Alan Milburn and the Labour agenda for the NHS

In a recent article in the Lowdown, John Lister gives an overview of Wes Streeting's team of advisors, and the man waiting in the wings. There is a steady drumbeat of reports that Alan Milburn will be brought in as part of Streeting's team to "reform the NHS". Here, I look a bit further into Milburn's past and his more recent activity with the accountancy transnational PricewaterhouseCoopers (PwC).

So far, an appointment does not seem to be confirmed, but the Telegraph report on 7 July 2024 was headlined "Starmer turns to key Blair ally to drive through NHS reform" with subhead "Alan Milburn, known for his closeness to Sir Tony, supports a greater private sector role in the health service". The Telegraph took it as "a sign that the private sector and consumer choice will be at the heart of their plans." A Labour source told the Telegraph:

"In opposition, he has been incredibly helpful to Wes and his team. Particularly in the last six weeks, he has been working really closely with the team on a daily basis to make sure we have the plans in place to hit the ground running... Alan brings the insight and the knowledge of what made the biggest difference last time Labour was in office... It was the reforms on transparency, choice, and use of the private sector that delivered the goods on cutting waiting lists and making the NHS sustainable for the long term."

On Election night, Milburn said "The state of the system, not just hospitals, is awful. There are 7.5 million people on waiting lists, massive staff shortages – you name it. It will be about how we reform the system. When we made progress in the early 2000s, we had very high waiting lists and it was the reforms that made the difference."

What did Milburn actually do?

So let's start with what Milburn actually did as Health Secretary under Blair. People were so glad to get rid of the Tories in 1997 that many – but not all – structural reforms went ahead unchallenged after Milburn replaced Frank Dobson as Health Secretary in 1999. John Lister's series on the history of privatisation has a lot of detail. A few extracts:

Back in 2002 a new policy statement from the Secretary of State Alan Milburn, Delivering the NHS Plan, had argued that "**the 1948 model is simply inadequate for today's needs**":

"We believe it is time to move beyond the 1940s monolithic, top-down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values"

The NHS Plan launched by Milburn in 2000 combined measures to entrench and institutionalise the market system that Tony Blair had correctly condemned as

'costly and wasteful' and committed to scrap in 1997, and to **extend the scope of outsourcing** well beyond the previous range of non-clinical support services, to include **diagnostic services** (new diagnostic and treatment centres) and **elective hospital treatment** as well as provision of so- called "**intermediate beds**".

The starting point came in June 2000 when Milburn proudly signed a "**concordat**" with private hospitals, under which they would treat uncomplicated NHS waiting list patients during winter and other peak periods when local NHS trusts lacked the capacity to deal with combined emergency and elective demand.

The funding to pay the private hospitals and the staff to deliver the treatment were taken from the trusts under the greatest pressure, and meant that there was no way for them to escape by investing in expanded NHS capacity.

The concordat was a massive boost for a flagging private hospital sector, where bed occupancy had been commonly averaging 50-60%.

Giving work to private hospitals was a **very expensive 'partnership' for the NHS**. Treatment costs for NHS patients admitted to private hospitals [were] a staggering 40% higher than the NHS. Hip operations costing an average £4,700 in the NHS had been charged at over £6,800 by private hospitals. [The History of Privatisation also has evidence from hospitals in London and Stafford that transferring patients to the private sector was more expensive than retaining or increasing NHS capacity.]

By 2002 the New Labour project was widening to include plans to **"franchise" the management of failing trusts** to private management consultants, which ended up with a disastrous experiment with management consultants Tribal Secta taking over control of Good Hope Hospital in Sutton Coldfield in 2003 (a forerunner of Hinchingbrooke). 2002 also brought plans to allow the best-performing trusts to become "**Foundation Trusts**" (FTs). A furious campaign began against the plan, backed by campaigners, health unions, the BMA and former Labour ministers, which culminated in battles in the Commons and House of Lords. Former health secretary Frank Dobson and other former ministers correctly attacked the plan as a return to the type of market-style methods wheeled in by Margaret Thatcher's government in the early 1990s, and which New Labour ministers was supposed to have swept away after 1997.

Although only 63 Labour MPs voted against legislation to establish FTs (while the Tories abstained), the autumn of 2003 saw the policy roundly defeated at Labour Conference – and the scale of the opposition did substantially blunt the edge of Milburn's initial plan.

Milburn's agenda was apparent even before he became Health Secretary. The new government's only legislation on the NHS in 1997 was a short Bill to facilitate **PFI**, the concept introduced by John Major's government. Health Minister Milburn made clear the Bill was intended to give the **bankers** just what they wanted: "[It's] about removing doubt, providing certainty, and above all getting new hospitals built".

Milburn told MPs PFI could deliver actual savings as well as value for money, stating: *"... Any scheme that is given the go-ahead has to prove it is cheaper, better, better value for money and better for patients than the public sector option, and I am convinced from all of the work that I have seen from officials that all of these schemes we have given the go-ahead to and all the schemes that we will give the go-ahead to in the future will prove, if they are built through the PFI, better value for money".*

Milburn may have thought this at the time, and may still think so, but almost everyone else knows it's untrue. The Treasury Select Committee report on PFI in 2011 was savage, and dealt specifically with Value for Money.

Strategy behind the structural changes

In an interview before publication of "The Plot Against the NHS" Colin Leys explained the strategy behind the structural changes brought in by Milburn, working with Paul Corrigan, Penny Dash, and Simon Stevens.

The NHS Plan, which was published in the same month, July 2000, was written by a team that included Stevens, Dash, Corrigan and Milburn. It mentioned the main elements of the shift to a market, but it disguised them as mere improvements in the existing system. Three major changes in the NHS were required. First, the **taboo on private provision of NHS clinical services** had to be overcome, and a bridgehead created for the private sector in the NHS. Second, **NHS organisations had to be converted into real businesses**, not the make-believe businesses of the so-called internal market. Third, the **ties between the NHS workforce and the NHS had to be weakened**, so that enough NHS staff would be ready to transfer to private sector employment as private providers took over more and more NHS work. **Milburn initiated all three of these changes.**

For example, the second major change was implemented through the introduction of **Foundation Trusts**. The concept was pioneered in Spain by the company Milburn later joined: **Ribera Salud, owned by US transnational Centene**. Leys explains: In Spain, the "health foundations" were publicly-built hospitals that were handed over to private companies to run for a fee. They had freedom from the health ministry and could set their own terms of service for their staff.

Milburn even took over the name, 'foundation', though when NHS hospital trusts got foundation status they were not handed over to private management. But they were freed from Department of Health supervision and could operate in many respects like private companies, including setting their own terms of service for their staff.

The central point about foundation trusts is that the contracts they make are legally enforceable, and if they run up unsustainable debts they won't be bailed out by the Department of Health. This means that they become fully exposed to the risk of

bankruptcy. This means that the crux of all policy decisions in the hospital becomes financial. Foundation trusts don't have to pay dividends to shareholders but in all other respects they have to behave like private companies. Milburn's aim was that all NHS trusts should become foundation trusts by 2008. But they couldn't behave like companies unless their income was related to their performance. So Milburn also introduced payment by results...

Do read the whole article!

Milburn resigned as Health Sec in June 2003 and took a post for £30,000 a year as an adviser to **Bridgepoint Capital**, a venture capital firm heavily involved in **financing private health-care firms** moving into the NHS, including Alliance Medical, Match Group, Medica and the Robinia Care Group.

In 2013 Milburn joined **PricewaterhouseCoopers** (PwC) as **Chair of PwC's UK Health Industry Oversight Board**, whose objective is to drive change in the health sector, and **assist PwC in growing its presence in the health market**. PwC currently lists him as a senior adviser. Milburn continued to be chairman of the European Advisory Board at Bridgepoint Capital, and continued as a member of the Healthcare Advisory Panel at **Lloyds Pharmacy**.

Transforming the NHS

PwC have been one of the biggest advocates of the transformation of the NHS through Simon Stevens' Five Year Forward View, Sustainability and Transformation Partnerships (STPs), Accountable Care Organisations, Accountable Care Systems rebranded as Integrated Care Systems, the NHS Long Term Plan, and the Health and Care Act 2022. It would be good to know more of what role Milburn played in their thinking, but here are three examples.

Milburn chaired the Steering Group for the Nov 2016 PwC report "Redrawing the health and social care architecture". The foreword explained:

"... We need a radical shift in the way health and care services are delivered... in line with the vision presented by the Five Year Forward View. However, to date there has been a missing piece to the jigsaw: what is the role of national structures in enabling the delivery of localised and integrated care, and how can this role be optimised?"

The report recommended that STPs evolve into local bodies similar to what are now called **Integrated Care Boards**, the budget holders and commissioners for Integrated Care Systems (for more on ICS, ICB and the Health and Care Act see https://keepournhspublic.com/integrated-care-systems/). It said "NHS England should delegate responsibility for improving standards and managing resources across health and social care to new, permanent Regional Care Groups (RCGs)... a more permanent structure, designed to oversee the delivery of system planning and management with delegated resources [with a remit to]:

- assume strategic responsibility for the delivery of national standards and value for money for their populations;
- co-ordinate planning and transformation within and between organisations;
- take responsibility for public health, primary care and specialist commissioning;
- aggregate routine health and social care commissioning across their geographies where it is in the interests of the system to do so; and
- resolve key local issues between providers and commissioners to deliver an integrated health and care system for service users."

However, while PwC advocated local political accountability for the RCGs, the ICBs are accountable upwards to NHS England.

Milburn then chaired the Steering Group for the June 2018 PwC report "Making money work in the health and care system". The foreword explained:

"The current financial system needs to be overhauled... financial flows need to be redesigned if the aim of integrated care is to be achieved". The report advocates that risk be shared across all providers. "Potential funding mechanisms include a single, incentivised shared outcomes framework across all providers and the introduction of gain/risk share arrangements... current performance metrics, which are focused around access targets, will need to be supplemented with appropriate outcome measures."

In plain English, this means that when people cannot get an NHS appointment with a trained clinician who has the knowledge and resources to diagnose and deal with their medical problem, the ICB can declare that risk is being shared across providers, so failure in any particular area is compensated by success elsewhere, and the system is meeting outcomes targets which it set for itself, perhaps with advice from PwC. More specific proposals appeared under headings including:

- "replace organisation-based control totals with system wide targets"
- "the National Expansion Plan for personal health budgets must be accelerated"
- "Local health, social care and public health budgets should be brought together"

The conclusions include: "Redefining the measures we use to assess performance of the system – moving away from access times and taking a broader view of the long term health of the population

"Ensuring the system remains open and agile to technological disruption that has the potential to change how we monitor and deliver care in the future (e.g. artificial intelligence, robotics, blockchain, predictive analytics, genomics and other advances not yet on the horizon)"

The report refers repeatedly to the private sector, for example:

"In the purest form of an ICS, a single organisation should hold the budget for the local health and care system. This organisation would have accountability for the provision of all care, including primary care (subject to notes below on things that should be paid for at a system level). This could be either done through direct provision (e.g. Ribera Salud's model, where the acute trust holds the budget for the population as the provider of last resort, and commissions community services where they can achieve better outcomes for less money) or by subcontracting some of the services to other organisations, which could be NHS or private organisations."

The single organisation holding the local budget is now the ICB. Ribera Salud, owned by Centene, is a private company which ran foundation hospitals in Spain. So PwC's vision for the purest form of an Integrated Care System includes as an option that the private sector either provides the services itself via an acute trust taking the ICB role to hold the budget for the whole population, or subcontracting some services to other private organisations.

What does it all mean for health workers?
The report says:

***"Staff should be paid for output rather than input**. Staff within the service are currently paid almost entirely for their input in terms of time (i.e. a combination of base salary, plus additional hourly rates), instead of output and outcomes. In circumstances where payments are varied, this is often done in a way that creates incentives that are contrary to what is best for the system."*

This appears to mean that health workers should not be paid for turning up to work, but for the successful outcome of their endeavours. A sort of "no win, no fee" for NHS staff, where "win" means "what is best for the system". The report does not mention trade unions.

Milburn then wrote the foreword to the 2020 PwC report "Tech powered healthcare". He explained:

"We previously argued that place-based integrated care should be at the centre of the UK's health agenda, supported by appropriate funding flows and financial structures. We have since seen these recommendations come to life as the NHS has created integrated care systems and devolved funding flows. However, what we have not yet seen is the system-wide uptake of new technology and innovative solutions that could enable transformational change across the NHS.

"The NHS is on the brink of a tech-led revolution. The advances the world is witnessing in big data, robotics, genomics, AI and a myriad of other changes, when they come together have the potential to transform what healthcare is and how it does it. In order to make sense of these potential changes we have concluded that

there are four structural themes which need to be addressed: culture, partnerships, money and people."

"It is, therefore, imperative that we consider partnerships with technology and innovation companies to identify and build these solutions..."

In a 2017 Guardian Comment is Free piece entitled Technology and Innovation are key to saving the NHS, Milburn argued for **greater collaboration with the private sector to take advantage of technological change**.

"Many of the technological changes do not emanate from the public side of health. They come from private players... It is no coincidence that the big tech players have placed large bets on the health sector. The future of healthcare will involve forging networks with the Googles, Apples, IBMs and Facebooks of the world, while maintaining strong relationships with the charity sector and not-for-profit organisations."

Real Agenda

This is the real agenda Streeting and Starmer have brought to the NHS. Whether he remains in the wings – "working really closely with the team on a daily basis to make sure we have the plans in place to hit the ground running" as a Labour source told the Telegraph – or is appointed to an official public role in Streeting's team, Milburn's agenda is unambiguous.

Unlike the Blair government, Labour does not have sufficient spare money to disguise the privatisation agenda with cash injections. And unlike 1997 – 1999, there won't be a two year delay before the plan emerges. If health workers, their unions, and the wider public understand what the plan is, perhaps it can be stopped.