

EXPERIENCIAS DE REFORMAS DE LOS SISTEMAS SANITARIOS EN EUROPA

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Introduction

In the 1980s and 1990s, under Conservative rule, a number of significant health reforms laid the foundations for later, more profound change. These include the introduction of general management, which replaced 'consensus' decision making in the NHS and began a process of attacking the privileges of professionalism; the introduction of compulsory competitive tendering in services such as cleaning and catering which drove down the costs of those services and the pay and conditions of those workers; and the introduction of the internal market. This separated out, at least notionally, organisations which had a purchasing function, purchasing or commissioning health care on behalf of local patients, and organisations which had a providing function, that is which provided health care to local patients.

These three trends - the strengthening of management over the professions; the contracting out of aspects of support services and the de-integration of the service through organisational fragmentation and competition have continued and intensified over the past decade under a Labour government.

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Principal health reforms under Labour

(1) The most significant change under the Labour government is that, despite insisting in the election manifesto that the internal market would be abolished, the government first prepared for and then implemented a radical **open market structure** in the NHS. This involves separate purchaser and provider organisations, competition amongst providers for contracts and a new financial system called Payment by Results which pays a nationally set tariff or price per procedure or intervention.

Unlike the *internal* market, this open market allows any organisation to provide health care providing it meets price and quality criteria. Thus, large transnational capitalist corporations can and do compete for contracts.

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This market structure and these market forces were introduced first in relation to **secondary care**, typically received in hospital; then in relation to **primary care** with GP surgeries being contracted out; and then in relation to **community services** such as therapists, health visitors who focus on babies and small children and district nurses who mainly look after older and inform people in community and home settings. So far, only a small minority of these services have been contracted out to commercial providers and, as far as I know, there are as yet no commercial providers of the community services I mention. Thus the picture is one of patchwork privatisation but the direction of travel is clear.

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The implementation of the market, which involves breaking health care into discrete activities which can be priced, has been difficult in many areas including mental health care and care for people with learning disabilities, but it has been implemented or is being implemented.

(2) The private provision of 'NHS' health services is not the only reform we have seen in England. So-called **support services** such as cleaning and catering continue to be contracted out along with back-office functions like pay-roll.

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(3) The provision of new amenities like hospitals and of asset-based services like maintenance and estates management has now for the last 10 or 12 years been secured almost entirely through the **Private Finance Initiative** (PFI). This means almost none of the 90 or so new hospitals either already in operation or in the pipeline are publicly owned or publicly maintained.

(4) The **commissioning** or purchasing function itself is also in the process of being privatised. A framework agreement with 14 transnational companies, including UHG, McKinsey, Aetna and Humana (in their European guises) allows them to provide commissioning services such as population needs assessment and marketing to NHS purchasers on contractual basis.

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(5) A final reform I wish to mention does not at first sight look connected to the market. This is the reconfiguration of health services. As well as reforming the internal structure and internal dynamic of the NHS, the physical organisation of health services is also being altered. Some major hospital departments (such as maternity and emergency) are being centralised into fewer, bigger units. Services which used to be provided within hospitals are now being transferred out into the 'community' such as some outpatient clinics, diagnostic tests, rehabilitation and some surgery. Also, primary and secondary services are being 'integrated' in new ways - for example through so-called poly clinics or health centres which are being established on a contracted-out basis. I believe reconfiguration is being used for two main purposes: one is the creation of opportunities for commercial involvement by bundling services into more economically attractive units; the second is to conceal cuts in services by diluting what is available, for example by providing services through a lower skills mix.

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So, the British National Health Service, a service which was famously socialised and famously economic to run, has, in England, been opened up to very big business and has become extremely expensive to administer. Providers in the NHS now include a subsidiary of the global corporation, United Health Group, which runs various GP surgeries and health centres and Netcare, based in South Africa, which provides mobile ophthalmic units and some routine surgery. It has become more common for a private company to locate its hospital or unit on the grounds of /adjacent to an NHS hospital [cld go in para on patients not being aware]. There are also a myriad of British-based companies of various legal forms competing for business.

For example, Circle is “co-formed, co-owned and co-run by clinicians”, both hospital consultant and GPs. These professionals do not want to be controlled by lay management for a big company but do want to take advantage of the opportunities created by the new market in the NHS. Besides this example, there are many other instances of entrepreneurialism as professionals are encouraged to develop a more market-wise culture and outlook.

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These market experiments are mainly confined to England and we now have four different NHS systems across the UK.

Some consequences of the reforms

There are a number of consequences which flow from these reforms.

(1) The NHS is now a much more expensive service. Although there has been some expansion in the amount of health care provided, much more money is now spent on managing or administering the health system. A market structure is costly: There are numerous bureaucratic or administrative roles which exist only because a market structure has been created. Billions of pounds have been spent on a controversial and not entirely successful IT system to underpin the market. It has proved very expensive to negotiate and set up some of the private sector contracts. On top of all this, the continuation of top down centralised control requires significant senior management time and resources to respond to the steady flow of policy initiatives from the Department of Health. Included in this is the constant flow of data demanded from NHS organisations demonstrating how they are performing against targets. In the 1970s, the administration of the NHS accounted for 5-6% of the budget. The estimate today is 20%.

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Additional costs are incurred through the private sector contracts themselves. Although private contractors are

not always more expensive than public ones, they often are. PFI is a notoriously expensive way of procuring new hospitals. The commercial Treatment Centres offering secondary care were also paid much more than NHS hospitals for their services.

(2) The service is becoming much more fragmented. In the short run this threatens continuity of care for patients but in the longer run threatens the NHS itself. The health service is able to offer free health care to all, even the very ill, because it pools risk and cross-subsidises care. We all contribute our taxes to the NHS when we can and we take health care from it when we need to. Because most of us are healthy most of the time, we can afford to do this. But fragmentation threatens to undermine this. A private company does not hand back its surplus to be spent on NHS patients elsewhere in the system.

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(3) Democratic scrutiny is undermined. Big business abhors regulation and invests significant resources in lobbying to prevent, reduce or dilute regulation. This affects our ability to hold these corporations to account. The details of contracts between the Department of Health and commercial companies are not in the public domain. This allows both the companies and the department to evade proper scrutiny.

(4) The reforms have given big business access to large public funds. More than £100bn per year is spent on the health service. The very big money is available through the contracting out of commissioning since the principal commissioners, PCTs, control about 80% of the NHS budget. A survey of corporate involvement in 2008 suggested roughly 25% of the health budget was in the hands of private business.

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(5) Through the commissioning function, private business is going to be able to reshape the health service from the inside. Increasingly, we can expect that patient pathways and the bundling of services will be designed in ways which are conducive to business involvement. Thus,

through both commissioning and the design of amenities in PFI, business will occupy an increasing role in the planning of the service.

Other characteristics of the reforms and reform process

There are other characteristics of the reforms.

(1) The NHS is a hierarchical organisation with power concentrated in the Department of Health. Reforms have been imposed by the top. There are no quasi-autonomous regional structures to resist or create barriers to change and there is no local political autonomy. .Both careful selection of the right sorts of managers (managers who will deliver the government agenda) and bullying and intimidation have been used to drive the market reforms. This has been disguised by the language of 'local decision-making'.

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(2) Despite the extensive and radical reforms, the vast majority of the public are completely unaware of what is happening. There have been some campaigns to save hospital departments when threatened with closure. But most of the changes are below the surface and are not perceived or understood by the public. News management by government has been cautious and controlled and the reforms are poorly reported by the media. Marketisation has been presented as 'personalisation', as an attempt to

introduce greater patient choice and greater responsiveness to patients as users.

(3) Health care is being re-commodified. This is not simply an economic process of profit-making but a cultural process through which the English are being encouraged to consider health care not as a public service to be used when needed but as a commodity to be traded. In a public service, my entitlement is tied to the entitlement of others and a collective perspective is required; in a traded commodity, I am interested in my own immediate wants and convenience as a consumer. Health care managers and professionals have also shifted culturally as they have had to learn to be market-wise.

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(4) Different reforms pull in different directions giving rise to tensions. The combination of transferring services out of hospital plus Payment by Results is making some hospitals unviable. The combination of PFI and Payment by Results is making some hospitals unviable. The use of market dynamics is ultimately at odds with hierarchical control and micro-management. So far, the hierarchical control is dominant.

(5) There has been a constant stream of reforms, resulting in a sense of turmoil and constant change for health care workers.

(6) The reforms are not often properly evaluated before they are either rolled out or replaced with different reforms. The reforms are typically not evidence based.

(7) The reforms illustrate a phenomenon which now affects many areas of policy. This is the breakdown of the barrier between private sector gain and public service. We see the use of higher service class personnel from the private sector who do not merely lobby on policy reform and implementation but who shape and guide it directly through a permanent presence in state institutions which have been reconfigured for the express purpose of managing and implementing the new policy. In addition,

former ministers of health now work for private health companies.

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Conclusion