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NHS reforms, market liberalisation and TTIP

Abstract

Community nurses have perhaps more than most felt the effects of commissioning as services reduced to what is made explicit contractually. Commissioning was rolled out as the solution to the global financial crisis in 2007/8 that directly impacted on the cost of the NHS and at the time the mantra was to accept service re-configuration and be fit for commissioning purposes. We suggest, in contrast, successive governments' over the past thirty years have been less than candid about their true intentions to reform the NHS. Instead of reforms to improve productivity, quality and cost efficiency, the agenda had all along been to introduce the NHS to market liberalisation, along the same lines as the United States model of healthcare. This agenda aimed therefore to move the NHS from being publicly owned and the next stage is further market liberalisation of the NHS through the trans-Atlantic investment partnership. This means the public's health, once again, will be subordinate to the "rights" of corporate healthcare industries to profit from the NHS.

Key words: Markets in healthcare Politics of healthcare Health policy

Introduction

Over the past thirty years successive governments have purposefully undermined the National Health Service (NHS) and the democratic process with the intention of reforming the NHS and introducing market liberalisation (Holmes, 2013; Tallis and Davis, 2011). This view developed significantly from our initial publication in 2010 discussing a new politics of

morals for the common good (Sandel, 2009) in this journal and the “soft” target of community nursing through commissioning services (Regan & Ball, 2010). Although not complete by any standards, the shift towards market liberalisation and for-profit healthcare services contracted by the NHS has been a steady process of attrition (Tallis & Davis, 2013). The process has been generally accepted by an unsuspecting public, whether working in the NHS or not, and subject to spin and rhetoric over the last decade with promises that often failed to be realised (Tallis & Davis, 2011). This paper therefore discusses the complicit behaviour of successive governments’ market reforms which aimed to move the NHS away from being publicly owned towards a United States (US) version of a publicly funded private healthcare system (Tallis & Davis, 2011). What is at stake is the principle of social justice and the notion of equality in society ensuring a fair distribution of rights, duties, burdens and advantages shared amongst the public (Ricoeur, 2000). When these conditions are upheld, autonomy and freedom are determined, yet the coercive acts from successive governments demonstrate misuse of their authorised responsibilities. The impact on community nursing, health visiting, district nursing and other specialities who have difficulty in further quantify the timeliness of clinical interventions will be at most risk from a culture of measurement (Hopper & Hopper, 2009).

Background

The British government has a history of selling off publicly owned industries such as British Telecom, gas, water, electricity, BNFL (nuclear fuel), the railways and the post office (Pollitt, 2000). The market liberalisation of these sectors resulted in the introduction of statutory regulatory bodies in order to monitor an industry, often with mixed results, skills and intellectual property lost and business decisions based solely on profitability (Birch &

Siemiatycki, 2015; Pollitt, 2000). In effect national assets and resources should profit the nation's interest, not corporations. More recent examples are the closure of coal mines in Doncaster in the United Kingdom (UK) leading to coal being transported from abroad and resulting in social (D'Silva & Norman, 2015) and health stress in the affected local areas (Walthery, Stafford, Nazroo et al., 2015).

Thirty years in the making

The global financial crisis of 2007/ 2008 led to a concern for the NHS and the direction which the government, through a number of Lord Darzi's consultations, were attempting to take it (Regan & Ball, 2010). At the time it was felt that the commissioning agenda had been a new innovation to what was considered a funding crisis for the NHS (Tallis & Davis, 2013). Nothing could be further from the truth (Tallis & Davis, 2013). Rather than being viewed as a solution to tackle the global financial crisis (Waring, 2015), the introduction of market liberalisation had been slowly developing for half of the United Kingdom's National Health Service (NHS) sixty year history (Tallis & Davis, 2013). In the 1980's NHS cleaning services were sub contracted out and other utilities were to follow (Tallis & Davis, 2013). The introduction of the purchaser-provider contract and commissioning expanded the low level marketisation of the NHS in 1990 with the *National Health Service and Community Care Act* (Evans, 2008). The use of public funds to pay for NHS patient care started in the year 2000 after the then Secretary of state for health Alan Milburn signed a concordat to allow NHS patients to receive treatment and care in the independent and private sector (Evans, 2008). Between 2000 and 2003 over 250,000 NHS patients were recipients of such an arrangement (Evans, 2008).

The UK government response to the global financial crisis led to a variety of policy documents: *Transforming community services* (TCS, DH, 2009), *Equity and excellence* (DH, 2010a) and the contentious *Achieving world class productivity in the NHS 2009/10 2013/14* (DH, 2010b). The proposed reforms promoted the expansion of commissioning (procurement) reforms with the express purpose of saving public money, increasing productivity, price based competition and more healthcare provision contracted out to non-NHS providers (Krachler & Greer, 2015). The negative impact of reforms on community nurses and other workers was a pay freeze, job losses, a loss of corporate memory, fragmentation of the service, reduced innovation and many staff taking early retirement (Seifert, 2014). The impact on health visiting was to decimate the work force under the myth of doing “more for less” and if it couldn’t be quantified it couldn’t be commissioned (Hopper & Hopper, 2009). This inevitably led to a crisis for health visiting with reduced numbers and an implementation plan to ensure there were enough health visitors to assess the needs of the most vulnerable families and children (DH, 2011). Finally *The Health and Social Care Act* (2012) referred to as the Act, became legislation and provided a degree of coherence. The Act was further clarified operationally in *The National Health Service (Procurement, patient choice and competition) Regulations* (2013) stating its aim to secure the needs of people using health service services, improve the quality of the services, and improve efficiency in the provision of the services through contracts and competition (part 2, 2, p.2).

The effects of the Act (2012) have so far have been varied and remain in dispute (Ham et al, 2015). Despite the promise of improved health outcomes, cost savings and productivity, the reforms have been criticised as distracting and damaging for a number of reasons (Ham et al., 2015). The reforms took just three years to dismantle old effective structures, such as the abolished strategic health authorities were replaced with health and wellbeing boards and

primary care trusts replaced with clinical commissioning groups, a new name for a consortium of General Practitioner fund holders (Ham et al., 2015). Ham et al (2015) suggest these reforms contributed to widespread financial distress and were significant in the failure to achieve key targets for patient care. Krachler and Greer (2015) however suggest the reforms have also led to an increase in health inequalities, reduced democratic accountability, increased service rationing and ending comprehensive preventative services (Krachler & Greer, 2015). The point about reduced democratic accountability reinforces our suggestion that the reforms have been far from transparent or democratic. The market liberalisation of the NHS also led to the expansion of management science and micro-management, reduced practitioner autonomy, increased bureaucracy, systems of control and performance management (Seifert, 2014). These factors were later found to have contributed to reports of NHS failings such as found in the *Francis inquiry* (Berwick, 2013). The assumption in 2009 (DH, 2009) was that the proposals appeared to open up the NHS to increased privatisation yet despite this not being wholly realised, the impression remains that privatisation was the intended overall plan (Seifert, 2014).

Despite the confidence placed in improving productivity within the NHS and market liberalisation being considered central to these aims, Appleby, Baird, Thompson and Jabbal (2015) suggest any “... *assessment of its success or otherwise is severely hampered by a lack of direct productivity measures...*” (p. 39). This is in spite of productivity measures already in organisations being the hallmark of management science methodologies (Hopper & Hopper, 2009). Appleby et al (2015, p. 42) estimate savings of £1.9 billion being due to the combined impact of NHS pay freezes and a reduction in NHS staffing number over two years to 2013. Productivity in the hospital sector by crude labour activities decreased per Consultant, (first outpatient attendance and elective admissions) by 4-5% over the whole

period between 2009/10 to 2012/13 (Appleby et al., 2015). However acute and general nurse outpatient productivity increased by 11% in the same time (p. 44-5). The productivity agenda however has been affected by the increased use of agency staff and patient demand which drove the foundation trust sector in 2014/15 to deficits of £321 million, doubling the deficit in the first quarter (Appleby et al., 2015).

Monitor, the health sector regulator for England expect the deficit to reach £375 million by the end of 2015 with forty to fifty per cent of trusts experiencing financial difficulties (Appleby et al, 2015., p. 52-3). Appleby et al (2015) conclude that NHS performance was good for the first three years since 2012 but there are signs of strain with waiting times, accident and emergency four hour breach target, increases in patients awaiting discharge and the number of providers in financial deficit with a 30 billion funding deficit by 2020/1. How these statistics are re-worked for public consumption in favour of market liberalisation remains to be seen. The above history had been staged in plain sight of the public generally unaware of the extent to which their government are willing to go to marketise healthcare and further reduce their responsibility to provide healthcare from cradle to grave through markets mimicking governance (Sandel, 2009). In other words, the markets, not democratic processes or hard won freedoms, will govern demand and supply.

TTIP

Ley and Player (2011) suggest market reforms enshrined in *The Health and Social Care Act* (2012) serve to position the NHS alongside the United States (US) managed care model, with service models removed from hospitals integrated into a new primary care model. The

current plans to harmonise the UK/ US in the trade deal called the trans-Atlantic trade deal (TTIP) also ensures trans-national companies needs will have priority over the UK's health issues to become a trade issue with a right to sue if profits are threatened (Khan, Pallot, Taylor & Kanavos, 2015). The non-democratic characteristic of NHS market reforms we wrote about at the beginning of this paper have been repeated in recent secret negotiations to harmonise UK/ US trade with the trans-Atlantic investment partnership (TTIP). TTIP would ensure trans-national companies get priority over British trade, and health issues becomes a trade issue (Khan et al., 2015). The minister in charge of the TTIP negotiations had gone on record as stating the NHS would benefit from further liberalisation of the markets (Khan et al., 2015). The secret TTIP and the thirty year campaign to expand market reforms into the NHS are now in plain sight and rather than be wary of the failings of NHS market reforms, the government are set to liberalise them even further (Khan et al., 2015). Tallis and Davis (2013) suggest there is a need therefore for continued vigilance to maintain pressure to re-nationalise the NHS as the service will become less transparent when patient and business outcomes converge to affect transparency. Tallis and Davis (2013) suggest in summary to the above discussion suggest that:

“It had taken thirty years of preparation, during which successive administrations had undermined the values and assumptions that had made the NHS possible, whilst at the same time seeming to uphold them...barefaced lying, of hypocrisy; of a contempt for democratic processes... ”(Tallis & Davis, 2013, p. 2009).

Tallis and Davis's (2013) strident view of deceit occurring to facilitate the market reforms is contrary to the value the NHS has to an unsuspecting and paying public, and what the NHS

signifies in relation to the social contract that binds citizens together may not be fully realised in a return to trade the nation's for profit. In such a profit orientated future for the NHS post TTIP, this deal somehow demeans the meaning of society as a whole, because our health is finally up for sale. If one were to accept Tallis and Davis's view, as Ley and Player (2011) and Taylor (2013) do, then any mechanism that evolved to cope with the NHS market reforms may also be similarly tainted.

Conclusion

This paper has discussed successive governments' coercive acts in the form of argument, rhetoric, policy and finally *The Health and Social Care Act* (2012) to progress the NHS market liberalisation agenda. The impact on community nursing, especially health visiting was most noticeable. This agenda started over thirty years ago with the full knowledge that the British public were happy with the NHS and its benefits to the health of the nation. We have discussed the impact of market reforms and some of the promises made that reforms will improve productivity and cost efficiency. Tallis and Davis (2013) suggest the democratic process has been purposefully undermined, along with the public's confidence in the NHS paving the way for non NHS healthcare to be considered acceptable, even reasonable (Tallis & Davis, 2013). The evidence suggests, despite market liberalisation for the NHS to be open to tendered competition, that little has changed for the better and if anything there is a distinct possibility of mission creep. What we now have is the possibility of TTIP and the government siding with the interests of healthcare corporations over the best interests of the public they were elected to protect. Such secrecy appears to be anti-democratic and the public in the future may be the worse for it.

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Referee 1:

This is a challenging article which does not seem to follow academic convention. Within this commentary there is an element of selectivity to back up rhetorical, emotive and subjective views. This article needs some revisions as follows:

- (1) It has numerous inaccuracies in its referencing style both in the text and in the end reference list. These need to be checked.
 - (2) The article needs careful proofreading, restructuring, and configuring into an academic format rather than what it currently seems to be - somewhat critical of government policy. Whether we agree with it or not, there still needs to be a balanced argument so people are aware of different stances.
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Referee 2:

Please provide some constructively expressed feedback for the author, designed to help them revise or rewrite the article for this journal or another. Your comments can be anywhere between a paragraph and something much fuller, depending on what you think appropriate to the particular article.

Thank you for your submission.

This article draws upon a range of literature & health service commentary to present your argument on market liberalisation. Further you aim to analyse this in relation to community nursing.

It is my belief that the construction of the paper needs review to ensure a more rigorous & balanced argument, make more explicit reference to community nursing & to improve readability.