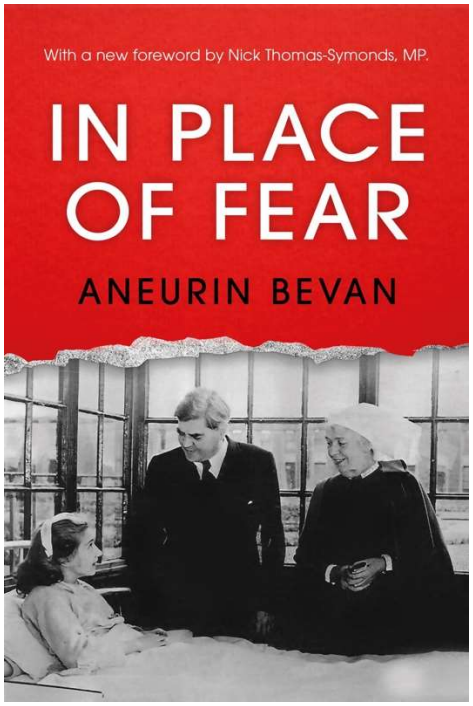
IN PLACE OF PROFIT

BRING THE NHS BACK INTO PUBLIC OWNERSHIP SO THAT WE CAN LOOK AFTER EVERYONE PROPERLY AGAIN



WE CAN RESTORE BEVAN'S FULL NHS ONLY IF WE TALK ABOUT ITS CORPORATE CAPTURE

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INTRODUCTION

England's NHS services have been pruned back from comprehensive, universal provision, to make space for the global healthcare industry.

This paper argues that the industry's means for reaching into the healthcare market include donations to MPs and, importantly, a revolving door between profit-making and state healthcare institutions. And that all such means must be understood within the context of the wider, policy drive against comprehensive/universal medical care, which has reproduced key elements of US government healthcare legislation and policy- notably Nixon's 1973 HMO Act and the US Affordable Care Act 2010 ("Obamacare"), and that these forays must be reversed as a precondition for recovering our illegitimately attacked NHS.

We produce this document in the year of the 75th Anniversary of the creation of the NHS. The NHS' 1948 creation under Aneurin Bevan's **"In Place of Fear"** gathered all health services and staff under public control, to bring everyone the healthcare they needed- from local general practice to the local general hospital. This would wipe out private, for-profit health care.

Bevan noted with satisfaction how these

> *"…innumerable harpies who battened on the sick […] are slowly being eliminated".*

For the harpies, the service and the wider welfare state became a problem to solve.

Most of the UK still cherishes Bevan's agenda and the principle upon which the NHS was founded**: that the publicly funded and provided NHS would meet everyone's health needs**. Nonetheless, corporate healthcare and its political representatives have led a four-decade counter-revolution against a service they called "monopolistic". They have done this to an antithetical, now dominant agenda, of shrinking essential services into socially insufficient profit schemes.

In the US, healthcare corporations' resistance to comprehensive, universal state healthcare (such as Medicare for All) has been more effective so far- than in the UK[i], but the drivers are the same.

We, therefore, have two incompatible agendas illuminated in this paper: the still popular Bevanite state model that was committed to providing all medical care based on need, versus purposefully reducing our public service along corporate healthcare industry models driven by profit.

This corporate model aims to undermine universal and comprehensive provision, as is its clear record in the USA. The changes towards US 'managed care' were kicked off in the UK by the 1990's internal market. This market, created in the NHS as a means of expanding private healthcare ethos and participation has meant retreating from the NHS' goals. Socially,

marketisation is unnecessary. In contrast to its rhetoric about efficiency, it exists at huge cost, and is a product of corporate capture in pursuit of profit[ii]. To quote Allyson Pollock:

"The law of the market is to create winners and losers. If you are working to contracts, then people are going to trim the services to make profits. Markets work against the interests of patients."

And to those who say that comprehensive public provision is unaffordable: austerity is a myth. Decades of lived experience say we *can* and have afforded a comprehensive, public NHS, no matter the age of the population -found by the 1979 Merrick Royal Commission to be the most cost-effective approach[iii] before it was abandoned. The actual constraint to the provision of services is human endeavour and skill, supported with the necessary buildings, equipment, and services. When the US has non-universal care that costs more than twice as much per head than that in the UK, it is imperative to understand that the political panic button of "austerity" is nothing but an excuse for corporate greed. Why have we emulated the US system in any way unless we wish to prioritise profiteering from sickness and disease over a comprehensive, equitable health service?

What we need is the publicly provided, complete health service operating in the context of a functioning welfare state which holistically addresses the social determinants of health.

THE CLASH OF VISIONS

PROVIDING ALL HEALTHCARE TO ALL VS JUST WHAT IS PROFITABLE.

These two visions of the state's role- as a public provider or as a private enabler- clash fundamentally. A major factor developing and implementing the latter role has been the revolving door between private healthcare and state healthcare institutions.

We will demonstrate here our critical concern with corporate CEOs' and their allies' interests in furthering their corporate vision from leadership positions they are given in the NHS.

In the UK, where people still value public service, such corporate interlopers hide behind depoliticised neutrality; behind a narrative where key personnel can pivot seamlessly from anti-public-service corporations to running a service established for the public good, as if these were variations of the same task. Disguising corporate healthcare's agenda like this removes the spotlight from its stealthy seizure of public services, especially of our NHS.

Because corporations focus inevitably and relentlessly on their interests!

Kaiser Permanente's late CEO Bernard Tyson not so long ago reflected: *"We have 150m-plus people getting coverage through private insurance. So, we must, as an industry, be doing something right."* What had they done right? His own company had invented and lobbied-for legislation minimising Medicare/Medicaid provision, which pushes so many people to take out insurance in the first place[iv].

Yet the Guardian signalled no such conflict of interest when reporting Tyson's inclusion on the 2013 shortlist to be CEO of the NHS England quango. Others included Mark Britnell, who'd infamously told New York investors that *"the NHS will be shown no mercy"* and UnitedHealth's later appointed CEO Simon Stevens, star of New Labour's efforts to copy the US state system[v], who in the US had then lobbied against Obamacare and to include healthcare in US trade deals.

Instead, like most mainstream discussion, everything in the Guardian's[vi] critique-free tone suggested a selection of technocrats to serve uncontested, no doubt public interest goals.

It is worth recalling here that, over three decades, pursuit of a shrinking UK state healthcare role, and expanded one for business has demonstrably followed the same principles (ACOs/HMOs/ICSs) Kaiser first lobbied for to support corporate healthcare's power in the US.

Every major UK election has been won on a promise to reverse policies involving this US scheme[vii], which has instead continually forged ahead. And, while claiming to act in the public interest, all major parties have (with a brief exception during 2016) remained committed to institutionalising care-reducing Healthcare Management Organisations (HMOs)/Integrated Care Systems (ICSs), reductions which help frame outsourcing and privatisation as a solution.

Figure 1: The Healthcare Management Organisation (HMO) Timeline in the NHS

REVERSING BEVAN

Our second contextual point on the revolving door is that our current system, institutions, and direction of travel are themselves **the fruit of a decades-long struggle *against* Bevan**. They are not Bevan's. They are not "the NHS."

The McKinsey-influenced 2012 Health and Social Care Act (HSCA), for example, created the powerful market purchasing and competition-monitoring quangos (the "Commissioning Board" and "Monitor", later renamed "NHS England" and "NHS Improvement" -subsequently merged) that are routinely passed off as "the NHS" in public discourse.

So, when a scandal erupted about appointing Dido Harding (another McKinsey graduate) to run "NHS Improvement," much effort was expended on defending a supposed public service institution from her as an individual, rather than critiquing how well she might fit this market body committed to undermining the public interest.

THE POLICY DIRECTION FOR THE HEALTHCARE INDUSTRY

Our third introductory point is that to understand and confront what the revolving door does to our NHS, we must see it as one weapon in business' arsenal, pursuing an agenda, which is what determines who is appointed.

Any movement to return the state to satisfying the country's healthcare needs -requiring nationalisation- threatens a 10 trillion-dollar global healthcare industry. Beyond focusing on individuals[viii], campaigning to expose the corporate capture of our public services must include

confronting corporations' strategic purpose within those services via the revolving door. Especially given the neoliberal right's rhetorical adeptness at re-signifying damaging policy as benign and socially motivated.

THE REVOLVING DOOR AT THE TOP

UNDERMINING BEVAN

In that light, let us look at some of the key routes between the role of NHS England director and the healthcare business, understanding individual careers as an aspect of systemic influence, rather than limiting analysis to who gained individually, or how much it all cost (which tend to be the limit of current mainstream critique).

We are inspecting how the revolving door undermines Bevan's NHS and instead provides opportunities for corporate profit.

MICHAEL MACDONNELL

So, firstly, taking the example of Michael MacDonnell -who became advisor to Tony Blair (one of at least six, high-placed under Coalition/Tory governments[ix]) when Simon Stevens joined United Health,[x]

Let us take the following two of his career points through the revolving door:

1. As NHS England director: declaring its policies he led on[xi] offered an "enormous opportunity" to the private sector.

2. Later, at Sensyne Health[xii], describing his NHS background and connections as useful for reaping such opportunities[xiii].

Beyond asking: "How dare he personally gain from turning our services for profit?" the real question that should concern NHS defenders is how, precisely, the NHS England policies he backed, which have provided those commercial openings, damaged our comprehensive, universal healthcare?

A non-exhaustive answer from evidence-based critics includes:

By reducing so-called "face to face" GP care to expand telehealth (years before Covid), so that privately-charging GPs were soon able to offer "face to face" appointments as an optional extra[xiv]. Incentivised via "integrated partnerships" with the likes of Babylon Health, driven by "savings" i.e., skimping on the right to see a GP in person[xv].

- By ending the local, general hospital to all[xvi], extracting its profitable bits to out-of-hospital *settings* (whether diagnostic centres, multi-specialty providers, virtual wards, perhaps social care) ditching locally accessible essential services which the NHS had universalised as a right[xvii].

- Replacing skilled staff with cheaper, more profitable alternatives (Taylorism "skill mix," whereby the person with the least possible skills for a particular production line task - eschewing holistic understanding- is chosen for that part of the process).
- Shrinking services to extract billions in real estate deals[xviii].

This kind of attack, facilitated by the revolving door, most deserves NHS defenders' voices to be raised and heard.

TIM FERRIS

Dr Timothy Ferris might need "a couple of years to lose the (US) accent" the *Health Service Journal* quipped inappropriately when he was made NHS England/NHS Improvement's director of "transformation" in May 2021. That followed nearly three years as "non-executive director" of NHS Improvement[xix], arrived at from being CEO of a Massachusetts Obamacare experiment in accountable care organisations (ACOs) -the US system that is now English law. Ferris' NHS England blurb says he "founded the Center for Population Health," as in *Population Health Management* (PHM), which ranks patients according to "cost"[xxxxi].

Let us take these two points from his career:

1. Offering UK policymakers, the example of his Massachusetts ACO business.
2. Implementing such examples as NHS England director.

Indeed, Ferris had in previous years joined the ranks of US politicians and corporates invited to teach the UK about US state healthcare, specifically Population Health Management[xxii] and ACOs[xxiii], speaking with mainstream UK think tanks.

He explained to the Health Foundation in 2014:

"If we can keep our spending below [set costs] then we will share in some of the savings, and that's the basis for the accountable care organization contracts." [xxiv] [Emphasis added]

NHS England's Strategy Unit makes clear this is central to an ICS' purpose:

"Risk and reward sharing is a key feature of the policy agenda for Accountable Care Organisations in the US and Integrated Care Systems in England.

It is a simple and attractive concept, offering a commissioner the opportunity to co-opt and incentivise a provider to moderate growth in healthcare demand by sharing in the savings or cost overruns." [Emphasis added][xxv].

Four years earlier, Ferris had explained further:

*"We identify the **highest cost patients** […] and this programme delivers a return on investment fairly quickly, so over a three-year period, and that's been the earliest success of the programme, which has clearly brought hospitalisations down **among that group**."*

Important lessons to draw here include the fact this reduction of care for state patients is explicitly core to the ACO agenda on both sides of the Atlantic, from policymakers' own mouths. In contrast, UK public debate and official statements on the policy have instead made the entire story about the elements of coordination those cuts required.

While ACOs/ICSs do bring together a number of providers (potentially including social care providers) around the budget which they are financially encouraged to cut, solely emphasising their plurality as 'integration' has falsely implied provision, rather than cuts to provision as the main goal.

This has helped deprive society of a democratic debate, and neutered public reaction on the number one political issue, for an entirely illegitimate result[xxvi]. As NHS defenders, it is our job to alert society to this undermining of democracy.

The year after Ferris' above UK visit, a segment for the US TV station PBS[xxvii] showed his organisation 'saving' money by using cheaper staff to monitor people at home instead of hospital. The president of Ferris' company, Peter Slavin, explained:

"Where we stand to gain financially is we've now freed up capacity within the hospital that the [state-funded Medicare] ACO patients used to utilise, and we can use that capacity to serve patients…"

Interviewer: *"-Patients who would be paying more for your services"*

Slavin: *"That's correct."*

So here, a single company, run by the now NHS England/Improvement director of 'transformation' to its system, shows us how ACOs intentionally grow privately funded business by reducing state-funded services.

"Freeing up capacity" is very much on the UK agenda today, as opposed to reversing the monumental, ongoing bed cuts that have been reducing capacity (and justifying private sector incursions). It would behove NHS defenders to be aware of this and address capacity-reduction policies accordingly.

SAM JONES

"Centene is a large corporation, and it has a presence in the majority of the states in North America. We are looking to learn from what is being done in these other geographies and make it context-specific for us here.

[...] We are a fundamental part of supporting and enabling integration of care models because this is a continuation of things that I have done throughout my professional life."

Sam Jones, then CEO of Centene UK.[xxviii]

An overview of Jones' timeline[xxix] through those revolving doors should include the following roles: Director of New Care Models at NHS England, CEO of US giant Centene's[xxx] UK operations, Operose Health[xxxi], undertaking a spate of major UK acquisitions for the company, then advising number 10 Downing Street on the continued "transformation" of our state healthcare in this vein under Prime Minister Boris Johnson (who later expanded her cabinet role).

Two useful career points to examine are:

3. Reshaping NHS services into business models (such as "primary care homes").
4. Expanding Centene's business into England's biggest primary care (GP) provider and biggest state-funded private hospital provider.

Again, let us take the perspective of how national healthcare policy has damaged services enough to make them profitable.

Although from the outset, researchers, (and the unanimous 2017 SHA-led Labour conference motion, reiterated in subsequent years), have called out NHS England's corporate practice of "down-skilling" from skilled, expensive staff to cheaper more profitable alternatives, this framing has been absent from mainstream discussion. This has enabled NHS England directors to mis-frame their restructuring to the managers involved, to politicians and others, as social in content and aims, and as a response to low funding/staffing and increased "demand." Neutral talk of new "skill mixes" (here, in the primary care context) often presenting non-GP staff as complementary rather than a commercial replacement for GPs (or as about reducing that vague thing called "pressures"), has relied on painting government refusal to recruit and retain GPs as somehow unrelated to its policy goals[xxxii]. US Medicare ACO examples[xxxiii] show instead how down skilling fits within their intrinsic, cost-cutting commercial logic. Something no staffing or funding increase will magic away.

In the same way, Operose Health's CEO, Sam Jones, was intimate with the NHS England Long Term Plan's commercial purpose and application, as someone who had taken part, in "creating and designing the future NHS today"[xxxiv] including institutionalising NHS England's diluted "skills mixes." Panorama showed Operose under her aegis applying this in practice, replacing GPs with physicians' associates explicitly because they are about half the cost.

Panorama quotes Operose rightly stating it did so in following the NHS Long Term Plan[xxxv] but neglected to note this is what the NHS Long Term Plan is *for*.

THE REVOLVING DOOR: OVERVIEW

These examples of national policy, achieved via the revolving door, represent what superficial, dominant NHS campaigning messages simply demand increased funding for. [xxxvi] We argue that:

Instead (of simply demanding more funding), defending the NHS means understanding the revolving door as one expression of corporate influence within a political system that business has tailored to its own purposes. And unbending clarity in the need to restore a service built on simply bringing the best local primary care, together with general secondary and specialist tertiary hospital care to meet the needs of the whole country, from the teeth of entrenched corporate opposition.

As profit-led bed cuts continue, leaving patients dying in ambulances and corridors, if we are ever to return to that NHS founding purpose, it will not be by acting and speaking as if it had never gone away.

We should be wary of language that refers to a contracting/competition-monitoring body, operating via a portal to big business as "the NHS"- and ask who it benefits to call it that.

Instead, we need a new, consistent, and everyday, practical language that accurately spells out the non-NHS we have today- in pursuit of retrieving one tomorrow.

Britain's potted healthcare privatisation history should be revisited in light of 30 years' copying US state, minimal healthcare provision, which benefits business, instead of Bevan's full service.

As today's supposedly centre-left newspaper of record retained a Zen composure about giving the heads of US healthcare giants unparalleled powers over our national services, we have to publicly acknowledge, and stir public reaction against the fact the *political project* they've fit so seamlessly into is no longer that of providing a National Health Service.

Instead- just like those same corporations' revolving door with Medicare- it is a power base that private healthcare has been developing for itself while we have looked elsewhere. Westminster's consensus has long ceased to support the welfare state and if we are to reverse that, our own language needs to catch up and acknowledge it.

CONCLUSION: THE WAY FORWARD FOR THE NHS

THE POLICY CHALLENGE

Policy thinking in the English NHS, more than in Scotland and Wales, is confined to a type of business thinking not dissimilar to the commercial practice of corner cutting. But after over thirty years' experience, this model has not proven it has any social purpose -despite repeated, performative "reforms" which have simply taken it further.

While it is important that we learn from international experience, the evidence tells us modern NHS policy and practice is driven solely by the US government's approach. It hardly needs to be pointed out that the US model is one of the most dysfunctional in the world, delivering poor value for money and patterns of care that fly in the face of fairness. The only justification for "learning from the worst" is that it is being driven by a neo-liberal, corporate agenda.

In a narrative that overlooked the continuity that has characterised three decades of copying managed care, the latest effort, calling itself "integrated care systems", came with crocodile tears claiming its Lansley predecessor was some kind of accident, based on competition and service fragmentation even more dysfunctional than the system it had made a show of replacing. And so, we have come to the Health and Care Act (2022). But given this merely confirms the embrace of the managed care market approach, we can discard the claims that it aims to "fix" anything at all.

Things do not have to be like this. This has been the political challenge to the Labour Party as it has developed its programme for government. But this is also a challenge to policy makers and managers – to them we ask, *"is there really no alternative than shrinking from such a valued public service as our NHS?"*

Our analysis of the levels of policy direction and delivery suggests that we CAN turn the NHS around- that the front line of the NHS would be well served and respond well to this reversal (Annex)

Below, we describe what the UK health care system should look like organisationally and what its mission ought to be. We support the NHS' universal distribution of local general practice (GP) to district general and specialist hospital care that has prevailed since 1948. We recognise that the NHS was designed to function within a context of quality mass social housing, full employment, universal education and so on and not in isolation, or even trying to make up for the lack of a welfare state.

We are all a step away from needing timely access to specialist hospital care, in addition to the task of the NHS nationally to deliver a range of public health, primary care, and protective health promoting measures designed to combat the causes of illness and disease.

Julian Tudor Hart's inverse care law still operates and, particularly in England, demonstrates how commercial forces engender the increasing maldistribution of healthcare. As a result, socially disadvantaged people receive less, and lower-quality, health care despite having greater need. The SHA strongly believes that a future Labour government must break with the mindset that our public services need the "discipline" of the market to succeed. The SHA strongly believes that that a future Labour government must break with the commitment to Integrated Care Systems'(ICSs')' smaller, US-government-like role for public healthcare- however many bridges this may burn with the private healthcare Establishment.

We have described how the Revolving Door between Global Corporate Health and the NHS has facilitated the transition of the NHS from a publicly provided service intended to meet all need, into part of a global healthcare business in pursuit of profit. The SHA and the Labour Party Conference already have as intent and/or policy the Reinstatement of the NHS as set out in the NHS Reinstatement Bill, which proposes to

"...restore the NHS as an accountable public service…abolishing the purchaser provider split, ending contracting and re-establishing public bodies and public services accountable to local communities."

THE ROLE OF THE NHS

Our NHS should provide:

1. Good primary care services equipped to identify and manage dental, ophthalmic, mental, and physical health concerns. We should understand Primary Care as much more than just the Gateway to Secondary and Tertiary NHS provision. Primary Care Services (GPs, dentists, ophthalmologists, Pharmacists) should be salaried as employees of the NHS -for which, again, we first must have an NHS, and not a collection of Health Maintenance Organisations. The allocation of primary care resources must recognise the unequal health experience of certain communities and social groups.
2. Public health functions tasked with ensuring healthy environments (for example clean air, clean water, safe food, safe working places} should lead on collecting, interpreting, and making available quality data on the health status of its served populations at both a macro and micro level. Data on the social determinants of good health and poor health should also be available. We must address the determinants of poor health, and communities must be enabled to improve their own quality of life and health experience.
3. Community based care staff offering assessments and direct personal and other care to vulnerable people whether young children, old people, or young adults.
4. Secondary care services -district general hospitals offering from diagnostic, elective, to accident and emergency - offering fast and local access to appropriate diagnostic and treatment facilities for both physical and mental health issues.

5. For more complex, specialist or rare conditions, tertiary care services serving large populations- including major trauma, cancer services, cardiac surgery, neurosurgery, renal services, intensive care units (ICU), coronary care units (CCUs), special care baby units (SCBUs) and stroke units
6. A range of proven screening services offering time appropriate screening designed to explore early on, any health limiting indicators in young children, teenagers, young adults, and middle-aged men and women. For example, screening for breast or bowel cancer in adults should deliver good outcomes where early diagnosis is made, and fast and effective treatment is provided. In primary care, screening services provided by dental and ophthalmic services should find mouth cancers and developing eye problems that would benefit from early treatment.
7. Skilled and timely ambulance services able to reach, diagnose, and deliver prompt treatment for people who need emergency care.

SHA VIEW OF THE NHS

- **The enduring task for the UK NHS is to deliver for the different populations and nations of the United Kingdom a level of health based on their needs rather than ability to pay;**
- **This task must be delivered by publicly provided and comprehensive NHS services;**
- **Our publicly provided, complete health service should operate in the context of a functioning welfare state which holistically addresses the social determinants of health;**

And:

- **We invite the authors of the NHS Reinstatement Bill to update it if appropriate in light of the NHS England changes sealed in by the Health and Care Act 2022. And clarify the need for reinstatement in contrast to embracing the US state model.**

SHA NHS Policy Influences Working Group

June 2023

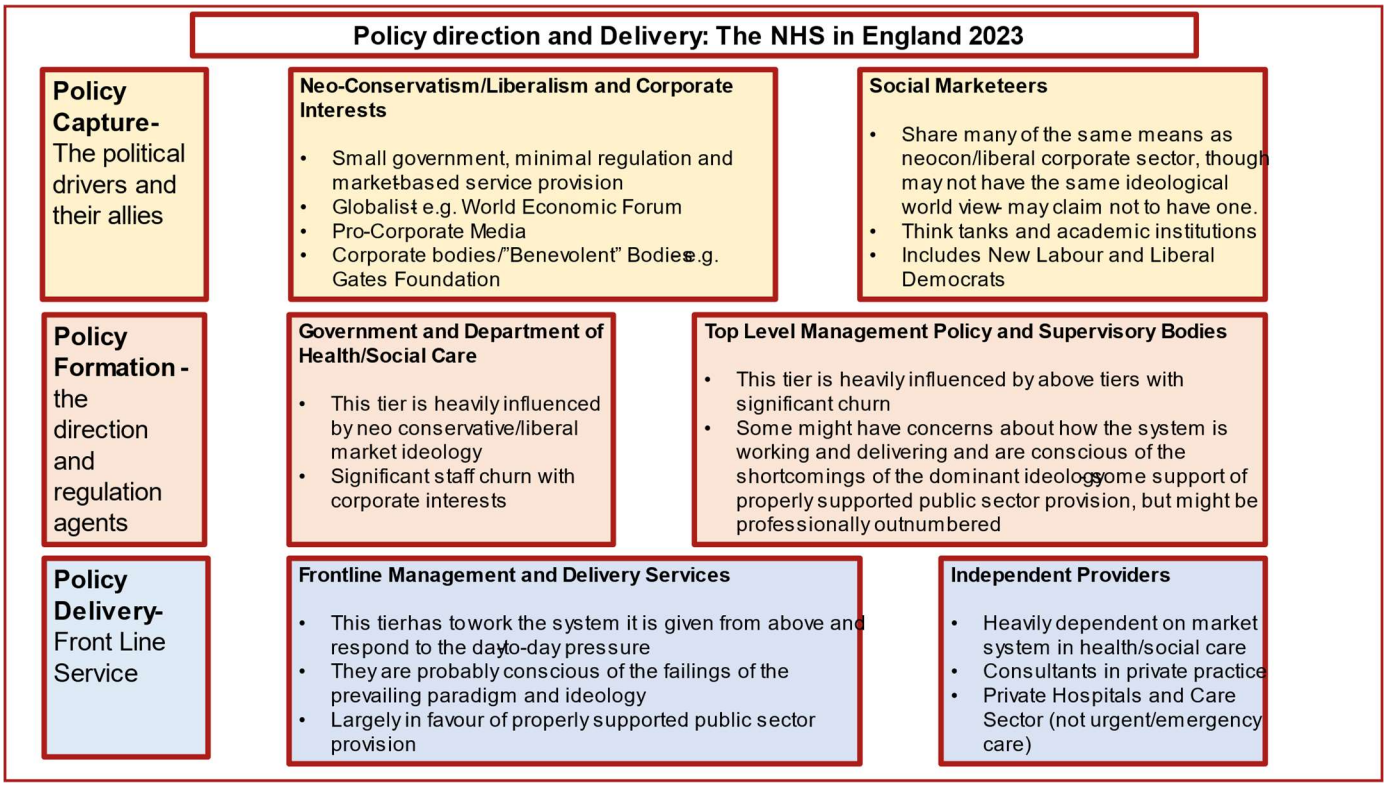
Members:

Esther Giles (Chair of Working Group): MA: MSc: CPFA; Tony Beddow: BSc; FIHSA;

Nico Csergo; Brian Gibbons FRCGP, MB, BCh, BAO; Mervyn Hyde

ANNEX: POLICY INFLUENCES AND LEVELS

Our analysis of policy influences and levels suggests that the reversal of corporate capture of the NHS will be supported by the Policy Delivery Level of the NHS- with the exception of Independent Providers.



END NOTES

[i] "An organisation called Partnership for America's Health Care Future, whose members include pharmaceutical companies, insurance companies, and private hospitals, has been running an online advertising campaign aimed at undermining support of Medicare for All," linked here

When [Centene boss Michael Neidorff was] asked about many of the Democratic presidential candidates' support for "Medicare for All," Neidorff said the idea is just unrealistic and "divisive." linked here

"The Army Built to Fight 'Medicare for All' The top health industry lobbies have joined forces to take down socialized medicine — or anything that looks like it. Will they succeed?" Linked here

[ii] The Marketisation and privatisation of the NHS described by Esther Giles here

[iii] Royal Commission on the NHS (June 1979): Merrison et al.

[iv] Nixon HMO legislation 1973, and *Obamacare*, 2010 (rebranded "ACOs"). The same core principle of financially rewarding reductions in care persists, as in its UK iterations (ICSs) also- linked here

[v] Work such as Public Matters' video, their writings, or Allyson Pollock's, Stewart Player's, Open Democracy's evidence-based research on copying the US state system, is glaringly and dangerously missing from almost all mainstream discourse of where Britain's healthcare is today.

[vi] Dennis Campbell, 2 Oct 2013, *The Guardian*, "Who will get the top job at the NHS?" (sic) here

[vii] HMOs were the explicit model for 'GP fundholding,' which Blair promised to repeal as part of repealing the 1990 Internal Market legislation. Instead, his government worked with Kaiser Permanente and UnitedHealth to set up "integrated care" pilot projects in England -explicitly meaning Kaiser's service-shrinkage system-, and instituted mass hospital closures on that (again explicitly US-copied) principle. Part of a body of policy aimed to "encourage […] greater diversity in the range of providers" (Alan Milburn, Washington D.C., 2002 here. Promising to stop those closure programmes ("top-down reorganisations") up to the 2010 election, David Cameron instead hired various of their Blairite architects to continue them, as they have done, with consequent reduced capacity in a pandemic, where we currently suffer a reported five hundred deaths a week. Simon Stevens, after 10 years at UnitedHealth whose approach he'd found "more promising" than his government's attempts at imitation, described here, said one of his 2003 government's pilot projects: "that's the sort of future that we want", as the model for his 2014-2029 national restructuring ("NHS England's Simon Stevens answers your questions".

Boris Johnson's "40 new hospitals" mirage implicitly claimed intent to reverse this hospital-closing trend. At the same time, cross-party claims insisted that legitimising "crony contracts" somehow meant "repealing" the 2012 act. Starmer's Labour Party is promising to continue the closure trend. (Echoing Thatcher's 1983 manifesto which promised to "promote closer partnership between the State and the private sectors in the exchange of facilities and **ideas**" -emphasis added).

[viii] Our analysis of political donations from those with an interest in profit from healthcare is here

[ix] Caroline Molloy, "Labour leadership, the NHS, and 'honest politics'", OpenDemocracy, 16 September 2016 https://www.opendemocracy.net/en/ournhs/only-article-about-leadership-campaign-i-ll-write/

[x] Remembering how this fit with New Labour's "Americanisation": https://www.theguardian.com/society/2004/may/26/nhs2000.health

[xi] Then in a phase labelled “STPs.” https://wellards.co.uk/whats-new/stps-provide-great-opportunity-for-the-private-sector-says-nhs-england. Article no longer up, but snapshot saved at the time.

[xii] A company founded by a Blair donor.

[xiii] “We really want to encourage many more NHS partners to come and join us […] so part of my role *given my background* will be to entice some others to come on this fantastic journey” [emphasis added], Interview by ‘Proactive’: “Sensyne Health appoints Google Health executive Michael MacDonnell as COO”: https://www.youtube.com/watch?v=1T8LWiftOrg

[xiv] Shadow health secretary Diane Abbott: “in a blizzard of apps and Skype, patients—particularly the elderly—will find it harder to access one-to-one care, and […] those who can afford it will find themselves forced into the private sector.” https://hansard.parliament.uk/Commons/2016-09-14/debates/175978A7-F5E3-4372-AD8C-E7D12DFA7270/NHSSustainabilityAndTransformationPlans

[xv] Although Babylon pulled out last year, this has not reversed policy. The Royal Wolverhampton Trust, for example, would “work to ensure the safe and smooth transition of patients from the Babylon platform onto alternative providers.” https://www.digitalhealth.net/2022/08/two-midlands-nhs-trusts-end-partnerships-babylon/ The pre-Covid context means the onset of the pandemic merely provided what Stevens called a “silver lining” for the expansion of such policies.

[xvi] National policy remains to reduce the number of acute hospitals in England from 144 (in 2013/14) to a national target of between 70-40, removing the A&E https://www.theguardian.com/society/2014/nov/30/accident-emergency-overhaul-shelved-warning-political-backlash which has been systematically making way for profitable urgent care centres. Part of what is now the NHS Long Term Plan, it is routinely framed as local decisions in an effort to contain public opinion. E.g., “Jeremy Hunt […] stressed that potentially unpopular decisions will be taken by local NHS and council leaders, and not by ministers. Theresa May is said to have recently told [Simon] Stevens to ensure that [national -NC.] hospital closure plans did not become a big issue in newspapers.” https://www.theguardian.com/society/2016/nov/18/ae-cancer-and-maternity-units-to-close-in-major-nhs-overhaul Governments have reframed national closure programmes as local events for decades, as New Labour did with its (national) Darzi Review.

[xvii] We do understand the imperatives of specialist trauma support and 24-hour medical cover; ultimately, national policy to cut local services should help explain why the resources required to provide comprehensive and safe cover are being reduced. This is first and foremost a political aim before it becomes a question of means.

[xviii] Set out in the Naylor Review, which expanded on the sections of the 5 Year Forward View/Long Term Plan relating to real estate’s role within the smaller overall system sought.

[xix] NHS England’s website states Ferris: “is internationally renowned for his pioneering work on improving health and care in both hospital and community settings.” https://www.england.nhs.uk/author/dr-timothy-ferris/ “Improving” things for the business sector (Ferris’ background), ACO-style tends to mean restricting -especially those hospital- services to the wider public, in favour of lesser, more profitable ones “in the community.” But “NHS Worsening” does not have the same ring to it.

[xx] Some ways PHM is supposed to reduce healthcare spending: https://healthitanalytics.com/news/3-population-health-management-strategies-to-cut-health-costs The Mirror pointing out this sees patients as a “cost” to rank (and avoid): https://www.mirror.co.uk/news/politics/health-firm-handed-7million-help-21556330

[xxi] An example of looking to this model in “Accountable care approaches and learning from elsewhere”, Preeti Sud, West Essex CCG, July 2017, who notes: “reductions in use of hospital and emergency services” citing

the example of "[l]ong-term case management examples from the USA (successive cohorts of high-risk patients 2006-2012 in Massachusetts [that] achieved savings of 4%, 8%, and 19% by pursuing complex case management approaches". Pptx.

[xxii] "Tim Ferris: Population health management to improve the quality of care and health outcomes", King's Fund, 1 November 2016, https://www.youtube.com/watch?v=HtooC2XukjM&

[xxiii] Such as the Nuffield Trust's Health Policy Summit 2014 https://www.nuffieldtrust.org.uk/summit/health-policy-summit-2014 The Nuffield Trust interviews him on the subject, here: "Tim Ferris: Accountable Care Organisations in practice" https://vimeo.com/88760184.

[xxiv] Health Foundation interview, "Dr Tim Ferris: Integrated care in the US", 21 March 2014: https://www.youtube.com/watch?v=wy4IAfyXjw0

[xxv]https://www.strategyunitwm.nhs.uk/sites/default/files/2018-06/Risk%20and%20Reward%20Sharing%20for%20NHS%20Integrated%20Care%20Systems%20-%20180605_0.pdf

[xxvi] A UK government that told the public it was copying the US, Simon Stevens joked to a US audience, would kill its plans "stone dead." https://youtu.be/XT3UX9tMcFQ?t=780

[xxvii] PBS News Hour, "Does this Obamacare experiment offer significant savings?", 6 Feb, 2017, https://www.pbs.org/newshour/show/obamacare-experiment-offer-significant-savings

[xxviii] "The Road to Integration: Interview with Samantha Jones", https://www.saxbam.com/canvas_article/the-road-to-integration-interview-with-samantha-jones/

[xxix] https://www.linkedin.com/in/samantha-jones-68bab287/?originalSubdomain=uk

[xxx] Centene having been a driver of the move to 'Integrated Care' in England, such as in Nottingham. Its Spanish subsidiary, Ribera Salud, having been held up as the model for England by Health Secretary Jeremy Hunt.

[xxxi] Another two senior NHS England officials involved in the current change of healthcare system who moved to Operose include Nick Harding https://www.linkedin.com/in/professor-nick-harding-49b01130/?originalSubdomain=uk and Louise Watson, "Chief Integration Officer", whose OH blurb states she: "was Managing Director for the Buckinghamshire Integrated Care System and prior to that she was the national lead for the development of the multi-speciality community provider (MCP) care model as part of the national NHS new care models 'vanguard' programme."

These are people who know the system they have helped create and its inbuilt business opportunities. As activist/researcher Jenny Shepherd said of Jones and Harding: "As public employees of NHS England, these two were funding and promoting the development of exactly the cost-cutting, healthcare-denying managed care models used in the USA by companies like Centene Corporation." https://calderdaleandkirklees999callforthenhs.wordpress.com/2021/03/24/10bn-private-health-companies-bonanza-to-clear-huge-nhs-cancer-waiting-lists-due-to-covid-19/

[xxxii] In fact, you can all too often hear nominally left-leaning NHS managers describe their support for the way policy has been sold to them, stating wistfully that it would all be wonderful if there were more staff and more funding. The lack of an audible left analytical framework to read policy allows such cognitive dissonance.

[xxxiii] Coastal Medical ACO, Rhode Island, USA "hired more support staff including pharmacists, physicians'

assistants and nurse practitioners" for the more costly, *sickest* patients. Within the business framework of an ACO (which is now the English legislative context and general policy context in the devolved nations) this tends to be determined by "cost," meaning it is precisely about replacing more expensive doctors. PBS News Hour, "Does this Obamacare experiment offer significant savings?", 6 Feb, 2017, https://www.pbs.org/newshour/show/obamacare-experiment-offer-significant-savings

[xxxiv] NHS England, "Vanguards - one year on", https://www.youtube.com/watch?v=LIhxF8qJn_0&t=19s

[xxxv] BBC, *Panorama* "BBC Panorama - Undercover: Britain's Biggest GP Chain," first broadcast (in England) 13 June 2022.

[xxxvi] The key issue is that we had public welfare services before and there is no reason we cannot have them again. The trend is to provide opportunity for profit for the private sector. These policies reduce the care that can be accessed. We should restore full services in primary and local acute care. The welfare state should provide all the aspects of the social determinants of health including housing and social care and preventative care so that people live long and healthy lives and have access to the services and care they need. **But we cannot demand any of this unless we vocally acknowledge what has been taken away.**