WARNING! NHS market reforms are damaging our health service

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Published version deposited in CURVE October 2012

Original citation & hyperlink:
Lister, J. (2010) *WARNING! NHS market reforms are damaging our health service* [Pamphlet]. London, UK: (BMA) British Medical Association.
http://lookafterournhs.co.uk/wp-content/uploads/doctor-final-270110.pdf

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WARNING!

NHS market reforms are damaging our health service

LOOK AFTER OUR NHS
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WARNING!

NHS market reforms are damaging our health service

Introduction

Since its inception in 1948 the NHS has endeavoured to provide a **high quality,** universal, **comprehensive** service, free at the point of use. It did this by being **publicly funded**, **publicly provided** and **publicly accountable**.

This NHS is now under threat.

Recent reforms in England have actively promoted a market in healthcare. This means we now have competition between health providers with NHS organisations having to compete with each other and with big business.

These reforms are moving the NHS away from its founding principles.

At a time when the NHS faces huge financial challenges we can save money by abandoning this market in healthcare; money that can be redirected to frontline patient care.

The BMA, at its annual representative meeting in 2009, voted overwhelmingly against the commercialisation of the NHS. It is now campaigning to raise awareness of the threats to the NHS and to keep the NHS **publicly provided**. The BMA believes that:

- the NHS must continue to have patients at its heart – not profits for shareholders
- the NHS must evolve and improve but that changes must be driven by quality and not by financial competition
- collaboration serves patients better than competition.

Read on to find out why our NHS is under threat…

From 'internal market' to a healthcare market

Government reforms in 1989-90 – strongly opposed at the time by the BMA, health unions and many local campaigns – created an 'internal market' within the NHS.

This split the 'purchasers' of healthcare (District Health Authorities and fundholding GPs) from the providers of services (NHS hospitals). It required hospitals to compete against each other for contracts with the real fear that those who lost out would face reduced budgets and cutbacks or closure.

It is estimated that these changes increased NHS overhead costs from 8% in 1991-92 to 11% in 1995-96 and increased administrative staff by 15% and general and senior managers by 133%.[1] Since 1995 Department of Health statistics show that the number of (WTE) senior managers has risen by 91%, more than double the 35% increase in the total number of doctors and nurses.[2]

The internal market cost more but failed to make the promised cut in waiting lists and its bureaucratic costs became an issue in the 1997 election. However, despite pledges in the

Labour party's manifesto, the change of government in 1997 did not bring the promised abolition of the internal market.

In 2000, a 'concordat' between the NHS and private hospital companies opened the way for elective care and diagnostics to be provided (at substantial extra cost) by private hospitals, paid for by the NHS. The NHS Plan set out a clear objective of closer working links with the private sector – in elective care, intermediate care and critical care.[3]

This increased use of private sector providers included:

- the establishment of new Independent Sector Treatment Centres (ISTCs) to focus purely on delivering elective services leaving more complex, costly and emergency cases to NHS hospitals
- the establishment of private diagnostic services – offering imaging and other diagnostic tests – paid for by the NHS
- and a new system for reimbursement of providers on the basis of a fixed tariff per item of treatment, known as 'Payment by Results' (PbR).

The creation of competition (or 'contestability') with private providers and a payment system through which money would 'follow the patient' – potentially out of the NHS – marked a transition point.

The NHS had gone from an '*internal* market' with limited dealings with private hospitals and services to a more extensive market in which a variety of contracts for clinical services, often on preferential terms, are offered to new private providers.

Winners and losers

The NHS has become a market offering many lucrative openings for private sector providers of a range of services. They have been lured by generous and preferential long-term contracts, the systematic exclusion of potential NHS providers from bidding for ISTCs and other services, and the commitment by senior ministers to incorporate private companies into the 'NHS family'.[4]

Whilst ISTCs may have contributed to shorter waiting times for patients, this has come at a high cost. The extra capacity provided by ISTCs could have been achieved by expanding NHS provision.

Administrative costs have continued to increase, most notably in commissioning.[5] Many ISTC and diagnostic contracts have received millions in guaranteed payments for contracts, despite treating fewer patients than planned.[6] In some cases the existence of private providers has *reduced* choice – for example in Southampton, where patients have been directed into the ISTC to use services expensively purchased by the NHS, and not to the local NHS provider which most patients had chosen to use.[7]

'The involvement of private industry in healthcare can never be conducive to running a fair and equitable system, it will only result in the sick and the poor losing out to the greed of the rich… If it ever gets to the stage that I have to make the choice between working for a private provider or leaving the profession that I love, then I am afraid that I would have to choose the latter.'

Never mind the quality?

There are also unresolved doubts over the quality of services delivered by some private sector providers. At primary care level, market incentives encourage the view of patients as ‘customers’ with freedom to ‘choose’ between walk-in centres, with care provided by nurses or GPs, and more traditional practices, but which threaten to undermine the special quality of primary care in which patients establish a long-term relationship with their GP – just as GPs get to know individuals, families and communities.[8]

The traditional NHS model has led the development of primary care internationally. It is envied by many other countries for the value for money it provides and the ability of its GPs to use their knowledge of patients and the social context – often gained over many years – to manage risk and act as a gatekeeper or navigator to potentially expensive investigations and secondary care.[9]

Big, impersonal ‘polyclinics,’ sometimes located further from communities and handling large numbers of patients, not only lack the human contact and approachability of GP practices but also risk increasing costs. Staff who do not know their patients so well may refer more and manage risk less, thus losing that crucial gate-keeping role which, when compared internationally, provides good value for money.[10]

GPs on NHS contracts fear that commercial companies will seek to cut costs. Patients will face a higher turnover of medical staff, undermining continuity of care, as companies reach the end of short-term contracts and are replaced by another company.

Payment by Results (PbR)

Despite the title, PbR has not been about payments related to clinical or other outcomes, but a crude cost-per-case system of paying NHS hospitals a fixed fee per item of treatment delivered ('payment by activity').[11] This is very different from the fixed-term 'play or pay' contracts offered to private sector providers, notably first wave ISTCs, which have been paid for a minimum caseload – whether or not any patients are treated.

In theory PbR should be a 'fair', 'transparent' and 'rules-based' mechanism to reward popular and successful hospitals that attract additional patients and encourage those which may lose patients to rival providers to improve their services to make themselves more competitive.[12] However, the cost-per-case payment can create perverse incentives to admit patients who might otherwise be treated as outpatients or in primary care, and to discharge patients as quickly as possible, irrespective of their individual needs.

PbR is also a mechanism to allow NHS funds to be used to pay 'other' (non-NHS) providers and 'support patient choice and diversity'. It costs money to implement – conservatively estimated at up to an additional £190,000 per PCT per year.[13] Health Secretary Patricia Hewitt in 2005 spelled out a longer-term objective of PbR – to force changes, posing a real threat of closure in NHS Trusts:

'It's not only inevitable, but essential that Payment by Results and these other elements create instability and change for the NHS. That's precisely what they are designed to do.'

Patricia Hewitt, 2005[14]

ISTCs

Based on successful NHS elective treatment centres (most notably the South West London Elective Orthopaedic Centre at Epsom Hospital), ISTCs offer uncomplicated day and short-stay procedures.

The DH argues that they create a 'market' in elective healthcare, offer patient choice and (third on the list of priorities)[15] reduce waiting times (although these had already been reduced by expanding NHS provision). The second wave of ISTCs abandoned any pretence that they were needed to create essential additional capacity and instead focused on creating 'contestability' and a viable market, with a target of capturing up to 15% of the NHS elective caseload.[16]

Unlike the NHS, which has to deliver a comprehensive service to the whole population, private sector providers are free to pick and choose which services they want to offer: many concentrate on orthopaedics and ophthalmology (cataract) services.[17] So the NHS carries sole responsibility for all emergency services and treatment (including problems arising in private hospitals), along with complex, chronic and costly cases or those excluded by the private sector such as patients with psychiatric co-morbidities, which the private sector sees as a risk.

Every patient who chooses, or is persuaded to accept, treatment in a private sector unit, takes a cash value with them out of the NHS leaving their local hospitals poorer. Since ISTC contracts have, as ministers admit, been paid an average of 12% more for each patient than the NHS tariff cost, every eight patients diverted to an ISTC cost the equivalent of almost 10 NHS tariff payments.[18]

Paying ISTCs for a pre-determined number of cases, regardless of how few receive treatment, is clearly a costly policy. Estimates of the costs vary, although data on the DH website shows only one first wave unit delivering 100% of contracted activity, four on 66% or below, and an overall average of just 85% – suggesting a shortfall of £220 million on the £1.47 billion contracts.[19] In Nottingham, Barlborough Treatment Centre has delivered operations worth just £41,000 in exchange for guaranteed payments of £791,000 this year, and carried out just £4 million of operations out of the £9 million contract, due to expire early in 2010.[20] Closing this and other failed first wave ISTCs at the end of their contracts could cost the NHS up to £400 million more in compensation.[21]

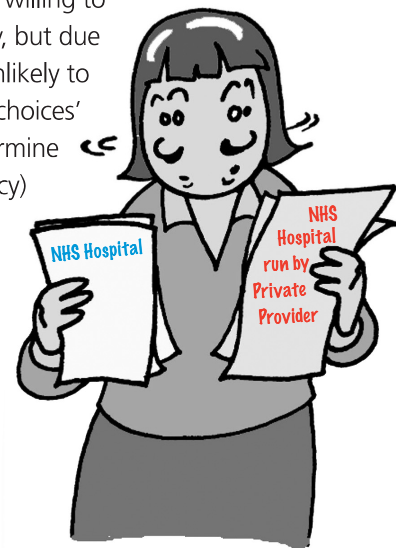
Despite the premium prices paid for treatment, ISTCs are able to select ('cherry-pick') the patients with the least complex health needs and to exclude others, leaving them to the NHS which is left with a reduced budget to pay for more costly treatments.[22] Even with this less complex caseload, there have been real concerns over the quality of care provided in some ISTCs. In September 2009 a BBC Panorama programme on ISTCs highlighted this problem and the Care Quality Commission subsequently carried out safety checks at all ISTCs.

In North London a treatment centre run by Clinicenta has closed after just eight months as NHS London launched an inquiry into how two patients died.[23] This follows an ongoing debate on the variable quality of care delivered by ISTCs, sparked by the death of Dr John Hubley who bled to death during a gall bladder operation at Eccleshill ISTC in Bradford in 2007 (as a result of which the ISTC, which held no blood stocks and inadequate swabs, was branded a 'Mickey Mouse outfit' by the Coroner)[24] as well as research on the outcomes of more than 200 orthopaedic operations carried out by Swedish doctors for a private company at an NHS Treatment Centre in Weston Super Mare.[25] BBC documentaries have spoken to a dozen surgeons and specialists who have expressed their concerns at the quality of care, levels of training of medical staff and limited follow-up delivered by ISTCs.[26]

Patient choice

The requirement for patients referred for hospital treatment to be offered a choice – to include any private hospital willing to provide treatment at the NHS tariff price – is set to be strengthened by legislation giving patients who wait longer than the 18-week maximum a legal right to free (NHS-funded) care in private hospitals.[27] However, this still leaves the private sector scope to decide which of these cases they wish to accept allowing them to retain their focus on uncomplicated elective work, while the NHS foots the bill and retains the more complex and costly caseload.

There has been growing concern that hospitals which lose out financially when patients choose to go elsewhere could be forced to close departments – or close down altogether. Ministers and senior NHS officials have said that they are willing to see this happen, arguing that it would not be their policy, but due to patients who made the decision.[28] But patients are unlikely to be aware of the potentially far-reaching impact of their 'choices' – few would willingly choose an option that might undermine future access for treatment (emergency or non-emergency) at a properly resourced local district hospital. Nor is there any option for patients to insist upon care and resources being kept in-house and local.

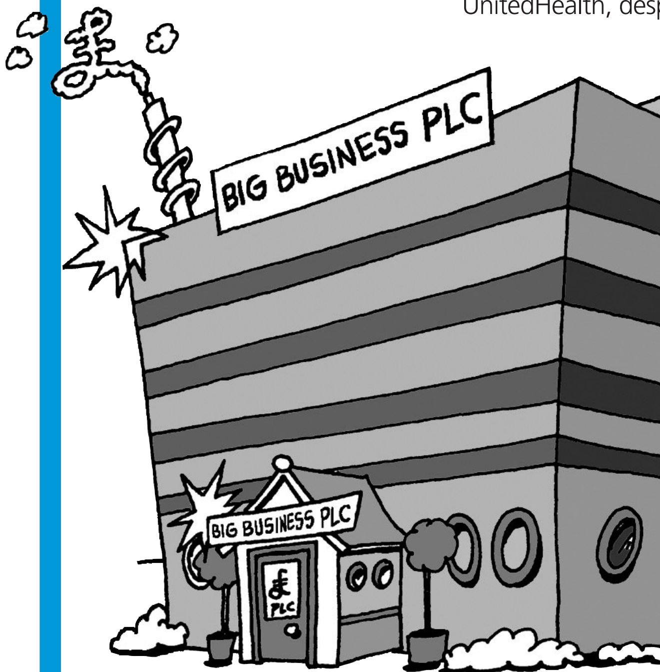


The Commons Public Accounts Committee has warned that the policy could result in private sector providers 'cream skimming' the most straightforward and lucrative cases, leaving NHS hospitals with reduced resources to cope with the most chronic, complex and costly patients.[29]

Polyclinics and primary care

What began with removing the responsibility from GPs to deliver on-call services and the consequent contracting out of Out-of-Hours services to a variety of co-operatives and alternative providers has grown into a range of initiatives including the tendering of contracts to run GP practices and the contracting out of community and primary care services – such as physiotherapy in Camden.[30] Ministers have made clear that primary care contracts worth up to £150 million a year would be up for grabs by the private sector.[31]

In Camden contracts to run three GP practices were given to US-based multinational UnitedHealth, despite the company scoring below local GPs on clinical quality.[32] The company bid a substantially lower price which local GPs and health campaigners argued could have been a loss-leader to steal a march on GPs with experience and links in the area.[33]



Since then Camden campaigners have run a high profile campaign to challenge plans for a private sector-run polyclinic, the contract for which was at first awarded to Care UK but then withdrawn after a legal challenge showed that patients had not been consulted.[34]

The full model for 'polyclinics' or GP-led health centres based on the model outlined for London by Lord Darzi in 2007[35] involves large centres covering a catchment of up to 50,000 and employing up to 100 staff, including 25 GPs, practice nurses and other professionals, and delivering minor injury services, outpatient clinics, mental health and minor surgery.[36]

Ministers were caught by surprise by the hostile reaction to these proposals from many GPs and primary care staff and the model was revamped, scaled down and diluted – but made mandatory. Every PCT was required to establish at least one 'GP-led health centre',[37] regardless of the cost or the wishes of local people whose existing GP services may be put at risk.

Pulse magazine has described the 'jaw-dropping' costs of establishing the new centres, which average three times the *per capita* funding of regular GP practices and health centres. Costs range from £64 per patient in two PCTs in the south of England to a staggering £560 per patient in Halton and St Helens.[38]

Even with these inflated levels of spending, many of the new centres are struggling to deliver more than walk-in services, with very small numbers of patients registering with the practice.[39] As a *Pulse* editorial points out, if the price of these new showpiece health centres remains so high, the model cannot be rolled out across the whole of the NHS; if such expensive services cannot be made available to everyone, how can they be justified for a few patients?[40]

Another problem for the so-called 'Darzi centres' is that the private companies involved are not making sufficient profit to keep them interested. The most successful firm in securing Darzi centre contracts, Assura, is making only minimal surpluses, well short of the £60 million a year or more that would be needed to sustain the business, and has been considering pulling out.[41]

Transforming Community Services

PCT directly provided services, which account for £11 billion of NHS spending and employ around 250,000 staff in primary care and community services, have been put into separate managerial units as a result of proposals first outlined in 2005.[42] This has increased managerial costs for little visible benefit. Former government adviser Professor Chris Ham, after an international search of the evidence, has raised serious doubts as to whether the commissioning model can work.[43]

The document 'Transforming Community Services' (TCS) published – but not publicised – by the Department of Health[44] proposes that many of these services should also be put out to competitive tender, opening the possibility of the biggest privatisation so far in the NHS.

In Hull and Bromley decisions have been made – despite local opposition – to hand over all PCT provider services to social enterprises – with minimal public consultation and minimal consultation with staff, who may lose many of the benefits of an NHS contract.[45]

TCS goes further, urging that bids should be invited from 'any willing provider' – and requiring PCTs to compile lists of potential providers who fit certain minimal criteria but who may well have no track record of delivering healthcare locally or at all.

A vague 'right to request'[46] opens the possibility for NHS staff to propose the formation of a 'social enterprise' – although it does not stipulate which health workers, or how many, need to make such a request, opening the possibility of a handful of managers forcing through changes regardless of the wishes of other staff.[47]

In late 2009 health unions in Kingston pressed for a staff ballot on whether or not PCT provider services should be transferred to a social enterprise.[48] Health workers or local people

who may wish to ensure services remain in the public sector are given no corresponding right to request the ending of a private contract and bring services back in house.

In September 2009 Health Secretary Andy Burnham announced a shift of government policy, insisting that the NHS should normally be the 'preferred provider' for services and that tendering should only proceed if other measures to improve the quality of services had failed.[49]

Meanwhile PCTs are being urged through the Framework for Procuring External Support to Commissioners (FESC) – which offers its own 'approved' list of suppliers[50] – to employ the costly services of private sector management consultants (including McKinsey, Ernst & Young and the US-owned UnitedHealth) to help shape their 'commissioning' decisions. Spending on management consultants, estimated at upwards of £300 million a year, continues to increase.[51]

Many PCTs are also recruiting their own 'Commercial Directors' and similar staff into their existing management teams, resulting in a massive expansion of 'back-room' staff costs – at a time when hospital Trusts are being pressed to cut costs and deliver efficiency savings.[52]

NHS hospital care

The government appears to want to save money by reducing acute hospital care and moving patients into 'cheaper' out of hospital care. The latter comprises polyclinics, elective care centres and urgent care centres, which would be tendered to private corporations. These would aim to profit from delivering high volumes of the less acute and less complex procedures.

The 2007 Darzi report[53] included proposals to reduce the number of district general hospitals in London by either closing them down or downgrading them to 'local hospitals'. However, local hospitals may not have A&E, acute surgical cover or intensive care units and may not be able to provide the all-round safety net of the district general hospital (DGH).

DGHs under consideration for downgrading or closure in London include Chase Farm, Queen Mary's, King George, Whittington, Newham, Barnet, Central Middlesex and West Middlesex. There are others in England including Newark.

Despite the welcome announcement in September 2009 about the NHS being the preferred provider, there remains in place a 'failure regime',[54] predicated on market competition leading to hospital 'winners and losers', with the potential for the private sector to take over NHS hospitals. We believe that the best way to protect acute hospital care is to ensure proper funding of our DGHs.

Private Finance Initiative (PFI)

PFI is a scheme whereby the private sector is contracted to build and manage a new hospital and then lease it to the NHS Trust for 25 or 30 years. The private sector designs, builds, finances and operates the new hospital. According to HM Treasury figures, PFI is now funding just over 100 new hospital schemes valued at £10.9 billion – but set to cost £62.6 billion by the time the final payments are made in 2048.[55]

'Unitary charge' payments by hospital Trusts to cover rent and services in new buildings designed, financed, built and operated by private sector consortia under PFI have topped £1 billion in 2009-10 and are set to rise year-on-year until they peak in 2029.[56] The soaring bill for these high-cost hospitals is now a major headache for local Trust bosses as eight years of increased budgets come to an abrupt halt: the extra cost to Trusts is not fully covered in the PbR tariff.[57]

The credit crunch, coupled with the astonishing increase in the cost of schemes – to unaffordable levels – has forced a virtual halt to new PFI contracts with long delays in signing schemes in Liverpool and elsewhere; at least one local scheme is now proceeding instead on the basis of public funding.[58]

Even when cancelled, PFI schemes such as Leicestershire (where cost increases of £200 million led to the £710 million scheme being scrapped) have left a grim legacy of squandered NHS cash and even lawsuits by aggrieved consortia.[59]

Where schemes are completed, hidden costs include inflated charges for additional site maintenance[60] and updating projects, which have been in complex negotiation for years. The National Audit Office in 2008 found that changes to PFI contracts cost the NHS an extra £180 million in 2006 alone[61] and high cost hospitals drain resources that might otherwise have been invested in community-based services.

The most expensive PFI hospital scheme – the £1 billion rebuild of Barts & The London (costing £1 million per bed) – is proceeding even as NHS London calls for drastic reductions in the use of hospitals for A&E, outpatient and inpatient treatment.[62]

'Having worked as a locum for [private provider] I am all too familiar with the negative undermining effects of such companies taking over provision of primary care. The whole ethos shifts from continuity, patient benefit and professional development to using the system to make money. As a believer in the principles underpinning our NHS I find this insidious erosion of our public service appalling.'

How could market reforms affect NHS staff?

There are fears that cuts in public spending will hit frontline services and lead to real job cuts, as proposed in an unpublished McKinsey report in late 2009. Whilst the DH claimed that the report contained 'early ideas' that had been rejected as policy, fears of job cuts and redundancies remain.

Similarly, faced with competition from private providers, NHS staff could find themselves changing jobs more frequently and ultimately working for large private employers who may not offer the same national terms and conditions and pensions as NHS employers. And the shift of care out of hospitals to commercially-run facilities could impact on staffing levels. Training of new generations of doctors has always been a core function of the NHS but this is under threat by market reforms. For example, it is proposed that tariff-based funding is introduced which means hospitals receive less money to pay the salaries of doctors in training. This could encourage Trusts to reduce the number of junior doctors, or substitute less qualified staff, to save money.[63]

At the BMA's annual representative meeting in 2009 doctors voted overwhelmingly to reject the commercialisation of the NHS in England and its break up into competing businesses. It also called for the proper funding of NHS GPs, DGHs and publicly provided community care, and for the maintenance of training opportunities for medical students and junior doctors.

The BMA's eight Principles for a public NHS

In response to our concerns about the current and potential damage of market reforms the BMA is calling for an NHS that:

1. Provides **high quality**, comprehensive healthcare for all, free at the point of use
2. Is **publicly funded** through central taxes, **publicly provided**, and **publicly accountable**
3. Significantly **reduces commercial involvement**
4. Uses public money for quality healthcare, **not profits for shareholders**
5. Cares for patients through **co-operation**, **not competition**
6. Is led by medical professionals **working in partnership with patients and the public**
7. Seeks value for money but puts the care of **patients before financial targets**
8. Is fully committed to **training future generations** of medical professionals.

1. Provides high quality, comprehensive healthcare for all, free at the point of use

The UN Declaration of Human Rights includes a universal right to healthcare.[64] But health systems around the world show that the private sector cannot and will not provide this, but instead can exclude patients with the greatest health needs and divert funds from patient care to shareholder profits.

Comprehensive and universal services can only be ensured by public sector services delivering treatment on the basis of clinical need, not the ability to pay. The BMA is committed to an NHS funded from general taxation which is the most effective way to share risk on the widest basis, provide care free at the point of use and advance the social goal of providing high quality healthcare fairly and transparently.

2. Is publicly funded through central taxes, publicly provided, and publicly accountable

The Wanless Report in 2002[65] showed that the system of financing the NHS through taxation is fair and efficient. But government reforms have used public funding from taxation to set up artificial 'markets' of high-cost private providers which are not accountable to local communities or the wider electorate.

The result has been money siphoned from NHS budgets to pay increased rates for routine cases delivered by profit-seeking companies. In many cases these decisions are highly unpopular and implemented with minimal, if any, consultation with patients, the public or NHS staff.

More money is being wasted on new tiers of management to create a market that has not been debated by the public and which doctors have explicitly rejected,[66] and a system that fragments and reduces NHS accountability.

3. Significantly reduces commercial involvement

As detailed in this document, the NHS is wasting hundreds of millions of pounds on a variety of private sector providers, management consultants and PFI when services could be delivered more effectively through developing NHS provision and improved through collaborative sharing of best practice rather than competition.

Any involvement of the private sector should be limited to areas where existing providers are unable to meet demonstrable demand, and only when it will function to complement existing capacity rather than undermine the comprehensive delivery of healthcare.

4. Uses public money for quality healthcare, not profits for shareholders

Many of the private providers, most notably the ISTCs, have been expensively developed instead of developing capacity through expanding NHS hospitals. Their existence destabilises many NHS providers and diverts vital resources from patient care into dividend payments, without any compensating benefit.

5. Cares for patients through co-operation, not competition

Evidence shows that patient care can be put at risk by competition which inhibits sharing of best practice, honest peer-review, collaboration and research. Systems experts argue for integrated systems and reject competitive models.[67] The BMA wants to see systems that promote greater integration and collaboration.[68]

6. Is led by medical professionals working in partnership with patients and the public

National politics should play a lesser role in the day-to-day running of the NHS. Instead, the NHS should be managed to a greater extent under the direction of health professionals, together with meaningful consultation with patients and the public and genuine accountability to the public.

7. Seeks value for money but puts the care of patients before financial targets

As healthcare resources are valuable, wasting them is unethical. The BMA defines 'efficiency' as being the duty to allocate NHS resources to obtain the greatest benefit in terms of patient care. However, increasingly, the concept of efficiency is linked with financial targets and cutting costs in the NHS.

8. Is fully committed to training future generations of medical professionals.

Allowing commercial companies to deliver increasing volumes of routine treatment has the potential to undermine the training of future generations of medical professionals and research on improved techniques. Since ISTCs and private hospitals are untypical environments and provide minimal – if any – training, they result in fewer opportunities for medical students to see and/or experience certain operations or clinical procedures.

To varying degrees, all major political parties see a continuing, if not increasing, role for the market in the NHS in England.

By contrast the BMA believes the way forward has to be based on evidence, not dogma; on breaking down divisions to create seamless care pathways and better co-ordination between healthcare sectors and on comparable outcomes data, rather than market forces, to stimulate health professionals to perform better. We also support an approach that encourages greater involvement of patients in the decisions about where and how their treatment will be provided.

61 years on from its inauguration our NHS, free at the point of use and funded through general taxation is still a fair, popular and cost-effective health system delivering quality care and we aim to ensure it remains so in years to come.

That's why we are determined to *Look after our NHS*.

'I worry about the fragmentation of care and the philosophy of "any competent doctor will do" or even "any competent healthcare professional will do". The core of general practice is relationships – built up over years. Multiple providers chip away at this.'

How you can help support the campaign

- **Show your support for the BMA's Principles at** **www.lookafterournhs.org.uk**
- **Provide examples of how market reforms have affected you – visit** **www.lookafterournhs.org.uk** or email **info.lookafterournhs@bma.org.uk**
- **Email your views, letters or articles to *BMA News* at** **bmanewstoday@bma.org.uk**
- **Put the website link on all your external emails – www.lookafterournhs.org.uk**
- **Raise the campaign with colleagues and at meetings. Share your views on the campaign message board and post comments on other relevant websites and blogs to get the message out.**
- **Join the campaign groups on Facebook and Twitter.**
  http://twitter.com/lookafterournhs
  www.facebook.com/group.php?gid=90614095414

Tell your patients what's happening to our NHS

Side A

DID YOU KNOW?

Some NHS care is provided by large multinational companies.

They are funded with taxpayers' money but their profits go to shareholders, not patient care.

We don't think that's right. Do you?

Help us put patients before profits.

Find out more at www.lookafterournhs.org.uk

BMA

LOOK AFTER OUR NHS
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Side B

Put up campaign posters and display leaflets in your place of work. Encourage patients – and staff – to visit the website where they can find out more and help support the campaign.

For further details visit
www.lookafterournhs.org.uk

Leaflet

References

1 Le Grand J (1999) Competition, cooperation or control? Tales from the British national Health Service, Health Affairs May-June (p31) **http://content.healthaffairs.org/cgi/reprint/18/3/27,** citing King's Fund (1997) 'Management Costs (Press Briefing) and UK Department of Health (1996) Statistical Bulletin 1995-6.

2 For the most recent (1998-2008) figures see **www.parliament.uk/commons/lib/research/rp2009/rp09-076.pdf** (page28): earlier figures are from the Department of Health Information Centre.

3 Department of Health (2000) *The NHS Plan*: 97.

4 Mulholland H (2006) Blair welcomes private firms into NHS. *The Guardian*, 16 February, **www.guardian.co.uk/society/2006/feb/16/health.politics**

5 Spending on admin and clerical staff by PCTs has more than doubled since 2004, increasing 126% to £1.2 billion, with spending on management consultants tripled to £139m according to a response to a Parliamentary Question in August. By contrast NHS hospitals were spending 9% less on admin and clerical staff – see Savage M (2009) Bureaucracy row as NHS spending soars. *The Independent* August 12

6 Figures for first-wave Trusts to April can be found on the DH website: **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101667.pdf**

7 Foster M (2009) GPs forced to send patients to ISTC to stop loss of £6.5m. *BMA News Review*, 10 October.

8 Iacobucci G (2009) US professor urges UK not to abandon continuity of care. *Pulse,* 6 November. **www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4124259**

9 Gordon P (1999) Primary care in context, in Sims J (ed) (1999) *Primary Health Care Sciences*. London: Whurr Publishers.

10 **www.acponline.org/advocacy/where_we_stand/policy/primary-shortage.pdf**

11 Office of Health Economics (n.d.) Assessing the Impact of Payment by Results, available at **www.ohe.org/page/consulting/case.cfm?articleId=19**

12 Department of Health (2007) *Departmental Report*. London: The Stationery Office.

13 *Health Service Journal* (2006) Trusts' admin bills on the rise, 20 July: 9.

14 Timmins N (2005) Hewitt admits that failing hospitals will be closed. *Financial Times,* June 14.

15 Department of Health (2005) *Independent Sector Procurement Programme Phase 2 Electives*. CPD0083: Phase 2 – Elective Care Services PQQ Part 1 Revision: Rev A (8 September) 2005.

The full text reads:
'2.2 Objectives (pages 4-5)
The primary, secondary and tertiary objectives of the Procurement are as follows:
Primary objectives
• To help to create a sustainable, VfM, IS market in the provision of elective care to NHS patients;
• To provide more choice for patients and real contestability in elective services;
• To support implementation of the 18-week waiting time target, which comes into effect from December 2008
Secondary objectives
• To ensure plurality of providers in all areas across England;
• To support the shift to primary care;
Tertiary Objectives
• To promote affordable innovative service models;
• To improve productivity and VfM in NHS-run services'

16 Commercial Directorate DH (2004) **IS-TC Market Sustainability Analysis, available: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4102662.pdf**

17 Rose D (2009) Treatment Centres accused of 'cherry-picking' less complicated patients. *The Times*, 9 November.

18 **www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/1190/1190w118.htm**

19 Available at **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101667.pdf**

20 *Nottingham Evening Post* (2009) Doubt over future of treatment centre, 13 November. **www.thisisnottingham.co.uk/ homenews/ Doubt- future- treatment- centre/ article- 1510356- detail/ article.html**

21 Timmins N (2009) NHS scheme in doubt over £400m bill. *Financial Times,* 30 July.

22 Rose D (2009) Treatment Centres accused of 'cherry-picking' less complicated patients. *The Times*, 9 November.

23 Camden New Journal (2009) Health centre deaths probe, 20 November. **www.thecnj.co.uk/ camden/ 2009/ 111909/ news111909_ 12.html**

24 Gilligan A (2009) The doctor who died as a result of Labour's ISTCs, *Daily Telegraph*, 20 November and West D (2007) Patient death sparks review of independent treatment centre. *Health Service Journal*, 12 January.

25 Cannon SR (2009) Quality of elective surgery in treatment centres, (Editorial) *Journal of Bone and Joint Surgery* **91-B**: 141-2; and Oussedik S & Haddad F (2009) Further doubts over the performance of treatment centres in providing elective orthopaedic surgery. *J Bone Joint Surg [Br]* **91-B**: 1125-6.

26 BBC West (2009) Inside Out: survey reveals surgeons' concerns about standards at Independent Sector Treatment Centres, Press release 10 February, available: **www.bbc.co.uk/pressoffice/pressreleases/stories/2009/02_february/10/west.shtml**

27 *Nursing Times* (2009) Free private care for patients who exceed waiting times target, 2 November, **www.nursingtimes.net/whats-new-in-nursing/news-topics/nursing-quality/free-private-care-for-patients-who-exceed-waiting-times-target/5008046.article**

28 Carvel J (2006) Cut more beds says NHS official (22 May) and Plan for wave of closures of NHA services (13 September) *The Guardian*.

29 Coombes R (2005) Private providers must be stopped from skimming off easy cases. *BMJ* **330**: 691 (26 March), doi:10.1136/bmj.330.7493.691-a; see also McGauran A (2004) It's time to rethink access to GPs within 48 hours, report says. *BMJ* **329**: 762 (2 October), doi: 10.1136/bmj.329.7469.762-a

30 Foot T (2009) Physio services are taken over by private firm. *Camden New Journal*, 13 August. **www.thecnj.co.uk/camden/2009/081309/news081309_09.html**

31 Marsh B (2006) Rush to take GPs into private sector. *Daily Telegraph,* 18 June.

32 Details of the LMC complaint over lower quality of the United Health bid can be found at: **www.healthcarerepublic.com/news/933445/PCT-awards-APMS-contract-private-firm-ahead-GPs** (30 January 2008) healthcarerepublic.com

33 Carrier D (2008) Here come the Sicko surgeries. *Camden New Journal*, 31 January, **www.thecnj.co.uk/camden/2008/013108/news013108_01.html**

34 Foot T (2009) NHS bosses forced to back down. *Camden New Journal,* 19 November, **www.thecnj.co.uk/camden/2009/111909/news111909_01.html**; also Davis A (2009) Protesters win fight to scrap polyclinic, Evening Standard 20 November.

35 Darzi A (2007) *A Framework of Action Technical Paper*. London: NHS.

36 NHS London (2007) *A Framework for Action Technical Paper*, July. **www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/FFA-Technical-Paper.pdf**

37 See **www.dh.gov.uk/en/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm**,

38 *Pulse* (2009) The jaw-dropping price of Darzi centres, 1 July (Editorial). **www.pulsetoday.co.uk/story.asp?sectioncode=20&storycode=4123168**

39 Iacobucci G (2009) Darzi centres set to miss patient registration targets. *Pulse,* 4 November. **www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4124211**

40 *Pulse* (2009) The jaw-dropping price of Darzi centres, 1 July (Editorial). **www.pulsetoday.co.uk/story.asp?sectioncode=20&storycode=4123168**

41 Quinn I, (2009) Private company's losses 'could lead to Darzi centre sell-off'. *Pulse,* 27 November. 27**www.pulsetoday.co.uk/story.asp?sectioncode=35&storycode=4124456**

42 Crisp N (2005) Commissioning a Patient led NHS, Department of Health, 28 July.

43 Ham C (2008) World class commissioning: a health policy chimera? *J Health Serv Res Policy* **13**: 116-121. doi:10.1258/jhsrp.2008.007177

44 Department of Health (2009) Transforming Community Services: *Enabling new patterns of provision.*

45 *Hull Daily Mail* (2009) NHS Hull agrees 'privatisation', 29 July. **www.thisishullandeastriding.co.uk/health/City-s-health-trust-agrees-privatisation/article-1205910-detail/article.html**, see also **www.bromley.nhs.uk/content.php?page=134**

46 Darzi A (2008) *High Quality Care For All – NHS Next Stage Review* (p62 ff) Final Report. London: The Stationery Office.

47 As in Central Surrey Health, where 84% of nursing staff voted against the social enterprise, which was set up by managers: see *Surrey Advertiser,* 6 October 2006. **www.getsurrey.co.uk/news/s/98335_health_workers_run_service_themselves**

48 Durham N (2009) Union calls for staff ballot on social enterprise plan, 27 October, healthcarerepublic. **www.healthcarerepublic.com/news/948214/Union-calls-staff-ballot-social-enterprise-plan**

49 **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107127.pdf**

50 Materials available at: **www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065824.pdf**

51 Gainsbury S (2009) Management consultancy costs to be laid bare. *Health Service Journal*, June 11. **www.hsj.co.uk/news/finance/management-consultant-costs-to-be-laid-bare/5002437.article**
Quinn I (2009) NHS management consultant spending 'a scandal'. *Pulse,* 11 November. **www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4124301&c=2**

52 Savage M (2009) Bureaucracy row as NHS spending soars. *Independent,* 12 August. **www.independent.co.uk/news/uk/politics/bureaucracy-row-as-nhs-spending-soars-1770989.html**

53 **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_079077**

54 Consultation on a regime for unsustainable NHS providers, Department of Health, 16 January. **www.dh.gov.uk/en/Consultations/Liveconsultations/DH_087835**

55 HM Treasury (2009) PFI signed projects list (November 2008) updated version available at: **www.hm-treasury.gov.uk/ppp_pfi_stats.htm**

56 HM Treasury (2009) PFI signed projects list (November 2008) updated version available at: **www.hm-treasury.gov.uk/ppp_pfi_stats.htm**

57 Hellowell M & Pollock AM (2007) *Private finance, public deficits: a report on the cost of PFI and its impact on health services in England*. Edinburgh: CIPHP.

58 Epsom & St Helier Trust is now seeking funds through Public Dividend Capital rather than PFI, see **www.epsom-sthelier.nhs.uk/about-us/our-strategy/redeveloping-st-helier-hospital/**

59 **www.pppfocus.com/shownews.asp?articleID=2851**

60 Dillon M (2009) Fit for special purpose? *Public Finance,* 2-8 October.

61 National Audit Office (2008) Making Changes in Operational PFI Projects, **www.nao.org.uk/publications/0708/making_changes_operational_pfi.aspx**

62 The NHS London HfL affordability assumptions can be found at: **www.london.nhs.uk/webfiles/tools%20and%20resources/Commissioning%20assurance%202009%**

63 Funding review threatens training posts, **www.hospitaldr.co.uk/blogs/our-news/mpet-funding-review-threatens-training-and-academic-posts**

64 The Universal Declaration of Human Rights 1948, available at **www.un.org/en/documents/udhr/**

65 NHS funding and reform: The Wanless Report, **www.parliament.uk/commons/lib/research**

66 'GP warning on threat to private providers', June 2009 **www.healthcarerepublic.com/news/915015/**; 'Doctors concerned about role of private companies', joint BMA/Doctors.net.uk poll, December 2009, **http://web2.bma.org.uk/pressrel.nsf/wlu/RWAS-7YYHDV?OpenDocument&vw=wfmms**

67 Ham C (2008) World class commissioning: a health policy chimera? *J Health Serv Res Policy* **13**: 116-121. doi:10.1258/jhsrp.2008.007177. See also Donald Berwick, Top Ten Tips for health systems at **www.scribd.com/doc/19176692/Don-Berwicks-Top-Ten-Tips**.

68 'Improving the management of long-term conditions in the face of system reform', BMA, 10 July 2007

All information correct at time of going to press. All quotes in yellow boxes are from doctors.

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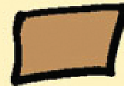

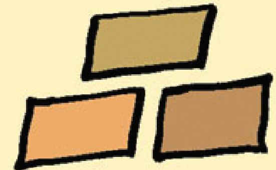

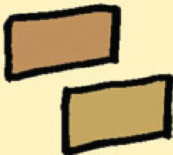

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