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controversial topics in surgery

Private provision in the UK National Health Service

The two papers by Professor Pollock and Mr Boyle are probably the most significant yet in the 'controversial topics' series. The health policies of the Blair Government, especially those of 'privatisation' of the NHS, will have untold consequences for us all, whether patient or surgeon.

Professor Pollock provides a cogent and strident defence of the NHS: in particular, she derides the phenomenal costs to the UK tax payer of remuneration of executives and shareholders of the private providers which are due to absorb up to 20% of NHS hospital diagnostics and treatments and, correctly, she points to the high level of administrative costs associated with healthcare in the US. She highlights the incredible and lengthy debacle of PFI hospital contracts, in which substantial sums of HM Treasury money are siphoned off for up to 20 years or more.

Professor Pollock lambasts those in office in all major medical institutions – first, for complacency in not defending the principles of the NHS and now complicity in the benefits of remuneration from private provider work.

Mr Boyle, a central figure in the private service provider 'Centres of Clinical Excellence', challenges the record of the NHS in providing choice, the poor rate of delivery of care, poor figures for preventable mortality and maldistribution of access to healthcare in the UK. He believes that the example of variety of providers, (as occurs in other countries) provide real choice for NHS patients: he infers that 'consultant' owned and run units not only enable consultants to regain control of their professional lives, but will encourage the responsibility to train.

Independent-sector hospitals have reduced waiting lists and increased access to healthcare for many, but at what price? Independent-provider healthcare companies have secured millions of pounds worth of payment from the UK Department of Health, yet fulfilled only a proportion of the contracted work. How much of the profits from these companies remain in the UK – European, American and South African companies have taken the lion share. Is there a real choice or does 'choice' of an independent provider come with a supplementary payment (inducement) to the GP? Does the overseas model of plurality of providers give us a good example of better healthcare delivery? Any surgeon who has worked in the US can attest to the difference, not only in quality but also access, in that free-market health economy in which some of the worst practices reside alongside some of the best.

In Australia, where increasingly surgeons have ownership of hospitals and clinics, observation indicates that selection for surgery in the doctor-owned establishments may be tainted by the fact of financial loss, should the patient choose an alternative provider down the road.

Independent-sector providers undertaking high-volume, routine, quick-fix surgery should provide an ideal training ground. Why, therefore, are these providers so reluctant to initiate training as part of their contract? Presumably because training cuts into the profit margins. Why has it taken so long for the UK Department of Health to recognise the need for training in these institutions?

No one could question that the NHS has lacked capacity, but much has been achieved to increase patient throughput by changing surgical practices. Hitherto, the NHS has been a non-profit organisation – any profits now made as a result of payment by results are returned into the system, even by Foundation Trusts. It remains to be seen whether NHS hospitals providing services for the less glamorous aspects of medicine will be forced to make cuts on account of loss of income from elective surgery to the private provider. One must question the fiscal integrity of a government that permits billions of pounds of taxation to be siphoned off by executives and shareholders of large, private, healthcare providers when similar resources could be provided by the NHS at a fraction of the costs, especially when the government has guaranteed an almost risk-free investment environment for these companies.

The majority of NHS surgeons regard their work as a public service duty: becoming established and gaining the respect of GPs and the local population takes time. Are the short-term employment contracts of private providers a good foundation for continuity of care, especially considering procedures such as arthroplasties?

Private providers are here to stay: their reputation has been besmirched by the secretive manner of their financial contracts with the UK Department of Health and some 'mistiness' concerning clinical outcomes.

Whilst state monopolies are generally thought of as being inefficient, the example of de-regulation of the railways has not been the greatest of successes of privatisation; ask the passengers if the fares and services to the West Country are to their liking? Perhaps British Rail was not so bad after all!

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The case against private provision in the NHS

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For almost two decades, I and my colleagues have researched and documented the gradual decline and erosion of the NHS, describing in detail every privatisation mechanism, from the internal market and private finance initiative (PFI) to tariffs, payment by results, and the new GP contract.[1] We have shown how each, in turn, will lead to fragmentation, privatisation, and service closure, with widening inequalities in access to healthcare. We did so in the hope that reason and evidence would prevail. We thought that politicians faced with the realities of their policy decisions would listen, and that doctors and nurses faced with the evidence would mobilise their professional power.

But it will be to the eternal shame of politicians, the royal colleges, and professional trade unions including the British Medical Association and the Royal College of Nursing that they have done so little to defend the rights we have collectively enjoyed. Not only have they failed to defend the NHS, but they are now actively participating in its destruction, exchanging the principles of fairness and redistribution which underpin the NHS for private gain: gongs for presidents, discretionary points for medical directors, business opportunity and sheer profit for the expanding army of business entrepreneurs including doctors in private practice.

Even medical journals, which so pride themselves on publishing evidence, have been silent on questions of government health policy. The *BMJ* allowed false comparisons of the American healthcare corporations Kaiser Permanente and the UK NHS to go uncorrected in the scientific literature. These misleading comparisons have been cited widely by government officials and policy makers in Department of Health white papers and Treasury reports, as a justification for privatisation despite all the evidence to the contrary.[2]

The government says it does not matter who provides care, but all the evidence shows otherwise. There is no country which provides universal healthcare, free at the point of delivery through private providers. And, as any first-year student of economics will tell you, markets are not a vehicle for providing universal healthcare or public goods. Companies within a market operate primarily in the interests of their shareholders, and thus must select out the most profitable patients, treatments, and services. They bear down on costs by squeezing staff terms and conditions, creating new inequalities. Take for example the evolving transfer market in NHS doctors and staff in profitable specialties, the cuts in education and training budgets, and widening differentials in pay scales. But introducing a market into universal healthcare requires a process known as commodification, whereby services are unbundled from other services and transformed into goods with a price tag.[3] Of course, some groups of patients and services are more difficult to commodify than others because they carry risks and costs which are unpredictable: mental health, chronic illness chronic disease, long-term care, and rehabilitation. These are the services that cannot be unbundled and so are among the first to be cut. In addition, markets fragment and render invisible those that get left behind, so they are neither counted nor included. Then there are the costs of the market known as transaction costs or administration costs. Once less than 6% of the operating budget, transaction costs rose to 12% following the introduction of the internal market into the NHS in 1991, and with the introduction of a real market will rise rapidly to approach 31%.[4] Administration costs include billing and invoicing, marketing, and management consultants. All these costs divert money away from patient care. Increasingly, cost data and contract details are deemed commercial and confidential, so the true costs of privatisation and the market will not be open to public scrutiny. And, of course, fragmentation makes it more difficult to monitor access to healthcare. In independent-sector, treatment centres, the data collected are not standardised, rendering any attempt at comparison futile, and making it impossible to conduct audits of quality, mortality, *etc.*[5] In any case, the government is moving rapidly to privatise data and its analysis, handing over our patient information to companies like Dr Foster, so that it will be impossible to know the truth.

In the process, the introduction of the market and private providers changes the contract between the state and the people. Nowhere is this more apparent than with PFI deals, which are negotiated for vast sums of public money – of the signed £8 billion, the cost to the taxpayer over the life of the contract is in excess of £53 billion. The government is tying-up the tax revenues of future generations through legally binding contracts, and transferring ownership of our services to the private sector. Some hospitals are paying 12–20% of their annual income in PFI charges. When pharmaceutical costs and administration costs of up to 30% are added in then, there is little left for patient care – small wonder services are being cut, except in profitable areas.[6]

The same thing is happening in general practice. GP services are the backbone of the NHS but also its Achilles heel. The government is fond of asserting that GPs are private doctors – they are nothing of the sort. True, they have run their premises as small businesses paying themselves out of the surplus,

but the rules that bind them included professional oversight and government regulation where public accountability was paramount, not private law and commercial contracts which give shareholders preference over public and patients.

The new GP contract changes all that. GPs can opt out of providing out-of-hours services, cervical screening, and child health and, indeed, general practice altogether.[6] The contract allows for all services to be put out to tender on the open market. Large American corporations are moving in – firms like UnitedHealth, presided over by Blair's former policy advisor, Simon Stevens and Richard Smith, former editor of the *BMJ*. Last month, their US bosses, whose annual pay comes to in excess of $100 million a year, had to resign, accused of share rigging.[7] Meanwhile ,the new NHS entrepreneurs who include among them the BMA negotiators of the GP contract, Drs John Chisholm and Simon Fradd, have formed companies that are buying up practices as commercial ventures and breaking up and privatising the services.[7] As doctors and nurses see NHS services cut and experience growing unemployment, they will soon have nowhere to go except the deregulated private sector. Meanwhile, the BMA is advising surgeons and anaesthetists to form chambers and a myriad of companies are feeding like vultures on the remains of the NHS.

All across the country, doctors, nurses, patients, and the public have been mobilising to protest at the devastating cuts and service closures which are either planned or have been implemented in response to the growing costs of privatisation. From Tory shires to Labour heartlands, the strength of feeling and unity is stronger than ever before. Just as more than a million people marched against the Iraq war, several million are rallying to defend their NHS. In every town and every city, the public is on the march, but their voices are ignored or dampened down by media reporting. The ballot box, their only resort, offers almost no hope, as no party seems willing to provide the defence the NHS needs (<KeepOurNHSPublic.com>). There is so much to fight for: the loss of services, their closure and ultimate privatisation will diminish us all. Above all, there are constitutional implications. It is our government that is tying up our taxes, and giving away our buildings and putting our land into the hands of unaccountable trans-national corporations and their shareholders through legally binding commercial contracts.

We are the generation of NHS doctors who have never had to think about whether our patients can afford healthcare, have never had to use debt collectors to collect health care fees or make a decision about our patients' ability to pay. We do not know what it is like to treat patients with differential entitlements to healthcare rather than differential healthcare needs. If we continue down this route, most of us will be co-opted to work within the new systems of private ownership, while a few with a conscience will become the medical missionaries of the future, working in a clapped-out public system which was once proud to call itself the NHS.

The future is bleak, but it is in our hands. Is this the future we want for our profession, is this the future we want for our old age, our family, and our friends? Every one of us will face the terrible consequences of our inertia. It is surely time for us all to ensure the colleges and trade unions act. If not, by the time you, the reader, experience the new reality of privatised healthcare, it will all be too late.

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The case for private provision in the NHS

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The case for reform of the NHS is overwhelming. This of course is why a Labour Government has embarked on a radical programme which will introduce real choice and encourage private providers to offer care to NHS patients free at the point of service and paid for out of taxation. Opponents of these reforms presumably do so out of political conviction rather than out of empiricism; certainly, they frequently claim that only a state owned and run healthcare service is equitable and fair. The evidence simply does not support this assertion.

The gap between average life expectancy in England and that in the lowest fifth of local authorities has increased while this Government has been in power – there has been a 2% rise for males and a 5% increase for females between

1997–2003.[1] The gap in infant mortality rates between the most and the least well-off groups continues to widen. In 1997–1999, the rate among the 'routine and manual' grouping was 13% higher than in the population as a whole. By 2001–2003 the gap was 19%.[1]

Intervention rates for coronary artery bypass grafts or angiography after a heart attack are 30% lower in the lowest socio-economic groups than in the highest. The same inequality is reflected in other areas such as hip replacements, which UK Department of Health figures show are some 20% lower among the lower socio-economic groups despite a higher need of about 30%.[1]

Politicians from across the political spectrum are finally acknowledging these facts. Alan Milburn said: 'In 50 years, health inequalities – the gap between rich and poor in terms of health outcomes – have widened rather than narrowed… Uniformity in provision has not produced equality of outcome'.[2] The Prime Minister described the system as 'deeply unequal'.[3]

The rich simply opt out of the system (the private health and care market covers about 20% of the population and grew by $200 million in 2005), while the poor and the disadvantaged have no choice. Professor Daniel Candinas, a consultant at the University Hospital of Bern in Switzerland, recently told a conference that the Swiss President and a pauper could easily lie side-by-side in his hospital. How often does this happen in today's NHS?

The second problem that those who would maintain the *status quo* face is that a largely unreformed NHS is failing to deliver on its promise of better performance and universal excellence, despite the record spending pumped in by Tony Blair's Government. Although there has been a 50% increase in funding in real terms from £44.9 billion in 2000–2001 to £76.4 billion in 2005–2006, productivity has barely grown – in fact, it has probably declined.[4] The number of surgical procedures taking place every year has actually decreased – in contrast to every other OECD country except Germany.[4] And, life-expectancy in Britain continues to lag behind that of the majority of OECD countries – particularly in cancer survival rates. Indeed, the most recent OECD health data catalogue poor comparative performance by international comparison in a raft of health outcomes. Among these, preventable mortality remained unchanged and the UK was ranked 20th out of 26 countries. In a ranking of 'potential years of life lost that are *a priori* preventable', UK performance actually deteriorated and slipped two places so that only 4 out of 26 countries performed worse.[5]

Stroke care and public health have also deteriorated and, despite specifically targeting elective waiting lists, British patients generally continue to wait far longer for treatment than virtually any of their OECD counterparts.[5] Around 1 million people remain on in-patient waiting lists – a figure that would be considered staggering by many of our European neighbours. As one leading cancer specialist put it recently: 'in places like France and Germany, the ideas of waiting lists for cancer treatment would be seen as grotesque'.[6]

In short, the NHS in its current form perpetuates unfairness, performs badly by international comparison, and has not responded to an enormous increase in resources.

And, of course, the existing NHS structure is unique in the Western world in which other countries operate mixed markets. These are characterised by plurality of providers some of which are state owned and some of which are privately owned and run for profit or on a charitable basis. Indeed the inspiration for Foundation Hospitals came from Spain where publicly funded but, largely, privately provided healthcare is now commonplace. Given the freedom to run themselves, these hospitals are providing excellent care in first-class surroundings. One, the privately owned Alzira in Valencia, has no waiting lists and a patient approval rating of 95%.

In France, a third of all hospitals are not state owned. In Germany, half of all hospitals are not owned by the state. Yet, in both countries, health outcomes are better and more equitable than in the UK. The state acts as the guarantor of services, not the monopoly provider. Choice and competition demonstrably drives up standards and give the consumer the control they lack in today's NHS and which they enjoy when they commission almost all other professional services.

Why should we be surprised by this? Competition is quite simply the optimum tool man has yet come up with to provide best value to consumers. Competition drives down price, encourages innovation, and improves quality. Is healthcare really any different to other, market-providing, essential services? Who today would argue that food, heating oil or housing, for instance, should be provided by a monopoly state organisation? And is healthcare really so fundamentally unique that, within a regulated framework, patients would not benefit from competition in the same way that consumers have in the pharmaceuticals, telecoms, airline or food distribution industries, or indeed virtually every other complex market? Of course, within the context of a competitive market, providers can succeed in giving consumers what they want and serve their own values. The constitution of the John Lewis partnership[7] which owns Waitrose states as its primary purpose the 'happiness of all of its members', and its aim to make only sufficient profits to sustain its commercial vitality, finance its continued development and to distribute a share to all its partners.

The benefits of the limited extension of private provision in today's NHS are becoming increasingly clear. A Department of Health pilot programme in London – the London Patient Choice Project – offered patients in one NHS trust who had been waiting for 6 months the opportunity to be treated at another NHS hospital, a diagnostic and treatment centre or an independent sector hospital. The Department of Health's own evaluation states the scheme: 'cut waiting times for those patients opting to go elsewhere from up to a year to less than seven months'.[8]

On a national level, the introduction of competition to the ophthalmology service has dramatically improved access and reduced waiting times. While there is argument about the nature of the newcomers to the market, there has been poor integration into the existing healthcare community and some existing providers have undoubtedly been challenged by competition; the people who matter, the patients, enjoy a better service than previously.

The simple fact is that people do not care who provides their treatment as long as it is timely and of a high standard and government policy simply reflects this. A recent ICM poll found that 83% of voters are ambivalent whether hospitals or surgeries are run by the government, not-for-profit organisations or the private sector, provided that everyone, including the least well-off, has access to care.[9] This is the structure that the government is evolving, not destroying the NHS but changing it.

Of course, the revolution in the service that increasing plurality of providers necessary to introduce competition brings will not be easy. Opponents argue, in much the same way as the miners did in the 1980s, that the national interest (aka patient care) is at risk. They will argue that removal of elective surgery and diagnostics from a rationalised DGH model will both remove revenue from them and fracture the clinical integrity of services. That some doctors will choose to spend all their time doing, for instance, simple elective operations and that their skills will be lost from the bigger units. That private providers will 'cherry pick', and that training will be threatened. These concerns are, of course, not unique to the UK and are issues confronting all healthcare systems, but internationally solutions have been found which work and which, as discussed earlier, provide better outcomes than the NHS currently does. Take training, for example; the best environment to learn a technical procedure is one in which it is repeated frequently. Units which specialise in this way are likely to provide better training than the rather haphazard way it all too often occurs in the UK, particularly against the background of the European Working Time Directive (EWTD) and a shortened training period. A clinician owned and run unit is most likely to recognise the importance of identifying future colleagues and partners as well as the professional responsibility to teach the next generation. Of course there is a cost to training, but this exists regardless of the ownership structure of the teaching institution and it seems strange to argue that the NHS has a monopoly on excellent medical training in the face of the international evidence. Some doctors may decide to work in just one elective unit, but many won't and, just as happens in many other countries, they will have the choice to work in more than one hospital performing complex procedures some of the week and simple ones at other times, rather like many already do in their private practices.

We should all be careful not to confuse the inevitable rationalisation in the number of big hospitals and what services they offer with the increasing involvement of the private sector in the NHS. For years, the medical profession has demanded centralisation of complex elective and trauma services because the evidence is clear that this model offers best outcomes. The cost of implementing the EWDT as well as the technology and scarcity of skills necessary to provide these services are driving the Government's implementation of this policy. Similarly, much of what currently takes place in large hospitals would be better performed more locally or in the community; the inevitable consequence of this is that large hospitals will concentrate on what they can do best and that much of the less complex and elective services will be move to other providers on the basis of who can do the best job.

Finally, the practice of medicine is a professional service and not a commodity. Britain boasts some of the leading healthcare professionals in the world and yet UK hospital consultants are almost unique among professionals in lacking ownership of their own practices or the facilities they work in. The existing NHS structure singularly fails to align the interests of consultants and indeed all who work for it and this is a major contributor to its relative failure. In the increasingly centralized and politicised NHS that has evolved in recent years, healthcare professionals not just consultants, have been increasingly de-professionalised and consequently de-motivated and disillusioned; these are facts that many reading this article will recognize in their colleagues and themselves.

The introduction of more competition will, in due course, reward those who provide not just cheap prices but rather a truly excellent service and value, and can offer evidence to that effect. This should be perceived not as a threat but as an enormous opportunity for all of us who wish to regain control of our professional lives. I would argue, on the basis of the evidence rather than political doctrine, that a model of partnership and ownership will work just as well in acute as elective services and that the winners in a competitive environment will be both the professionals who deliver the bedt services, and most importantly the patients they wish to treat.

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