

Book Reviews/Comptes rendus

ALLYSON M. POLLOCK, *NHS plc: The Privatisation of Our Health Care*. London: Verso, xvi + 271 p. \$40.00

Democracy, like medical practice, assumes and requires informed consent. At the September First Ministers meeting, there was considerable discussion about how the Premiers are accountable to their electorate for health care reform. As more Premiers move to public/private partnerships for hospitals and other health services, the electorate should read Allyson Pollock's book on the privatisation of the British National Health Service (the NHS of the title). Pollock, a British physician and professor of Health Policy and Health Services Research at University College London, has published widely in both policy and medical journals. NHS plc (plc is like inc. or ltd. in Canada) is based on her own experience as a physician, researcher and policy expert, as well as on the work of the Public Health Policy Unit at University College London and a host of other investigations.

The book examines three fundamental policy changes in Britain. One such change, the application of business models within national health services, is very familiar to Canadians. Indeed, it is now understood as common sense to apply managerial practices taken from the for-profit sector to public services. A second change, or for-profit delivery and public-private partnerships, is well underway but still an issue in this country. A third change – internal markets that attempt to create competition among providers – has been promoted recently here by Senators Kirby and Keon in their policy paper published by the Institute for Research on Public Policy. The Premiers are focusing our attention on pharmacare, but the most critical reforms underway are the three examined in *NHS plc*. According to this book, these processes are dismantling universal health care in ways that will be extremely difficult for the public to reverse or even control.

The argument and evidence are clear. As with the Canadian case, successive British governments have promised to save the public system, keep public payment for care, and increase choice. Meanwhile, they have been busy privatizing the system in the name of saving the public one. The consequences contradict their claims for better, cheaper, more accessible and more locally-controlled care. Indeed, the reverse is more often the case. Business models, internal markets, and for-profit delivery have resulted in higher costs and poorer quality as well as fewer, more centralized services. At the same time, central planning virtually disappears

and informed consent by the public to changes in their health care system becomes much more difficult.

Standardized procedures, measurement tools, and funding systems drawn from for-profit systems tend to limit choices for both patients and providers. Costs rather than care become the priority. According to the author, “it is precisely the model of hospitals as so many business units, competing to supply standardized products to standardized ‘consumers’, that underlies the dehumanization and stress experienced by patients and staff today.” Those who own the private services, along with the public sector managers operating like them, have increasing control not only over cleaning and laundry but also over hospital discharge and treatment. Their training is much more likely to be in finance than in care.

The integration of services made possible by a single public system is increasingly undermined by internal markets with competing providers, as are comprehensive services and equal access to similar standards of care for both individuals and regions. Administration costs are rising along with a multiplicity of contracts with an emerging monopoly by giant, often foreign-owned, for-profit firms. This, in turn, is related to informed consent. For-profit organizations claim they need to maintain confidentiality in order to remain competitive. The company reports only to shareholders, which leaves citizens without any means to assess what they collectively pay for through the public purse. Equally important, once these services become commercial, international trade regulations make it very difficult to return them to public or national control.

The book develops these arguments first through an examination of the overall transformations in the NHS. It then moves on to examine in greater detail the three core sectors of hospitals, primary care, and long-term care. In each case, it looks at the international and national forces that have pushed an agenda in which “scientific evidence has been ignored, distorted and even invented, and objective criticism has been suppressed.” The arguments are carefully substantiated with references to multiple sources.

For-profit delivery began with what are often termed ancillary services, the cleaning, laundry, maintenance and dietary services. As is the case with the Romanow report, governments defined such services out of care. A growing body of research, however, warns of the consequences for both quality care and teamwork. The increasing “apartheid” among public and private employees undermines morale, just as cleaning hospitals like hotels undermines safety. But privatization mainly began with the failure to invest in public care. The deterioration lent credence to the argument that a public system was not the best way to deliver services. It was fueled by the media promotion of discontent. It was reinforced by attacks on doctors’ competency, by warnings about sustainability and the muzzling of NHS staff as well as other critics. Privatisation in all its forms was presented as a necessary response to rising costs as well as an inevitable outcome of changes in clinical care.

These were not the only factors, however. Successive governments actively promoted privatisation in spite of the growing evidence challenging the basic thesis. Investors with close government ties pressed for changes and international trade organizations reinforced their claims. For-profit firms saw Britain's public health system as a new space for investment. Like Canada's system, it was seen as "an unopened oyster" where they could grow their own pearls. Moreover, it was a low-risk investment because governments promised to foot the bill. Equally important in risk terms, governments could not afford to have a hospital or other service to fail – a win-win for shareholders, but seldom for most of those in need of care or providing care.

The book recognizes the need for reform. It argues, though, that reforms must begin with the traditional NHS commitment to equity, universality, and comprehensiveness. New funding is required. The "structures that make possible planning and a population focus must be restored and then strengthened." However, there is a real danger not only that significant amounts of new funding will go to profit, but also that it will be used to further justify privatization as the system improves. To avoid this, and provide informed consent, "the enormous transaction costs and waste associated with the market need to be exposed and brought to an end." There should be public scrutiny of the amounts spent on "private sector duplication, transaction costs and fraud." Sound familiar?

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