POLICY

# Privatisation by stealth?

**'Government lights the fuse for privatisation' blazed the Health visitor journal's front cover when the NHS and Community Care Act was passed in 1990. Since then the debate on the future of the NHS has raged. In the first of a series in which different authors look at policy issues, ALLYSON POLLOCK argues that the introduction of charges for dentistry, eye tests and long-term care – is undermining the principle of a universal national healthcare service, free at the point of use.**

Prior to the setting up of the NHS in 1948, 3000 voluntary and municipal hospitals competed for work. Each was separately administered: there was duplication of services as they vied for patients: most were completely broke. Rich areas had better services and hospitals; poor areas had none. Rich patients had ready access to care but poor patients did not. Doctors and hospitals competed against each other: the patient was caught in the middle; many were not caught at all.

Overnight, the NHS did away with territorial rights and rivalry. It introduced a planned service which strived to respond to need and to allocate resources accordingly. Need, not ability to pay, was the essence of provision. The NHS was built on a national consensus that it should provide a service for everyone, from the cradle to the grave; above all that it should be free at the point of delivery.

Until 1991 the NHS largely succeeded in this, despite chronic underfunding from year one, when the amount needed to fund the huge pool of previously unmet need was seriously underestimated. NHS spending has never been out of control. The myth of spiralling demand and spending has been perpetuated by successive governments, failing to look at the comparatively very small amounts required to ensure that the NHS keeps pace with technology and the growing needs of an ageing population.

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### Efficiency

The NHS has been the envy of every government in the world; it has been an undisputed success. Part of its success lies in its incredible efficiency: the NHS accounts for only six per cent of Britain's GDP on health care – less than half of almost every other country in Europe, and this has barely risen since its inception. It was so efficient that between 1948-58 the cost of the NHS fell from £8 and ten shillings to £8 and five pence per head of population. More recently, between 1980 and 1990 the cost of an acute bed fell by ten per cent, the cost of a geriatric bed by 15 per cent, the throughput increased by 40 per cent and the average length of stay fell by 25 per cent while the number of beds available also fell by 25 per cent. It is worth noting that, at the same time as the NHS lost about 200000 beds, the private sector more than doubled its beds, but that half of these were empty and making huge losses.

### The market

The government introduced the 'internal market' to stifle the protests at the continued underfunding of the NHS. Since 1991, the market has transformed the health service into the unplanned, fragmented system of pre-1948, and it has increased the costs of administration from five per cent to an estimated 14 per cent.

The market has forced the pace of closure of NHS beds. They have closed not because of the state of the buildings or because there is too much provision: beds have closed because of underfunding and political decisions not to spend on health care. Purchasers have left providers with no option but to close beds in order to meet their budgetary targets.

Faced with decreased NHS capacity and long waiting lists in the public sector, other purchasers such as GP fundholders have felt they have no choice but to transfer business into the empty, waiting private sector. The private sector can afford to sit back, lower its prices and wait, the good times will come when the NHS supply dries up. The private sector has increased its throughput, taking business from the NHS, but it still has plenty of spare capacity.

### Patient charging

Trusts and health authorities are increasingly looking at introducing patient charges for some treatments and services. Patient charges now make up four per cent of NHS income. But in dental care and eye tests, charging is now the rule.

Patient charges make up one third of the £1.2 billion spent on NHS dental care. Each course of NHS treatment requires the adult to pay up to 80 per cent of the costs, up to a ceiling of £275. Pregnant and nursing mothers and people on income support are exempt; the elderly are not, unless on income support. However, only 58 per cent of the adult population (23.2 million people) are registered with NHS dental services. There are no figures on the uptake or costs of services for the 42 per cent of people not using the NHS, because the government does not require the private sector to submit returns on coverage or the total costs of care. No one knows the actual level of private dental health insurance, but it is thought to be about ten per cent. The remaining 32 per cent either have no cover, get no care or pay out of pocket. The average annual premium covers only basic dental care and prevention, and has many exclusions.

The changes to the dental contract have left many parts of the country with a limited supply of NHS dentists. Some dentists will only take children on the NHS in exchange for their parents going private. The only monitoring of the impact of dental charges are national and local surveys, which point to a growing polarisation of dental disease and a reversal of the trends in improved dental health which have taken place since the 1950s. The majority of dental disease occurs in the most disadvantaged groups and areas which have the poorest access to services and the rates are rising in young children. These disadvantaged groups are experiencing deterioration in their dental health and increasing inequalities.

Dental care charges have two effects: they act as a deterrent to seeking help and care at an early stage, but they also mean that dentists are less likely to set up practice where they are unable to make a good income from private patients.

Eye tests are another example of the failure of government to monitor the impact of introducing charges. The sight test is the only means of screening people for eye

disease. Since 1989 60 per cent of adults have had to pay for sight tests. The uptake of eye tests is not monitored because there are no official records kept of private tests, so it is not known what has happened to access. Unlike dental caries, there are no national surveys of eye disease.

Screening of eye disease is important because the three major and common causes of blindness are treatable at an early stage: glaucoma, diabetes and cataracts. However, these diseases are also asymptomatic in the early stages and do not present with visual deterioration until late. It will be some time before we know what is happening to the trends in blindness from these diseases, but we do know from a study in Bristol that, since 1989 and the introduction of charges, the identification of glaucoma fell by 20 per cent.[5] This means that a lot of people are being missed. We also know that only 100 000 cataract operations were undertaken last year: a third of the number expected.

A third example of the increase in patient charges is in long term continuing care. The Community Care Act has transferred the responsibility for the long-term care of old people and people with mental illness, physical and learning difficulties to local authorities. The effect of redefining health care as social care, is that patients are transferred from a system where they receive health care free at the point of delivery to a system where it is charged for.

### Creeping privatisation

So, what NHS treatments will be charged for next? One suggestion is that people could start to pay for 'predictable' operations and life events such as childbirth. The fact is that in the end all health care has an element of predictability: one in three of us will get cancer, one in 12 women will get breast cancer and most of us will suffer coronary heart disease. Becoming ill is as predictable as growing old and needing care: four out of ten of us will need continuing care after the age of 56, and one in four over 75 will need long term care for more than a year.

Moreover, predictable treatments are only a very small part of what the NHS does. Only seven per cent of the NHS budget is spent on elective surgery, such as hernias and varicose veins, at the cost of about £100 per head of population. The rest of what the NHS does is concerned with emergency work: care of people with devastating diseases, and long-term illness.

The average private health insurance plan covers people mainly only for elective work, but will cost about £400 to £600 per year. The cost of the NHS per person is £1035: the difference is that private health insurance covers only seven per cent of the care available on the NHS. Not only that, but the NHS subsidises private health insurance. The NHS trains private sector staff and it provides cover for high-risk patients who are excluded by the small print of most insurance policies. When an emergency happens in the under-staffed and inadequately covered private sector, and the small print comes into action, a transfer is effected free to NHS facilities, displacing those waiting in the NHS queue.

Patient charges and private health care insurance (the two go hand-in-hand) are hugely inflationary. UK spending on health care is lower than countries with insurance schemes, because the NHS has not had to spend money on administering patient charges, because there are no 'middle men' taking a cut in the negotiations between hospitals and insurers; and finally, because the US style 'fee-for-service' system actually promotes unnecessary intervention. Most importantly however, patient charges create inequities in access and treatment.

### Conclusion

Debates about NHS funding should centre on the consequences of *not* providing health care through central taxation. The myths of public expenditure spiralling out of control and inefficiencies are just part of the armoury of ideological tactics used by supporters of privatisation.

The introduction of the internal market to the NHS in 1991 has accelerated the despoliation and the erosion of universal coverage in healthcare. The Community Care Act has all but destroyed the principle of comprehensive care in the NHS from cradle to grave, by opening the door to patient charges. We get the NHS on the cheap: £1035 a year per person for coverage from the cradle to the grave. This is a low price to pay for a fully comprehensive policy with no small print. Private health insurance costs as much and covers less than ten per cent of what the NHS provides ■

*This is an edited version of a recent issue of the* Health Service Journal *(autumn 1994). Debates on the NHS*



# Preventing criminal disease

**After 30 years in policing, I am convinced that policing has much to contribute to health and health visitors can contribute much to policing. Child abuse highlighted the need for collaboration and greater understanding between them, but there is scope for more. Health visitors should involve themselves more in preventive policing and the police more in disease and ill-health prevention.**

**There is much research that links ill-health and crime as well as ill-health and diet. I am not saying that poor diet causes crime, but good nutritional health will help to prevent crime.**

**Many persistent offenders have nutritional health problems such as allergies, mineral deficiencies and/or neurotoxin overloads. We readily blame alcohol or illicit drugs for causing criminal behaviour. Yet food is a cocktail of chemicals just like them. The difference is, we do not readily identify food substances as contributors to bad behaviour. Yet there are signs and symptoms.**

**One sign is hyperactivity. Often this begins in the womb, with a restless and disturbed foetus. Mothers complain about the behaviour of their children and want help from their doctor and health visitor. Later they will appeal to teachers and social workers. They are often let down by being blamed as bad parents or told not to worry because the child will 'grow out of it'. I have many letters pleading for help from mothers who fear their children will become criminals. Sadly, they have been rejected or blamed by health professionals.**

**One example concerns a five-year-old girl who had not slept properly since birth. Her mother worked in my department and I noticed that she was not coping with the job. I discovered her domestic life was disrupted, even threatened, by the problem behaviour of the daughter. I asked what the doctor had done. He had said she would grow out of it and there was nothing to worry about! It did not take long to discover that the child was allergic to blackcurrant cordial. That was all she drank – and lots of it. She had other allergies as well. Within a few days of avoiding the allergic foods and taking only mineral water to drink, she began sleeping through and behaving better.**

**Nutritional problems can be significant, if obscure, contributory factors in criminal behaviour. They have been found to be involved in child and sexual abuse as well as eating disorders. Many can be identified in the first few years of life. Of course, not every person who has such problems will become criminal. Nor does every alcoholic! It might be helpful if health visitors kept record of signs, symptoms and their professional judgement or predictions about becoming a criminal. Health visitors could be expert criminal preventers. If successful treatment is applied, there should be credit to the health visitor in performance**

Not just a fizzy drink

**indicators or reviews. Kenneth Baker, when home secretary, called for more attention to the individuals who are most likely to commit crime, rather than crime prevention. To develop criminal prevention, health visitors and police both need to understand how each can contribute to the work of other. Health visitors can cut crime rates as well as death and disease rates.**

**We need a screening methodology for health visitors and police. Nutritional health problems may not be evident in early childhood, but may be more readily found in children who become persistent offenders. Police already have a legal duty to consider health problems in arrested offenders, but they need the expertise of health visitors to help screen detained juveniles. This would produce benefits in efficiency and effectiveness in the criminal justice system, and establish health visitors as principal preventers of criminal disease ■**

***Peter Bennett***

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