Health and social services: do we know what's happening?

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The health group's session was a series of short presentations describing how the NHS is being privatised and the implications of this for statistics. Allyson Pollock gave an overview of the policy changes which had taken place over the last fifteen years and what has been happening since the implementation of the NHS and Community Care Act in 1991. Alison Macfarlane presented some of the data which are collected and described gaps in them. Sandjiv Sachdev talked about the Private Finance Initiative. These talks were an overview of work which is under way in a longer and more detailed article. The article sets out the trends in privatisation of health care and will be ready by late autumn.

A cornerstone of the NHS in 1948 was public accountability of services funded publicly through taxation. Nevertheless Aneurin Bevan soon realised that local authorities were too small to plan for most medical conditions and client groups. He felt that a regional tier would be more appropriate to identify a large enough population to plan and provide comprehensive services for the whole population and always intended to pursue that accountability through regional and local government. Although this never happened there have been some safeguards to accountability within the NHS. Elected local councillors sat on health boards and community health councils were created in 1974. Above all, most services were publicly owned and managed. Services were held accountable to the local populations they served through health boards or authorities. Even though health authority members were not directly elected, they included local councillors up until 1991.

The NHS has always been seen as facing a crisis in funding although its share of the Gross Domestic Product has risen only around 2.5 per cent since its inception. Cost containment has been achieved because central government has managed to control spending and the provision of services. Until recently, the NHS has been relatively cheap to administer and there have been no profits.

The shift from public to private provision of acute NHS services can be traced back to the early 1980s. The government contained costs by holding back health care spending and encouraging reductions in public provision. For example the numbers of acute NHS beds decreased as the major communicable diseases were controlled. Some of the oldest and poorest NHS hospitals and other facilities which the NHS inherited in 1948 were rationalised and replaced. At the same time, policies of community care were being developed. These eventually led to the closure of the long stay psychiatric hospitals, hospitals for people with learning difficulties and, more recently, large geriatric hospitals. All these closures resulted in a reduction of public provision of residential care. This enabled the NHS to stay within its allocated share of the total spending, which was around 6 per cent of the Gross Domestic Product. Since 1979 there has been a dramatic shift from public to private provision, however. This first occurred in the 1980s in long term care[1] but is now happening in acute care.[2] So far, privatisation has meant that public funds have been used to fund private provision at the expense of public provision. Over the last fifteen years, however, there has been a gradual shift of responsibility for funding from the public to private sources. This so-called 'cost shunting' occurs when people are expected to pay an increasing contribution towards the cost of their care

The NHS and Community Care Act 1991 created an internal market in health and social care with a split between purchasers and providers of care. It also brought about far reaching changes in accountability for care and the relationship between the NHS and the private sector. Since 1991, providers of NHS services are no longer accountable to their local populations through health authorities. They have been set up as independent trust boards who are now expected to bring in their own funds. People who provide services are accountable to trust boards rather than to local people.

The purchaser provider split was also introduced into local authority social services. The government devolved the budgets for long term care to local authorities in the form of block grants, leaving local authorities responsible for funding and purchasing services. Social services which had traditionally been provided by local authorities now have to be largely bought in from outside and 85 per cent have to be bought from the private sector. This has led to fragmentation among providers. In addition, competition may result in duplication of services and

inappropriate selection of patients. Once again service providers are no longer directly accountable to the local authorities which fund them.

While breaking up public accountability for NHS spending at a local level, the government continued to keep a tight rein on public spending. It did this by stipulating that health authorities must purchase services at the start of each financial year on the basis of contracts. Providers which find that they overspend risk going to the wall.

In addition to the structural changes, the government has also brought in a number of other policy initiatives which will increase the degree of privatisation of the NHS and social services. Under the private finance initiative, which applies right across the public sector, NHS trusts who want new equipment or buildings to develop services must first try to find private companies who might be interested in investing in the proposal before NHS capital can be made available to them. Under compulsory competitive tendering, large areas of public services have to be put out to tender.

Another perhaps more long standing policy is the move towards charging patients for both health and social care. Patient charges for social care are on the increase but show huge inequities across the country because charging policies are not standardised. Although charges for home care services are supposed to be discretionary, more and more social services departments are charging for them. Moreover, when the government makes its standard spending assessments to local authorities, it assumes that the authorities will charge users for services and it reduces the level of the assessment accordingly.

In health care there is a growing trend towards charges. In the 1980s, ophthalmology services were removed from the NHS and privatised so that most individuals bear the full costs of tests and glasses. Dentistry has followed a similar trend. Even when NHS treatment is available, people can pay up to £250 per course of treatment. The impact of these changes on access and uptake of services is not known, since no data are collected routinely about care given outside the NHS and hence the population's use of these services is not monitored.

Prescription charges are another important source of in, even though a high proportion are dispensed to people who are

exempt from charges. There have been 17 increases in prescription charges since 1979. About 57 per cent of prescribed items now cost less than the prescription charge. As a result some GPs are issuing private prescriptions for these items. Private prescriptions are not included in routine data collection so this means that prescribing statistics and PACT data will no longer reflect GP prescribing patterns. The move towards private prescribing will also increase the net costs of drugs because of the NHS will be buying fewer cheaper drugs and there will be no cross subsidy between these and more expensive drugs. Finally, costs of drugs prescribed privately will not appear in practice prescribing budgets. This will increase inequalities by favouring practices in affluent areas where the demand for private prescriptions will be greater since fewer people will be exempt from charges. Such practices therefore will have lower NHS prescribing costs than practices in more deprived areas. If the GPs are fundholders they will be able to use these savings on their prescribing budgets for other purposes.

Charges are also occurring at local level where NHS and private care are being mixed. For example there may be charges some tests and investigations carried out during a routine NHS visit. Trusts are known to vary in their charging policies and there is no monitoring of which items are is charged for. Thus considerable inequalities are likely to arise in the extent to which people are towards the cost of their care and the charges they pay.

References

1. Pollock AM. Where should the health services go: local authorities versus the NHS. BMJ 1995; 310: 1580-1584.
2. Pollock AM. The NHS goes private. Lancet 1995; 346: 683-684.