

THE NHSCA EXECUTIVE SUMMARY

This report highlights what appears to have been a dual approach by the Department of Health with regard to the consultant workforce, which was revealed in a little-known article in the *Guardian* just after the initial contract negotiations had broken down at the end of October 2002. The author, Dr Penny Dash, speculated that the “no” vote had played into the hands of Blair and his Health Secretary, Alan Milburn, by opening up the possibility of greater provision by the private sector. It also extolled the virtues of the various private forms of organization to which consultants might wish to migrate, to escape the increasingly “monolithic” and “oppressive” nature of the NHS. Yet that aspect of the health service, with its emphasis on productivity targets and greater control by financial managers, was a direct result of the NHS Plan of 2000; and Dr Dash had been Head of Strategy and Planning within the DH when the Plan was drawn up, and hence one of the co-authors of the increasingly oppressive regime within the NHS – particularly for consultants. This suggested that the real aim of the new contract might have been to disenchant consultants with the NHS, and make them think seriously about leaving it.

In the event fracturing consultants’ fidelity to the NHS proved to be but one strand of a unified approach that was being pursued by strategists within the DH. Among them, Dash was (and remains) a key figure, along with others such as Professor Chris Ham and Mark Britnell, not to mention the Department’s Commercial Directorate. The strategy being developed appeared to be that of an “integrated” model of care, involving a major shift of resources from acute care within district general hospitals towards a more generalist approach, with a far greater concentration of resources in primary, secondary and ambulatory facilities, geared towards managing an increased prevalence of chronic, complex ill-health. While such a shift has much to recommend it, the template on which it was based drew most heavily on the Kaiser Permanente HMO model of care. This was a format that Ham in particular, as Dash’s successor at the DH and latterly as Chief Executive of the Kings Fund, has been keen to promote, despite the fact that a *BMJ* paper purporting to show Kaiser achieved similar levels of productivity at lower cost to the NHS had been thoroughly discredited.

Developments within the NHS have shown a marked and growing degree of correspondence with the Kaiser template: namely its tripartite structure of (a) groups of doctors who, while nominally independent, work exclusively for (b) the company’s insurance plan and within (c) its own network of hospitals. While the Kaiser model is only one of several

possible options for the shift to marketization, it has achieved the dominant ideological currency in policy circles. To achieve this template three processes must be realized: detaching both workforce and infrastructure from the NHS, and altering the insurance function.

Many of these processes were mapped in a document produced in 2006 by the NHS's National Leadership Network (NLN), a body comprising 150 policy makers, management consultants, NHS Trust and private healthcare executives, as well as selected clinicians, professional leaders and regulators. Both consultants and primary care clinicians were to be increasingly "decoupled" from the NHS and encouraged to set up competing networks of multi-disciplinary teams aligned with private sector providers and social enterprises, or as joint commercial ventures with Foundation Trusts or "large chronic disease management companies" and "clusters of GP commissioners". The NHS infrastructure was likewise to be removed from full public ownership. Many of the clinical workforce teams could be housed in purpose-built ambulatory or primary care facilities, akin to the polyclinic model, or be networked with the growing range of private hospitals providing services under the Extended Choice Network.

Subsequent developments have confirmed this overall direction of travel. Foundation Trusts are increasingly able to act as autonomous bodies, able to resource funds on the private capital markets and develop commercial ventures, and the removal of the private patient cap means they will be housing a mixed economy of care. The threat to the NHS consultant workforce was also revealed in a leaked document in January 2010 by the Foundation Trust Network (representing all existing and would-be FTs) that envisaged a 30-40% loss in acute clinical activity. Meantime most polyclinics or health centres seem likely to be privately owned, with the possibility of franchised models financed via NHS Lift, the primary care version of PFI. Independent Sector Treatment Centres also offer ready-made venues for ambulatory care.

The final part of the jigsaw, the insurance function, has been kept in the background. But the ISTC programme had the effect not only of transforming the private sector's business models to adapt to high volume and lower cost procedures financed by the public sector; it also increasingly altered the insurance companies' relationship with the consultant workforce through the creation of specialist networks of clinicians paid at lower rates but with guaranteed volumes of work. Major insurers have also seized upon the introduction of personalized budgets and the prospect of co-payments, particularly in areas of chronic care, as a signal for the rapid and large-scale shift to a mixed economy of healthcare, encouraged by the fact that personalized healthcare budgets

have been rolled out to cover many NHS Trusts, without any evaluation of the pilot schemes.

Last, but certainly not least, the commissioning function would appear to be the means through which many of the above processes is expected to be fully realized. The “World Class Commissioning” programme deemed PCTs incapable of effectively allocating resources, so that recourse had to be made to the private sector. Through the Framework for Procuring External Support for Commissioners (FESC) fourteen major insurers, healthcare providers and management consultancies – the majority of which are US companies with global reach – were to be increasingly determinant of how, where, and by whom services were to be provided. The new government’s plan to transfer the task to GP Consortia will not act to alter this trajectory.