



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

■ A SPECIAL REPORT



Unite – Amicus section is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations - the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians and estates and maintenance.

You can also keep up to date with policies, events and campaigns by visiting the Unite health sector pages, [www.unitetheunion.com/health](http://www.unitetheunion.com/health)

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## The 'Patchwork Privatisation' of the NHS

Unite-Amicus is concerned at changes taking place to the principles and concept of the NHS. We have commissioned this booklet to try to explain what these are in regard to parts of the service which we believe are being privatised. Whilst this is not a precise phrase it does help us to understand what is currently going on within the NHS. A change from a comprehensive, public owned and accountable direct provider of healthcare into one where a myriad of private sector contractors vie to provide parcels of healthcare funded from taxation.

We believe this is a fundamental shift in the core principles and values of the NHS.

**Kevin Coyne**  
Unite-Amicus section, National Officer for Health

## What is Privatisation?

'Privatisation' does not have a precise definition. The classic model has involved whole enterprises being moved into private ownership through the mass sale of shares, although this is only one type 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 ending services that were once offered by the state can all constitute privatisation.<sup>2</sup> This is the form of privatisation we see in the NHS today. The government denies that it is privatising the NHS as the health service remains free at the point of need, funded from taxation, but this claim does not stand up to these academic definitions of privatisation.

Further, in its 'reform' programme the government has used these methods of privatisation on such a scale and in so coordinated a way as to make it a unique phenomenon. Individually, policies such as encouraging the private sector to takeover GP surgeries can be presented by the government as an attempt to solve a specific problem. However, when all the different forms of NHS privatisation are knitted together a grand design can be seen; the accumulative impact of which threatens the future of our NHS. In short, we are seeing something new: the 'patchwork privatisation' of a major public concern.

**This guide gives an overview of the many spheres within the health service where this is taking place. It is aimed to give Unite reps and members an understanding of the scale of the NHS reforms, so you can lobby and campaign, locally and nationally, to ensure the new Labour government changes its policy direction on the NHS.**

## What's so bad about privatisation?

There are many reasons why NHS privatisation is deeply worrying.

- **Cost**

Privatised healthcare tends to cost more. It requires a large bureaucracy to operate, with huge transaction costs that come with contracts, billing and litigation. We can also see the poor value derived from Independent Sector Treatment Centres (ISTCs) and the high extra costs associated with PFI builds. 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

Accountability suffers when private involvement increases. 'Commercial confidentiality' makes it impossible to scrutinise public spending because the information is not available.

### • Fragmentation and profiteering threaten the quality and quantity of services

The most important consequence of privatisation is the fragmentation of the health service. It has been an explicit goal of government health ministers like Alan Milburn to break up the "state monopoly," opening gateways for the entry of the private sector.<sup>3</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. Having organisations and services competing against each other undermines collaborative working practices and good communication across services. The creation of a lucrative health care market can also impact upon the continuity of care people receive, there is always the threat that the private sector or other providers who take on service that does not secure the expected financial returns may cut their losses and withdraw from the provision of that service.

The profit motive also encourages 'cherry-picking', where the private sector takes on the lucrative work, leaving the rest to an NHS under increasing financial pressure. 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. 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 ran a scheme offering pregnant women a one-to-one midwife service (the recommended NHS standard) for a £4,000 fee<sup>4</sup>.

This really is an attack on the very foundations of the NHS as a comprehensive, integrated health service. The great strengths of the NHS have always been cooperation and service, not competition and profit.

## The Anatomy of NHS privatisation

Below we look at some of the 'reform' policies introduced by the government in recent years. 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!

### Create a market

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 provides the foundation that makes the patchwork privatisation of the NHS possible.

**Purchaser/provider split** – This is fundamental to creating the NHS market. It divides the function of providing healthcare (such as hospitals and for some services the PCT) from NHS Trusts function of purchasing health services on behalf of patients and service users in that Trust's locality. For example, PCTs 'purchase' hospital operations on behalf of patients.

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-1990's. 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>.

**'Payment by results' (PbR)** – 'Payment by results' is the new financial system underpinning the NHS market. Service providers are paid by NHS Trusts (the purchasers, or commissioners of care), rather than being given a budget guaranteeing funding in advance. (These rules are not applied to the private sector for ISTCs, 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, so a larger volume can be treated. 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. 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. Under the 'choice' agenda, 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. This all has a destabilising impact on NHS hospitals and services by taking away their ability to plan, as they no longer have any idea how much income they will have.

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 to earn income, while Primary Care Trusts try to cut their costs as much as possible. '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.

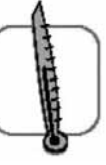
In April 2006 'payment by results' was rolled out to cover over 80% of hospital work – a move that went faster and further than in any comparable country. It effectively made the English NHS a giant experiment in an untested system of funding healthcare. The government has consulted on rolling Payment by Results out further, to cover primary care.

**Choose and Book** – This is the electronic system that lets patients choose where to have their operation. 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>6</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>.

### The Impact on 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 and is responsible for 90% of NHS activity. Whereas the previous section was about the market system that makes privatisation possible, this is where privatisation-proper begins.

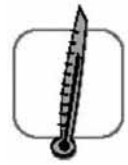
**Privatising GP services** – In 2006 huge multinational corporations started to takeover GP surgeries. This marked the beginning of a massive change in general practice that will have profound implications. The 'alternative provider of medical services' (APMS) contract is the vehicle being used to bring in the private sector.<sup>9</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>10</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>11</sup>



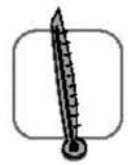
Originally, the government justified the policy by saying there were not enough doctors in the deprived areas that need them most. But private companies are moving in across the board. The government claims this does not represent a big shift, as traditional GPs are independent contractors making profits. This is misleading – traditional GPs take as their salary whatever is left of the money needed to run their practice, after covering the running costs of the surgery and staff wages. They consider themselves – and are considered legally – part of the NHS.

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.

“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.

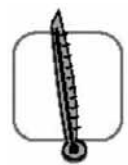


**Outsourcing PCT care** – As well as commissioning care for patients, for example, from hospitals, PCTs also provide a wide range of direct services like district nursing and health visiting. NHS reforms, as set out in ‘Commissioning a Patient-led NHS’ (2005) and ‘Our Health, Our Care, Our Say’ (2006), aim to create a health service where Trusts to divest themselves of directly providing health care. Instead, using their purchasing function, Trusts commission (contract) others to provide health care services. Private companies and third sector organisations will be able to bid to run and provide services contesting against current public sector provision.



**Privatising the commissioning function of Primary Care Trusts (PCTs)** - This takes privatisation one step further into the heart of the NHS, giving 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 the management functions of PCTs. The Department of Health is drawing up a list of approved companies that PCTs can contract to carry out part, or all, of the PCTs commissioning of health services. This would place large, multi-national private companies in the driving seat of strategic primary care decisions.

“We are moving to a position where we’ll have companies not only providing health care but also deciding which healthcare 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 Montford University.



**Practice Based Commissioning** – Practice based commissioning transfers the buying power for purchasing many treatments from PCTs 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 may 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.

“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 from other providers. Currently, commercial providers have won 20% share of the market revenue in out-of-hours contracts<sup>12</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>13</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 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>14</sup>

## The Impact on 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. There have been two ‘waves’ of ISTCs, the first at cost of £1.7 billion and the second is worth £3.75 billion<sup>15</sup>.

The government claimed ISTCs were needed to provide extra capacity quickly to reduce waiting times, stimulate innovation and enhance patient choice. However, Parliament’s Health Select Committee found ISTCs have made only a very modest contribution to cutting waiting lists; the reduced waiting times are overwhelmingly the achievements of the NHS<sup>16</sup>.

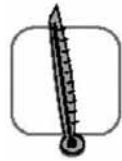
The Department of Health documents explaining the second wave of ISTCs make it clear the point is no longer to expand capacity, instead using the term ‘contestability’, i.e. increased competition.

ISTCs mean that 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>17</sup>

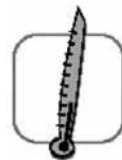
The government will not release its method for calculating value for money because of ‘commercial confidentiality’, but does admit that on average ISTCs have been paid 11.2% more than the NHS for each operation. This higher price is paid despite the fact that ISTCs only take on uncomplicated cases and 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>18</sup>. ISTCs have also been criticised by the Healthcare Commission for the quality of the data collected, meaning that a systematic assessment of care could not occur<sup>19</sup>. It is to be welcomed that the government has said there will be no further phases of ISTC development.

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 the 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 6 months.<sup>20</sup>



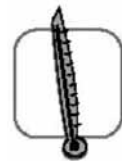


**Privately run NHS Hospitals** – Lymington New Forest Hospital in Hampshire became the NHS first hospital to be fully privately run. A £36 million PFI (Private Finance Initiative) hospital was purpose built and immediately transferred to be run by the Partnership Health Group, a subsidiary of Care UK in December 2006. The huge expense of building the hospital has been met by the taxpayer to enable a private company to make profits.



**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 have been paid to carry, with some patients have been left waiting for up to nine hours.<sup>21</sup>

## Diagnostics



**ICATS and CATS** – Integrated Clinical Assessment and Treatment Services (ICATS), or Capture, Assess, Treat and Support Services (CATS) are centres that sit between primary and secondary care, carrying out diagnostic tests and performing some operations. They also have the power to refer patients on to hospitals and treatment centres. They are not always privately run, but where they are (as in Cumbria and Lancashire) they represent a 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>22</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 unease in the local NHS” Debbie Abrahams, former chair of Rochdale Primary Care Trust who resigned in protest at the 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 1.5million diagnostic procedures, including x-rays, ultrasound scans, and blood and other tissue tests, under contracts worth £1bn over 5 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>23</sup>

## 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. 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>24</sup>

There are now over 700 PFI schemes and it estimated that private companies will profit by £23 billion over the next 30 years (the average length of contract) from NHS PFI buildings. An accountants report for the Audit Commission of Queen Elizabeth Hospital in Woolwich found that half the Trust's deficit of £20million in 2005-6 was due to the annual PFI charge it has to pay, £9million a year more than it would have to pay if the hospital had been traditionally funded<sup>25</sup>. This is a significant amount of money leaving the NHS, and as PFI annual charges have to come from operating budgets there is an immediate impact upon the services Trusts can afford to run.

The purported purpose of PFI is to transfer the risk attached to building a hospital to the private sector. 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>26</sup> The signing of PFI contracts locks NHS services into a 30 year fixed way of delivering services, at a time when the government is arguing for flexibility. Many PFI schemes – especially the more expensive ones – have been for large scale acute hospitals, which are likely to be less and less in demand as resources and the focus of healthcare delivery is shifted to more community based care. Yet the PFI annual charge will continue having to be paid.

“For an NHS trust to have a PFI hospital is like having a massive 30 year old mortgage, except the terms are worse than you'd get from any high-street bank and even when its all paid off, you still might not own the house”. Kevin Coyne, National Officer for Health, Unite-Amicus

**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 8 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>27</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>28</sup>

## 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>29</sup> There is also a wealth of evidence to suggest that Novation's activities inflate the price of medical supplies in the US.<sup>30</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 Zwig of the 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>31</sup>

## What can you do?

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 has been to disguise what it is doing, and to deliberately confuse people by using jargon.

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.

The direction of government policy can be changed, but it requires a collective effort from all of us.

You can,

## Lobby your MP

Make your MP aware of the changes to the NHS, and what you think about these policies! You can find out who your local MP is by looking at [www.theyworkforyou.com](http://www.theyworkforyou.com)

## Pass the information on!

Many people simply aren't aware of the scale of the changes occurring to the NHS – make sure they do know. Talk to your colleagues, family and friends, write to newspapers and post comments on relevant blogs to get the message out.

## Be active in your union

Whether you work in the NHS or not, be active in your union. Help us to build and promote events locally and nationally that highlight what is happening to the NHS, and show our opposition to these policies.

If you work in the NHS and there are changes proposed where you are, then let us know so we always have an up-to-date national picture of what is taking place.

Visit [www.unitetheunion.org.uk](http://www.unitetheunion.org.uk) to keep up to date with information.

## Join keep our NHS public

Keep Our NHS Public is a broad based campaign, that Unite-Amicus supports. It also has the backing of hundreds of senior doctors, academics, health workers, trade unions, celebrities, MPs and local campaigners.

The campaign aims to keep the NHS public - 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, with no further fragmentation and privatisation. KONP aims to inform the public and the media what is happening as a result of the government's 'reform' programme and calls 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.

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, telephone 01273 234 822.

You can help the campaign to raise the profile of health issues by making a donation via our website:

[www.keepournhspublic.com/donate.php](http://www.keepournhspublic.com/donate.php).

## Notes

<sup>1</sup> E Savas, *Privatization: The Key to Better Government* 3, 1987

<sup>2</sup> See P Starr, *The Meaning of Privatization, Yale Law and Policy Review* 6, 1988. He identifies four types of privatisation: "First, the cessation of public programs and disengagement of government from specific kinds of responsibilities represent an implicit form of privatisation. At a less drastic level, the restriction of publicly produced services in volume, availability, or quality may lead to a shift by consumers toward privately produced and purchased substitutes (called "privatization by attrition" when a government lets public services run down). Second, privatization may take the explicit form of transfers of public assets to private ownership, through sale or lease of public land, infrastructure, and enterprises. Third, instead of directly producing some service, the government may finance private services, for example, through contracting-out or vouchers. Finally, privatization may result from the deregulation of entry into activities previously treated as public monopolies."

<sup>3</sup> See A Milburn, *Cascading power to citizens: the new public service agenda*, Speech to Dr Foster Strategy Summit, 22 November 2006, <http://www.alanmilburn.co.uk/diary/view.cfm?eventid=160>

<sup>4</sup> *Fears over £4,000 midwife scheme*, BBC Online, 13 February 2006, <http://news.bbc.co.uk/1/hi/england/london/4709308.stm>, and 'The future of the Nuffield Orthopaedic Centre in Oxfordshire is threatened by an independent sector treatment centre in Banbury, which is taking work away. The Nuffield played a pioneer role in developing prostheses and techniques for hip and knee replacements', see *World famous Nuffield faces closure*, The Daily Telegraph, 14 December 2006 <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/12/14/nuff14.xml>

<sup>5</sup> See *Health Policy & Health Services Research Unit, What's good about the NHS and why it matters who provides the service*, Unison, 2002. p8.

<sup>6</sup> *NHS 'to fund 40pc of private surgery'*, The Daily Telegraph, 18 February 2006 <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/02/17/nhs17.xml>

<sup>7</sup> *'Twin-track' strategy remains to reap NHS work*, Financial Times, 26 August 2006 <http://news.ft.com/cms/s/9a963b5e-d4c0-11da-a357-0000779e2340.html>

<sup>8</sup> Conference attacks referral centres, British Medical Journal, 1 July 2006 <http://www.bmj.com/cgi/content/short/333/7557/9-a?etoc>

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