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Going private can seriously damage your health service

Attempting to force the NHS into an economic battle between competing providers is proving both costly and perverse

By Michael Meacher

It is becoming increasingly clear that the model being imposed on the health service is the wrong one. The strategy isn't working. NHS trust deficits have reached nearly £1bn and hospital treatments are being deliberately postponed for several months to save money. These are just early signs of the effects of the rapidly emerging healthcare market. And as Patricia Hewitt and David Cameron vied last week over who will provide the bigger role for the private sector in the NHS, the Audit Commission has warned that trusts' financial volatility will continue as the volume of private-sector provision increases and payment by results is applied more widely.

Other cost-reduction plans, to prevent a projected deficit of £1.6bn by the end of this fiscal year, include service cuts and hundreds of bed closures, some in new PFI hospitals such as the Queen Elizabeth, in Woolwich, south London. And these are in addition to recruitment freezes and staff redundancies. Though there is a widespread shortage of doctors, BMA figures suggest a tenth of junior doctors cannot find a UK post.

This growing instability is seen by New Labour as the price to pay for strengthening incentives to efficiency. It believes that introducing competition and giving patients a choice of provider will lead to greater equity as they are able to switch from poorly performing hospitals to better ones; and this will push up standards as providers improve in order to recruit patients, or else risk being forced out of business. This will in turn lead to greater efficiency as hospitals compete to drive down costs and money flows to the most popular ones.

Such is the theory behind the new NHS market. But there are good reasons for thinking it will not work like that, and may indeed produce results that are perverse and counterproductive.

Under the government's new centrally fixed pricing system, providers will find some services and treatments more profitable than others. To balance their budgets they will compete for those patients that are most financially rewarding while excluding, if they can, patients on whose treatment they would make a loss. Another threat to equity is that some patients are clearly less able to assess the medical options open to them and, even if they could, may well be prevented on income grounds from travelling to distant providers.

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Quality may also become hostage to the emerging private market. Where a patient treatment cost is higher than the national tariff price, but the provider cannot get out of doing the work, there will be pressure to drive down costs at the expense of quality.

Efficiency in delivering healthcare does not work as in classical economic theory, where many competing providers enter or exit quickly and costlessly. Hospital services require substantial capital investment to obtain economies of scale, and inevitably involve significant time lags to respond to demand. Moreover, the transaction costs of the market - providing information, operating the pricing system, and monitoring and enforcing contracts - are very high and a serious barrier to value for money. If market logic is pursued, and hospitals are allowed to close, services dismantled and trained professionals dispensed with, the wastage of public resources and investment will be huge.

Nor is the new NHS market even a genuine market. It is rigged to protect private entrants against fair competition. Privately run independent treatment centres were introduced in December 2003 to carry out routine hip, knee and cataract operations on NHS patients at a cost of £2bn a year. For standard low-risk surgery they are paid substantially more than the rates laid down in the NHS national tariff. Another key aspect of NHS privatisation has been the courting of PFI to secure new buildings without having to raise taxes or admit the cost as part of public debt.

There are two things wrong with this whole approach. First, it's the wrong model; there is no evidence that private-sector health is more efficient, cost-effective or better-managed, or even that it provides net additional resources. Rather it is ideologically driven, and bought at a high price in terms of the enormous transaction costs and waste that the market has generated. What is needed instead is a genuine public-service model. That does mean tackling the delays and queues that were allowed to develop: partly by the huge extra resourcing steadily coming onstream; partly by greater internal management transparency to drive up standards; and partly by stronger local democratic involvement and a rigorous system of complaints and redress. But at the same time it means restoring the principles of comprehensiveness, universality and equity - and the professional morale that goes with them - that the market has subverted.

Second, the passion for PFI, outsourcing and privatisation is a fearful distraction from the real underlying issue for the NHS - how to shift from being an illness-alleviating service to a health-creating one. Less than 1% of the NHS budget is spent on the promotion of healthy living - improving diet and exercise, tackling smoking and excessive drinking, reducing stress at work and providing better housing and domiciliary care for the elderly and disabled, to reduce demand on hospitals. The canard about the need for private healthcare is irrelevant to what's really required.

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