Market based reforms in the provision and financing of healthcare in the UK

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Introduction

The UK has led the way in introducing ›reforms‹ in the form of market mechanisms as part of its neo-liberal agenda that seek to make the public sector more like the private. By and large, these have not come from the public nor indeed have they been popular with the broad mass of the population. They have been introduced by successive governments at the behest of the financial markets, giant corporations and their financial advisors (Shaoul *et al.* 2007). Big business demands that public services be cut back so as to reduce corporate taxation thereby enabling them to remain internationally competitive on the world's capital markets. Where services cannot be sold or eliminated for political or financial reasons, then they must be turned over to the private sector to provide a new source of profit.

In the early 1980s, such policy measures took the form of privatising and/or opening up the state owned enterprises to competition. In the 1990s, when the most commercially viable industries had been sold, the government turned its attention to public services such as health, educations, roads and prisons, sectors that could not be sold because they were not cash generative and their privatisation would arouse widespread political opposition. The ›solution‹ was to turn to outsourcing and market based mechanisms that bring in private providers to be paid by the state and/or user charges or co-payments.

The purpose of this paper is to explain the various forms that market based reforms have taken in the provision and financing of healthcare, focusing particularly on the acute hospital sector, which takes by far the largest proportion of the public healthcare budget, and the introduction of private finance for new hospitals. While the paper focuses on UK healthcare, since similar measures are being implemented in most of the advanced capitalist countries and developing countries that have a public healthcare system, whether funded by taxation or insurance contributions, they have an international relevance. Furthermore, since the National Health Service (NHS) was held up as a model to be emulated, its decline has an additional resonance.

The paper is organised in several sections. It firstly explains the establishment and organisation of the National Health Service, the public provider of healthcare to the overwhelming majority of people. It then outlines the range of measures that have been implemented over the last twenty-five years. The third section describes the Private Finance Initiative (PFI), a means of procuring new hospital premises and ›non-core‹ services. The fourth section presents evidence about the financial cost of PFI procurement, and the final section presents the conclusions.

The National Health Service

In 1948, the Labour government created the National Health Service (NHS) out of the patchwork of healthcare services provided on a limited basis by charities, mutual funds and local authorities. It would offer a comprehensive ›cradle to grave‹ service, including primary care, acute hospital care, mental health, long term care for the sick and the elderly, dental, ophthalmic and some pharmaceutical services. The NHS would be structured as a public corporation which owned its hospitals and equipment. It would employ healthcare professionals to provide healthcare services. Services would be integrated and planned on a regional basis and be available to everyone, free at the point of use and funded out of general taxation, not social or individual insurance. Budgets, allocated on a weighted capitation basis, would be held at a regional level rather than at individual unit level.

At its inception, the NHS inherited an old and inadequate stock of hospitals unequally distributed around the country. The hospital building programme, which did not start until the 1960s, was funded separately by the government on the basis of grants with no repayment or debt service obligations.

There were several important provisos that were subsequently to provide the levers for privatisation and ›market mechanisms‹. Firstly, the NHS would pay for some services to be provided by ›independent contractors', including general practitioners (GPs) or family doctors, opticians, dentists and community pharmacists. Secondly, some ancillary services such as ambulances, child health, public health and preventative services would remain the responsibility of local government although funded by the NHS. Thirdly, private practice in the form of GPs and private hospitals would co-exist alongside the NHS and doctors and consultants could work part time in the private sector if they wish.

Having eliminated the ›market‹ and billing for all except the independent contractors, and always short of cash, the NHS offered what has been widely accepted by international analysts as an efficient low cost, albeit a ›no frills‹ service, at least by comparison with France and Germany. The lack of resources and tight capacity constraints meant that GPs acted as gatekeepers to the NHS and there was *de facto* rationing via waiting lists.

The vast majority of people use the NHS. Less than 10% of the population have private healthcare insurance, typically paid for by employers, and this is used to cover the cost of diagnosis and acute care treatment in private hospitals, largely for elective surgery. The private hospitals are small, have a parasitic relationship with the NHS, and do not provide either emergency services or a comprehensive range of treatments, with the result that almost everyone uses the NHS at some point.

Irrespective of its consumerist limitations, the NHS has always been immensely popular with the public, inspiring a fierce loyalty that few other institutions in Britain can rival. The NHS was to become the largest public corporation in Europe, employing now about one million people. It soon set a benchmark for the right to healthcare provision all over the world. It also served to impress that principle in the minds of the working class, making them determined to defend it. No political party has therefore felt able to call for the outright privatisation of health-care.

Healthcare ›reforms‹

Although within three years of the establishment of the NHS, the Labour government introduced charges for prescribed medicines, this basic model – with some reconfiguration – held until the 1980s. Since then, a variety of reforms, initiated by the Conservatives, but enthusiastically embraced by the Labour government in 1997 with all the evangelism of a convert, have radically changed the NHS. Part of a broader reform of the public sector which was assumed to be inefficient or at least less efficient than the private sector, these measures were introduced under the rubric of ›increasing efficiency‹ because the public sector was assumed to be inefficient.

A wide range of inter-related and overlapping measures have been introduced over the last thirty years that have profoundly affected the provision and financing of healthcare. These include:

- A series of macro-economic measures to control health-care expenditure as a whole and generate income;
- A raft of financial, organisational and managerial measures to increase outputs and reduce costs through greater efficiency at the point of service delivery;
- Measures to cap the activities and scale of the NHS; and
- The introduction of quasi-markets, the reconstitution of health care providers as business units charging purchasers the full costs of service provision, ›patient choice‹ of an alternative supplier of acute services, including privately owned polyclinics, and thus competition.

Each of these will be summarised very briefly.

Firstly, in the mid-1970s, the Labour government introduced macro-economic measures aimed at curbing public expenditure, including expenditure on health, as a result of loan conditions imposed by the International Monetary Fund. In relation to capital expenditure, the government immediately halted its limited hospital building programme. For the next 20 years, there was little new building. Even the most basic maintenance and refurbishment were curtailed. By the mid-1990s, it was impossible to ignore the vast backlog of maintenance or the need for new hospitals. For example, half of all hospital beds were in pre-1914 buildings.

In relation to recurrent annual expenditure, the government moved from a system of volume planning and funding to a system of cash limits for departments and units within departments. Ceilings were placed on annual public expenditure based on assumptions that real growth would not exceed a certain percentage, for example, 2 per cent. User charges and co-payments were introduced and/or increased for some services such as dental treatments, eye tests, prescription medicines and long term care, so that for a number of services, patients were paying almost the full cost, albeit with exemption for certain categories of people. The net result was that the amount spent on public healthcare provision by the late 1990s was among the lowest in Europe. Services were allowed to ›wither on the vine', fuelling public discontent and encouraging a belief that the problem was public sector ›inefficiency‹ that could only be cured by a dose of private sector management.

Secondly, there were a series of measures to reduce costs and increase outputs, including:

- An emphasis on management's responsibility to achieve a balanced budget limited in cash not volume terms at a time of high inflation that led inevitably to a reduction in real wages;

- Devolved budgets and cost centres leading to decentralised decision-making and internal payments between units and departments were introduced;
- More explicit procedures for capital budgeting and project appraisal, based on the financial methods of private sector corporations seeking finance from the capital markets rather than social objectives;
- Performance indicators and targets against which individual units were compared; and
- An ever-increasing emphasis on regulation, inspection and audit techniques through the establishment of the National Audit Office and the Audit Commission to audit and monitor the NHS. Others include the Healthcare Commission, Monitor, and the Nursing and Midwifery Council, to name but a few.

Thirdly, *the scope* of health service activities was cut back:

- Financial responsibility for long term care and care of the elderly was transferred to local government which was encouraged via a system of sticks and carrots to outsource and privatise their provision, and sell off or close their own homes.
- A further range of healthcare services, such as some ophthalmic and dental treatments, were excluded from the NHS. Henceforth they were to be provided by the private sector. In some cases, there are now full cost user fees, while in others, certain categories of people, and individuals are paid for by the state on a means tested basis;
- Some treatments were excluded locally on an *ad hoc* basis on the grounds of cost;
- Many of the ›non-core‹ low paid manual services, such as cleaning and catering, and, more recently, the higher paid professional services such as laboratory and IT functions, were contracted out; and

Fourthly, the Conservative government (1979-1997) introduced a quasi-market into health-care. Health Authorities would commission and pay health-care providers such as hospitals and general practitioners for health-care treatments on behalf of the population in their area. But integral to the introduction of the market was the policy of corporatisation – the reconstitution of the hospitals on the one hand and the GPs on the other as businesses to be known as Trusts. The hospital Trusts were required by statute to take responsibility for their capital infrastructure and operate as private sector corporations by making a financial surplus or profit, equal to 6 per cent, now reduced to 2.5%, of the value of their capital base, to be paid to the government, a system known as capital charging. This, although not explicitly stated at the time, would facilitate a turn to leasing both premises and equipment, which become key to a future market based reform, the Private Finance Initiative.

The Trusts were also required to charge for each diagnostic related group (DRG) on a full cost basis, which included the cost of capital. This meant that specialist hospitals with expensive equipment or those in city centre locations where property values were high would necessarily have a high cost of capital and thus higher DRG costs. Cross subsidies between treatments would not be permitted. The hospitals‹ charges for each DRG were compared and the average cost was used as the basis for funding them. Thus, cost comparisons were used to force down costs and/or increase outputs for the same level of inputs.

While successive Labour governments have since 1997 repeatedly changed the specific form and mode of operation of the quasi-market, they have vastly expanded

it. To this end, it has brought the private sector into core clinical services. For example, it has introduced private healthcare providers, known as Independent Sector Treatment Centres (ISTCs), for diagnosis and some standardised treatments such as cataracts and hip replacement, from whom (public) healthcare purchasers would procure treatment for their patients at public expense. It has encouraged GPs or Primary Care Trusts (PCTs), which now control the budget for healthcare, to commission hospital treatment from the private sector. With money now beginning to follow patients, some hospitals will become and indeed have already become financially unviable, leading to further ward and hospital mergers and closures.

Fifthly, in 1993, the government announced that new hospitals would be financed by the private sector, via a leasing arrangement, under the Private Finance Initiative (discussed in the next section). Under a further reform announced nearly 10 years later, the Trusts would be able to become Foundation Trusts, provided they satisfied certain financial criteria, which would give them greater financial freedom. This would enable them to take out commercial loans, undertake joint ventures with the private sector, determine their own pay scales, and set their own priorities. In other words, they would be free to act like commercial companies but without the need to make and distribute their surplus to shareholders.

While this list is not exhaustive or very detailed, it does give some idea of the wide range of measures introduced by successive governments (for a comprehensive survey see Pollock, 2004). Several inter-related points flow from this brief survey. Firstly, these measures were justified in terms of increasing efficiency, innovation, value for money and responsiveness to users. The changes marked a move away from planning on the basis of need, to managing by financial numbers, and decision making and control by managers instead of healthcare professionals. Secondly, these measures are the techniques used by the private sector to generate profit out of the production of commodities for distribution to the providers of finance. Thirdly, the administration of this market, including the accounting systems for the DRGs and billing systems, has added considerably to the NHS's costs. It can be expected that administrative costs will increase until they approach the levels in the US and elsewhere. Fourthly, this creeping privatisation of healthcare and the introduction of new private providers have led to a growth in the number of new corporations and an increase in the size of existing corporations that service the NHS and deliver healthcare treatments. Finally, since each unit within the market, the procurers and providers, has to achieve certain financial targets, their strategy and actions are increasingly being driven by their own financial interests not those of their patients.

The combined effect has been to render health-care a commodity produced for profit, irrespective of whether it is publicly or privately provided; enable direct comparisons with costs in the private sector and make it possible for the private sector to deliver health care treatments and services. From a healthcare perspective, these measures have fragmented the NHS, militating against a planned and integrated system of healthcare provision, accessible to all.

These measures took their toll on the NHS. By the late 1990s, as waiting lists lengthened and deficits spiralled leading to ward and hospital closures, nothing could disguise the fact that the NHS was seriously underfunded by an amount estimated at £267bn between 1972 and 1998, compared to the European average that includes the poorer Mediterranean countries (Wanless 2002). In recognition of the mounting public an-

ger over the NHS, in 2001, the government announced an extra £42bn over 6 years, claiming that it would take Britain's spend on health as a percentage of GDP up to that of the European average by 2008. But even then, Britain would still be well below Germany and France. The total planned net expenditure for England in 2007-08 was £91bn (DoH 2007) or 9.2% of GDP. This represents a major increase on NHS spending in 1996-97, when actual expenditure was about £33bn in England (DoH 2001).

By far the largest part of NHS spending is on hospitals. While some of this increase went on substantially higher salaries for doctors and consultants, a more modest increase for nurses and ancillary staff, much has gone on the additional costs associated with the reforms. The number of managers has doubled since 1997, while the amount spent on management consultants has topped £600m a year, more than the whole of British manufacturing industry.

Private finance

The crumbling nature of the hospital estate provided the excuse for the turn in 1993 to private finance, via the Private Finance Initiative (PFI), to build new hospitals and healthcare premises. Slow to get off the ground, it was the Labour government that was to implement the policy, which it rebranded as Public Private Partnerships (PPP), particularly in the health sector. PFI has now become the predominant mode of financing new hospitals, under what the government likes to describe as the largest new building programme in the history of the NHS. The government also expanded PPPs to include a wider range of financing mechanisms (Treasury 2003). In the context of health, it set up joint venture arrangements with the private sector, such as the Local Improvement Finance Trust (LIFT), for primary care facilities.

Under PFI, a hospital Trust commissions the private sector to build a hospital that will provide a specified level of activities, maintain it and operate all non-clinical services such as cleaning, catering, laundering and portering for a 30 year period, the precise requirements for which are set out in a legal contract. In return, the Trust pays an annual fee that covers the cost of leasing and maintaining the hospital and the cost of the services. Non-availability of facilities or inferior performance are subject to penalties although these are typically small. Correspondingly, any change in service requirements will be subject to additional charges. In effect, the Trusts would be leasing fully serviced hospitals. At the end of the contract, the hospitals would revert to the state or be subject to a new service contract.

But such a policy is more expensive than public finance for several reasons: governments can borrow more cheaply than corporations; and the annual charge must include the profit margin of both the private partner and its extensive supply chain, and the not inconsiderable legal and financial advisors‹ fees to structure and negotiate the deal. Any costs incurred by private contractors on unsuccessful bids are likely to be recovered in future successful contracts, increasing the cost of subsequent PFI deals.

Furthermore, the services which are the subject of partnership deals have never been sufficiently cash generative, if they are cash generative at all, to be run on a commercial, comprehensive and universal basis, which is why they have been provided thus far by the state. In order to make such projects financially viable and attractive to the private sector, the government must therefore ensure some combination of capital grants, subsidies, implicit or explicit underwriting of the private sector's debt

or the public authority's payments, bundling together of projects to increase their size relative to transaction costs, new build rather than refurbishment, project and service downsizing, higher charges for the public authority or the users and a reduction in workers‹ jobs, wages and conditions as Froud and Shaoul (2001) show.

All this has the potential to distort a capital prioritisation programme based upon an economic and social cost benefit analysis in favour of schemes that can be made to generate the requisite cash flows. Should income turn out to be lower or costs higher than expected for the public agency, then PFI must come at the expense of other services, further distorting rational resource allocation. But should the private partner find that its income is less than expected or costs higher, then it will either seek ways of increasing its income – typically by high charges for the inevitable changes to the original contract over its 30 year life – or hand back the keys.

Such a policy, so fraught with contradictions, has necessarily proved difficult to sell to a sceptical public. Indeed, as with so many neo-liberal policies, the rationale for PFI/PPP, like the justification for the war in Iraq, has changed so much over time that even its proponents have described it as ›an ideological morass‹ (IPPR 2001). It was originally justified as a way of accessing the finance the state could not provide, or at least not within the strictures of the European Union's Stability and Growth Pact. Within the UK, the higher cost of private finance is justified in terms of value for money (VFM), in the form of lower discounted whole life costs, including the cost of transferring some risks to the private sector, compared with conventional procurement as measured by a public sector comparator (PSC).

As of July 2007, signed hospital deals had a capital value of £8.7bn, with annual payments estimated at £885m in 2008-09, rising to £1.5bn in 2019-20 (Treasury, 2007). Total commitments for all hospital PFI projects between 1995 and 2034 are estimated at £48bn. However, since these projections necessarily omit the new deals yet to be signed, these annual payments are set to increase. This means that future payments will take an increasing amount of the key denominator, the annually managed public expenditure that is still spent ›in house‹, which is itself falling due to different forms of outsourcing (Pollock *et al.* 2001). To the extent that they constrain budgetary flexibility, they raise issues about the control and sustainability of investment and expenditure on health in the future. Such future payments in effect constitute »an explicit off balance sheet liability … which has significant implications for future borrowing or taxes«, as the IMF, citing an article in *The Times* (July 7/2003), pointed out.

Furthermore, the governments may give explicit or more often implicit guarantees such as ›letters of comfort‹ to the financial institutions that payments will be made to the private sector, thereby in effect underwriting their debts (Barclays Capital 1998). Irwin *et al.* (1999) note that because the contingent liabilities flowing from these guarantees are rarely recorded in the accounts or budgets, governments may be unaware of the total extent of their exposure.

The cost of PFI hospitals

By 2001, there were 12 operational PFI hospitals in England, which had cost about £1.2bn to build. A recent study (Shaoul *et al.* 2008) shows that these 12 Trusts were paying about £260m a year in 2005 in charges to the private sector. This means that the contracts will cost about £7.8bn over the 30 year life of the projects.

But 10 of the 12 hospitals were paying more than expected at financial close due to volume increases, inflation, contract changes and failure to identify and/or specify the requirements in sufficient detail. While the average increase was 20%, the increase was 71% for North Durham, 60% for South Manchester and 53% for Bromley (Shaoul *et al. 2008)*. Such contract drift so soon after financial close suggests that there will be further increases and the total cost of PFI will be very much more than the £7.8bn based upon 2005 payments. Extrapolating across all the 100 signed deals means that total costs will be far more than the £48bn cited earlier.

The private sector companies are special purpose vehicles (SPV) or consortia organised as shell companies with no employees. They operate in a complex and opaque web of subcontracting to their sister companies that increases the costs and complexity of monitoring and enforcing the contract. This also makes it impossible to assess the parent companies‹ total returns. Data from the private sector's accounts show that the 12 corresponding SPVs had operating costs that took 53% of their revenues (Table 1), and financing costs (interest and post tax profits) that took 44% of their revenues (Table 2).

Table 1: Cost structure of PFI schemes

Year ending	12 hospitals 2005	
	(£m)	% income
Income	263	
Operating expenses (payments to subcontractors)	140	53%
Operating surplus	123	47%

Source: annual report and accounts

Table 2: Returns to providers of finance

Year ending	12 hospitals 2005	
	(£m)	% income
Tax payable	6	2%
Interest payable	103	39%
Surplus after interest and tax	14	5%
Finance (interest and surplus after tax and interest)	117	44%

Source: annual report and accounts

Table 3 compares the actual annual cost of private finance with an estimate of the annual cost of public finance. It assumes conservatively a public loan of the same size as the private sector's debt, even though the debt was greater at £1,384m than the £1.2bn construction cost and an interest rate of 4.5%, the cost of public borrowing. The extra cost of private over public finance was £55m in 2003, or 21% of the companies‹ income from the Trusts. In other words, the Trusts will be spending about 21%

of their income every year for the duration of their contracts on the *additional* cost of private finance.

Table 3: Extra cost of private finance

Year ending	12 hospitals 2005
	(£m)
Actual debt	1,384
Shareholders funds	24
Total capital employed	1,408
Actual returns to providers of finance (interest and surplus after tax and interest)	117
Return on capital employed	8.5%
Estimated interest on same level of debt at public sector rate of interest (4.5%)	62
Extra cost of private finance (line 4 less line 6)	55
Extra cost of private finance as % income from Trusts	**21%**

Source: annual report and accounts

However, this measure of the additional cost of private finance is an underestimate since there are leakages in the private sector's supply chain that cannot be quantified: the contractor and subcontractors‹ cost of capital (typically subsidiaries of the SPV's parent companies), third party revenue from canteens, car parking and patients telephones, and the proceeds from any land sales and refinancing of the SPV's loans, all of which accrue to the subcontractors. Such information is either not publicly available or available but not in a systematic way amenable to analysis. Furthermore, while tax payable has been omitted in these calculations, arguably tax should be included since the public authorities would not be liable for tax. Thus the estimate cited earlier of the additional cost of private over public finance is a very conservative one.

While the government recognises that private finance is more costly, it believes that this is VFM and represents the cost of the risks transferred to the private sector, the main justification for PFI. However, such claims rest upon calculations made at the time of procurement of *expected* savings from risk transfer over the life of the project, not actual savings. There is little reporting about how the contracts are working out in practice. It is far from clear how the actual savings made from transferring risk are be measured in practice, as Broadbent *et al.* (2003) noted in their study, and thus whether this 21% of income is in fact VFM. The lack of transparency means that it is therefore unclear whether the rewards to the private partners are commensurate with their risks.

But irrespective of whether this annual £55m represents VFM, this analysis raises questions about the affordability of PFI in practice and future service provision, issues that the emphasis on VFM and risk transfer downplays. The hospital Trusts‹ PFI charges took 12% of income in 2005. The case of Dartford is particularly interesting because even after a refinancing deal that led to a reduction in their charges, PFI charges still took 17% of income. While the Trusts received a 56% increase in funding between 2000 and 2005, as well as in some cases a specific increase to cover some of

the extra costs of PFI, PFI charges were still taking the same proportion of income. Without the increase in funding, PFI would probably have been unaffordable. But this in turn means that the additional spending on hospitals has not increased front line services to the public, especially as these new hospitals have less capacity than the ones they replace.

Despite the increase in funding, the Trusts‹ financial situation was neither stable nor robust, as indeed were many non-PFI Trusts. Without a detailed study of each Trust's caseload, it is difficult to determine the role of PFI as other factors have intervened. But two examples illustrate some of the problems. In the case of South Manchester, which had suffered a £7m deficit in 2003, this was because it was unable to shift a £20m caseload to other hospitals that had been part of a wider reconfiguration underpinning the original business case. The QEII Greenwich Trust, with one of the largest deficits – £9.2m in 2005 – declared that it was technically insolvent and was locked into a PFI deal that added £9m to its annual costs over and above that built under conventional public procurement (PWC 2005). Without government support, its long term financial situation was insoluble.

Additional confirmation of these findings is provided by the Audit Commission (2006, p27), which noted a "marked correlation between the presence of large new building projects and deficits in the NHS". McKee *et al.* (2006) in their international review of the turn to private finance for hospitals, note not only the higher cost, but also problems relating to quality, flexibility and complexity in operating hospitals.

But there is a further problem for the local healthcare economy. Since PFI charges constitute a ›fixed cost‹ that cannot be reduced due to penalty clauses, this serves to reduce the Trusts‹ flexibility in managing their budgets and to make conventionally funded hospitals vulnerable to cutbacks and service rationalisations in order to ensure that sufficient income flows to the PFI hospitals (South London and Maudsley Strategic Health Authority 2007).

Finally, if this additional annual *observable* cost of £55m for 12 hospitals is generalised across the entire £8.7bn building programme agreed thus far, then the extra cost of private finance for the deals signed thus far is about £4-500m every year. Thus far from providing additional resources, the use of private finance must come at the expense of other healthcare services.

Conclusion

These changes mark a very definite transformation of social relations in a number of important respects. Firstly the relations of production in health are being realigned so that they match those of the private sector, and hence some of the main differences between the forms and practices of the public and private sectors have in practice been eliminated. Secondly, services, funded by the public through taxation, are being organised by the state to serve more directly the financial interests of private corporations, particularly the financial institutions, via outsourcing and partnership arrangements. Thirdly, the public is being reconstituted as the customer for the goods and services so produced.

While these measures may appear and indeed were often presented as a form of decentralisation that permits local decision making, a means of generating greater efficiency or transferring risk, their real function was to generate new revenue streams

for the corporations and financial institutions and to create the structures and mechanisms for the private sector to more easily control, own and direct public services and public policy. These changes are part of an ongoing process whereby the social and public services pass into the private sector through buyouts, subcontracting and leasing operations such as the PFI. Finally such services, following the path of the former nationalised industries before them, are then integrated into the wider international economy as they are taken over by the transnational corporations. In other words the social welfare functions of the nation state are being integrated into the world economy, but for the benefit of capital, not labour or the population at large. The significance of these neo-liberal policies is that they provided the ideology and mechanisms to accomplish an international market for health.

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