INTRODUCTION

Healthcare is the world’s biggest industry with a turnover in excess of $5 trillion in 2005, 88% of which is spent in the wealthiest countries with just 16% of the world’s population, in most of which the majority of spending takes place through tax funded systems, or through social health insurance (WHO, 2008; Gottret & Schieber, 2006). The private sector, looking to rebuild its profit margins, has been increasingly determined to recapture a larger share of this health budget, especially in Europe.

But because of the political obstacles to most European governments being seen to break up and privatise healthcare systems, which currently deliver near-universal care – in general with few copayments or charges at point of use (Wismar et al., 2011) – the privatisation process has been of a special kind.
This is very different from the process of privatisation in the UK and in other countries in the 1980s, in which whole utilities such as gas and telecoms and electricity were simply sold off — lock, stock and barrel — as businesses to shareholders, and became private for-profit businesses.

There are three reasons for this: the first is the political sensitivity of the issue for governing parties, which in general are trying to appear different from the old style Thatcherite neoliberal parties of the 1980s: and a political climate in which there is little sympathy for the private sector and privatisation, especially in the health care sector.

The second reason is that the private sector itself has limited interest in taking over the whole of healthcare systems: their focus is primarily on cherry picking those parts of the system which appear to offer them a profit, primarily uncomplicated elective surgery — the mainstay of private medicine around the world.

Certainly in England there has been very little pretence from private sector companies of any interest in taking over for example work on accident and emergency services, complex and risky surgery, or chronic care for older people and community services of any type.

And finally there is the issue of resources in the private sector: healthcare systems are far larger than the utilities of the 1980s, while the private health care sector is centred on small-scale hospitals and providing relatively uncomplicated elective services (Healthcare Europa, 2008): it therefore has nowhere near the management or capital resources required to contemplate a takeover of entire health systems.

“REFORMS” WHICH CUT COSTS AND THOSE THAT INCREASE THEM

It is important to distinguish between spending cuts, which are occasionally loosely termed as “reforms,” and structural reforms. On the one hand severe outright cuts in spending are being imposed in a number of European countries (notably Ireland, Portugal, Spain and Greece) as a result of external constraints on public spending in the aftermath of the 2008 banking meltdown and the instability of national economies. Similar cuts, dressed up as “efficiency savings” are being pursued in England by the right wing coalition government with the target of cutting £20-£30 billion from spending by 2014.

Although the results of such cuts can be far-reaching and serious for those dependent on the services in the firing line, the structure and operation of the system remains largely intact. These measures are not new: as “the blunt instruments of budget constraint and cost shifting” (Tuohy, 1999, p. 4), such policies have a history reaching back at least to the 1970s, when global economic factors and the rise of neo-liberal ideology began to rein in the post-war expansion of welfare provision.

Their effect on health services varies according the scale of the cutback imposed, and whether this represents a real terms reduction in spending, or simply a restriction on the rate of increase: in many cases, as in England, where a decade of rapid real-terms expansion of health care spending has come to an abrupt and traumatic halt, to be followed by at least three years of real terms cuts, both factors apply.

In some areas of England cost-cutting means that very substantial numbers of elective treatments and operations are being effectively excluded from the National Health Service, leading to a potential transfer of costs from public budgets to individual service users and their families. This does not change the basic structure of the NHS, but of course is inequitable, harking back to the pre-NHS situation, in which the availability of health care depended not on clinical need but on the ability to pay.

On the other hand, often behind a cosmetic rhetoric of seeking “better value for money” or addressing growing pressures on health services, various packages of far-reaching restructuring “reforms” are being carried through in a number