHS throughout most of its history, with some relatively brief exceptions. It is rather the new need for all NHS care providers to adopt the motivation and culture of the for-profit companies with which they must now compete. That motivation and culture is determined by company law, which requires all employees to maximise the return to shareholders. Among other things this adaptive change in the culture of the NHS involves a major change in the relationship between clinicians (doctors and nurses) and patients, since commercial considerations are no longer excluded from the advice and treatment that clinicians give.

7. The need NHS providers feel to adopt this culture is made more urgent by financial pressures. While demand for NHS services is increasing, due to the ageing of the population and other factors, and while the cost of inputs such as power, equipment, and drugs is rising, the funding available for patient care is falling, for several reasons:

i) The cost of operating a market. In 2004 a study carried out by the University of York for the Department of Health estimated the NHS's administrative costs at about 14% of the total budget, up from 5-6% in 1976. Not all of this increase will have been due to the costs of contracting, monitoring, marketing and advertising, auditing, legal actions, etc; on the other hand the introduction of Payment by Results (billing for each Finished Consultant Episode) since 2004 has added further large additional transaction costs. It seems likely that the additional costs due to operating the NHS as part of a market rather than as a planned public service is of the order of 10% of the total NHS budget, i.e. about £10 bn.
ii) As CCGs 'unbundle' individual services currently provided by hospitals and award contracts to non-NHS providers to provide them instead, hospital revenues become uncertain and unit costs will tend to rise if they are left with the more costly work.
iii) Hospitals with PFI-financed buildings have to pay a ring-fenced fixed charge, uprated for inflation, before meeting operating costs out of their reduced income.
iv) The government's 'Nicholson Challenge' requires NHS providers to save a total of £20 bn between 2009 and 2014. This means that the funds given to CCGs to purchase services are being cut by 4% a year.

The impact on the original vision and principles of the NHS

8. The principle of universality has been eroded by the fragmentation of the service. While Monitor will be concerned to minimise the degree to which the operation of competition gives rise to the financial collapse of hospitals and other NHS and private providers of NHS-funded care, there will be gaps in provision. There will also be significant variations in quality and an overall drop in quality. It was a central element in Bevan's politics, and very much part of the public culture of the time, that NHS service should be first class – it should, for example, be the standard of care previously given to paying patients in the voluntary hospitals, as opposed to that given in the old municipal hospitals. But in the absence of regulation to prevent it the most obvious effect of market competition in health care is to drive down quality, above all by reducing the most expensive cost element, staff-patient ratios and the ratio of highly trained to less trained staff. Numerous examples can already be seen, in hospitals with PFI projects, in the Stafford Hospital tragedy, in for-profit out of hours provision in Cornwall, and elsewhere.

9. Comprehensiveness is also being reduced by the combination of market provision and limited funding. CCGs are now free to determine what care can 'reasonably' be provided, and faced with funding cuts they have begun to curtail or withdraw access to a wide range of minor and not-so-minor elective procedures. Waiting times for elective surgery are also increasing, which in effect means that services are not available for some patients who need them; and limiting NHS provision to a defined 'package' of free services, has been canvassed, including by the BMA. Under the 2012

Act free NHS provision is also withdrawn from significant categories of resident (including foreign visitors and refugees awaiting decisions on their applications), or limited to emergency care which may be charged for. It seems fair to say that this would not have been acceptable to Bevan and the other founders of the NHS.

10. On the issue of free services, the 2012 Act does not state that all NHS-funded services must remain free at the point of delivery, and would appear to leave it open to NHS England to allow CCGs to authorise charges to be made for some services. This may be unlikely to happen in the short run, although most proponents of a healthcare market have long advocated charges. But the government plans to offer direct payments ('personal budgets') to patients with long-term chronic conditions (of whom there are over 15m in England), to allow them to purchase care from whatever kind of provider they wish. This has the implication that the sums involved will be fixed; patients who can afford to 'top them up' may do so, so to the extent that this happens better care will in effect be partly charged for. The most likely medium-run scenario is that a gradual decline in the accessibility, comprehensiveness and quality of NHS-funded services will lead more people who can afford it to 'go private' for more treatments.

Accountability

11. Accountability is as important a casualty of the conversion of the NHS into a market as the primacy of patient needs. The Secretary of State is no longer accountable to parliament for providing the services funded by the NHS, nor is Monitor; its chair and chief executive are appointed by the Secretary of State to act as an independent regulator. CCGs, which are controlled by their GP members, are accountable to NHS England, which like Monitor is appointed by the Secretary of State; but also like Monitor, not accountable to him or her.

How far have the changes been openly debated?

12. The conversion of the NHS into a healthcare market has not been put to the electorate as a policy proposal, nor openly debated in Parliament. The changes made before 2010 were presented as modernisation, not as preparation for conversion to a market. In the 2010 election David Cameron said there would be 'no more top-down reorganisations' of the NHS, so that the issue was not debated during the election. With the publication of Andrew Lansley's White Paper in July 2010, the previously unstated intention to create a market was made clear, but the Health and Social Care Bill which followed was not seriously challenged by the opposition during its passage through the House of Commons. Outside Parliament opposition grew, but the government steadfastly maintained that the Bill did not portend privatisation, and this was not strongly contested by Labour. The BBC did not offer debating room to expert critics of the Bill who thought it pointed to a full healthcare market. One of the few expert voices to articulate that position was that of Lord Owen, who has since (January 2013) tabled an 'NHS reinstatement Bill'. A notable feature of the debate in the House of Lords in March 2013, which finally approved the Section 75 Regulations mentioned in para 6 above, was that 145 members of the House had a financial interest in a company which stood to profit from the regulations, and most of them voted to approve them.