

## **Patients not Profits; the NHS and Corporate Healthcare.**

I've written this because I believe that the corporatisation of healthcare is dehumanising. By this I mean that real, whole people living with their hopes and worries, ideas and expectations, are broken down by the process of corporatisation into biological parts not for diagnosis and treatment but so that they can be measured and converted into profits. We are far more than the sum of our biological parts; we also have relationships with our past and future, our family and friends, our work and environment, our country and our home. We are irrational and passionate as well as calculating and objective; we need kindness, affection and understanding as well as diagnoses and treatments. And healthcare is far more effective when this is taken into account. Whilst the NHS can and will always need to be improved, the government's proposal to introduce competition and markets into the NHS risks seriously damaging it, not only because it has been shown to make it more expensive and less efficient (as in America) but because it dehumanises us all.

A patient-centred NHS understands and respects the complexity of human health and puts human relationships at the heart of healthcare. Corporate healthcare converts human health into commodities and commercialises human relationships, putting profits at the heart of healthcare.

People, (institutions/ states etc) are unequally autonomous; they vary hugely in how much they can articulate their concerns and act in their own best interests. With autonomy comes freedom and responsibility; freedom to flourish and succeed and the responsibility to care for those who are less fortunate. Markets offer the possibility of individual and corporate freedom without the necessity of responsibility. Illness robs each and every one of us of the autonomy necessary to flourish in a competitive environment, compromising choice when it is most important. Instead of a culture of competition, the NHS needs a culture of care and cooperation.

Ideas:

1. NHS general practice does not operate within market economies, though the UK government is trying, through the purchaser provider split and the provision of APMS contracts, to create primary healthcare markets.
2. Markets depend on identifiable commodities that can be bought and sold, so markets in healthcare depend on breaking down complex health into simple commodities.
3. Profits are made by the provision of services and trading of commodities
4. Trading includes marketing risk in the form of derivatives, e.g. trading future risks of cancer or diabetes.
5. Market commodities have no intrinsic value, only the value that the market will pay. This can vary widely according to economic conditions.
6. The markets for preventative services (screening, statins) are greater than those for curative services because far greater proportions of the population are 'at risk'. This results in a shift of emphasis from cure to prevention, i.e. from treating the ill, towards treating the well.
7. Profits are increased by the invention of new services (screening and other investigations) and commodities (new diseases or risk factors).

These last 2 points are examples of ‘disease mongering’.<sup>1</sup>

### Differences between NHS General Practice and Corporate healthcare

ITEM	NHS General Practice	Corporate healthcare
Interests	A traditional general practice has only one interest, the care of its patients	Corporations have a portfolio of interests
Responsibility	The partners are responsible to their stakeholders (their patients)	A corporation has limited liability and is responsible to shareholders.
Profits	The partners are allowed to do as they wish with their profits but are not obliged to put profit before any other consideration	A corporation is legally obliged to put profit before any other consideration
Commitment	Traditional general practice has an open-ended commitment to the care of its patients	A corporation has a limited tenure and may move on at the end of the tenure if the business is not profitable
Proximity	Partners are usually GPs and therefore are directly involved with the patients they are caring for	A corporation is a legal entity, it can have no involvement with patients

#### Patient 1

*KM, a 50 year old woman has been unable to find work for the last year. She started coming to see me because her blood pressure remained high despite 4 antihypertensive drugs. Having discussed smoking, diet and exercise, increasingly we discuss her past. She worked as a nightclub singer and barmaid for years, but stopped to care for an elderly aunt until she was admitted to a nursing home last year. Over the last few months she has become increasingly frustrated as a result of the loss of her relationship with her aunt, lack of employment and difficulty controlling her blood pressure. In spite of expensive train fares, she continues to visit her aunt in the midlands, who now only occasionally recognises her. She has lost count of the jobs she has applied for, but thinks that her age and years out of employment whilst looking after her aunt are putting potential employers off. She would be happy working as a barmaid again. She’s become increasingly bored, isolated and depressed and smokes, “because there’s nothing else to do”. Her cardiac risk over 10 years is 23% and she should be taking a statin to reduce her cholesterol. Her depression score (PHQ) corresponds to moderate depression and an antidepressant medication is indicated. She looks me in the eye and asks rhetorically if I think she would need all these tablets if she could find a job.*

<sup>1</sup> Disease mongering is the increasingly widespread practice of widening disease parameters and thereby extending treatment thresholds ‘in order to expand markets for those who sell and deliver treatment’. Selling Sickness: The Pharmaceutical Industry and Disease Mongering. Ray Moynihan, Iona Heath, David Henry. *BMJ* 2002;324:886-891

## **Purchasers and providers.**

### *Patient 2*

*LW has bought her 12 year old grand-daughter to interpret for her though she really ought to be at school. She missed her recent orthopaedic appointment because... well, it's not really clear exactly why she missed it, but I know enough about the chaotic situation at home to imagine how difficult getting to appointments must be. Her knee replacement last year was not a success and she's been in more pain since then than before the operation. Because she missed her outpatient appointment, she has been sent a letter to see her GP to get another referral. She is the second patient this week sent back to me for re-referral. It happens because without a new referral letter the hospital cannot charge for the new outpatient appointment. As always my new referral is a copy of the original with an additional plea that she is seen urgently rather than having to join the waiting list again. I suspect she will be sent a routine appointment which may well be lost in the domestic bedlam. She asks if she should go to the accident and emergency department instead. She has been there twice already in the last month, hoping to be admitted for surgery. She is on a register of patients who attend the local emergency department excessively because our practice is charged every time she attends and the Primary Care Trust who ultimately bear the cost are trying to reduce A&E attendances. The A&E charges are complicated, but increase according to the age of the patient, the amount of time they are in the department and any procedures performed. Dealing efficiently and appropriately with kind words and reassurance isn't necessarily cost effective and I note that her last attendance resulting in a long stay in the department and a charge of £400.*

Because of the introduction of an internal market, the most appropriate clinical course of action, for example, that of referral back to the GP or outpatient assessment, has to be measured against the financially prudent course of action. As a result, different hospital departments, struggling for their own financial viability, ignorant or indifferent to the overall costs, are forced to compete with each other in order to treat patients themselves and claim their fee.

## **Health commodities.**

Markets depend on units that can be bought and sold, so markets in health depend on breaking down healthcare services (investigations, procedures and prescriptions), health (e.g. biological values such as blood pressure and cholesterol) and illness (diabetes or cancer) into unit parts that are measurable and saleable.<sup>2</sup> The challenge, according to market advocates, is technical. All they have to do is define and value those parts in order that they become commodities. Critics of the market are accused of failing to have the wit or imagination to come up with a solution to fit the market model, the idea that a market itself is flawed isn't even entertained by those who support them.

## **Specialists and generalists.**

The complex interactions between diseases, for example diabetes and cardiovascular disease, and the relationships between health and society, (culture, employment, family and so on) are well recognised by primary care physicians (GPs) who are presented by their patients' undifferentiated symptoms and un-interpreted stories. Secondary and tertiary care hospital specialists with their

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<sup>2</sup> Mitchell. Sick in the Head, Harper's Magazine February 2009 pp 33-44

increasing subspecialisation frequently lack this holistic understanding because the patient's story, their signs and symptoms have been converted by the referring doctor into a medical narrative, a differential diagnosis and the supposedly extraneous material (the patient's experience) sifted out. The further up the chain of specialisation away from primary care the more the undifferentiated patient is broken down into constituent commodities of pathologies, investigations and treatments. Not surprisingly, these specialist doctors, like Professor Sir Ara Darzi, a tertiary care cardiac surgeon who drew up plans for redeveloping primary healthcare in London, are amongst the most influential market advocates.<sup>34</sup>

### *Patient 3*

*SA has come back from her appointment with the hospital cardiologist to say that she didn't understand what was said. She was given the results of some investigations and told to change her medication. She hasn't started taking it yet because she wanted to check it was ok with her own doctor, "I know she's the specialist, but you're my doctor". I've been looking after her for the last 4 years. After receiving her notes from her previous GP I called her in because her blood pressure had been very high. Unfortunately she has been unable to tolerate at least half a dozen different anti-hypertensive medications, though the side effects she complained of only occasionally coincided with those listed in the literature. This prompted the cardiology referral. I told her the name of the medication they suggested and she flatly, but politely refused, clearly recalling the ankle swelling she experienced when she took it before, a well recognised complication with this medication. She takes her medication infrequently because she doesn't like to take it when she's feeling unwell, which she quite frequently does. Her hypertension started 4 years ago after her husband died. Since then, she freely admits, she has lost the will to live. I think she comes to see me because she doesn't like to disappoint me in my vain attempt to treat her hypertension. The bereavement counsellor referred her to the psychiatrist who referred her to the psychologist who sees her frequently though her letters to me now simply say, "we have had our monthly supportive chat and things are much the same"*

### **'Evidence-based medicine'.**

Science is a part of medicine though not the major part of it. Evidence-based medicine refers to the application of the scientific method to disease management. It depends overwhelmingly on quantitative studies of diseases (or quantifiable markers of disease) in carefully selected populations. The patients are selected so that the disease under investigation is uncomplicated by coexistent disease, they are motivated to take the treatment exactly as prescribed and attend for monitoring and follow up. They are also less likely to include ethnic minorities, the very elderly, mentally ill, pregnant or institutionalised. And yet most patients encountered in primary care, the point of over 90% of all doctor-patient contacts, are not suitable for medical research. Barely half take their medication as prescribed, many, especially those most likely to suffer disease, are mentally unwell and/or elderly and in inner-city areas are from ethnic minorities. And yet the results of evidence-based medicine are applied to them.

### *Patient 4*

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<sup>3</sup> <http://www.healthcareforlondon.nhs.uk/>

<sup>4</sup> Ara Darzi (Saturday Interview, December 29th) gives an example of a patient who develops abdominal pain and, like all patients in Darzi's isolated surgical world are merely a scan away from a diagnosis and a cut away from a cure. <http://www.guardian.co.uk/politics/2007/dec/29/publicservices.uk>

*DS is a 38 year old Afro-Caribbean man who our practice nurse asked me to review because of his very poorly controlled diabetes. He is prescribed 21 tablets a day though his records indicate he isn't taking them regularly. He has refused insulin consistently for the last year. His mother died when he was a child, following blindness and amputation of both her legs as a result of her poorly controlled diabetes. His father (also diabetic) died at 60 following a stroke and his older brother has diabetes. The nurse found him difficult to talk with and said he seemed suspicious. She has been trying to help him address his obesity and unhealthy diet. I thought he seemed shy and reluctant to talk about his health or his family. After meeting him now for the third time he has indicated that his childhood was traumatic for reasons other than his mother's illness and death. His records show that he has never remained under the care of a single doctor for long and he admits he doesn't trust people. I know that it will take a long time to develop a relationship with him so that I can help him deal with his past experiences, his present health and his future wellbeing and that there may be little or no improvement in his diabetes before then.*

### **Markets are unstable and corporate healthcare is a risky business.**

The creation of these health commodities allows them to be bought and sold on global markets like other commodities such as pork-belly or barrels of oil. Future risks, for example, of diabetes, cancer, heart disease or mental illness can then be traded as derivatives, with the disease risk traded against the possibility of a new or cheaper treatment in the future. Essentially, health is converted into chips which are gambled on markets with all the inherent risks which the global economic crisis is making us painfully aware of. Corporations such as the investment banking firm Bear Sterns and the insurance and financial services/ asset management firm AIG are major healthcare investors and have a portfolio of interests that are exposed to market risks. Both of these corporations have collapsed in the last year.<sup>567</sup>

### **High cost private healthcare.**

The US spends more per person per year on health than any other country as a result of greater administration costs, defensive medicine (over investigation and treatment due to fear of litigation), greater use of branded drugs and high-tech equipment and so on.<sup>8910</sup> The costs will rise as new treatments become available and an aging population needs more health-care.

### *Patient 5*

*GF wants a referral to a neurologist. For the last 2-3 weeks she has had a sensation of unsteadiness and nausea caused by a self-limiting condition called 'Acute vestibular neuronitis'. In most cases the condition resolves in 6 weeks. She accepts my explanation and has read the patient information leaflet, but she would nevertheless like to see a specialist. She has private health-care insurance. We*

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<sup>5</sup> Bear Stearns expands Health Insurance Investment Banking practice

[http://findarticles.com/p/articles/mi\\_m0EIN/is\\_2002\\_July\\_18/ai\\_89209805](http://findarticles.com/p/articles/mi_m0EIN/is_2002_July_18/ai_89209805)

<sup>6</sup> Red Flags in Bear Stearns' Collapse [http://www.usatoday.com/money/industries/banking/2008-03-17-bear-stearns-bailout\\_N.htm](http://www.usatoday.com/money/industries/banking/2008-03-17-bear-stearns-bailout_N.htm)

<sup>7</sup> Last year the US government had to bail out the insurer AIG in return for a loan facility of \$85 billion. John Lanchester, Cityphobia. <http://www.lrb.co.uk/v30/n20/lanc01.html>

<sup>8</sup> <http://content.nejm.org/cgi/content/short/349/8/768>

<sup>9</sup> <http://dll.umaine.edu/ble/U.S.%20HCweb.pdf>

<sup>10</sup> <http://economix.blogs.nytimes.com/2008/11/14/why-does-us-health-care-cost-so-much-part-i/>

*joke that if I referred her to an NHS consultant the condition would have spontaneously resolved by the time she got to see them. Two weeks later I receive a letter from the private neurologist, he agrees with my diagnosis, and notes that the medication I prescribed has improved her symptoms, but just to be on the safe side he arranged a MRI brain scan, which was normal. Although everyone involved, including the patient, agreed that she did not need the MRI, it was arranged according to what the insurer would pay rather than clinical need.*

## **Health, the new illness**

Because the elderly sick are expensive to care for and frequently not working, corporations need look to the young, working well for new profits. This is linked to the redefinition of health as a state of incipient illness. People pay for what they can afford rather than what they need so they are increasingly encouraged to have expensive, ineffective and potentially harmful<sup>11</sup> screening such as whole body scans<sup>12</sup> and routine ECG heart tracings whilst they are healthy<sup>13</sup>. In the past, for most people, health was to be enjoyed until it was interrupted by illness, at which point a visit to the doctor was appropriate. Now people are worried into illness by an obsession with risk factors for illness rather than illness itself. Pharmaceutical companies spend more money on advertising drugs to compete for their share of the market in wealthy countries, than on research and drugs for treatable infectious diseases in the majority of poor countries in the world. They advocate for new treatment thresholds so that medications are prescribed for risk factors as well as disease, for example for milder forms of depression and anxiety, increasingly lower blood pressure and cholesterol levels, and so on. For many patients, if a doctor gives them a prescription, especially if they are expected to take for the rest of their life; it means that they have an illness<sup>14</sup>.

### *Patient 6*

*WJ looks tired and anxious. He is accompanied by an advocate interpreting for him. He says he cannot sleep and he is suffering from headaches and general weakness. He denies any triggers. He runs his own business with a not excessive mix of stress and success. He is recently married. I am the fourth doctor he has seen in the last 2 months with the same complaints, and he has had his blood pressure measured on several occasions and had routine blood tests. Eventually he asks if I could recheck his cholesterol. He says he thinks it is the cause of his illness. He has been worrying about it ever since he came for a new patient check 6 months ago when it was 5.3. His 10 year cardiovascular risk is 13%, so any benefit from lowering his cholesterol would be negligible, certainly compared to stopping smoking. Like many men from his ethnic background he smokes and like many smokers he invokes stress as a reason for being unable to stop. I note that each of the other doctors he saw discussed 'cholesterol, cardiac risk factors and smoking'. Eventually he reveals that he believes his cholesterol is also responsible for his occasional impotence and he pleads for medication. We discuss*

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<sup>11</sup> Harmful; because the chance of an abnormality on a scan turning out eventually to be normal is higher in someone with a low background risk of disease, hence most screening is targeted to people who have already reached a certain level of risk, such as the elderly or people with a strong family history of the disease being screened for. For details read about the Wilson and Junger criteria for screening

<http://www.patient.co.uk/showdoc/40000745/>

<sup>12</sup> <http://www.samedaydoctor.co.uk/bodyscreening.aspx?cd=google&gclid=CIOz8JittpoCFQ0FZgodzAhxhg>

<sup>13</sup> [https://www.harvardpilgrim.org/portal/page?\\_pageid=1391,1&\\_dad=portal&\\_schema=PORTAL](https://www.harvardpilgrim.org/portal/page?_pageid=1391,1&_dad=portal&_schema=PORTAL)

<sup>14</sup> Freemantle N, Hill S (2002) Medicalisation, limits to medicine, or never enough money to go around? *BMJ* 324: 864–865.

*it at length, but as the consultation progresses it seems that there is little I can do to shift his concern from cholesterol towards his anxiety or his smoking. I do suspect, from experience of many similar situations that in time, perhaps after several more consultations I will gain his trust and he will achieve a level of confidence to effectively overcome his impotence.*

### **Health transformed and commodified.**

Health has been transformed in other ways by pressure from different sources, including government, media and industry.

1. Genetic. Biotech corporations market the myth of genetic determinism, by over emphasising the degree to which your future health can be predicted by genetic profiling. By promoting the idea that entire genomic profile is riddled with illness potential, the body is filled with genetic time-bombs waiting to go off and trigger cancer, heart-disease, diabetes and other conditions. This results in the promotion of genetic screening to predict disease despite the fact that very few can be accurately predicted because of complex interactions between genetic and environmental factors. It shifts the balance of control over the prediction and treatment of disease from people to biotech corporations despite a lack of evidence.
2. The separation of health and illness from the person. When a patient presents with an illness, the doctor names the disease and then it becomes transformed into something other, named so that doctor and patient can work together to 'struggle against it'.<sup>15</sup> The patient experience of 'having cancer' or 'being depressed' is transformed into ownership of 'my cancer' and even 'my depression' and this disease rather than the patient is treated. One of the reasons that 'medically unexplained symptoms', that category of illnesses that cannot be named, present doctors with such difficulties, is that without a name it cannot be separated from the patient and yet most of the symptoms patients present with in general practice do not fit the diagnostic criteria for a disease entity.
3. Health as leisure. Physical work has become mechanised or exported. Aside from the fact that factory conditions have often been dangerous and dirty, the result is now that at the end of a long shift, people have used few calories in their sedentary service sector jobs and structured mealtimes have become replaced by constant snacking contributing to an 'obesogenic' or 'diabetogenic' environment. After work, leisure time that might have been spent relaxing with the family has become replaced with healthy work to compensate for the 'unhealthiness' of work and the self improvement industry of personal trainers, nutritionists, relaxation therapists, psychoanalysts and self-help gurus are cashing in. For those that can't afford the personal touch there are gyms and training aids, diets and supplements, books, classes, courses and on-line resources.
4. The body project. Like illness, the body has been objectified and commodified.<sup>16</sup> It is a project of constant improvement to be modified, manipulated and enhanced. It is worked on in the gym, modified by drugs, supplemented with vitamins, and surgically enhanced. It is scanned, scraped and sampled. In the pursuit of the perfect body and perfect sexual, physical and social/ intellectual function people take drugs to lose weight, gain muscle,

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<sup>15</sup> Berger, J. A Fortunate Man. Allen Lane The Penguin Press 1968; 68

<sup>16</sup> Orbach, S. Bodies. Profile Books 2009

improve sex, stimulate hair-growth and increase confidence. Not because of any illness, but in the vain pursuit of an idealised, homogenised, very heavily marketed ideal. The global corporations marketing the images are often the very same corporations selling the means, pharmaceutical, surgical, cosmetic, fashion and so on which are claimed to make your project a success.

### **Your health, your choice.**

The Kantian imperative, “you can because you must”, has been inverted; “you must because you can”<sup>17</sup>. This is made explicit in the NHS mantra, ‘Your health, your choice’<sup>1819</sup>. In other words you *must* be healthy, (and slim and beautiful), *because you can*. Fat or thin, sedentary or active, smoker or non-smoker, whole foods or junk-foods, in short, whether you are in control of your life or not, according to ‘Your health, your choice’, it all comes down to a matter of personal preference. Health differentials based on social class and circumstances out of your control are blamed on lifestyle choices.<sup>20</sup>

In developed countries such as ours, there is a social gradient in health, which means that the lower your socioeconomic group the greater risk you have of suffering from almost all types of illness, especially cardiovascular disease and most types of cancer. As the level of inequality increases, as it has done over the last 40 years, the social gradient widens even if the level of absolute poverty stays the same. As the rich get richer, the poor get relatively poorer and consequently become more socially excluded as the costs of participating in society increase. The health gradient “cannot be attributed, in the main, to diet, smoking or other determinants of ‘lifestyle’”<sup>21</sup>

The result of the government’s failure to protect health by increasing social inclusion through education, employment, and housing, is to shift the burden of responsibility onto patients who are expected to improve their lifestyles, and doctors who have to spend more and more time promoting healthy choices. Corporations are encouraged by the Government to offer a market driven culture of dependency; your choice, you choose yourself the products you need to be healthy.

The naive consumerist position is based on the imaginary construct of an ideal consumer based on rational choice theory which assumes that people are fully informed and fully able to understand the information, are rational and not subject to bias, and self interested rather than altruistic, in short, fully autonomous.

This position assumes that society consists of equally autonomous individuals making rational choices in their own best interests. Autonomy is not equally distributed; it’s strongly associated with educational and financial empowerment so the least educated, poorest and unhealthiest are also the least autonomous. Corporations are more interested in the financially better

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<sup>17</sup> Zizek. S. You May! London Review of Books 18<sup>th</sup> March 1999 [http://www.lrb.co.uk/v21/n06/zize01\\_.html](http://www.lrb.co.uk/v21/n06/zize01_.html) (accessed 2.2.9)

<sup>18</sup> <http://www.nhs.uk/Pages/homepage.aspx>

<sup>19</sup> <http://www.nhs.uk/choices/Pages/Aboutpatientchoice.aspx>

<sup>20</sup> Heath, I. A Mystery of General Practice in Matters of Life and Death, Key Writings. Radcliffe Publishing 2008, 97

<sup>21</sup> Marmot, M. Status Syndrome, How your social standing directly affects your health. Bloomsbury 2005, 249

endowed, for obvious reasons. When people are ill and hence most vulnerable they use their ability, through advertising, fear-mongering and government sponsored health promotion to manipulate consumers to choose their products. Markets create dependency because it's not in any corporation's interest to say that patients are going to be fine without their products.

#### *Patient 7*

*I opened the window of my consulting room wide in the hope that the smell of cigarettes would fade before the evening clinic. I had just been to visit SD at her home which was always thick with smoke and the 1970s decor – memories of my own childhood, was stained yellow like an old pub. For the last 2 years I'd been visiting her to check on her blood pressure and give her a general check up. She was well aware of the risks of smoking and hypertension and had guessed rightly that she had suffered a stroke during the night, but wanted to see me before calling an ambulance. She had started smoking 60 years ago as a 15 year old. Then she smoked Lucky Strike because that's what everyone was smoking, but for the last 20 years or so she's smoked whatever was cheapest at the local store. That's what everyone smokes these days. You can even buy single cigarettes for 30 pence if you can't afford a packet. Disabled by severe arthritis, she rarely goes out, but she's always cheerful and denies being lonely. She has tried giving up cigarettes on a few occasions, and managed for a couple of years before her husband died, but started again afterwards to help fill the gaps in the day. She tried again after a chest infection shortly after we first met, but became depressed and rapidly returned to her cheerful self when she started smoking again. She gestured to her flat and the estate around, "when you live somewhere like this, it's not like where you live doctor, we don't mind smoking here"*

Even in the absence of market pressure, the assumption underlying choice is that people like SD and doctors like me are equally able to take control of our lives and define ourselves by our choices. It assumes, wrongly, that providing information is enough to empower people to choose a healthy lifestyle. Offering choice without addressing the conditions within which people live their lives, the experiences that affect their decisions, and aspirations which shape their vision of the future, widens inequality by empowering those ready to make those choices and alienates those people who have very different priorities.

#### *Patient 8*

*RT has pain in her knees and ankles, she starts telling me about them as we walk from the waiting room to my consulting room. She is also morbidly obese and eats to cope with her emotions. She finds herself overwhelmed by first comfort and then remorse as she cries throughout her eating binges. She has spent thousands of pounds on countless diets including one from a private clinic that injected her with amphetamines and resulted in a psychotic episode. She has spent hundreds of pounds on gym-memberships and bought dozens of self-help guides, none of which have had a lasting effect. Recently we discussed referral for gastric bypass surgery but the thought of the risks and future complications frightened her. She rarely goes out except to work or to collect her daughter from school. For a long while she stopped going to the doctor, because whatever she wanted to talk about, all they seemed interested in was her weight, "it was like they stopped seeing me as a person".*