



## THE 'PATCHWORK PRIVATISATION' OF OUR HEALTH SERVICE: **A USERS' GUIDE**

- A KEEP OUR NHS PUBLIC REPORT



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## FORWARD

With every week it seems that there is some new form of private involvement in the health service. People are noticing that their services are increasingly provided by the private sector, but the picture is confusing. For the first time, this guide brings together the many forms of privatisation currently afflicting the NHS in a way that is easy to understand. The cumulative effect is quite staggering and should worry anyone who values a public health service.

A publicly funded, publicly provided health service is the fairest and most efficient way of providing high quality health care to all. It must be based on rational planning to meet the specific needs of the people it serves. These needs vary between communities and across the country, meaning the financial system must be fluid and integrated so that funds can be distributed easily. There must be cooperation between hospitals, between primary and secondary care and between different forms of care. Account also needs to be taken of public health and the prevention of illness, an area totally lost within the private sector.

In Britain we are lucky to have a health service that was designed on precisely these lines. But it is being dismantled by stealth, cloaked by the rhetoric of 'patient choice'. Instead of money flowing to where it is most needed, it is increasingly flowing to shareholders. Instead of cooperation, we have competition. In place of the invaluable public sector ethos that has sustained the NHS, we have the profit motive.

Unless this drive is resisted, a comprehensive and equitable health service will be a memory. To resist we must first understand what is happening to our NHS. This guide should help in that endeavour.

Wendy Savage MBCh FRCOG MSc (Public Health) Hon DSc

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## THE 'PATCHWORK PRIVATISATION' OF THE NHS

The government has a vision for the English NHS. It is transforming it from what we have known – a comprehensive, equitable provider of healthcare – into a tax-funded insurer, paying for care provided by others. What emerges will still be called the NHS, but it will be a mere logo or kite-mark attached to selected services.

In its pursuit of this vision, the government is carrying out the 'patchwork privatisation' of the health service. Unlike the Thatcher privatisations of utilities and state enterprises in the 1980s, the entire NHS is not being put up for auction, with the State then washing its hands of the result. Instead, it is being parcelled up into bite-sized pieces, and handed over to private control bit-by-bit. The result of this process will be privatised and fragmented health care, with the state as a general health insurer. Such a system is at odds with the idea of planning the care that is required to meet the health needs of the population, which has been the main principle of the NHS since it was created in 1948. It also removes healthcare from democratic control, destroys accountability and will lead to services being withdrawn and the introduction of more charges.

## PRIVATISATION, OLD AND NEW

'Privatisation' is a politically-charged term without a precise definition. In Britain it is associated with the sell-off of nationalised industries and utilities under Margaret Thatcher and John Major. The classic model involved whole enterprises being moved into private ownership through the mass sale of shares.

But historically this is only one manifestation of privatisation. Some supporters of privatisation have defined it so broadly as to mean "the act of reducing the role of government, or increasing the role of the private sector, in an activity, or in the ownership of

assets.”<sup>1</sup> Academic definitions accept that the deregulation of state monopolies, the outsourcing of state responsibilities and the cessation of services that were once offered by the state can all constitute privatisation.<sup>2</sup>

The latter are the forms of privatisation we see in the NHS today, but in its 'reform' programme the government is using these methods on such a scale and in so coordinated a way as to make it a unique phenomenon.

We are seeing something new: the 'patchwork privatisation' of a major public concern. This guide catalogues the many spheres within the health service where this is taking place. Individually, policies such as encouraging the private sector to take over GP surgeries can be presented by the government as an attempt to solve a specific problem. But when all the different forms of NHS privatisation are knitted together a grand design can be seen. The consistency of the government's approach means its actions can only be explained as a conscious effort to redesign the health service, driven by an ideological preference for the private sector. Important policies like the 'independent sector treatment centre' programme make no sense otherwise.

The government denies that it is privatising the NHS. It argues that while the health service remains free at the point of need, funded from taxation, it is still public. But access does not determine whether a service is public or private. ITV is free for all to watch, but everyone recognises that it is different from the BBC. Neither does public funding automatically translate into public service status. There are examples of private ventures that are publicly funded, such as care homes whose residents have their fees paid by local authorities.

The government's claim does not stand up against the academic definitions of privatisation – if the state is outsourcing services that it previously provided, it is reducing its role. Instead of delivery by bodies ultimately accountable to the public, we have relationships based on contract law with companies accountable to shareholders for the profits they make. When this process is repeated simultaneously across many different areas, it adds up to the 'patchwork privatisation' of the NHS.

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## WHAT'S SO BAD ABOUT PRIVATISATION?

There are many reasons why NHS privatisation is deeply worrying. Privatised healthcare tends to cost more. We can see this in the poor value derived from independent sector treatment centres, and the huge transaction costs that come with contracts, billing and litigation. On a wider scale, America, where private healthcare is most developed, spends over 16% of its GDP on health, yet more than 45 million Americans lack any health insurance. Britain spends half that, yet the NHS covers everybody.

Accountability suffers when private involvement increases. The fog of 'commercial confidentiality' descends, making it impossible to scrutinise public spending because the information is not available. The profit motive encourages 'cherry-picking', whereby the private sector takes on the lucrative work, leaving the rest to an NHS under increasing financial pressure. This can ultimately lead to services being cut. Already some services are being dropped and fees are creeping in. For example, the Queen Charlotte's and Chelsea Hospital in London offers pregnant women a one-to-one midwife service (the recommended NHS standard) for a £4,000 fee. Cherry-picking also results in the loss of training opportunities for junior doctors as ever-larger shares of routine surgery are diverted away from the NHS. Centres for research and medical innovation, like the Nuffield Orthopaedic Centre in Oxfordshire, are also threatened.<sup>3</sup>

The most important consequence of privatisation is the fragmentation of the health service. It has been an explicit goal of New Labour health ministers like Alan Milburn to break up the "state monopoly," opening gateways for the entry of the private sector.<sup>4</sup> This has gone hand in hand with a process of commercialisation – putting public bodies on a commercial footing (as with foundation hospitals) and redesigning the system along market lines.

This really is an attack on the very foundations of the NHS. If the NHS is not a comprehensive and integrated health system, able to plan to meet needs, then it is not the NHS. The great strengths of

the NHS have always been cooperation and service, not competition and profit.

## THE ANATOMY OF PRIVATISATION

The Keep Our NHS Public thermometer indicates how hot the different aspects of the 'patchwork' are. A high reading means acute danger for the NHS!

### I. CREATING A MARKET

A market system is being forced on the NHS. The process began under the Conservatives back in the 1990s. Labour briefly called a halt following the 1997 election, but accelerated after 2001. Running the NHS on market lines means all aspects of healthcare have to be bought and sold – even within the health service. This does not constitute privatisation in itself, but it provides the foundation that makes the patchwork privatisation of the NHS possible.



**Purchaser/provider split** – The legacy of the internal market created by the Conservative government in the 1990s is the purchaser/ provider split. Where previously the NHS had been run as a single system, the split divided the health service between those who purchase or commission care for patients (such as local primary care trusts), and those who sell or provide that care (such as hospitals). In other words, the NHS was made to buy services from itself. In Scotland the purchaser/provider split was abolished after devolution, but in England the Labour government has entrenched it. Payment by results and the whole market system arise out of the split.



The purchaser/provider split and the market system have cost the taxpayer millions in contracts, billing, legal fees and the like. Transaction and administration costs, which before the purchaser/provider split accounted for 6% of the NHS budget, leapt to 12% in the mid-1990s. The new market system could push them close to wasteful American levels, where they account for over a quarter of healthcare spending.<sup>5</sup>

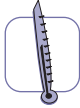
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'Payment by results' (PbR) - 'Payment by results' is the new financial system underpinning the NHS market. Under 'payment by results' hospitals only get money for the actual number of patients they treat, rather than being given a budget guaranteeing funding in advance (these rules are not applied to the private sector for treatment centres, which are given guaranteed funding - see below). This creates a powerful incentive to treat the patients with less complex conditions who can be pushed through the system quicker. On the flip side, there is an incentive to squeeze out people who are more time consuming, such as those in need of chronic care. These incentives are so strong because in April 2006 'payment by results' was rolled out to cover over 80% of hospital work - a move that went faster and further than in any comparable country. It effectively made the English NHS a giant experiment in an untested system of funding healthcare.



If a hospital loses patients to another hospital or to a private facility, it loses income. This puts hospitals in competition with each other to attract patients, meaning they will have to spend taxpayers' money on advertising. Every patient who opts (or is sent) on the NHS for care in a private hospital or treatment centre takes the funds with them out of the NHS - thereby destabilising NHS hospitals and taking away their ability to plan, because they no longer have any idea how much income they will have. One of the purposes of 'payment by results' is to create opportunities for the private sector to take work away from the NHS.

The prices for treatments under 'payment by results' are set according to a fixed tariff, a rigid system that does not take into account that certain NHS trusts have historically higher costs than others, meaning some are plunged into deficit while others make big gains without doing any extra work. 'Payment by results' also creates tension within the NHS as hospitals do as much work as possible while primary care trusts try to cut costs. This leads some managers to 'game' the system. More generally, 'payment by results' is designed to force NHS bodies to act like competitive businesses. This fragmentation destroys much of the flexibility that the NHS used to have, making it difficult to move money around to where it is most needed. This rigidity is a prime cause of the periodic deficit crises that lead to cuts and closures.



**Choose and Book** - This is the electronic system that lets patients choose where to have their operation. It sounds harmless, but the 'menu' of choices has to include at least one private or non-NHS facility. This acts as a golden stairway for the private sector to raise its business within the health service. Tony Blair said that by 2008, 40% of the work carried out by private hospitals will be paid for by the NHS.<sup>5</sup> This has precipitated the arrival of huge foreign healthcare corporations like United Health, the merger of South African giant Netcare with BMI (Britain's biggest private hospital group) and a surge in the share prices of companies like Care UK.<sup>7</sup> Meanwhile, many PCTs have established 'referral management centres' to vet doctors' referrals and, in some cases, divert patients to private sector facilities, completely undermining the notion of patient choice.<sup>8</sup>



**Creating a market by stopping a service: Long-term care** - Another way of creating a market is to simply stop providing a service and pay others to do it. This is what has happened over the last 20 years or so to long-term care. The NHS has withdrawn from providing long-term care in hospitals and within the community. It now buys it from the private and independent sector and the loss of control of this supply has led to problems for patients and for those managing their care. Moving long-term care outside of hospitals is generally thought to be desirable, but has opened up changes in funding. Many more patients now pay for care that used to be free when it was provided in NHS settings. The government places great store in claims that NHS care is free at the point of use. Yet patient experience with long-term care shows that as the NHS retreats the likelihood of patients being asked to pay greatly increases. The cost of care is high and it is estimated that 40,000 people a year have to sell their homes to afford it. A recent investigation by the BBC TV Panorama programme showed that even where patients have a right to free long-term care many are still being asked to pay.<sup>9</sup> Long-term care is not an isolated example - optical treatment is another area where a market has been created by the NHS ceasing to provide services like free eye tests.

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## II. PRIMARY CARE

Primary care is the front-line of the NHS, and has found itself on the front-line of the privatisation battle. Primary care comprises most non-hospital services, such as GPs and district nurses. Whereas the previous section was about the market system that makes privatisation possible, this is where privatisation-proper begins.

**Privatising GP services** - In 2006 huge multinational corporations started to take over GP surgeries. This marked the beginning of a massive change in general practice that will have profound implications. The 'alternative provider of medical services' (APMS) contract is the vehicle being used to bring in the private sector.<sup>10</sup> This is a new form of contract, which according to the government is intended to be "light touch" - i.e. not have much public oversight.<sup>11</sup> It requires a dramatic shift towards a commercial business model in general practice, as contracts must be bid for in competitive tenders. The government has already awarded the contract for a 7,000-patient practice in Barking and Dagenham to private company Care UK, and other contracts are waiting to be signed. Under political pressure, PCTs have begun to put practices out to tender - a survey showed that one in three plan to strike a deal with the private sector for GP services.<sup>12</sup>



Originally, the government justified the policy by saying there were not enough doctors in the deprived areas that need them most. But private companies are moving in across the board. The government claims this does not represent a big shift, as traditional GPs are independent contractors making profits. This is misleading - traditional GPs do not make profits; their salary is whatever is left of the money needed to run the practice, after covering the running costs of the surgery and staff wages. They consider themselves - and are considered legally - part of the NHS and are primarily concerned for their patients. Doctors employed by private health firms are ultimately accountable to shareholders, whose only concern is profit.

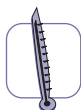
One of the central fears attached to privatised GP services is that continuity of care will suffer. Company doctors will be less

wedded to a particular area and the doctor-patient relationship will be harmed. This has certainly been the experience for patients in Longton, Stoke-on-Trent. ChilversMcCrea, a private company singled out for praise by the Department of Health in its January 2006 white paper, won the contract to run a practice at the Longton Health Centre in October 2004.<sup>13</sup> In its opening three months, the company first had to pay the NHS to supply doctors. It then used temporary doctors, including one from France. Eventually in late 2005 it recruited a German doctor who was unable to drive. Months later, in February 2006, she resigned.<sup>14</sup>



"My fear now is that GPs will struggle to win contracts because these big firms want to get involved. That will be a shame. Firms have to make profits for their shareholders and that leads to care being compromised, whereas GPs have been trained and worked for the NHS all their lives, the ethos is different."

GP Elizabeth Barrett, who was instrumental in the successful campaign to halt the handover of a practice in Derbyshire to the giant American healthcare corporation United Health



**Privatising the commissioning function of Primary Care Trusts (PCTs)** - This takes privatisation one step further into the heart of the NHS. Whereas much of the privatisation drive is focused on the actual provision of health care, this gives the private sector a role in the decisions on what care patients can receive. In late June 2006 the Department of Health advertised for large companies to tender for all the management functions of PCTs (the public bodies responsible for local health spending). This includes commissioning - the act of deciding on behalf of patients which treatments to buy. Private companies will thereby gain control over which treatments patients receive and who provides them, and with it unparalleled knowledge of which areas of healthcare are most profitable. This raises the risk of conflicts of interest and of private commissioners favouring their private friends, and it undermines closer cooperation between different areas of healthcare and social care. It raises questions about whether there will be proper accountability in what is a quintessentially public role. It will effectively put private companies in the driving seat of the local NHS.

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The original advertisement for this outsourcing was withdrawn after Keep Our NHS Public alerted the press, resulting in front-page headlines about the "stealth plan" to privatise NHS care. But two-weeks later the ad reappeared, this time using vague language to the same end.<sup>15</sup> The tendering process is being handled by the Department of Health, which is drawing up a list of approved companies that PCTs can contract to take on commissioning. Management consultants McKinsey, one of the companies bidding for the job, had previously been hired by the Department of Health to 'scope out' the possibility of a market in commissioning, raising accusations of an unfair advantage.

"We are moving to a position where we'll have companies not only providing health care but also deciding which health care patients will be able to receive - in other words, deciding to some extent how the NHS budget should be spent."

Dr Sally Ruane of the Health Policy Research Unit at De Montfort University



**Practice-based commissioning** - 'Practice-based commissioning' transfers the buying power for purchasing many treatments, including hospital operations, from primary care trusts to groups of GPs. Instead of the money being held by a public body with responsibility for the whole local population, it is handed to practices accountable only for their registered patients. Increasingly these will be run by corporations like the American giant UnitedHealth, which could easily dominate the market in any region and gain huge power over what kind of care patients receive and who provides it. The result would be the same as with outsourcing PCT commissioning above, arrived at in a more piecemeal fashion.



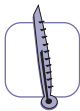
**Outsourcing PCT care** - As well as commissioning care for patients, primary care trusts also provide a wide range of direct services like district nursing and health visiting. But in summer 2005 the government published a document called Commissioning a patient-led NHS that set out plainly its vision: PCTs were to stop providing services, which would instead be handed to the private sector and social enterprises. Hundreds of



thousands of NHS workers would be transferred to new employers outside the NHS. The policy was so rushed that health secretary Patricia Hewitt had to apologise, but the vision remained the same. Then in January 2006 the government's *Our Health, Our Care, Our Say* white paper spelled out how primary care is being opened up to the market.<sup>16</sup> Community nurses are being encouraged to leave the NHS, set up social enterprises (non-profit companies) and sell their services back to their former employer. The trailblazer is Central Surrey Health, a social enterprise of 700 nurses. The shift of employer was forced through despite the fact that 84% of the staff voted against the move in a union ballot.<sup>17</sup> Staff were fearful of the prospect of social enterprises proving easy prey for private sector takeovers. Just as with the private sector, the use of social enterprises can fragment the NHS. Instead of PCTs providing services out of their own budgets, they are now expected to pay outside organisations to do the work, hiking up administration costs and reducing the flexibility of the services.



"I work in the NHS as a health visitor. The government might prefer it if I worked for some private company or voluntary organisation, but I believe in the NHS. It's there to provide the care patients need, not to buy it in like a glorified insurance firm." Norma Dudley, health visitor



**Unbundling of primary care services** – Primary care services are being broken up into saleable commodities in a process known as unbundling. The compulsory duties of all GPs have been whittled down to a core, which primary care trusts can then top up with extra services provided by traditional GPs or, increasingly, by companies and corporations. These new markets are already being exploited for out-of-hours GP services and immunisation, and mean that in many situations patients have no choice but to use the private sector.<sup>18</sup> There are already serious concerns about out-of-hours GP care – inadequate services have put extra pressure on A&E departments, as people have found themselves with nowhere else to go. There has been a high number of complaints about the quality of services in some areas.<sup>19</sup>

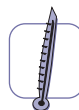
Out-of-hours GP cover in Cornwall was controversially taken over by private company Serco in April 2006. Since then, many people have had problems seeing a doctor in the evenings and at weekends. Serco has missed almost all of its targets, including for emergencies and urgent home visits. Most worryingly, only 55% of emergencies received a visit within one hour in the peak holiday month of August.<sup>20</sup>



### III. SECONDARY CARE

Secondary care is the treatment patients receive after referral, usually in a hospital or treatment centre. It is the highest-profile part of the NHS where private involvement has been very controversial.

**Independent Sector Treatment Centres (ISTCs)** – ISTCs are private sector clinics usually specialising in straightforward treatments, such as cataract operations or hip replacements. The NHS signs contracts with private companies to carry out the work at a fixed overall price, which is paid whether the operations are actually performed or not. This means that, unlike NHS hospitals that are subject to 'payment by results', ISTCs get special treatment, with contracts that guarantee full funding regardless of how many patients opt to use their services. By January 2006, 25 ISTCs were either up and running or shortly to be operational with a further four under negotiation, at a cost of £1.7 billion. These are known as the first wave of ISTCs. The second phase, worth £3.75 billion, was announced in March 2005 and is currently being rolled out.<sup>21</sup>



The government originally made lofty claims for ISTCs, saying they would provide the NHS with extra capacity to reduce waiting lists, stimulate innovation and enhance patient choice. But a July 2006 report by Parliament's Health Select Committee found that the evidence paints a different picture. ISTCs have made only a very modest contribution to cutting waiting lists - these reductions are overwhelmingly the achievements of the NHS. Indeed, the Department of Health documents explaining the second wave of ISTCs make it quite plain that the point is no longer to expand

capacity. Instead, they use the term “contestability”, which implies two-way competition. In fact NHS hospitals are not allowed to compete with the private sector for ISTC contracts, so it is simply private companies competing with each other for guaranteed profits. As a result the NHS loses funding for the routine work that has been taken away, but must still provide the expensive care, such as emergency admissions and chronic cases, which the private sector is not interested in ‘competing’ for. This is causing the finances of some hospitals to become destabilised.<sup>22</sup>

Neither do ISTCs provide value for money: the government will not release its method for calculating value for money (because of the “commercial confidentiality” that accompanies private sector involvement), but it does admit that on average ISTCs have been paid 11.2% more than the NHS for each operation. This higher price is paid despite the fact that ISTCs only take on uncomplicated cases and do not have to train junior staff – another area where they are having a damaging effect. With these factors added in, private companies are being paid around 30% more than the NHS.<sup>23</sup>

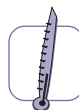


Cataract operations at a private treatment centre in Oxfordshire have cost up to 600% over the odds. The ISTC was forced on the local NHS by the Department of Health, but performed only 93 of 572 contracted procedures in half a year. Meanwhile eye operations at an ISTC in Portsmouth have cost seven times more than they would on the NHS in its first six months.<sup>24</sup>



**Privately run NHS hospitals** – the fullest extension of the ISTC policy is the handing over of an entire hospital to the private sector. This is what has happened at the Lymington New Forest Hospital in Hampshire. A £36 million PFI (private finance initiative) hospital was purpose-built to be run by Partnership Health Group, a subsidiary of Care UK. The huge expense of building the hospital has been met by the taxpayer to enable a private company to make profits. This is the first time a whole NHS hospital, including emergency care, is to be run by a private company, meaning local patients will have little choice but to use the private facility.

**Off-shoring medical secretaries** – An increasing number of NHS trusts are cutting trained medical secretaries in favour of cheaper services abroad – typically in India or South Africa. This has raised fears for safety, with examples such as hypertension being mistaken for hypotension in medical notes, with potentially fatal consequences.<sup>25</sup> Such policies result from the extreme pressure being put on NHS trusts to reduce deficits in a short space of time.

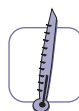


“Patients’ medical records must be absolutely up to date and accurate. The consequences of typing errors are too frightening to contemplate.”

Dave Prentis, general secretary of Unison

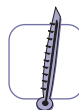


**Private ambulance services** – In many areas non-emergency ambulance services are being put out to tender. Where the contracts are won by the private sector, there have been problems. For example, the South East Coast Ambulance Service NHS Trust is having to deal with patients who private company GSL has been paid to carry. Some patients have been left waiting for up to nine hours, and there are reports that hospital staff have been classifying patients as more ill than was first thought, to secure an emergency NHS ambulance.<sup>26</sup>



## IV. DIAGNOSTICS

**ICATS and GATS** – These appeared on the scene almost completely unnoticed in mid-2006. They are centres that sit between primary and secondary care, carrying out diagnostic tests and performing some operations, but also have the power to refer patients on to hospitals and treatment centres. They are snappily called Integrated Clinical Assessment and Treatment Services (ICATS), or Capture, Assess, Treat and Support Services (CATS). They are not always privately run, but where they are (as in Cumbria and Lancashire) they represent a particularly dangerous development because of the possibility of conflicts of interest. For example, in August 2006 South African company



Netcare was awarded the contract for an ICATS in Manchester. Netcare also runs an ISTC in the area, the Greater Manchester Surgical Centre. Netcare's ICATS could now refer patients to Netcare's ISTC, or, on the other hand, direct unprofitable patients with complicated conditions away from the Surgical Centre.<sup>27</sup> As well as these conflicts of interest, ICATS and CATS will take outpatient and day-case work away from NHS hospitals, possibly rendering the latter non-viable and harming the training of junior doctors.



"The Manchester ICATS is of considerable concern because of the obvious conflicts of interest. It was a scheme that came from above – from the Department of Health – and was pushed through despite of considerable concern the local NHS."

Debbie Abrahams, former chair of Rochdale Primary Care Trust who resigned in protest at market reforms



**Privatisation of pathology services** – In August 2006 the Government announced an expansion of private sector involvement in pathology and diagnostic tests. Five private companies were chosen to supply more than 1.5 million diagnostic procedures, including X-rays, ultrasound scans, and blood and other tissue tests, under contracts worth £1bn over five years. This came after a review by Lord Carter warned of the dangers of fragmenting pathology through privatisation – a position reinforced by the Royal College of Pathologists.<sup>28</sup>

## V. FACILITIES



**PFI** – Under the private finance initiative (PFI) an NHS trust signs a contract with a consortium of companies, which builds and maintains a hospital. The NHS trust then rents the hospital from the private consortium, typically over a 30-year period. There is overwhelming evidence that this is a hugely expensive way of building hospitals. According to the Conservative Party £8bn-worth of PFI hospital building projects will cost £53bn over the course of the contracts.<sup>29</sup> PFI deals come with so called 'soft-services' like cleaning and maintenance, which the NHS

trust has to pay the private consortium for, often at hugely inflated prices. One PFI consortium charged a trust £333 to change a light switch.<sup>30</sup>

The purported purpose of PFI is to transfer the risk attached to building a hospital to the private sector, although it also has the political advantage of keeping expenditure off the Treasury's balance sheet. Once a hospital is built the risk is so small that astronomical profits can be made from refinancing deals – as in the case of the Norfolk and Norwich Hospital, where the Octagon consortium made gains of £95m, and tripled its original expected internal rate of return from 19% to 60%, but left the hospital with extra potential liabilities of up to £257m should it need to terminate the contract early.<sup>31</sup> PFI also has a direct effect on patient services, as the fixed costs are borne by the local NHS trust and have first call on the available money, squeezing other parts of its budget. By the same measure, PFI has been responsible for sending trusts into deficit: the Queen Elizabeth hospital in Woolwich was forced to announce it was technically bankrupt after paying £9m a year more for its PFI than it would have done for a traditionally funded hospital.<sup>32</sup>

“For an NHS trust to have a PFI hospital is like having a massive 30-year mortgage, except the terms are worse than you'd get from any high-street bank and even when it's all paid off, you still might not own the house.”

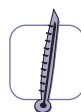
Kevin Coyne, head of health for Amicus



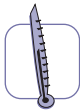
£333 – the price one PFI consortium charged to change a light switch



**LIFT** – The local improvement finance trust (LIFT) scheme is often referred to as the primary care version of PFI, but there are differences. The rate of profit flowing out of the NHS to private shareholders is just as high, despite the much lower risk of building a GP surgery compared to building a hospital. LIFT projects are costing up to eight times more than traditional ways



of building. In Newham in east London, two LIFT premises that cater to just 9% of the local population are taking up 28% of the PCT's accommodation budget.<sup>35</sup> As with PFI, the cost can only be met by starving other areas of funding, ultimately leading to deficits and cuts in services. Furthermore the LIFT model institutionalises conflicts of interest, as it requires an NHS trust to have a stake in a profit-making company, while at the same time buying services from it and evaluating its value for money.<sup>34</sup>



**Subsidising private sector infrastructure** – The government seems to be willing to bend over backwards to entice the private sector into the NHS. Department of Health guidance advises that the NHS could pay a “supplement... to cover the set-up or development costs faced by a new provider,” guarantee them a “minimum income” and “lower the barriers for new providers” through “reducing the capital investment required” – i.e., supplying the buildings.<sup>35</sup>

## VI. SUPPLIES

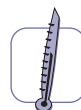


**Privatisation of NHS Logistics** – NHS Logistics bought and distributed health equipment to hospitals. It was an award-winning non-profit organisation, reinvesting its surpluses in the NHS. The government decided to outsource it and a large part of the NHS Purchasing and Supply Agency to the German delivery firm, DHL, and its sub-contractor, Novation, in the biggest single privatisation in the NHS yet. Novation will carry out the crucial role of procurement with control over £4 billion of NHS money. There are serious outstanding allegations against Novation in the US. The Department of Justice is currently investigating the company over bribery and defrauding American public health schemes.<sup>36</sup> There is also a wealth of evidence to suggest that Novation's activities inflate the price of medical supplies in the US.<sup>37</sup>

"Putting Novation in charge of NHS supplies is like appointing Jack the Ripper to run your neighbourhood watch. Or to use a more recent analogy, hiring Enron to operate your power grid." Phil Zweig of US medical supplies company Retractable Technologies, which received a \$155 million settlement from Novation and other companies over allegations of foul play



**Privatisation of oxygen supplies** – The service supplying oxygen to patients with breathing difficulties was privatised in February 2006. Previously it had been run by local pharmacies working with GPs, and oxygen was delivered within a strict NHS target time of hours. But after the service was handed over to four multinational companies – Air Products, Allied Oxycare/Medigas, Linde and BOC – there was chaos, with patients arriving at pharmacies blue in the face after being unable to obtain oxygen for three days. One woman, Alice Broderick, died while waiting for an emergency delivery of oxygen that took nine hours to arrive. As late as August 2006, GPs were still reporting problems with the service and were having to issue prescriptions in the traditional manner.<sup>38</sup>



## WHAT NEXT?

The direction of government policy and its determination to push through market reforms is clear. But there has never been any clamour from the public for this patchwork privatisation of the health service. In fact one of the government's main concerns seems to be to disguise what it is doing, presenting a confusing picture awash with jargon, euphemisms and acronyms.

Most of the policies analysed in this pamphlet were not discussed in parliament. Crucial changes like payment by results and private treatment centres were never put to the vote, nor advertised in election manifestos. The NHS is being fundamentally reshaped without an honest debate.

Parliament must redress this. But it is up to patients and NHS staff to force the issue. United campaigning linking community groups, unions and individuals can make NHS privatisation a political embarrassment.

Keep Our NHS Public was launched for this purpose and has won the backing of hundreds of senior doctors, academics, health workers and trade union leaders, celebrities, MPs and local campaigners. Now it is inviting all sympathisers to join Keep Our NHS Public to build local broad-based campaigns that can stop and roll back the juggernaut of a government policy that is wrecking the NHS. Join at [www.keepournhspublic.com](http://www.keepournhspublic.com) or by writing to Keep Our NHS Public, c/o NHS Support Federation, Community Base, Brighton, BN1 3XG.

### THE CAMPAIGN AIMS TO:

1. Keep our NHS public! This means funded from taxation, free at the point of use, and provided as a public service by people employed in the NHS and accountable to the public and Parliament.
2. Build a broadly based non-party political campaign to prevent further fragmentation and privatisation of the NHS.
3. Inform the public and the media what is happening as a result of the government's 'reform' programme.
4. Call for a public debate about the future of the NHS and halt the further use of the private sector until such a debate is had.

A broad popular movement is the only way to achieve these goals. As Nye Bevan said of the NHS, "it will last as long as there are folk left with the faith to fight for it."

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## NOTES

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Keep Our NHS Public is a grass roots coalition of groups united by a desire to defend a public health service against marketisation and privatisation. It brings together medical professionals, health service unions, academics, user groups and concerned citizens. The model is decentralised with local Keep Our NHS Public groups active all over the country. The campaign is politically and financially independent.

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