NHS Devolution pilots: another step to a privatised NHS

The announcements of NHS devolution plans and pilots for Manchester (Devo including NHS), Cornwall, Gloucestershire, North East Combined Authority, Liverpool and London came as a surprise to local residents. The most shocking part is that the plans were all agreed by senior - mainly Labour - politicians in negotiation with the most cold-blooded Chancellor of the most ruthless Tory government ever, behind closed doors and without any public consultation.

The models for NHS devolution set out in these proposals actually date back to the 2014 NHS' *Five Year Forward View (5YFV), published by* Simon Stevens, Head of NHS England (NHSE). Stevens is no friend of a publicly funded and publicly provided health service. Before becoming Head of NHS England, he worked for over a decade in senior positions at UnitedHealth, the largest single health insurance provider in the US. He was previously an advisor to Tony Blair's Labour Government where he was an outspoken supporter of NHS market reforms and PFI. With Alan Millburn he co-authored the '*2000 NHS Plan'* which resulted in significant private sector involvement in the NHS.

Devolution will result in further caps on the NHS budget and local authorities taking the blame for hospital closures and cuts in health services. But NHS campaigners have pointed out that the 5YFV itself - and the new care models proposed for NHS devolution - are themselves designed to facilitate NHS privatization.

A devolved NHS with integrated care would be particularly attractive to US health multinationals. The scale of local devolved and integrated project would be well within their purchasing power, and would match models already prevalent across the US.

More on the models in the 5YFV below. First a look at some of the major issues for current devolution pilots and plans.

Implementing budget cuts

The main reason behind Chancellor Osborne's enthusiasm for devolved budgets is that local authorities have to limit spending to balance their budgets, while the NHS, with its overwhelming national support, has been able to put pressure on the government to cover budget

overspends. As John Lister points out: ‘It’s obvious to all but gullible, power-grabbing councilors – this is about dumping blame for closures’.

To counteract the risk of devolved services turning to government if NHS finances overrun, it’s likely that prime providers and other bodies responsible for managing local budgets will be ‘credentialed’ by Monitor – the NHS regulator with responsibility for managing markets. The overriding qualification will undoubtedly be a proven ability to stay within budget. NHS trust prime providers who overrun budgets will forfeit their right to manage local services in future. This in turn will open the way for takeovers by major healthcare corporations with fewer scruples about service cuts.

Devolution and NHS Regulation

A last minute amendment by the Lords to the Devolution Bill means the Act now prohibits the transfer of NHS regulatory functions from national to local bodies – so, for instance, national standards set by Care Quality Commission or Monitor will continue to apply following devolution. But the fact that adherence to national standards was not included as part of the draft bill provides little assurance on the future of these standards.

Integration of health and social care

No one questions the need for good co-ordination between health and social care and this has been a priority for several decades already – well before even the 1990 NHS and Community Care Act re-stated the need. The £5.3bn ‘Better Care Fund’ creating a local single pooled budget to incentivise joint work to move people out of hospital is just one recent example. The injunction to work jointly, including powers to pool budgets has also been in place for decades. There are no new powers available to the devolution pilots that will make integration a reality.

So what might we expect from devo schemes and pilots focusing on integration? One thing that’s missing is the focus on an integrated National Health Service, replaced, as pointed out by Greg Dropkin with 'the prospect of a devolved, deregulated local service … competing with other localities for patients and funds, with local pay and conditions for healthworkers’.

Budgets for adult social care have been slashed. The Association of Directors of Adult Social Services (ADASS) reported a real-terms

reduction of 31% in adult social care budgets between 2010 and 2014, with 400,000 fewer people receiving care services, and most of those still in receipt getting a reduced service(ADSS budget survey 2015). These are massive reductions in service for the most vulnerable of people.

There is huge concern that cash-starved local authorities will view the millions pouring into a new pooled budget as a golden opportunity to plug gaps in their own services, oblivious to the dire impact on the local NHS. Even if the NHS cash is ringfenced by NHSE, creative local authority accounting could still wreak havoc, for instance by designating new categories of preventive health services, thereby posing a massive threat to NHS services.

Replacing acute hospital beds with health care out of hospital

Britain already has far fewer hospital beds per person than any comparable economy – just 3 per 1,000 compared, for instance, with 8.3 in Germany, 7.7 in Austria or 7.2 in Hungary. Despite this, the 5YFV plan to modernize the NHS proposes many fewer beds still, declaring: 'Out of hospital care needs to become a much larger part of what the NHS does'. The 5YFV proposes that many more people will receive healthcare at home, with high-tech remote monitoring and visiting nurses. This enthusiasm for alternatives to hospital bed-based care is echoed in Hackney's devo proposals, for instance, which include the 'creation of safe and high quality alternatives to higher cost hospital-based or residential care'.

An authoritative commission of inquiry led by experts including Professor John Appleby of the Kings Fund found no evidence whatever that this approach would lead of significant cashable savings either in acute hospitals or across health economies, and described plans to save the NHS by moving care out of hospital as 'magical thinking'. But mere evidence doesn't prevent the plans to reduce hospital beds steaming through to the devolution pilots.

The promise to get more people out of acute hospitals will definitely achieve at least one government objective. Much care that is currently provided free in hospitals by the NHS will be re-designated as 'community care' which is chargeable - at significant cost to vulnerable individuals. Even many people in receipt of Income Support must still

pay community care charges, with a high proportion of disability benefits charged for their care.

And while many patients with relatively stable care needs may welcome the chance to be treated at home, many prospective carers (most of them women) of very sick children, partners or elderly relatives, will be appalled at the new expectations that will fall to them. The hardest hit, hit yet again.

Fewer people in hospital means greater need in the community. In the current financial climate this inevitably means community care eligibility criteria will be squeezed yet further, denying tens of thousands more people the benefit of even their current 15-minute homecare visits.

NHS estate

Alongside service integration, another theme of the London pilots is review of NHS estates. NHS Property Services Ltd currently manages some 4,000 properties on behalf of the NHS. Those deemed surplus to need can be sold off, but proceeds go back to central government rather than being retained locally, so there has been little scope or incentive to make best use of these sites. The London devolution pilots across North London will involve identification of 'surplus' NHS sites that can be sold on the open market and used:

- to transform health and care estate, including the potential for co-located services.
- to contribute to the financial and service sustainability of NCL's health and care economy.
- to create opportunities for new housing and better coordinate across boundaries to promote housing and development.

What this means in practice for NHS services remains to be seen, particularly when the NHS seeking to re-invest in healthcare facilities is in direct competition with local authority plans for housing.

Privatisation

Devolution plans and pilots will test and pilot the various models set out in the 5YFV. Stevens' plan is clear that 'one size won't fit all'; different parts of England need different models for healthcare with further variations to these basic models. Deconstructed, this tells us the NHS will be organized and managed completely differently throughout the country – a final farewell to our *National* Health Service. On the other

hand, Stevens doesn't want to see the proverbial *1,000 flowers blooming*, so NHSE will retain many important controls centrally. This has led the Kings Fund to conclude that NHS functions and resources are being 'delegated', not 'devolved' to combined authorities or joint commissioning boards.

Among the new care models proposed in the 5YFV are "vertically integrated Primary and Acute Care Systems (PACS)"… "allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services". This is the model to be piloted by Hackney Council and its partners. The proposal to abolish the purchaser-provider split locally and replace it with a single integrated provider is likely to appeal strongly to those keen to abolish the NHS market (many of us would gladly abolish the social care market, too, though that's for another day). Sadly, hopes that this pilot will grant Hackney the right to shape and chose our own health services are a delusion.

It's unclear who or what will be overseeing transformation plans in the local pilots. The 5YFV suggests local Health & Wellbeing Boards might take on this role – but as a somewhat alarmed committee of MPs looking at devolution recently noted, these boards don't actually have the skills needed to manage such a complex process. Manchester's proposal for a provider organisation in charge of commissioning services could put private sector companies – which can call on much useful technical expertise – at the forefront of choosing new providers.

Commissioning services for the NHS

Far from being able to pick choose the health (or social care) providers we (whoever *'we'* is) want, in practice services will be commissioned through procurements.

Through the pilot phase, we might expect a relatively light touch from Monitor in exercising its responsibility to 'address restrictions on competition that act against patients' interests'. The Government and Simon Stevens are keen to implement NHS devolution (or delegation) throughout England, so they're likely to facilitate and appear respectful of local plans. Once the NHS has been entirely broken up and devolved to local authorities and regions, it will be infinitely easier to demand that services be opened up fully to market competition.

NHS procurements are tightly controlled through a combination of UK and EU procurement requirements, plus additional requirements set by NHS England and by Monitor, which is responsible for regulation of the market in healthcare services. Procurement rules are devised by corporate lawyers and carefully worded to outlaw requirements that many might regard as essential on the grounds that they are anti-competitive (for instance limiting profit levels, demanding tax is paid in the UK, or specifying that a hospital must have links to a university).

NHS England has already run a procurement to determine which organisations are fit to provide commissioning support for NHS services. Most of the existing Commissioning Support Units staffed by NHS staff who understood the NHS ethos failed to be selected for this work. The NHS can now procure health services with commissioning support from such worthy friends at Capita, eMBED Health Consortium or the Arden-Gem partnership and Optum – itself a subsidiary of Stevens' old gaff, UnitedHealth.

With commissioning support from these corporates, hopes for local partnerships of trusted providers and local service leaders shaping the NHS to reflect local needs will disappear completely.

Private sector providers in the NHS

There is no reference in Steven's 5YFV to any private sector providers. This absence reflects both the avoidance of controversial issues and indicates that private sector healthcare is now commonplace and unremarkable.

NHS providers may have better clinical services than private healthcare corporations, but this has little impact on their ability to win tenders. Private corporations focus on driving down costs by reducing services, locations and staffing so they will meet the minimum clinical standards set by Care Quality Commission (CQC) regulators and fulfil contract requirements, but offer nothing beyond. Corporations have the added benefit of dedicated corporate procurement arms and slick PR. These factors give them a huge advantage in procurements based overwhelmingly on price.

Private sector involvement is growing strongly in the primary, community and elective care sectors. In the last 3 years, £7bn of new NHS contracts have been awarded to private sector providers. Just one of

these, Virgin, runs 358 GP surgeries and 100 community healthcare services and in January 2016 won a £126m contract for Sheppey and Sittingbourne Hospitals in Kent. Care UK, UnitedHealth / Optum, Serco, Circles, General Healthcare, Spire, HCA, Ramsay - the list of private providers is very long and fast growing. There are several references to the voluntary sector as partners and innovators in the 5YFV, but these will have to take their place in the competition for contracts alongside a corporate sector ready to pounce legally on any 'anti-competitive' acts by commissioners.

However, devolution has much bigger prizes in store for multinational healthcare corporations. Up to now, potential NHS areas for private profit don't yet include major hospitals – for one thing, PFI debts are a major obstacle. Hence government can still insist that private sector involvement in NHS clinical services is marginal. However, the size and emerging shape of devolved and integrated health and social care services makes them particularly attractive to giant US healthcare multinational corporations.

The prospect of England's NHS and social care turned over into the hands of these corporate giants should send shivers down the spines of all those CCGs and local authorities promoting devolution.

Future of the NHS

Most of the problems highlighted above exist whether services are commissioned by CCGs or devolved locally. But it will be a thousand times easier for government to cut NHS budgets and open the NHS market significantly if they are dealing with a diverse set of new and completely inexperienced local boards with devolved powers. Far from local authorities and local people having the power to shape local services, by signing up to devolution agreements, local authorities are greatly increasing the power of government to cut NHS budgets leading to disastrous cuts in services, and impose further marketization and privatisation.

Which opens up a further area where UnitedHealth and their like enter openly, rather than hiding as now behind the NHS logo. Once the NHS is degraded through funding cuts and devolved locally, healthcare corporations are in with a real chance of selling the private insurance cover that will allow those who pay to access healthcare privately.

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