nef
economics as if people
and the planet mattered

The wrong medicine

A review of the impacts of NHS reforms in England

New Economics Foundation (NEF) is an independent think-and-do tank that inspires and demonstrates real economic well-being.

We aim to improve quality of life by promoting innovative solutions that challenge mainstream thinking on economic, environmental and social issues. We work in partnership and put people and the planet first.

Contents

Summary

The NHS is rated more highly than any other comparable healthcare system in the world. But it is often thought to be beset by crises and in danger of falling into decline. Market-based reforms have been presented as "solutions" to a continuing "problem" of an under-performing public institution. Does the evidence support these changes?

Market-based reforms began in the 1980s, when support services were first contracted out, and continued in the 1990s, with the creation of an internal market for clinical services. In the 2000s, patients were allowed to choose where they received some treatments; prices were attached to units of completed healthcare; the first privately owned centres were established to take on NHS business; some hospitals became independent foundation trusts; and private companies built most new hospitals, recovering their investment by renting them back to the NHS for 30 years or more.

From 2010, under the Coalition government, the speed of change intensified. The health budget was drastically constrained, leaving the NHS in a mounting financial crisis with shrinking resources to meet expanding volumes of need. The Health and Social Care Act introduced the biggest set of changes ever imposed on the NHS. It removed from government the primary responsibility for providing healthcare, established open competition as the new norm, and aimed to turn all NHS trusts into foundation trusts, independent of government control.

While there is now a "level playing field" between sectors, large commercial organisations have advantages in the new NHS marketplace and are winning more contracts. The Transatlantic Trade and Investment Partnership (TTIP), due for completion in 2015, will remove trade barriers between the European Union and the US. Unless the NHS is excluded from TTIP, any future government trying to return privatised health services to public hands will risk severe financial penalties.

Another big shake-up is on the way. Many critics say the NHS has suffered more from constant reorganisation, which is costly, wasteful and distracting, than from anything else.

Where's the evidence?

The claim that increased competition can improve both efficiency and quality of care is a central justification of market-based reforms and the Health and Social Care Act. Yet we could find no sound evidence to support it.

Academic studies, including systematic reviews on both sides of the Atlantic, find the effects of market mechanisms and privatisation in healthcare systems have largely inconclusive or negative effects on quality and equity

in healthcare. International comparative studies of healthcare systems have given high rankings to the UK and low rankings to the US.

There is no conclusive evidence that patient choice has made UK health services more responsive to patients or more competitive. The Private Finance Initiative has inflicted dangerously heavy long-term financial obligations on the NHS with no compensating savings or benefits. Independent sector treatment centres have been found to 'cherry pick' straightforward cases, take payments for treatments not delivered and to have damaging impacts on the NHS.

What else could justify the changes?

Successive governments have claimed the policies they are promoting are not ideological but based on evidence. As we could find no sound evidence to support market-based reforms, we looked for other ways to justify the changes.

- Could the NHS benefit from the expertise of commercial organisations, such as those in the United States? Evidence suggests the poor performance of US healthcare is directly attributable to reliance on market mechanisms.

- Is healthcare a suitable case for market treatment? Markets rely on perfect information being available, but this is rarely the case for patients. In fact, the NHS was created because markets failed to provide adequate healthcare. Competition can also undermine professional ethics and cannot respond adequately to most chronic conditions. Against this background there are no grounds for allowing public resources intended for healthcare to be turned into shareholder dividends.

- Can healthcare markets be managed effectively? An open competitive healthcare market makes regulation extremely complicated. Neither Monitor nor the Care Quality Commission has yet proved itself fully up to the job. Tariffs for completed episodes of care have been manipulated to improve results for providers rather than for patients.

- Can market mechanisms help to prevent ill health? Market-based reforms focus on treatment and cure, rather than prevention, and so far have done nothing to shift investment or action "upstream" to stop people needing healthcare. A healthy patient is not a source of income.

How much has all this cost?

The recurring costs of market mechanisms in the NHS have been conservatively estimated at £4.5bn a year. This could pay for ten specialist hospitals, 174,798 extra nurses, 42,413 extra GPs or 39,473,684 extra patient visits to A&E. If, as the evidence suggests, market reforms damage the capacity of the NHS to provide high-quality care, the people most likely to suffer are those who use the NHS most frequently: women and older people.

The drive to turn the NHS into a competitive marketplace flies in the face of evidence showing that markets in healthcare almost invariably fail taxpayers, citizens and patients. If policy makers continue in this direction, it will be on ideological grounds. If instead they applied the lessons learned so far, they would change course to enable the NHS to build on its strengths and evolve and flourish in public hands, for the benefit of us all.

1. Introduction

The National Health Service in England is vast, popular and rated more highly than any other comparable health service in the world. It costs the taxpayer nearly £96bn a year, worth approximately £1,700 per head of population.[1] It deals with more than 1 million patients every 36 hours. It employs more than 1.3 million people: three-quarters are women and nearly 30% are nurses.[2]

It's a well loved institution. Seven people in ten say their NHS is one of the best in the world and provides them with a good service locally.[3] But it's widely thought to be beset by crisis and in danger of falling into decline. These worries are partly about money and partly about the direction in which government reforms are taking the NHS.

The NHS budget has been severely constrained since 2010, following a decade of substantially increased funding. To break even against rising costs, it has been challenged to find "efficiency savings" worth £20bn by 2015 – an unprecedented demand.[4] Meanwhile, spending cuts in other areas, including social care, housing and social security, are adding to pressures on health services. A "sudden, sharp and dramatic deterioration" in the financial health of the NHS was reported in 2014, with a prediction that three in four hospitals could be in the red by the end of March 2015.[5] Eight in ten people think the NHS will "face a severe funding problem in the future".[6]

Compared with other health systems, the NHS is said to be outstandingly efficient, ranked first among 11 rich countries in 2014.[7] However, there can be no doubt that it faces increasingly severe financial difficulties and that these will make it harder to keep providing high-quality services. This brings us to the second worry: the impact of government reforms.

Recent polling shows that just over one in five people (22%) agree that the government has the right policies for the NHS, while nearly half (45%) disagree. Most people (67%) know little about changes being made to the NHS. Among a minority who are aware of "greater provision of services by the private sector" and "cuts to services", seven in ten expect these changes to make matters worse for patients.[8] Overall levels of satisfaction with the NHS have fallen over the last five years.[9] Attitudes recorded for its 65th birthday in 2013 found the NHS to be "tender, fragile, fragmented, strained, vulnerable, in disarray and at a cross-roads".[10]

The Health and Social Care Act

In 2012, Parliament passed the Health and Social Care Act, which introduced fundamental changes to the NHS. These have been described as "the biggest bang and set of changes ever to be imposed on the NHS since its creation some 62 years ago".[11] According to Lord Owen, the Act carries the potential to create "a fully marketised National Health Service".[12] Most notably, the Act changes the legal foundations of the NHS; changes the way money is spent; opens the NHS to competition between providers; and alters the status of most NHS trusts. The huge disruption of another "redisorganisation" of the NHS is widely seen as costly, distracting and futile.[13] Senior Conservatives are now calling it the Coalition government's biggest mistake.[14]

One prominent feature of the Act, which causes most general concern – and is the principal focus of this report – is the encouragement of service provision by non-government organisations, including for-profit businesses. David Bennett, Chief Executive of Monitor, now the main regulator of health service providers in England, remarked in 2011 that the NHS could soon resemble other privatised utilities, with Monitor acting like Ofcom, Ofgem and Ofwat.

> *"We, in the UK, have done this in other sectors before. We did it in gas, we did it in power, we did it in telecoms […] We've done it in rail, we've done it in water, so there's actually 20 years of experience in taking monopolistic, monolithic markets and providers and exposing them to economic regulation."*[15]

The momentum towards a competitive open market in healthcare has been widely opposed by professional bodies, including the Royal College of Nursing, the British Medical Association, the Royal College of General Practitioners, the Royal College of Paediatrics and Child Health and the Royal College of Physicians.[16]

What's in this report

Will the direction of government reforms help the NHS to maintain its world-class performance or undermine its capacity to do so? This is the central question of our report We examine the character and trajectory of NHS reforms. We consider how far these reforms have helped or hindered the NHS in providing high-quality, cost-effective healthcare to all who need it.

We begin by tracing the development of market-based reforms since the government of Margaret Thatcher in the 1980s. We explore in more detail three major changes since 2010: the Coalition government's austerity drive, the Health and Social Care Act and the Transatlantic Trade and Investment Partnership. We consider the scale and pace at which NHS services have been contracted out to non-NHS providers.

Next we turn to the evidence base, to see how far the reforms can be justified by knowledge accumulated through academic studies and practical experience. We consider arguments for and against markets in healthcare, the potential of "managed markets", the impacts on preventing ill health and the costs of market reforms.

Finally, we draw conclusions about where the reforms are carrying the NHS and whether the anticipated ends justify the means.

Our findings are based on a review of published and unpublished literature, drawn from both sides of the Atlantic, and on a number of interviews, conducted between July and September 2014.

Case 1: Personal testimonies / Dr Mike Warburton, Former Senior NHS Manager

"There seems to be an ever-diminishing proportion of the NHS in the public sector. The provider side was always going to involve private companies, but it has been the commissioner side which is so much less visible, and which is losing its public sector ethos. The back office function is being privatised now, and there has been a deadline for foundation trusts to put this out to tender. There are also increasing numbers of external management consultancy teams working to support CCG commissioners. I don't think many people are aware of how much of the commissioning function is being carried out by private companies.

Although politicians say that the NHS is safe in their hands, actually the public sector part of it has become smaller and smaller. What you risk then is losing the public sector ethos, where people go above and beyond what they are supposed to do – because that was their career choice. When the management is private sector, you lose that.

The management style in the NHS also became fairly dictatorial, bullish and top down, and so the ability to work in a local environment, be creative and respond to local needs was less easy. Things you were trying to achieve for the local population fell behind, and staff morale dipped considerably because of that. We had a fantastic team, who were enormously enthusiastic about their areas, but they were performance managed on national priorities alone.

People who go to work in the NHS are at best ambivalent about private sector involvement, especially when in 2011–12 commissioners had to choose from a list of services to put out to tender, whether the services were successful or not. That is an example of political dogma, and that is demoralising."

2. The ground prepared: changes prior to 2012

Over the past 25 years, successive governments have tried to reform and reorganise the NHS. They have done this partly in response to mounting worries that a large, centrally controlled organisation could not adapt successfully to changing conditions – most notably a growing and ageing population, and changing public attitudes. Public dissatisfaction with the NHS rose sharply between 1994 and 1996, and again between 1999 and 2001. Levels of satisfaction rose steadily from 2001 to an all-time high in 2009 and have fallen sharply since.[17] Satisfaction ratings cannot simply be attributed to people's experience of health services. They are strongly linked with political affiliation, which party is in government and the dominant messages conveyed by media coverage of the NHS.[18]

Over time, there have been changes in some people's expectations of the NHS and how they perceive their relationship with health services. According to one commentator, the model of healthcare in Britain has transmuted from "church to garage". Once imbued with an almost theological sanctity, the NHS has become more like a repair shop; faithful supporters of a single entity have been converted into customers in a multi-faceted marketplace.[19]

The transformation has been attributed to new healthcare technologies and methods, as well as to a shifting political climate. Certainly, the founding ethos of shared ownership and collective provision has gradually ceded ground to the principles of individual consumer choice and competition between multiple providers, opening the way for non-government organisations, including private companies, to compete for NHS business. It has happened slowly but steadily, with each step paving the way for the next – and largely by stealth, with little public debate of the issues at stake. Neither the Conservatives nor the Liberal Democrats advertised the coming healthcare reforms in their 2010 election manifestos.

Case 2: Serco's clinical services

Complaints about providing equipment like hoists, specialist beds and slings have beset the Serco[20] contract for Suffolk Community Healthcare.[21] Serco took over the £140m contract in 2012, covering 600,000 patients and including investments of £4m in the service, new computer systems and a 24-hour care co-ordination centre in Ipswich, which provides a central point for all patient referrals, all paid for originally by Serco.

But NHS commissioners soon complained that it was failing to meet key targets. In 2013, they issued a 'performance notice' and launched a review into potential safety issues. This attracted the attention of the BBC's *File on Four* programme, which was given access to unpublished figures showing that Serco's community intervention teams were failing to meet urgent four-hour response targets for nurses and therapists to reach patients at home. They were also failing to meet non-emergency 72-hour targets. The BBC reported concerns from some nurses working for Serco that staffing shortages mean some community intervention teams in Suffolk don't have cover at night, resulting in some patients being admitted to hospital.

Serco agreed an improvement plan with the clinical commissioning group (CCG) but complaints have carried on into 2014. Serco's original bid was £10m less than the former NHS trust's best price. Serco made a loss in the first year, and told the BBC it now doesn't expect to make a profit during the life of the contract, which lasts until 2015.

Serco has pulled out of other health delivery contracts, arguing that it had over-committed itself, and had racked up losses of £17.6m on three contracts. Their GP out-of-hours contract in Cornwall and their clinical services contract at Braintree Community Hospital were both cancelled prematurely as a result, and recommissioned.

Before pulling out of the Cornwall contract, Serco had replaced clinicians on its out-of-hours service with call-handlers who did not have medical training but followed a computer-generated script. The new system quadrupled ambulances called. Call handlers were then told to make new checks before calling 999 when they received what appeared to be emergency cases, so that managers could cut down the number of referrals they made to the ambulance service. A leaked management email to staff described how they should use their computer system to meet targets set down in the company's contract on 999 responses.[22]

Introducing market rules

The first market-based reforms of the NHS took place during the Conservative governments of Margaret Thatcher and John Major. During this period, concerns about the NHS being too big, slow, centralised and unresponsive to do the job properly chimed with an increasingly confident right-wing critique of traditional welfare state policies. Where state institutions were not up to scratch, markets could provide solutions. The Adam Smith Institute said at the time that the NHS was doomed to fail as a public healthcare system. It needed radical reforms – including a universal private insurance scheme, a voucher system for buying your own care, or US-style health maintenance organisations – but in the circumstances of the day, what was required was "a slow and progressive reform of the system, rather than a sudden and dramatic upheaval".[23]

The Thatcher government began in 1983 by contracting out support services such as catering, cleaning and facilities management through competitive tenders. Outsourcing was largely restricted to non-clinical services for the next 25 years, but during that time, NHS organisations learned how to handle the process of competitive tendering and contracting to private sector providers.

Margaret Thatcher and her ministers considered proposals to replace the NHS with a US-style insurance-based system, but opted instead to introduce market rules into the NHS as a whole, including clinical services.[24] This involved separating "purchasers" from "providers" of health services and establishing a new quasi-commercial relationship between them. Known as an "internal market", it laid down the foundations for a new kind of NHS, on which most subsequent reforms have been based.

The "purchaser-provider split" was introduced as part of the NHS and Community Care Act in 1991.[25] The stated intent was to apply market disciplines to drive down costs and improve service quality. The practice of commissioning services and generating competition among provider organisations started here. The NHS was still financed collectively through general taxation, but public providers were no longer guaranteed funding. Instead, they had to compete with one another, and with (as yet) a small selection of private providers, in order to win annually renewed contracts from public commissioning bodies.[26] Initially, district health authorities (DHAs) commissioned most services, alongside groups of general practitioners who became "fund-holders". The latter were able to keep savings they accrued through new contracts to spend on developing services, which acted as an incentive to drive down prices.[27]

In addition, some hospitals and other providers (such as mental health services), which had previously been under the control of health authorities, were constituted as separate legal entities – NHS Trusts. These were the precursors of foundation trusts (see below): semi-independent provider organisations competing with others for block contracts from purchasing bodies, for example for Accident and Emergency (A&E) services.

Since 1991 the NHS has been subject to an unrelenting sequence of reorganisations, all attempting to recalibrate the internal market. The commissioning function shifted from health authorities and GP fund-holders, to total purchasing pilots (TPPs), primary care trusts (PCTs) and practice based commissioning (PBC). For two decades, the "quasi market" in healthcare remained a predominantly public market, where funding was collective and services delivered by public providers and professionals. Throughout, the "purchaser-provider split" prevailed and, as institutions, managers and clinicians learned how to conduct their new relationships, the market norms of competitive tendering, financial efficiency and customer choice were increasingly embedded in the NHS. Successive reforms reportedly aimed to improve clinical outcomes, value for money and patients' experience of care. Although there was little evidence to support these claims, the idea took hold among policy-makers that *applying market rules to healthcare* would have a benign influence. It was not, then, a great leap to imagine that a *market in healthcare* would be good for – or at least do no harm to – the NHS.

New Labour's reforms

Between 1997 and 2010, New Labour governments under Tony Blair and Gordon Brown took a number of steps to accelerate and deepen this trend.

Patient choice

Patients were formally entitled to choose where they received elective healthcare, selecting between a number of options, sometimes including private sector providers.

The idea of patients being able to choose between different providers helped to develop a broader perception of patients as customers in a marketplace rather than beneficiaries of state services. It became a key element of "putting patients at the heart of everything" – one of seven founding principles of the NHS constitution published in 2013.[28]

Payment by Results

This system for paying providers by means of a fixed price per unit of completed healthcare for each patient was introduced in 2004. It focused initially on a small number of elective procedures and was gradually expanded to include nearly all elective and emergency care.

It aims to support patient choice by making the money follow the patient and to reduce waiting times by rewarding providers for the volume of completed units of healthcare, rather than by means of block contracts. It pre-empts competition in terms of price alone, but allows providers to retain the difference if they can provide the required standard of care at a lower cost than the national tariff.[29]

Foundation trusts

From 2003, NHS trusts could apply to become foundation trusts, independent of the NHS. They are set up as public benefit corporations, each with an independent board of directors and regulated by Monitor. They are free from central government control and performance management. They can borrow money within limits set by the regulator, retain surpluses and decide on service developments and innovations.

By 2014 there were 147 foundations trusts spanning acute, mental health and ambulance services. The model is intended to become standard for NHS trusts over the next three to five years.[30]

Private Finance Initiative (PFI)

This is a scheme that enables private companies to design, build and operate NHS (and other) facilities, using capital raised through financial markets, and then rent them back under long-term contracts lasting 30 years or more.

First introduced by the Major government, this approach was popular with New Labour, with nearly three-quarters of hospital building schemes funded through PFI between 1997 and 2009.[31]

It appeals to governments by enabling them to launch substantial infrastructure programmes without raising taxes or public borrowing. It appeals to private investors by enabling them to get reliable returns on investment over long periods from NHS organisations backed by public funds.

Case 3: Partnerships in Care

Partnerships in Care, founded in 1977, has annual revenues of more than £170m, mainly from the NHS, for specialist hospitals dealing with mental health issues, learning disabilities and substance abuse.[32] It was owned by the private equity firm Cinven.[33] In October 2013 it ran into difficulties with the Care Quality Commission after inspections of two of its psychiatric hospitals triggered concerns about patient safety, low staffing, and a lack of respect for basic dignity.[34] The Dene,[35] a medium-security psychiatric hospital in West Sussex, failed all seven categories of their inspection and enforcement action was taken. Annesley House[36] in Nottingham failed four out of five areas inspected, while whistleblowers claimed that patients were treated in a 'disrespectful' and "degrading" way.

Partnerships in Care was among NHS providers which the *Independent* claimed were avoiding tax (about £7m estimated in 2012) using a legal loophole.[37] The newspaper reported that it cuts its taxable UK profits by taking high-interest loans from its owners, through the Channel Islands Stock Exchange, thereby reducing tax bills. This way, it has turned what would have been a large tax bill into a tax credit in 2012, according to accounts filed at Companies House. It owed £321.9m to its owners, the European private equity house Cinven, but – by paying interest of £29.7m on these borrowings in 2012 – it helped to turn a healthy operating profit of £31.7m into a pre-tax loss, leaving the group with a tax credit of £629,000.[38]

The loophole, known as the Eurobond exemption, is popular with private equity firms, lending money at very high interest rates through offshore stock exchanges. It has been used, according Corporate Watch, not just by Partnerships in Care but also by Independent Clinical Services, Priory Group, Acorn Care, Tunstall, Lifeways, Healthcare At Home, Spire Healthcare and Care UK.[39] HMRC usually deducts a 20% withholding tax on interest payments going overseas. But as the loans are issued through the Channel Islands Stock Exchange, the exemption means they leave the UK tax free. If their owners had provided funds to the companies by investing in shares instead of issuing loans, any dividends would be paid after the companies' profits had been taxed.

Partnerships in Care was based in Hertfordshire, but has now been sold to the US company Acadia Healthcare,[40] based in Nashville, Tennessee. The deal was worth $660m to former owners Cinven.[41]

By 2012, the Department of Health had more PFI schemes than any other government department: 118 in all, with a capital value of £11.6bn.[42]

Independent sector treatment centres (ISTCs)

In 2000, the New Labour government's NHS Plan instigated 'a concordat with private providers of healthcare to enable the NHS to make better use of facilities in private hospitals'[43] and enabled the NHS to do business with independent sector treatment centres (ISTCs).

These are privately owned centres contracted by the NHS to perform low-risk common elective surgery and diagnostic procedures and tests, such as cataract removals and hip replacements, with the aim of reducing waiting times.

Since 2003 some £5bn of NHS resources have been transferred through ISTCs to for-profit companies such as Ramsey Health Care UK, Netcare and Virgin Health.[44]

Other changes

These market-related reforms went hand-in-hand with other changes more in the style of a traditional welfare state. Vast new sums of public money were injected into the NHS across the UK, more than doubling annual expenditure.[45] This made it possible to expand the workforce by 7,500 consultants, 2,000 GPs, 20,000 nurses and 6,500 therapists, as well as adding 7,000 beds in hospitals and intermediate care, building more than 100 new hospitals and 500 new one-stop primary care centres, and refurbishing more than 3,000 GP premises.[46]

With the new billions came a raft of new performance targets, most notably aiming to reduce waiting times and mortality rates from cancer and heart disease. In the years of apparent plenty, before the financial crash of 2008, the government's expansionary drive generally found favour with the public and helped to improve performance. While there seemed to be an adequate supply of public money flowing in, there was less concern than there might have been about the underlying drift towards market norms in the NHS, or how much money was flowing out into the private sector.

Some commentators were worried nonetheless claiming that – while the reforms were "billed as measures to reduce waiting times, to offer more 'choice', to achieve 'world class' standards, to make the NHS more 'patient centred'" – the underlying aim of the key strategists involved was "to turn healthcare back into a commodity and source of profit".[47]

3. Changes since 2010

The direction of travel of reforms to the NHS has been influenced by three main factors since the Coalition government was formed in 2010.

"Austerity" following the crash of 2008

In the aftermath of the economic crisis, the NHS faced much harder times. The ten-year expansion set out in the NHS Plan in 2000 had come to an end. The government spent huge sums bailing out the banks (in the region of £456.33bn or 31% of GDP),[48] but chose not to spend elsewhere.

Instead, the Coalition decided to build its economic recovery plan on an intensive programme of public spending cuts. This could be seen as financial prudence, but it was also an expression of the same political impulses that led Margaret Thatcher to put NHS support services out to competitive tender in the 1980s. The commitment to seeking market solutions to perceived problems in the public sector now prevailed across the main political parties. New Labour in government had pursued this approach consistently. David Cameron and George Osborne aimed to cut back state institutions and develop a different kind of welfare system in which public services would give way to self-help, philanthropy and markets. Put another way, Osborne's "austerity" drive has involved "a restructuring of welfare benefits and public services that takes the country in a new direction, rolling back the state to a level of intervention below the United States – something which is unprecedented".[49]

As the diagram on page 17 shows, the health budget was not cut but drastically constrained. The expansionary tap had been turned off while levels of demand for services continued to rise. The NHS faced a mounting financial crisis, with shrinking resources to meet expanding volumes of need. The more it fell prey to financial pressures, the easier it became to describe the NHS as a failing public institution – a problem begging for market solutions. It's a standard technique, according to a leading US analyst: "defund, make sure things don't work, people get angry, you hand it over to private capital".[50]

Case 4: Clinicenta

An otherwise healthy 86-year-old died after a routine knee operation at an NHS clinic run by a private sector subsidiary, because the clinic had no available ventilator.[51] Anita Mansi died in 2012 from multiple organ failure two days after her operation at the Surgicentre, a contracted out NHS service at the Lister Hospital in Stevenage. Surgicentre was run by Clinicenta,[52] a subsidiary of Carillion,[53] which used to be part of Tarmac.

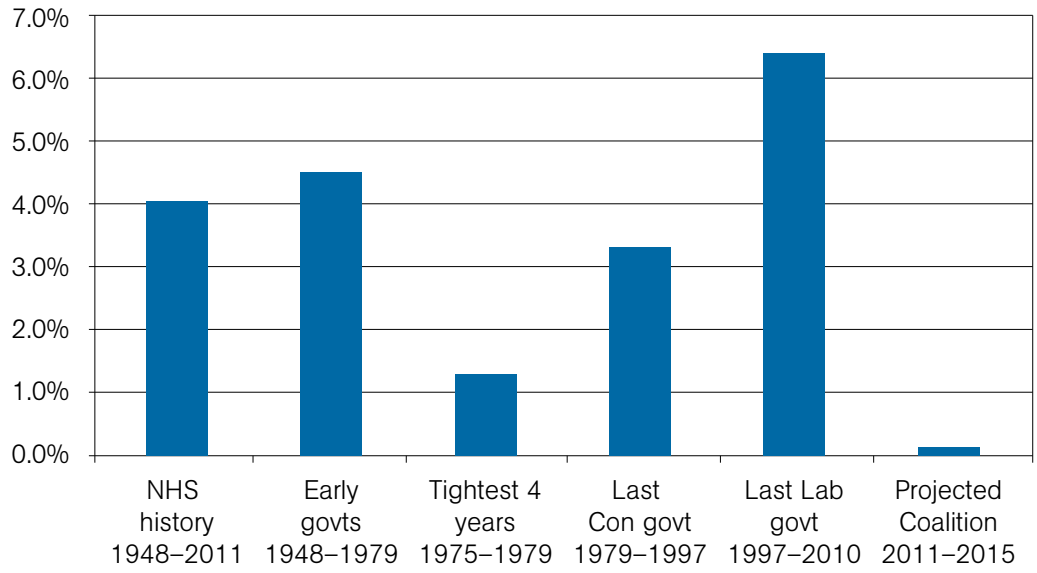
This was one of three deaths at the Surgicentre that prompted independent investigations by NHS Hertfordshire and the Care Quality Commission (CQC) in December 2012 into the care of four patients, including one who survived. The centre provided referred NHS patients with routine surgery in areas such as ear, nose and throat, trauma, orthopaedics, gynaecology and ophthalmology. It is also said to have lost 8,500 outpatient medical files.[54]

In the same year, the CQC inspectors failed the Surgicentre in four out of five areas and, a few months later, local GPs were being told not to refer patients to the eye department because of over-long waiting times. In 2013 the Department of Health bought Surgicentre from Clinicenta for £53m (money which went to Carillion) and transferred services to East and North Hertfordshire NHS Trust. The transfer was said to be by "mutual agreement". A spokeswoman for East and North Hertfordshire NHS said that most of the payment related to the value of the building and equipment, which would be retained for NHS services.

> *"We are contractually bound to pay for this even if the contract is not terminated and runs for its full term."*[55]

In January 2011, another Department of Health contract with Clinicenta was scrapped after an investigation prompted by the death of an elderly woman found it put patients' lives at risk.[56] Clinicenta had been providing out-of-hospital services to 20 primary care trusts across London, ostensibly to help reduce GP waiting times. Their contract was terminated – again "by mutual agreement" – because it was not providing value for money. The internal NHS investigation had found in 2010 that "a catalogue of blunders and system failures had contributed to the pensioner's death". NHS officials claimed the contract was ended not because of these findings, but because numbers of patients referred to the clinic were lower than expected.[57]

Figure 1: Annualised growth in real terms health spending



Source: New Economics Foundation

The Health and Social Care Act 2012

This controversial new law officially aimed to promote the interest of patients, stimulate innovation and improve the quality, integration and efficiency of services. In pursuit of these aims, it has significantly increased the intensity with which market rules determine transactions within the English health service. This is chiefly (though not exclusively) due to the following provisions.

Changing role of the Secretary of State

The Act removes the duty of the Secretary of State to "provide or secure provision" of health services. While retaining ministerial accountability and a duty to "promote a comprehensive health service", he or she must "have regard to the desirability of arm's-length bodies, commissioners and providers having autonomy when exercising their functions or providing services".

The move is officially described as eliminating "political micromanagement", but some commentators regard this as undermining the nationwide consistency and democratic accountability of the NHS, diluting authority to safeguard its capacity to provide equitable and comprehensive healthcare across the population.[58]

Promoting competition between providers

The Act shifts the commissioning function to new clinical commissioning groups (CCGs) for most services and to NHS England for specialist care, backed by commissioning support from NHS England and regional support units. CCGs hold real budgets and are able to retain any savings generated through commissioning, for reinvestment in patient care.

The step-change achieved by the Act is to make competition between providers the new norm, with providers in the for-profit sector treated on equal terms with others. All services are henceforth to be commissioned by means of competitive tender, with "any qualified provider" entitled to bid. Monitor, now the chief regulator of the English healthcare sector, is tasked with ensuring

that commissioners do not engage in anti-competitive behaviour, unless doing so can be shown to be in "the interests of patients". These interests are nowhere defined. Commissioners can decide what they are, while Monitor will assess whether they justify overriding the obligation to behave competitively.[59]

There is a framework of regulations governing the commissioning process, with copious guidance, issued by Monitor. It is claimed, somewhat counter-intuitively, that competition is not inconsistent with striving for more integrated healthcare (bringing together different services around the needs of a patient), which is another objective of the Act. Monitor can instigate inquiries into breaches of the regulations only if it receives a complaint – with the single exception of regulation 10, which governs anti-competitive behaviour, where it can take the initiative.

All NHS trusts to become independent foundation trusts (FTs)
The Act determines that all NHS trusts will become foundation trusts (although this was not implemented by the deadline in 2014). FTs, as we have noted, are not subject to government control or performance management. In addition, the Act enables FTs to generate up to 49% of their income from non-NHS sources (mainly from privately paying patients).

The Transatlantic Trade and Investment Partnership (TTIP)

This is a new "free trade" deal currently being negotiated between the European Union and the United States, and scheduled for completion in 2015. According to the European Commission:

> *"It aims at removing trade barriers in a wide range of economic sectors to make it easier to buy and sell goods and services between the EU and the US."*

This means cutting tariffs as well as other barriers to trade such as regulations and standards.[60] The NHS is due to be included in TTIP, although a campaign is underway to have it excluded.

The TTIP deal has been vigorously backed by the Coalition government, which claims it will stimulate jobs and growth. It is almost certain to include a mechanism for 'Investor State Dispute Settlement' (ISDS), allowing corporations to sue governments through international arbitration, should they introduce policies to the detriment of their commercial interests. Once TTIP is agreed, should a government decide to take a privatised service back under public control then companies affected could choose to sue. The process occurs through international arbitration, administered by corporate lawyers, independent of countries' domestic judicial systems. It has been used in the past, for example, by tobacco giant Philip Morris to sue the Australian government over cigarette health warnings.[61]

Critics have pointed out that barriers to be removed under TTIP "are often our most prized and hard-won regulations and standards that protect, for example, our labour rights, the environment, food safety, digital privacy, and banking standards"[62] and that negotiations for the new partnership have been secretive and dominated by private sector interests. Of 560 meetings held by

the EU Trade Department in preparation for negotiations, 520 were with business lobbyists and only 26 were with public interest groups.[63]

Case 5: Personal testimonies / Josh Bridgens, Consultant paediatric surgeon, Leeds

"I have been working for the last few years in a service that was poor. I don't believe services should just be allowed to stay poor so I worked for two years on a social enterprise that would have gone about the service differently. My impression during that period was that there is a huge inertia in the system.

The NHS commissioners told me that, if they accepted my proposal, then they would have to open it up to a formal procurement process. So I talked to Monitor and they said that this was not correct, and the CCG could just go ahead and commission it if it was the right thing to do for the local health services.

But the scheme didn't happen. In the end, the CCG had no problem contracting a private provider because they already had a series of NHS contracts. But it is a shame because the private provider will simply take 30% for themselves, which could have been used in a range of innovative ways by a social enterprise. There seems to be something about the current system that prefers this kind of conventional solution, rather than working hard to do things differently and better.

It's only going to be the very big providers, like Virgin Healthcare, which are able to do this. Despite all the rhetoric about social enterprises and innovation from the Cabinet Office and the Department of Health, and despite the fact that everyone supports social enterprises, it appears that the system makes it very hard to be innovative."

Increasing share of healthcare outsourced to non-NHS providers[64]

The proportion of spending by the NHS on private sector providers more than doubled between 2006 and 2012, as the figures below show. While there is supposedly a "level playing field" between competitors in all sectors, large commercial organisations have advantages in the marketplace not shared by those in the public and voluntary sectors, including longer experience of, and more staff specialising in, competitive tenders; and more powerful legal and lobbying capacity.

Spending on private providers over the period has grown by 165%, from £1.83bn to £4.85bn, while in comparison expenditure on voluntary sector and local authority providers has increased by just 45% and 13%, respectively. Links between many of the new private sector providers and the Conservative Party have been extensively documented, showing how donors and lobbyists have won lucrative healthcare contracts.[65] One investigation found that "since 2012 a scandalous £1.5bn has left the NHS and gone into the pockets of just 15 private companies linked to 24 Tory MPs and Lords who voted for the Health and Social Care Act".[66]

Figure 2: Types of non-NHS providers providing NHS secondary care (£ bn in 2011–12 prices) 2006–07

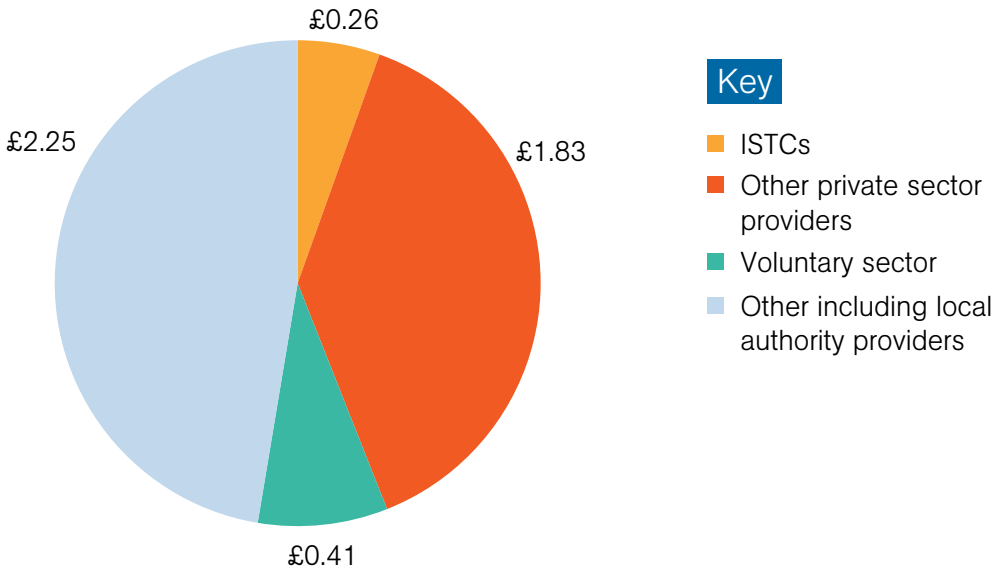
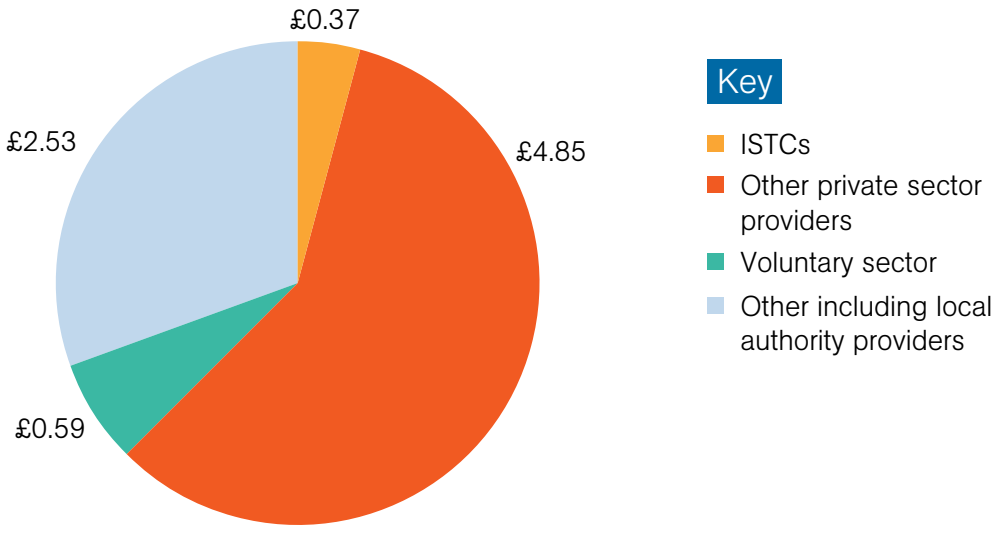


Figure 3: Types of non-NHS providers providing NHS secondary care (£ bn in 2011–12 prices) 2011–12



Source: New Economics Foundation

A thorough analysis of the market for outsourced healthcare is difficult. NHS England no longer provides an online list of all providers who have qualified to provide services on behalf of the NHS and holds no amalgamated information on the contracts which have been won, in terms of their value, size, length and who the winning providers are. That makes it almost impossible to keep track of the major providers in this rapidly changing market for outsourced healthcare.

Clearwater, the independent corporate finance house, stated in 2013 that "it is little wonder that more investors are eyeing up the sizeable opportunities", with specific market developments, such as American Real Estate Investment Trusts (REITs) moving into the UK healthcare market.[67] They note a rise in mergers and acquisitions within health and social care – 83 in 2012, 97 in 2011 and 56 in 2010 – suggesting that providers may be looking to secure market strength in response to new opportunities.[68] They point to new partnerships such as that between Care UK and the Sussex Partnership NHS Foundation Trust, which formed a joint venture company, Recovery and Rehabilitation Partnership Ltd.[69]

Research for the *Financial Times* in 2013 estimated that around 160 large-scale NHS contracts worth £5bn were being advertised to private sector bidders. This was described as "an arms race … whoever can prove first that they are effective in working with the public sector and creating value will be best positioned to become future leaders".[70]

Nearly 200 contract opportunities came into the pipeline in 2012–2013. Contracts awarded since April 2013 show that the private sector won 21 contracts while only four were awarded to NHS bidders. In terms of service types, outsourcing is increasing fastest in diagnostics (16%); mental health (8%); home care (8%); and pharmacy (6%).[71] The number of NHS-funded operations carried out in the private sector rose from 215,044 in 2009–10 to 401,357in 2012–13.[72]

Case 6: Personal testimonies / Noah, Paramedic, London

"We began to notice recently, when I was out on the road, that private ambulance services were beginning to pick up the shortfall in the work which needed to be done. It began with private ambulances taking what we call 'green' calls, where there is no imminent threat to life, and gradually more and more of them appeared in the hospital car parks. Then they began to take emergency calls. I was spending time working on response vehicles at the time, when you get sent to life-threatening incidents ahead of the ambulances, and I began to be followed by private ambulance crews, regardless of what the job was.

The private crews get paid a lot more for their shifts than we do. Private paramedics are on much more than we are. It was said that a certain amount of the work had to go to private crews. It was generally thought of as backdoor privatisation of the ambulance service."

NHS Reform Trajectory: 1983–2015

1983

Competitive tendering contracts out catering, cleaning and facilities management.

1991

The NHS and Community Care Act introduces a 'purchaser-provider' split.

1992

Private Finance Initiatives (PFIs) introduced for the first time.

2000

The NHS Plan seeks to 'modernise and reform its practices alongside an historic increase in funding'.

Go ahead given to contract common elective surgery and diagnostic tests and procedures to independent sector treatment centres.

2003

NHS trusts can apply to become Foundation Trusts, independent of government control.

2004

Payment by Results introduced. Providers are paid a fixed price per unit of completed health care.

2012

The Health and Social Care Act:
Removes the Secretary of State's duty to 'provide or secure provision' of health services.

Promotes competition between providers, with for-profit providers treated on equal terms with others.

Outlines plans for all NHS trusts to become independent Foundation Trusts.

2015

The Transatlantic Trade and Investment Partnership (TTIP) due to come into force.

Under TTIP, companies affected by a privatised service coming back under public control will have new rights to sue.

Between **2006** and **2012**, NHS spending on private providers has grown by 165% from £1.83bn to £4.85bn. Expenditure on voluntary sector and local authority providers has increased by just 45% and 13%, respectively.

The NHS today

The sequence of changes that have taken place over the last 30 years has gradually transformed the NHS from a conventional public service into a healthcare market. Patients can allegedly choose where and how they are treated. Some patients with long-term conditions can now apply for "personal health budgets", and choose how and where to spend them. Doctors, through their clinical commissioning groups, are supposed to buy services from competing providers. The sector regulator, Monitor, is charged with preventing anti-competitive behaviour. Most NHS providers are due to become independent organisations, able to generate nearly half their income from privately paying patients.

For-profit businesses, including large US-based multinationals, compete in an open market with public sector providers, and are winning more and more contracts. Private sector consultancies are increasingly employed to advise commissioners or to act as sub-contractors doing the job for them. Analysts have noted a "revolving door" between private companies and consultancies on the one hand, and government bodies on the other, blurring boundaries between public and commercial interests and raising concerns about transparency and accountability.[73] Unless the NHS is excluded from TTIP, a future government is likely to incur severe financial penalties if it tries to return privatised services to the public realm.

Further reorganisations are imminent. Simon Stevens, Head of NHS England, has launched a "NHS Five Year Forward View", which he describes as a "scene-setter for the bold action needed", to include eroding historical demarcations between different levels of care, introducing technology and new care models to "unleash greater productivity" and upgrading infrastructure. Stevens says he wants to "get serious about prevention and patient power" among other things, and so the NHS must be "up for change" and "can't be hostage" to its history.[74] This marks the latest stage in what has been called a "worldwide epidemic" of healthcare reform, where "Britain stands out from all the rest".[75]

If constant reorganisation has achieved anything, one analyst observes, it has been to nurture "a cadre of managerial 'change junkies' who survive and prosper" by delivering whatever ministers desire; contrary evidence "has no place in such a machismo 'can do' environment".[76]

Some things don't change. The NHS still delivers health services that are funded through taxation and available to all who need them, giving better value for money than most other healthcare systems. Another constant is the widely purveyed impression that the NHS is under extreme pressure, unable to cope adequately with its burdens: it is portrayed as a problem requiring solutions. The idea that markets can solve the problems faced by the NHS remains prevalent.

However, what was a young and promising idea in the 1990s is no longer an appealing novelty. It has failed to prove its worth in areas such as railways and utilities. In healthcare it is severely challenged to demonstrate that it can fulfil that early promise.

In the next section we examine the impact of NHS reforms and ask how far market-based strategies have improved or damaged health services in England.

Case 7: Psychological therapies

One side-effect of the purchaser-provider split has been to encourage providers to "game" the system to maximise their profits. A report by Chester University in 2014 set out some of the effects of "any qualified provider" (AQP) and "payment by results" (PbR) on psychological therapies.[77] The authors found "widespread perverse incentives for providers and perverse outcomes for patients", for example:

- the tariff and PbR affected the decision to take patients on, and what treatments to offer
- the service was rendered less stable and suffered some deterioration while provider organisations were destabilised, affecting their viability
- the pressure of mechanistic throughput of patients affected decision-making and quality
- there were financial incentives to misuse measurement scales within therapy to improve measured outcomes and trigger payments, when these measurement scales were not designed or validated as a payment method.

Providers told the report authors about the risk of investing in the range of interventions and therapies demanded by some service specifications while there was no work guaranteed; and about the wisdom of investing in required infrastructure, especially given the risk involved in "zero value contracts". There was "severe strain" among providers in the AQP areas, and it meant that they were taking on work against their professional judgment. One anonymous large provider had been threatened with insolvency because the tariffs had been set too low, so that commissioners had been forced to re-commission the service, at great expense. More providers meant more administrative costs for contracting.

One provider warned:

> *"In stepped care, if a client has only one session it is considered as no therapy and no payment. If it is two sessions, the therapy is considered completed and therefore the provider can claim a flat rate. It makes a slightly perverse model where some rogue organisation might be able to get a sizeable fee just by offering two sessions."*

Another provider explained that they stopped working for the NHS because fees were too low.

"There's an assumption I think, that the cost is what a cheaper-end therapist will charge. But there's no provision for the administrative overhead, or the overheads of running a company… There has to be an element there for the manager earning an income, and that's just not in there."

4. Where is the evidence?

The claim that increased competition can improve both efficiency and quality of care is a central justification of market-based reforms and the Health and Social Care Act. Yet there is no sound evidence showing improved efficiency or quality of care, let alone that competition has helped to cause such outcomes.

Competition and mortality

David Cameron told NHS staff in June 2011 that "competition is one way we can make things work better for patients" and insists that this is based on evidence, not "ideological theory".[78] He appeared to clinch the argument by citing an LSE study which "found hospitals in areas with more choice had lower death rates".[79] He was referring to a study by Cooper *et al* which suggests that competition-based reforms after 2006 in England led to a 7% reduction in heart attack deaths.[80] Following the introduction of patient choice, say the authors of this study, mortality fell faster in areas where there was greater competition (i.e. more patient choice) between hospitals.

This research has been strongly criticised in several quarters: in the *Lancet* for failing to show a causal relationship between more competition and lower death rates;[81] in the *British Medical Journal* (BMJ) for using inadequate data to draw conclusions;[82] by the Centre for Health and the Public Interest for failing to take account of the complex relationships on which good healthcare depends;[83] and by the government's own cardiac "tsar" for using patient choice between hospitals as a proxy for competition, while studying mortality from heart attacks, which are medical emergencies where patients seldom have a choice.[84]

Most academic experts would agree that more research is needed to explore the impacts of competition. Meanwhile, the weight of existing evidence provides no endorsement of market rules in healthcare systems.

A survey of the literature on competition and health outcomes in UK hospitals in the *BMJ*[85] finds most studies show that competition has been ineffective, highlighting how difficult it is to design and implement policies in favour of competition. The survey shows that some studies find that competition has resulted in lower prices and shorter waiting times, but these are often combined with higher mortality rates. And the authors point out that studies taking hospital mortality as the proxy for quality cannot gauge the effect of competition on elective surgery (where deaths are relatively rare).

Case 8: Personal testimonies / Catherine, Cardiac nurse, Bristol

"We have a new hospital that was built five years ago that has an awful lot of single rooms – partly for clinical reasons, and partly so they can be used for private patients. There are definitely more private patients than there were ten years ago. The consultants do private work in a private hospital during normal working hours, but they also do private patients out of hours (evenings and weekends) in our hospital, when they wouldn't be doing inpatient NHS work. If they can do private work out of hours why can't they do NHS work out of hours and reduce inpatient stays?

Everything is targets based. I'm not sure if there are more targets, but it is more obvious and more talked about. It is seen as a kind of incentive to people. It is also because the push to get people discharged is not just because there should be free beds but also because hospitals don't get the same payment unless they hit a certain target.

A standard patient is expected to stay a certain number of days in hospital, and the trust will get a certain amount of money. After that time, we get less money – though actually, if they stay longer, it is usually because there are problems about going home, and nurses have very little control over that kind of thing.

I like my trust, but the whole image is much more corporate now. They had a big push a couple of years ago, training everyone in what they called their 'trust values'. It was all appropriate stuff about embracing change, which is fine, but it doesn't sound so good – if you were to look at it cynically – if there's not enough help for us to provide services on the ward properly. There are a lot of sound bites, a lot of posters, sometimes without substance behind them."

International evidence

In 2014 the *International Journal of Health Services* published two reviews of international evidence about the impact of "how you organise and pay for health care" on equity and quality. The authors reviewed studies related to funding systems and organisation of healthcare. They found that on the basis of such evidence as existed, which was sparse and often of poor quality, the "privatisation and marketisation of healthcare systems" did not improve quality or equity, with most financial and organisational system-level reforms having either "inconclusive or negative effects".[86]

Global rankings

Global rankings of healthcare systems routinely award low ratings to the United States, widely regarded as a leading exemplar of a marketised system. In 2000 the World Health Organisation (WHO) compared 190 countries according to their performance in trying to achieve "good health, responsiveness to the expectations of the population and fairness of financial contribution"; progress towards these goals was judged depending on "service provision, resource generation, financing and stewardship". The WHO ranked the UK 18th and the US 38th, despite the latter having the highest level of health expenditure per capita.[87]

In 2014, the Commonwealth Fund compared the US with the UK, Switzerland, Sweden, Norway, New Zealand, the Netherlands, Germany, France, Canada

and Australia according to the effectiveness, safety, co-ordination and patient-centredness of their healthcare systems. It gave the highest ranking to the UK, which had the second lowest expenditure per capita, and the lowest to the US, which had the highest expenditure – more than twice that of the UK ($8,508 per capita compared with $3,405 in the UK).[88]

Case 9: Hinchingbrooke Hospital

Hinchingbrooke Hospital in Cambridgeshire became the first hospital in the NHS to be managed by a for-profit company when it was taken over in 2012 by Circle in a ten-year contract worth around £1 bn. Some 160,000 patients are treated there each year.

The Care Quality Commission (CQC) visited Hinchingbrooke in September 2014 and found patients were being neglected, hygiene was inadequate and staffing problems were affecting the quality of care. Detailing examples of "poor care provided to patients", the CQC said patients who lacked the capacity to consent had been sedated on medical wards, despite no "best interest decision" about their treatment having been taken. "The use of sedation without best interest decisions in place can be classified as restraint or a deprivation of liberty safeguarding concern," said the CQC in a letter providing "early feedback", which was leaked to the Health Service Journal.[89]

The inspectors encountered examples of staff caring for patients in an "undignified and emotionally abusive manner". Standards of hand washing among staff in the A&E department and some wards were said to be "very variable" including "an incident whereby staff failed to follow hand washing guidance after seeing to a patient isolated for C difficile". The CQC also voiced concern about "the length of time taken to grasp the seriousness of the situation for patients," and responses from senior management that "suggested a blame approach, rather than that of a supportive and patient-focused approach".

Abdel-Rahman, Chief Executive of Hinchingbrooke, who is also a consultant gynaecologist, said he was sure that the CQC would approve Circle's plans for addressing the problems found.

> *"Quality and safety at Hinchingbrooke have come a long way in two years. As a clinician-led partnership, patients are our priority and we are constantly looking for ways to improve our care."*

Circle Health's parent company, Circle Holdings plc, is owned by a number of hedge funds, involving several prominent donors to the Conservative Party.[90] Nick Seddon, Downing Street advisor on health policy, is former head of communications at Circle.[91]

5. Lessons from UK experience

In this section we consider what can be learned by changes introduced prior to 2014 about the impacts of market-based reforms: patient choice, the Private Finance Initiative and independent sector treatment centres.

Patient choice

Successive governments have championed patient choice, ostensibly to tackle two main problems: unresponsiveness to patients and poor performance. For the first, choice is intended to give people more control over decisions that affect them. For the second, it is meant to stimulate competition between providers to improve their performance.

Problem one: Has more choice made health services more responsive?
There is widespread agreement that people generally want choice in matters of healthcare, but there is less agreement about what choice means to people or how it works in practice.

The *Barriers to Choice Review*, commissioned by the Coalition government, reported in 2013. It found three inter-connected bundles of reasons why patients can find choice difficult.[92] First, established systems are not geared to accommodate anything but straightforward choices, so that business as usual tends to prevail where patients express more complex or ambiguous needs. Secondly, some people find it harder than others to navigate the choices before them, especially when they don't use the internet, and many find choices bewildering.

A related point is made in studies of pilots introducing choice in 2002–03, which found that age, class, income and family obligations affected patients' ability to travel to a non-local provider, and therefore their choices.[93] In a resource-constrained system with limited capacity and no slack, choices for some patients may reduce others' capacity to choose, with negative impacts on health inequalities.

Thirdly, the *Choice Review* found that there was a mismatch between what people expected under the banner of choice and what was actually on offer. In the NHS, formal choice tends to be between different establishments, yet people may prefer to nominate clinical teams or to choose a consultant who will listen to them, or to select from a range of other options, including forms of self-management that particularly appeal to people with chronic conditions.

A number of studies suggest that choice between providers is unlikely to make the NHS more responsive to patients' actual needs and preferences.

Research in 2005 found that choice is a relatively low priority for many, compared with other aspects of health delivery in the NHS.[94] Other studies suggest that, rather than choice of provider, most patients in England are more concerned to have safe, good quality services provided locally. They tend to favour a provider they know and trust and opt for choice only when no such provider is available, and often appear more interested in choosing treatments.[95] These attitudes are often influenced by the severity of the medical condition and the complexity of the procedure involved. The more life-threatening the disease and technologically advanced the treatment, the lesser is the patient's desire for choice.[96]

Problem two: has more choice made health services more competitive?
Several analysts point out that treating patients as customers in a marketplace is inappropriate, because health is not a commodity, few patients are able to make fully informed choices, and treating people who seek professional help as customers "is incompatible with ways of thinking and acting that are crucial to healthcare".[97]

We have noted that patient choice is a poor indicator of competitiveness between providers, and that the choices on offer do not respond to the multi-dimensional needs and preferences that patients actually experience. Lacking sufficient information, as patients almost always do, their need for healthcare professionals they can trust will generally override any desire to shop around.

The only way choice may help to promote competition is where providers can choose between patients. ISTCs (see below) are known to cherry pick patients for elective surgery who have better underlying health and fewer complications, while some GP surgeries have been found to turn away patients because they lack sufficient funds to deal with them.[98] In these cases, patients themselves have no choice at all. Choosing patients may help some providers to improve their performance, but will do nothing to improve the performance of the NHS as a whole, against its mission to secure "high-quality care for all".[99]

The Private Finance Initiative

PFI has become the main way of financing NHS hospitals. By 2009, 101 of 133 new hospitals built or under construction were financed through PFI deals.[100] This arrangement has given for-profit companies far-reaching influence over health services in England, with notable impacts on NHS budgets, as well as on access to services, quality of care and public accountability. Experience of PFI sheds some light on how far market-based solutions can solve problems encountered by a public healthcare system.

When PFI took hold, the perceived problem was that the NHS needed a lot of new and refitted hospitals, while the government was unwilling to increase public debt to finance them. As we have noted, PFI allows governments to fund public infrastructure projects using private sector finance, instead of increasing public borrowing. Costs to the taxpayer for repaying debts to the private companies involved in PFI schemes are spread over 30 years or more, rather than featuring upfront on public sector balance sheets. But has this solved the problem?

The Initiative has been found wanting on many grounds. Three are especially relevant to this report: cost, impact on care and impact on control over health services.

Impact on cost

The PFI has been found to be a great deal more expensive than public borrowing. In 2011 the House of Commons Treasury Committee observed:

> *"Private finance has always been more expensive than government borrowing, but since the financial crisis the difference between the costs has widened significantly."*

The Committee found:

> *"The cost of capital for a typical PFI project is currently over 8% — double the long-term government gilt rate of approximately 4%. The difference in finance costs means that PFI projects are significantly more expensive to fund over the life of a project. This represents a significant cost to taxpayers."*[101]

In October 2014, Northumbria Healthcare Foundation Trust borrowed £114 million (m) from the local council to pay off private contractors who built and ran Hexham General Hospital through a PFI deal. The buy-back is the first of its kind and is estimated to save the trust £3.5m a year over the next 19 years.[102]

In 2012, the National Audit Office (NAO) reported that "the public sector may often be paying more than is necessary for using equity investment" and that in 84 of 118 projects "investors were reporting returns equal to or exceeding expected rates of return", generally of between 12% and 15%.[103]

Repayment costs, which are ring-fenced and indexed to inflation, outstrip budgets set aside under a national tariff for capital charges for many NHS trusts by a considerable margin. A study of 18 trusts paying charges on schemes with a capital value of more than £50m, showed that average annual capital costs were 10.1% of total income in 2005–06, compared with 5.8% in the national tariff. These trusts experienced an average funding shortfall of 4.3%.

Impact on healthcare

Paying off debts incurred through PFI has greatly increased financial pressures on NHS organisations, with subsequent impacts on services available to patients. Trusts have been merged, hospitals, wards and A&E units have been closed and, according to the National Audit Office, bed-occupancy rates have risen far above the recommend upper limit in some hospitals, to cope with financial pressures triggered or exacerbated by PFI.[104]

One consistent critic of private finance has estimated:

> *"The NHS can only operate anything from a third to a half as many services and staff as it would have done had the scheme been funded through conventional procurement. In other words, for every PFI hospital up and running, equity investors and bankers are charging as if for two."*

This leads to the observation that "it is PFI deficits that are driving service closures, not patient demand or an ageing population".[105]

The Treasury Select Committee has been unable to find any compensating savings or benefits, reporting:

> *"The out-turn costs of construction and service provision are broadly similar between PFI and traditional procured projects, although in some areas PFI seems to perform more poorly. For example we heard that design innovation was worse in PFI projects and we have seen reports which found out that building quality was of a lower standard in PFI buildings."*[106]

Impact on public control over health services

It has proved difficult or impossible to scrutinise thoroughly how PFI schemes work in practice, because contracts are subject to commercial confidentiality and data are inadequate. The National Audit Office found in 2011 that some trusts were paying more for PFI services than they needed to but could not examine sources of variation because of "the lack of reliable data"'.[107] Service cost analysis could not be done after 2008–09 because "the NHS stopped collecting the data".

However, the NAO identified substantial but unexplained variations in fees charged by contractors for outsourced, non-clinical services. For example, the price for feeding a patient varied from £3.16 to £12 a day, and the price per item of laundry varied from 20p to 96p. The NAO concluded that, in the absence of formal mechanisms for assessing value for money, prices and actual costs would bear little relationship to each other.[108]

In these circumstances, NHS organisations risk losing control of their budgets and being unable to plan ahead – risks that are likely to impinge on availability and quality of care. The companies behind PFI deals are largely unaccountable, with some channelling funds to offshore tax havens.[109] In effect, through PFI, control over significant parts of the NHS is passing from the public to the private realm.

Independent sector treatment centres

As we have noted, ISTCs were set up as part of New Labour's health service reforms. They were intended to add capacity to the NHS, bring in more medical professionals and reduce waiting times. It was also hoped that they would improve care through innovation and competition. Although they have taken only a small share of NHS business, they represent the first concerted attempt by government to introduce private enterprise into the delivery of routine clinical services. As such, they offer some insights into how a larger influx of private sector providers could affect the NHS.

Four main points emerge from what is known about ISTCs in practice: a paucity of evidence; payment without performance; cherry picking; and other negative impacts on the NHS. Together, they show little evidence that ISTCs have helped to solve problems of under-capacity or long waiting times, or to innovate to improve quality of care.

A paucity of evidence

It has been difficult to assess performance because contracts are shielded by commercial confidentiality and most ISTCs do not collect data in line with the NHS.[110] The first research on the quality of work undertaken by private centres, carried out by the National Centre for Health Outcomes Development, found that data were so variable in quality and so incomplete as to render "any attempt at commenting on trends and comparisons between schemes and with any external benchmarks, futile".[111]

Payment without performance

One study of NHS Tayside in Scotland, by the consultancy firm Price Waterhouse Coopers, appeared to show that a private company carrying out elective surgery under contract to the local health board gave better value for money than the NHS by a margin of 11%. These findings were challenged by academic researchers on a number of fronts, notably finding that the contractor, Amicus Healthcare (a subsidiary of Netcare) could be paid up to £3m for patients who did not receive any treatment.[112] The contract guaranteed block payments for an estimated volume of referrals – a practice not restricted to Tayside.

The Bureau of Investigative Journalism claims that public funds worth £200m have been spent on ISTC treatments that never took place; £186m has been spent on buying back treatment centres and equipment from the private sector; and £60m has been spent on cancelled contracts with Netcare, Care UK, Alliance, Atos Origin, and Clinicenta.[113]

Cherry picking

The Royal College of Surgeons of England and the British Orthopaedic Association told the House of Commons Select Committee on Health that there was "a significant body of evidence of ISTCs cherry picking the more straightforward cases" as well as "a relatively high level of complications", where patients were referred back to NHS services.[114] They went on to explain how this left local NHS trusts with the complex, higher-risk and more expensive cases.

> *"[A] complex hip replacement may take a half day list at a cost of £25,000, compared with a straightforward one in which three cases could be done in the same time, each being reimbursed at nearly the same rate per case."*[115]

Other negative impacts on the NHS

A number of professional bodies have raised concerns about ISTCs, including "the use of foreign trained doctors unfamiliar with NHS surgical techniques, lax standards of vetting and training, lack of continuity of care, and a large number of pending litigation cases".[116]

Furthermore, junior doctors being trained by the NHS are said to be losing opportunities to learn and practice techniques.[117] According to the Royal College of Surgeons, no evidence could be found of innovative technical advance by ISTCs established in 2003–06; instead:

"Primary care trusts have expended significant sums of public money in the advance purchase of surgical procedures which have not been taken up. There is clear evidence from a number of areas that triaging arrangements have diverted patients into ISTCs leaving existing NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances."[118]

Case 10: Scotland and Wales

Scotland has no purchaser-provider split, no tariffs for hospital services and outsources far fewer contracts to the private sector than England. By 2012, the NHS in Scotland was putting 1% of spending towards private providers, compared with 5% in England.[119] Scotland, unlike England, adopted the recommendation of the 1999 Royal Commission on Long-Term Care that personal care for the elderly should be free.

Scotland brought together NHS boards, acute hospital trusts and PCTs into 15 unified boards (now 14, plus specialist boards), from 2004. This reduced ministerial appointees by one-third and increased reliance on professionals working together for the benefit of their area. Scottish health policy is designed "to create an integrated health system with close connections between different components. The aim is to develop care pathways by building on clinical networks between specialist acute services and primary care."[120]

The 2011 report of the Christie Commission on the future of public services in Scotland did not use the term "markets" at all (except to refer to labour markets). The word "competition" only appears twice.[121]

Wales, like Scotland, has no internal market. Seven local health boards plan and provide hospital and community services and are responsible for primary care, while specialist services are commissioned by a national committee answerable to the boards. In 2011, the Bevan Commission said:

"Unlike the NHS in England, NHS Wales is avoiding the marketplace and competition in favour of an integrated system, where the assets of the health service in Wales are owned by its government and its people."[122]

The emphasis has been on building public health by integrating health and local government. In Wales, as in Scotland, more people live in remote rural areas than in England – often less appealing to profit-seeking healthcare providers.

The Welsh boards, which are bigger than the Scottish ones, have faced some criticism for being remote. There is a flow of patients in north and mid-Wales over the border to England and there are difficulties in compensatory payments. Some waiting times are longer in Wales, where there is less emphasis on targets to reduce them than in England. But there are signs that policy decisions in Wales are bearing fruit. Emergency hospital admissions of people with chronic conditions fell sharply in between 2011 and 2012, down by almost 15% for diabetes and 17% for lung diseases such as bronchitis, while readmissions dropped even more steeply, by almost 30% and 25%, respectively.[123]

6. What else could justify the changes?

Successive governments have claimed that the policies they are promoting are not ideological, but based on necessity and evidence.

When David Cameron launched the Coalition government's austerity drive in 2010 he declared:

> *"We are not doing this because we want to. We are not driven by some theory or some ideology. We are doing this as a government because we have to, driven by the urgent truth that unless we do so, people will suffer and our national interest will suffer too."*[124]

This echoed Tony Blair's famous claim that New Labour was "beyond ideology" and only "interested in whatever works".[125] It would therefore be reasonable to assume that fundamental changes to something as important as the National Health Service would be backed, at the very least, by strong evidence that introducing market norms to the service would make it more efficient and improve the quality of care for patients.

Put another way, the burden of proof, in the age of "evidence-based policy", should be on the change-makers.

From our review of current knowledge, we can only conclude that the direction of travel of NHS reforms – powerfully reinforced by the 2012 Health and Social Care Act – will not help to achieve NHS England's stated mission of "high-quality care for all, now and for future generations" or its vision of "services that are compassionate, inclusive and constantly-improving".

As there is no persuasive, evidence base to support the changes, can we search for more intuitive indications that they will lead to improvements over time? Do markets offer unique benefits to healthcare? If markets function well for food or telecoms, for example, will they function well in healthcare? Can a healthcare market be managed effectively? Do market reforms represent a good "upstream" investment to prevent greater expenditure on treating illness later on?

Are the costs acceptable?

Commercial know-how and the US healthcare model

Part of the case for insisting that all contracts are put out to competitive tender and enabling 'any qualified provider' to bid is that the NHS will benefit from the expertise and experience of commercial organisations, who know how to satisfy their customers, run a tight ship and grow their business in a challenging environment. Market protagonists claim that the incentive to turn a profit will drive up quality and efficiency, leading to more and better healthcare.

There are not yet any convincing signs that the incursion of large commercial organisations into the NHS will improve healthcare, while all the evidence points in the opposite direction. The experience of the United States is a case in point.

The US healthcare system is shown to be excessively expensive, to provide a deeply unequal service with many patients receiving poor-quality care or no care at all. According to the World Bank, it spends nearly 17.9 % of GDP on healthcare, compared with 9.4% in the UK.[126] We have noted that it scores much lower on overall performance than the UK in international rankings. An analysis of US experience in the *British Medical Journal* finds that market forces drive up prices at the expense of inclusiveness and quality, with significant transaction costs incurred through billing and marketing functions, and inflated salaries of senior personnel.

> *"While private contracting has benefited executives and shareholders, it has increased costs and worsened quality because healthcare cannot meet the fundamental requirements for a functioning market. It is fashionable to view patients as consumers, but seriously ill people (who consume most care) cannot shop around, reduce demand when suppliers raise prices, or accurately appraise quality. They necessarily rely on their doctor's advice on which tests and treatments to 'purchase'."*

The authors conclude:

> *"The poor performance of US healthcare is directly attributable to reliance on market mechanisms and for-profit firms and should warn other nations from the path."*[127]

Markets, ethics and healthcare

The NHS was set up as part of the new welfare state because healthcare was seen to be a case of market failure. This has not changed since 1948. Risks of ill health are unevenly distributed and bear no relation to people's capacity to purchase care. Profit-seeking organisations tend to avoid complex cases. Healthcare is not reducible to market transactions, but instead relies on high-trust relationships between patients, carers and healthcare professionals. Reasons for locating health services in the public realm have been summarised as follows:

> *"Having services available to all and paid for by all is good for social justice and instils greater equality; services that are best provided publicly are those which are complex, consume scarce or finite resources, and which involve setting priorities and negotiating trade-offs that must be handled through the political process rather than through markets concerned primarily with profit and increasing shareholder value."*[128]

These factors may not apply to food or telecoms, but they do apply to healthcare.

Former Labour Chancellor and Prime Minister, Gordon Brown, set out a remarkably cogent argument against markets in healthcare in 2005 (remarkable not least because he failed to follow his own advice). He lists

the “many market failures in health care” that “challenge the adequacy of markets to provide efficient market solutions”. These include “the asymmetry of information between consumer and producer, clusters of local specialisms, and the difficulty of contracting”. He asked what would happen if such failures were combined “with a policy that put profit maximisation by hospitals at the centre of health care” and answered that the patient “would be at greatest risk of being overcharged, given inappropriate treatments for financial rather than medical reasons, offered care not on the basis of clinical need but on the basis of ability to pay – with some paying for care they do not need and others being unable to afford care they do need, as a two tier healthcare system developed”.

Brown concluded that, where there is “an explicit undertaking that medical treatment must be given at the highest level to every patient based on health need and not ability to pay … public provision is likely to achieve more at less cost to efficiency and without putting at risk the gains from the ethic of public service where, at its best, dedicated public servants put duty, obligation and service before profit or personal reward”.[129]

Some argue that there are no ethical or practical grounds for taxpayers’ money intended for the NHS going into shareholders’ pockets, rather than into more and better healthcare. The dynamics of today’s capitalist markets are thought to harness such private vices as “rivalry and predation, envy and ostentatious luxury”, which begs the question: “Should such human motives be nurtured and encouraged in a public service?”[130]

Furthermore, market disciplines can seriously undermine the professional ethic in health, resulting in poorer quality care and health outcomes for patients.[131] Nor can competitive markets respond adequately to most chronic conditions, where there are few – if any – measures of outcome, complex patient pathways, highly contingent approaches to treatment and a high reliance on interactions with other agencies, such as social care.[132]

Managing markets

Defenders of NHS reforms would argue that these ethical and practical difficulties can be overcome by keeping the NHS as a free service, available to all and funded through taxation, with healthcare rendered efficient through competition and choice, partnered with publicly controlled mechanisms to assure fairness and universality. Two examples of such mechanisms are regulation and nationally fixed tariffs.

Regulation

If competition cannot improve and safeguard quality of healthcare, while market reforms are opening the NHS to multiple providers, a huge responsibility falls to the regulators, Monitor and the Care Quality Commission. A system for checking performance against nationally agreed standards would be necessary with or without recent reforms.

But an open, competitive market makes the job of regulating healthcare a great deal more complicated, navigating between conflicting interests, increasingly fragmented services and a large, rapidly expanding field of

organisations. Structuring a regulatory environment to defeat the inherent tendency of markets to generate inequities has been likened to "riding north on a southbound horse".[133] The two main healthcare regulators in the UK cost the taxpayers in excess of £280m a year.[134]

Monitor

Monitor is the main sector regulator of health services. Concerns have been raised about its capacity to regulate effectively. It has been "set a formidable task with little precedent and supporting analysis, so the risks of failure are considerable".[135]

The Public Accounts Committee (PAC) declared in 2013 that Monitor would have to "get much better at identifying and taking radical action in trusts at risk of failure" and pointed out that the regulator lacked NHS experience.

> *"Only 7 of Monitor's 337 staff have a clinical background and only 21 have experience of running or working with a hospital trust."*

This cast doubt on its "ability to diagnose problems and develop solutions", said the PAC, and resulted in Monitor spending £9m a year on consultants.[136]

Monitor claims that its primary duty is "to protect and promote the interests of NHS patients" and that it puts "patient interests first in everything". As we have noted, Monitor is supposed to assess if and when patients' interests can override the obligation of healthcare organisations to foster competition. One of its main objectives is to prevent inappropriate anti-competitive behaviour, yet there is no agreed definition of what patients' interests may be, or when anti-competitive behaviour is "inappropriate".

It is also tasked with promoting better integration of health and social care services, and encouraging innovation.[137] While Monitor claims that the goals of competition and integration do not pull in opposite directions, the case is not convincing. Integration in healthcare calls for information-sharing, long-term planning and collaborative working. It also calls for high-trust relationships between people working in different organisations; high levels of tolerance for uncertainty and complexity; and a willingness to share rewards or even let others reap the benefits of one's own endeavours. Commercial bodies trying to gain a competitive advantage in a market place seldom exhibit these traits.

Nor does Monitor have the last word on integration. In 2013 the Competition Commission blocked a merger between the Royal Bournemouth and Christchurch Hospital and the Poole Hospital on the grounds that it was uncompetitive. Managers had claimed that it would save money and integrate services better for patients, but this was trumped by competition.[138]

Further insight into the regulation of "anti-competitive behaviour" can be gained from a complaint to Monitor in 2013 from Spire, a private healthcare provider operating 38 private hospitals and a number of clinics across the country. Spire alleged that two CCGs (Blackpool and Fylde and Wyre) were breaching their obligations under article 75 of the Health and Social Care Act, in particular by failing to direct patients requiring elective surgery towards Spire hospitals. The CCGs recorded their disappointment that Spire had gone directly to Monitor, rather than taking the matter up with them. Monitor's

investigation did not uphold the complaint but found that the CCGs "had not ensured that patients were being offered choice and that patient choice was being publicised and promoted".[139]

Case 11: Personal testimonies / Dr Naomi Beer, GP in Tower Hamlets

"Tower Hamlets has a collective ideology of working together, so we may have experienced fewer of the ill effects of marketisation than other GPs. We offer an alternative model of integration and collaboration across services and GP practices. We are a kind of antidote to marketisation. But when one of our local practices had to go out to tender, we did feel the effects.

The contract was awarded to a big private provider. They took over the practice and, within a very short period of time, they had left. They couldn't run it either to the contractual standards required or within the budget, and this kind of hit-and-run approach is a problem with the whole theory. Marketisation assumes that the costs of healthcare are only related to specific measurable interventions such as tests, prescriptions and referrals. It doesn't take account of the relationships which are the bedrock for good care. Continuous care is an almost irrelevant concept in marketisation.

When you have one practice outside the collaborative model, when outside organisations are not necessarily used to working in that way, and when they may not have experience of or understand the problems of an area, they will struggle. Patients may want to leave and register with surrounding practices. For us, that meant pressure to register more patients and confusion if they wanted to register from outside the boundaries. If one practice isn't working well, it can drive down the quality for the whole network.

To make healthcare work, you need good working relations between doctors and other caregivers. Otherwise care is fragmented and you end up with very frustrated patients and very demoralised doctors, because you can't deliver what people need in a joined-up way. Then instead of alleviating need, it drives need – because patients don't trust the service and demand more tests and more referrals. On the other hand, if you go for the more long-term model, it allows you to keep costs down because it recognises that trusting relationships with patients allow doctors to manage risk more effectively."

Care Quality Commission (CQC)

The self-declared purpose and role of the Care Quality Commission is to "make sure health and social care services provide people with safe, effective, compassionate, high-quality care" and to encourage improvement. It does this by monitoring, inspecting and regulating services against standards of quality and safety, and by publishing performance ratings "to help people choose care".[140]

A big challenge for the CQC is to be able to "monitor and inspect" an expanding multitude of health and social care organisations across the country. It has manifestly failed on several occasions to keep services from harming patients.[141] In 2012 the Public Accounts Committee found that the CQC had "a long way to go to become an effective regulator".[142] And in 2013 doctors belonging to the British Medical Association declared that it was "not

fit for purpose", citing the scandal of poor standards and abuse at the Winterbourne View care home, which had previously been inspected three times by the CQC and judged compliant in terms of quality.[143]

Case 12: Primary healthcare in Camden, North London

Some of the patients at the GP surgery at 142 Camden Road in North London had been going there for more than 20 years. But more recently they saw it change from a stable practice with well known local GPs to a privatised business that was taken over twice and staffed entirely by locums, serving 4,700 local patients.[144]

Then, in February 2012, they discovered that The Practice plc,[145] the UK's largest operator of privatised NHS GP practices, was ending its service in the area. It was hard to find another practice at short notice, and the new one was 20 minutes away rather than a 10-minute walk.

The Practice plc closed the Camden Road surgery after it bought the business from the American-based company UnitedHealth, which had originally won the contract from the local primary care trust. Camden Borough Council was appalled, but was forced to use freedom of information requests and appeals just to get a copy of the contract.

Before the closure, clinical data for the Camden practice showed a drop in diagnoses for depression and atrial fibrillation to prevent strokes, both of which take more time to diagnose than other conditions. "The prevalence of chronic disease appeared to drop spectacularly in the community, which means they were either brilliant doctors preventing it or they stopped diagnosing it," said Dr Paddy Glackin, former secretary of the local medical committee.

Local commissioners said that the contract had been monitored and that service quality had not gone down. Camden Council held an inquiry into the closure and neither The Practice nor UnitedHealth would take part. It concluded in 2012 that the surgery urgently needed replacement and that the "loophole" which had allowed UnitedHealth to sell their interest in the surgery without oversight by the NHS, needed to be closed.

The Practice has also closed practices they had bought in Woking, Leicester and Nottingham, mainly in poorer areas, explaining that loss-making activities were unsustainable. Their involvement followed the losses made in the same sector by United Health, which entered the UK health market under Tony Blair in 2003. By 2010, it was making a loss of £13.9m on it. In April 2011, it pulled out of primary care in the UK and transferred shares in its six practices, including the three in north London, to The Practice plc. Instead, UnitedHealth has been providing commissioning support services to clinical commissioning groups.

Fixed tariffs

We have noted that payment by results (PBR) is intended to prevent providers from competing on grounds of price. However, it is not always clear what a "result" is or when it occurs and the system is vulnerable to manipulation or "gaming".

For example, the tariff for referrals inside hospitals is lower than it is for referrals from outside. This can mean that patients are sent back to GPs to refer all over again, rather than being tested or treated then and there. There have been reports of senior managers in some hospitals forbidding medical staff from talking to local GPs, in case it discourages a referral. Perhaps most seriously, there have been allegations that the process of coding (the classification of clinical episodes for pricing purposes) has been manipulated to make death figures look better, for example by coding people with serious diabetes as receiving palliative care rather than treatment.[146]

Observers of the US experience have pointed out that coding matrices that are intended to link payment to results "instead reward entrepreneurs skilled in clever circumvention. Their financial and political clout grows. Those who guilelessly pursue the arduous work of good patient care lose in the medical marketplace".[147] A UK-based commentator says of PBR:

> *"Provider trusts have an incentive not only to attract as many patients as possible but also to diagnose and treat them in such a way as to maximise their income. In short, there are... incentives to over-treat: a phenomenon familiar in the USA and other health-care systems based on payment by results (more accurately defined as payment by activity, since money flows irrespective of outcomes)."*[148]

An "upstream investment"?

The idea of preventing illness features a little more strongly today in official NHS literature than in the 1990s. The vision of NHS England is that:

> *"Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by high-quality health and care services that are compassionate, inclusive and constantly improving."*

The Health and Social Care Act has returned public health to the control of local government, setting up Health and Wellbeing Boards, to help improve the health of local residents. In his five-year Forward View for the NHS, Simon Stevens calls for "a radical upgrade in prevention and public health", with the NHS backing "hard-hitting national action on obesity, smoking, alcohol and other major health risks". However, other factors militate against the current reforms helping to reduce ill health or health inequalities.

One is the way in which reforms absorb attention, energy and funds. Healthcare organisations are preoccupied with the latest imperative to reorganise – coping with new rules for competition and choice, and with the need to find unprecedented savings – rather than with how to stop people getting ill in the first place. There has long been a problem of healthcare professionals deriving their salaries, identity, status and job satisfaction from making people better, rather than from helping them to avoid any need for healthcare.[149] The incursion of commercial providers into the NHS may exacerbate this tendency. A healthy patient is not a source of income.

Paradoxically, the focus on integrated care may also jeopardise efforts to prevent ill health. There is a danger that the drive to achieve joined-up health and social care through the Better Care Fund and other means will syphon energy and resources away from the core role of Health and Wellbeing Boards, which is to improve health and wellbeing. Meanwhile, no convincing evidence has been found that integrated care will save hospital costs.[150]

There remains a huge imbalance of funds between health and illness. The budget for preventative healthcare and other measures to promote better health is a tiny fraction of the budget for "downstream" services to treat illness. The lion's share of the NHS budget (£91bn) is allocated to CCGs and National Health England to commission local and specialist healthcare services. By comparison only £1.8bn is allocated to Public Health England to cover clinical aspects of preventative healthcare such as immunisation, screening and health visiting. In total, local authorities receive £2.79bn in grants for public health, ring-fenced for the purpose. There is some evidence that councils are diverting funds to other service areas, to help plug gaps left by spending cuts.[151] Since action in a wide range of local authority services, such as childcare and housing, can help to tackle the "upstream" causes of ill health, this may lead to positive outcomes in the longer term. But the funding gap, between "upstream" prevention and "downstream" treatment remains huge.

Failure to prevent ill health will inevitably increase demand for healthcare in future, further adding to financial pressures on the NHS. A report for the Treasury in 2002 set out three scenarios for the NHS – "slow uptake", "solid progress" and "fully engaged" – representing different degrees of success in achieving an affordable high-quality health system over 20 years.[152]

The latter, "fully engaged", represented a "massive shift away from seeing the NHS primarily as a 'sickness service'", to one where health services aim to "keep healthy people fit, and people with morbidities and chronic conditions as active as possible". Projected spending on health services was significantly lower under this scenario, rising to 10.6 % of GDP by 2022–2023, compared with 11.1 % for the "solid progress" scenario and 12.5 % for "slow uptake".[153]

Twelve years later, there are no convincing signs that the NHS is drawing closer to the "fully engaged scenario". To give just one indication, between 1993 and 2012 the proportion of adults who are obese increased from 13.2% to 24.4% among men and from 16.4% to 25.1% among women.[154] Obesity can lead to a number of serious and potentially life-threatening conditions, such as type 2 diabetes, coronary heart disease, breast and bowel cancer, stroke and depression.[155] Simon Stevens has called for substantial additional funding for the NHS. It remains to be seen whether this will be forthcoming, and if so, how much will actually be spent on upstream preventative measures, rather than being absorbed by yet another round of reorganisation.

7. Costs of market reforms

Failing to prevent illness is just one way of driving up the costs of healthcare. The move towards competitive markets in healthcare has swallowed up large quantities of public money that could arguably have been spent in better ways. The Health and Social Care Act has unleashed new costs and inefficiencies, and has made it much more difficult for government to control expenditure.

One estimate, based on data from the National Audit Office, put the costs of implementing the Act at between £2bn and £3bn.[156] A 2014 investigation by *The Times* found the NHS struggling to cope with, and pay for, an "extraordinarily complicated structure" with "25 national organisations managing and regulating the NHS and dozens more at a local level". The report revealed £5bn wasted each year through NHS inefficiencies, including "big discrepancies" between prices paid for different products; £1.6bn spent on redundancy payments; more than 4,000 staff re-employed by the NHS after taking redundancy; and a year's bill for management consultants of £584.7m.[157]

A 2005 paper by academics at York University, commissioned by the Department of Health but never published, suggests:

> *"Historically, Beveridge-type systems like the 'old' NHS (pre-1991 reform) have been relatively inexpensive to manage and administer… [whereas] the purchaser-provider split, private finance, national tariffs and other policies aiming to stimulate efficiency in the system and create a mix of public and private finance and provision mean almost unavoidably that more information is needed to make contracts, hence transactions costs of providing care have increased, and may continue to increase."*

The Department of Health has not provided clear or consistent data on such costs, which makes precise calculations difficult. However, the House of Commons Health Committee has noted that, given the department's lack of transparency "the suspicion must remain that the DH does not want the full story to be revealed".[158]

The authors of the York paper estimated that in 2005, annually recurring administrative and management costs accounted for 14% of total NHS costs. Comparative costs during the 1980s have been estimated at 5% of the total.[159] A more recent estimate has put the costs of market mechanisms in the NHS at around £4.5bn a year, or "enough to pay for ten specialist

hospitals".[160] Our own calculations suggest this sum could alternatively cover the annual cost of 174,798 extra nurses,[161] 42,413 extra GPs,[162] or 39,473,684 extra patient visits to A&E departments.[163]

Case 13: UnitedHealth

US-based healthcare provider UnitedHealth operates internationally, providing clinical services, management consultancy, IT and health insurance. In December 2013 it had approximately 156,000 employees worldwide.[164] Its total revenues grew from $87bn in 2009 to $122bn in 2013.[165]

Now rebranded as Optum[166] in the UK, UnitedHealth started its relationship with the NHS in 2002.[167] It has worked at different levels of the Health Service and supported more than 60 primary care trusts.[168] In 2012 the company signalled that its main interest in the NHS was with commissioning. It pulled out of primary care provision to focus on winning bids to support the new clinical commissioning groups,[169] which spend two-thirds of the NHS budget.[170]

It is hard to trace the full extent of business conducted by UnitedHealth and its subsidiaries in the UK, as there is no central database of NHS contracts.[171] Optum's website gives some idea of the services it offers. For healthcare commissioners, Optum offers a range of consultancy and management services.[172] It also offers Scriptswitch, an IT service to manage prescriptions that is widely used across the UK.[173] The software is a growing source of revenue for UnitedHealth: in accounts filed in 2012, it recorded revenue of more than £25.3m, up from £16.6m in 2010.[174]

When Cambridgeshire Community Services NHS Trust announced in 2013 that it would partner with Optum to bid for a contract worth as much as £1bn with the local clinical commissioning group, the trade union GMB contended that the company had a poor commercial record in the UK. In particular, the union pointed out that it had made losses in the last 11 years' trading, which could put the stability of the service at risk.[175] UnitedHealth had earlier withdrawn from services in the UK. In 2008 it won a five year contract to provide GP services at three surgeries in Camden, North London. However, it later sold the responsibility to another healthcare provider, The Practice Plc.[176] The primary care trust had thought it contractually impossible for the firm to sell its responsibility. However, the contract not only allowed the sale but also allowed UnitedHealth to choose a new provider to take over the service without any oversight from the NHS. A year later the new provider closed the surgery, forcing 4,700 people to register elsewhere.

In the US, UnitedHealth has faced criticism from the American Association for Justice, a coalition of lawyers promoting a safe and accountable civil justice system. In 2011 it named UnitedHealth as one of the ten worst insurance companies in the US, alleging that at the time the company's reimbursements for medical procedures were low and often delayed, risking patients' health.[177]

Case 13 continued

Annual reports by UnitedHealth outline regulatory matters and lawsuits in which the company has been involved. In 2007 the Securities and Exchange Commission (SEC), the US financial regulator, alleged that William McGuire, then CEO of UnitedHealth, had over a period of 12 years issued stock-options in the company to himself and other executives without recording them properly.

McGuire settled with the SEC without admitting or denying the accusations. According to the SEC, this entailed "a record $468 settled enforcement action".[178] McGuire subsequently resigned from the company, with a package worth $286m, according to a study by GMI, a US firm that monitors executive pay.[179]

In 2009, UnitedHealth reached a deal with New York attorney general Andrew Cuomo in which it agreed to spend $50m to reform its billing practices. In doing so it avoided a lengthy court case after it was accused of inaccuracy in determining insurance reimbursements.[180]

In its 2013 company accounts, UnitedHealth declared that it had been sued for $24m in compensatory damages and $500m for punitive damages for a clinic, linked to the company, which regulators associated with an outbreak of Hepatitis C. The payment was later reduced to $366m and UnitedHealth has filed an appeal, stating that it is "vigorously defending these lawsuits".[181]

UnitedHealth has consistently been ranked as one of the largest companies in the world. It now sits at number 39 on the Fortune global 500 list largest companies, above firms such as BNP Paribas and tech giant Verizon.[182] Poor returns in the UK appear to have made little impact. Shareholders' dividends tripled between 2010 and 2014.[183]

8. Who will bear the brunt of the changes?

If, as the evidence suggests, market reforms damage the capacity of the NHS to provide high-quality care, the people most likely to suffer are those who use the NHS most frequently. According to the latest available figures from the *ONS General Lifestyle Survey*, which identifies trends in the use of NHS services, women and people over 65 consistently visit their GP more often than men and people in other age groups. And people over 65 visit hospitals more often than others, with the over 75s having far higher rates of hospital visits than other age groups.[184]

Case 14: North Cumbria University Hospital

North Cumbria University Hospital,[185] formerly known as the Cumberland Infirmary, was the first hospital to be built using the Private Finance Initiative (PFI). Based in Carlisle, it cost £67m to build and was opened by Tony Blair in 2000.

The investment came from Interserve, a multinational support services and construction company based in London with a turnover of around £2bn a year.[186] To manage the facilities, Interserve set up a joint venture with engineering giant AMEC,[187] called Health Management Carlisle (HMC)[188] based in Berkshire. Early in 2014 the hospital board announced that it had "lost confidence" in HMC, when told the company would be increasing its annual charges by £1m (from £8m) a year.[189] This followed a report on the facilities management contract that uncovered "major issues" with the maintenance of operating theatres, water systems and gas pipelines at the hospital.

North Cumbria University Hospitals Trust was predicting a deficit of £23m for 2013–14, and said that the planned price rise was "entirely inappropriate" given its concerns. It warned HMC that they were "open to corporate manslaughter and fraud risks in relation to [bacteria such as] legionella, pseudomonas, etc". The contract for facilities management was agreed as part of the original PFI deal and both last for 30 years. Even without confidence in the provider, the hospital is contractually obliged to keep paying.

The trust is also paying £18 million a year for the original investment by Interserve, up from £11 million at the start of the contract. The total paid back on the PFI contract is estimated to be £587 million by the final instalment in 2030.

Interserve was in the news in 2012 when it sold its contract – and its right to get continuing interest payments in a range of PFI projects including ones in Carlisle – to the Dalmore Capital Fund, an investment fund based in London.[190] The deal was for 19 PFI projects and earned them £90m. They continue to manage the contracts on behalf of Dalmore, which pays them a fee of £1m a year for the privilege.

Conclusion

The central question of this review is whether the direction of government reforms will help the NHS to maintain its world-class performance or undermine its capacity to do so. We have traced the reforms since the 1980s and reviewed the available evidence. Our findings point to the following conclusions.

- Over 30 years the NHS has been changed from a public service into an open, competitive marketplace.
- The 2012 Health and Social Care Act is the latest and most severe stage in this process.
- The weight of evidence shows that markets fail in healthcare – they cannot be relied on to provide high-quality care for all who need it, regardless of ability to pay.
- The costs of introducing and managing markets in healthcare are unacceptably high.
- Healthcare in the United States, which is the leading exemplar of a marketised system, is much more expensive, less inclusive and less effective overall than the NHS.
- Protagonists of US-style healthcare and major US healthcare businesses are increasingly active in UK health policy and in the NHS. If the NHS is included in the new trade deal (TTIP) between the US and the European Union, they will have new rights to sue any government that brings privatised services back into public hands.
- Successive reorganisations of the NHS have been costly, wasteful and distracting.
- Regulation alone cannot solve the problems caused by market failures in healthcare.
- Integration of health and social care cannot be achieved more effectively in a competitive market place.
- Competition between service providers will not help to shift the balance of investment and action “upstream” to prevent ill health.

- Women and older people are likely to suffer most from deteriorating quality of care.
- Health policy today is driven by ideology, not evidence.
- Most people know little or nothing about this, and there has been limited public debate.

In spite of all the evidence, the momentum towards an increasingly marketised healthcare system appears unchecked. Indeed it seems that market protagonists, faced with the problem that market rules and mechanisms are failing to improve the performance of the NHS, want to introduce yet more market features to help solve the problem.

For example, the idea that healthcare should be funded through US-style private insurance schemes has champions in government circles,[191] and there are influential advocates for charging patients for GP visits or for failing to show up for a clinical appointment.[192] Rather than developing the best features of a collectively owned and democratically controlled system, they would prefer to import yet another scheme from the United States, such as Accountable Care Organisations,[193] which are designed to improve the disastrously expensive, inefficient and inequitable US healthcare market, but have still to show better than mixed results. When a patient's life is threatened by food poisoning, few doctors would prescribe another meal from the same source.

Some critics predict that within a very short span of years the NHS will be nothing more than a franchise, inadequately overseeing a fragmented and largely privatised service.[194] Scotland and Wales could provide useful points of comparison, as neither has chosen to retain the purchaser-provider split, or to put services out to tender with profit-making companies. Researchers have noted a lack of comparable data and have found little evidence so far that markets – or lack of them – affect performance one way or the other. However, while England has until recently performed better than the devolved countries across a range of indicators, this gap narrowed between 2011 and 2014.[195] It remains to be seen whether financial or political pressures force either country to adopt the "English solution" in future or whether a change of government at Westminster will alter the current trajectory of the NHS in England.

In the meantime, we recommend that present and future policy-makers pay much closer attention to the evidence – both from academic studies and from practical experience. They would learn that markets in healthcare almost invariably fail taxpayers, citizens and patients. If they absorbed that lesson, they would face two options: they could own up to a purely ideological drive to destroy a well loved and uniquely successful collective healthcare institution; or they could build on the lessons learned so far to enable the NHS to evolve and flourish in public hands, for the benefit of us all.

End notes

1. NHS England. (2013, 8 January). *NHS allocations for 2013–14.* Retrieved from www.england.nhs.uk/allocations-2013-14/
2. NHS. (2013, 28 January). *The NHS in England.* Retrieved from www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx
3. Ipsos MORI. (2012). *Public perceptions of the NHS Tracker Survey: Spring 2012 Wave Report.* Retrieved from www.ipsos-mori.com/Assets/Docs/Publications/sri_Public_Perceptions_of_the_NHS_Tracker_Spring_2012.pdf
4. Parliamentary Health Committee. (n.d.). *Public Expenditure – Health Committee, para 53.* Retrieved from www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51208.htm
5. Campbell, D. (2014, 15 September). NHS faces mounting financial crisis as deficit heads towards £1bn. *The Guardian.* Retrieved from www.theguardian.com/society/2014/sep/15/nhs-financial-crisis-deficit-1bn-hospitals
6. Ipsos MORI. (2012). op cit. p. 7.
7. Davis, K., Stremikis, K., Squires, D. & Schöen, C. (2014, 16 June). *Mirror, mirror on the wall, 2014 update: How the US healthcare system compares internationally.* Retrieved from www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
8. Ipsos MORI. (2012). op cit. p. 6.
9. The King's Fund. (2012) *British social attitudes survey 2012: Public satisfaction with the NHS and its services.* Retrieved from www.kingsfund.org.uk/projects/bsa-survey-2012
10. Timmins, N. (ed) (2013). *The wisdom of the crowd: 65 views of the NHS at 65. Nuffield Trust. p.8.* Retrieved from www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130704_wisdom_of_the_crowd_1.pdf
11. Ham, C. (2010). The coalition government's plans for the NHS in England. *BMJ, 341:c3790*, doi: 10.1136/bmj.c3790; Walshe, K. (2010). Reorganisation of the NHS in England. *BMJ,* 341:c3843, doi: 10.1136/bmj.c3843. Both cited in Hunter, D.J. (2011). Change of government: One more big bang healthcare reform in England's National Health Service. *International Journal of Health Services, Vol 41, 1*. p. 164.
12. Molloy, C. (2013, 08 May). *After Section 75: Where next for NHS campaigners?* Retrieved from www.opendemocracy.net/ournhs/caroline-molloy/after-section-75-where-next-for-nhs-campaigners
13. Hunter, D.J. (2011). *op cit.; Sylvester, R. & Thomson, A. (2014 13 October) The Times, pp. 6–7.*
14. Smyth. C, Sylvester. R, & Thomas, A. (2014 13 October) *The Times*, p. 1.
15. Smyth, C. (2011, 25 February). NHS reforms raise prospect of Tesco-style hospital chains. *The Times.* London. p. 5.
16. Royal College of Physicians. (2013, 24 February). *Section 74 of Health and Social Care Act:– The privatisation agenda (i.e. what the College Survey warned about.* Retrieved from www.rcplondon.ac.uk/forum/health-reforms-%E2%80%93-implementation/section-75-health-social-care-act-privatisation-agenda-ie-what
17. Appleby, J. (2012, 12 June). *Public satisfaction with NHS plummets in 2011. The King's Fund.* Retrieved from www.kingsfund.org.uk/blog/2012/06/public-satisfaction-nhs-plummets-2011
18. Ibid.
19. Klein, R. (2006). *NHS values: Between devolution and Europe. Nuffield Trust. p. 2.* Retrieved from www.nuffieldtrust.org.uk/talks/nhs-values-between-devolution-and-europe
20. Serco. (2014, 22 October). Homepage. Retrieved from www.serco.com/
21. Stott, M. (2014, 10 July). Suffolk: Serco defends fresh criticism of delays over equipment provision for vulnerable patients. East Anglian Daily Times. Retrieved from www.eadt.co.uk/news/suffolk_serco_defends_fresh_criticism_of_delays_over_equipment_provision_for_vulnerable_patients_1_3679828
22. Lawrence, F. (2013, 23 January). Private health contractor's staff told to cut 999 calls to meet targets. The Guardian. Retrieved from www.theguardian.com/society/2013/jan/23/private-health-contractor-999-calls
23. Pirie, M. & Butler, E. (1988). *The health of nations: Solutions to the problem of finance in the healthcare sector.* The Adam Smith Institute. Retrieved from: www.adamsmith.org/sites/default/files/images/stories/The%20Health%20Of%20Nations.pdf
24. Paton, C. (2013). Garbage-can policy meets neo-liberal ideology: 25 years of redundant reform in the English NHS. *Social Policy and Administration*, Volume 48, Issue 3, pp. 319–342; Scott-Samuel, A., Bambra, C., Collins, C., Hunter, D.J., McCartney, G., & Smith, K. (2014)The Impact of Thatcherism on Health and Wellbeing in Britain. *International Journal of Health Services,* Vol 44, 1, pp. 53–71.
25. Exworthy, M., Powell, M. & Mohan, J. (1999). Markets, bureaucracy and public management: The NHS: quasi-market, quasi-hierarchy and quasi-network? *Public Money & Management, Volume 19, Issue 4, pp. 15–22.* Retrieved from www.tandfonline.com/doi/pdf/10.1111/1467-9302.00184

26. Propper, C., Burgess, S. & Gossage, D. (2003, May) *Competition and quality: Evidence from the NHS internal market 1991–1999. CMPO Working Paper Series No. 07/077.* Retrieved from www.bristol.ac.uk/cmpo/publications/papers/2003/wp77.pdf

27. The King's Fund. (n.d.). *Clinical commissioning: What can we learn from previous commissioning models?* www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning [accessed on 08 October 2014].

28. NHS. (2013, 26 March). *The NHS constitution: The NHS belongs to us all. p.3.* Retrieved from www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

29. Appleby, J., Harrison, T., Hawkins, L. & Dixon, A. (2012). *Payment by results: How can payment systems help to deliver better care? The King's Fund.* Retrieved from www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf

30. Foundation Trust Network. (n.d.). *About foundation trusts.* www.foundationtrustnetwork.org/about-foundation-trusts/ [accessed 08 October 2014].

31. Pollock, A., Price, D. & Liebe, M. (2011, 9 February). Private finance initiatives during NHS austerity. *British Medical Journal.* Retrieved from www.bmj.com/content/342/bmj.d324

32. Partnership in Care. (n.d.). *Homepage*. Retrieved from www.partnershipsincare.co.uk/ [accessed 26 October 2014].

33. Cinven. (2014, 21 October). *Homepage*. Retrieved from www.cinven.com/

34. Whittel, R. & Dugan, E. (2013, 21 October). Tax special investigation: Firms running NHS care services avoiding millions in tax. *The Independent*. Retrieved from www.independent.co.uk/news/uk/home-news/tax-special-investigation-firms-running-nhs-care-services-avoiding-millions-in-tax-8892925.html

35. Partnerships In Care. (n.d.). *The Dene*. Retrieved from www.partnershipsincare.co.uk/hospitals/dene [accessed 26 October 2014].

36. Partnerships In Care. (n.d.). *Annesley House*. Retrieved from www.partnershipsincare.co.uk/hospitals/annesley-house [accessed 26 October 2014].

37. Whittel, R & Duggan, E. *op cit.*

38. Ibid.

39. Ibid.

40. Acadia Healthcare. (n.d.) *Homepage*. Retrieved from www.acadiahealthcare.com/ [accessed 26 October 2014].

41. Or, A. (2014, 4 May). Cinven sells healthcare company in disappointing exit. *Financial News*. Retrieved from www.efinancialnews.com/story/2014-06-04/cinven-sells-partnerships-in-care-to-acadia-healthcare-company?ea9c8a2de0ee111045601ab04d673622

42. Rogers, S. & Ball, J. (2012, 05 July). PFI contracts: The full list. *The Guardian.* Retrieved from www.theguardian.com/news/datablog/2012/jul/05/pfi-contracts-list

43. NHS. (2000, July). *The NHS plan: A plan for investment, a plan for reform: A summary. p. 7.* Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118523.pdf p. 7

44. Pollock, A. (2014, 15 August). NHS privatisation keeps on failing patients – despite a decade of warnings. *The Guardian.* www.theguardian.com/commentisfree/2014/aug/15/nhs-privatisation-failing-patients-warnings

45. London School of Economics. (2011). *Doubling expenditure on the NHS between 1997 and 2010 had a variable impact on health service performance.* Retrieved from www.lse.ac.uk/newsandmedia/news/archives/2011/03/nhsreport.aspx

46. NHS. (2000, July). *The NHS plan: A plan for investment, a plan for reform.* Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

47. Player, S. & Leys, C. (2011). *The Plot Against the NHS.* London: The Merlin Press.

48. Curtis, P. (2011, 12 September). Reality check: How much did the banking crisis cost taxpayers? *Guardian,* Retrieved from www.theguardian.com/politics/reality-check-with-polly-curtis/2011/sep/12/reality-check-banking-bailout

49. Taylor-Gooby, P. & Stoker, G. (2011, January to March). The Coalition Programme: A New Vision for Britain or Politics as Usual? *The Political Quarterly,* vol. 82, No.1.

50. Noam Chomsky. (2011, 7 April). *The state-corporate complex: A threat to freedom and survival.* Lecture given at The University of Toronto. Retrieved from: www.chomsky.info/talks/20110407.htm

51. Boffey, D. (2013, 5 January). Calls to close privately run NHS clinic after death. *The Guardian*. Retrieved from www.theguardian.com/society/2013/jan/05/nhs-clinic-closure-patient-death

52. Companies in the UK. (2014, 1 October). Clinicenta (Hertfordshire). Retrieved from www.companiesintheuk.co.uk/ltd/clinicenta-(Hertfordshire).

53. Carillion Plc. (n.d.) *Homepage*. Retrieved from www.carillionplc.com/ [accessed 26 October 2014].

54. Martin, D. (2013, 2 September). Failed firm's £53m from Labour NHS deal: Taxpayers foot huge bill after ministers terminated contract when GPs stopped referring patients to failing hospital unit. *The Daily Mail.* Retrieved from www.dailymail.co.uk/news/article-2382926/Failed-firms-53m-Labour-NHS-deal-Taxpayers-foot-huge-ministers-terminated-contract-GPs-stopped-referring-patients-failing-hospital-unit.html

55. Ibid.

56. Anekwe, L. (2010, 26 May). Leaked report into patient death exposes failing of private provider. *Pulse*. Retrieved from www.pulsetoday.co.uk/leaked-report-into-patient-death-exposes-failings-of-private-provider/11033082.article#.VEEKitFOXcs

57. Quinn, I. (2011, 28 January). NHS London drops Clinicenta a year after inquiry. *Pulse*. Retrieved from www.pulsetoday.co.uk/nhs-london-drops-clinicenta-a-year-after-inquiry/11051590.article#.VEELBdFOXcs

58. Price, D. & Pollock, A. (2013, 14 May). *Duty to care: In defence of universal healthcare*. Retrieved from http://classonline.org.uk/pubs/item/duty-to-care ; Pollock, A., Price, D. & Roderick, P. (2012, 08 March). Health and Social Care Bill 2011: A legal basis for charging and providing fewer health services to people in England. *British Medical Journal.* Retrieved from www.bmj.com/content/344/bmj.e1729

59. Hudson, B. (2013, June). *Competition and collaboration in the "new NHS". Centre for Health and the Public Interest.* Retrieved from http://chpi.org.uk/wp-content/uploads/2013/06/Bob-Hudson-Competition-and-collaboration-in-the-new-NHS.pdf

60. European Commission. (2014, 15 March). *What is the Transatlantic Trade and Investment Partnership (TTIP)?* http://ec.europa.eu/trade/policy/in-focus/ttip/about-ttip/

61. World Development Movement. (2014, April). *The Transatlantic Trade and Investment Partnership (TTIP): How the EU-US deal threatens people and planet.* Retrieved from www.wdm.org.uk/sites/default/files/TTIP%20briefing.pdf

62. Patients4NHS. (n.d.). *EU/US free trade agreement (or TTIP).* www.patients4nhs.org.uk/eu-us-free-trade-agreement-or-ttip/ [accessed 08 October 2014].

63. Corporate Europe Observatory. (2014, 08 July). *Who lobbies most on TTIP?* Retrieved from http://corporateeurope.org/international-trade/2014/07/who-lobbies-most-ttip

64. Some of this section draws on research by J. Mohun Himmelweit and H. Kersley for the New Economics Foundation, published by the Trades Union Congress (2014 forthcoming).

65. Social Investigations (2014, 02 March). *Compilation of parliamentary financial links to private healthcare.* Retrieved from http://socialinvestigations.blogspot.co.uk/2014/03/compilation-of-parliamentary-financial.html; Lyons, J. (2014, 08 February). Fury as Tory party donors are handed NHS contracts worth £1.5 BILLION under health reforms. *Mirror.* Retrieved from www.mirror.co.uk/news/uk-news/fury-tory-party-donors-handed-3123469

66. UNITE. (2014). *Tories in £1.5 billion NHS sell-off scandal.* Retrieved from www.unitetheunion.org/news/tories-in-15-billion-nhs-sell-off-scandal/ (15.10.2014).

67. Clearwater International. (2013). *Health and Care Report 2013*. Retrieved from http://clearwaterinternational.com/library/uk-health-social-care-report-2013/

68. Ibid.

69. Ibid.

70. Plimmer, G. (2013, 29 July). "Arms race" over £5bn in NHS work. *Financial Times*. Retrieved from www.ft.com/cms/s/0/6424b29e-f60a-11e2-a55d-00144feabdc0.html#axzz2v1OHTE2p

71. NHS Support Federation. (2013, 04 August). *Contract alert.* Retrieved from www.nhsforsale.info/uploads/images/database/contract%20alert%20(3)_summary%20Apr-Aug.pdf

72. Sylvester, R. & Thomas, A. (2014, 13 October). Disastrous diagnosis that could yet prove fatal for the Tories. *The Times, pp. 6–7.*

73. Craig, D. (2006). *Plundering the Public Sector.* Constable.

74. Stevens, S. (2014, 13 October). Inconvenient truth is that the NHS has to make bold reforms. *The Times.* p. 9.

75. Klein, R. (1995). Big bang healthcare reform – does it work? The case of Britain's National Health Service reforms. *Milbank Quarterly, Vol 33 (3), pp 299–337.*

76. Hunter, D.J. (2011). Change of government: One more big bang health care reform in England's National Health Service. *International Journal of Health Services, vol 41, 1.* p. 161.

77. Griffiths, S., Foster, J., Steen, S. & Pietroni, P. (2014). Mental health's market experiment: *Commissioning psychological therapies through any qualified provider*. Chester: Centre for Psychological Therapies in Primary Care.

78. Cameron, D. (2011, 14 June). *David Cameron NHS speech in full.* Retrieved from www.politics.co.uk/comment-analysis/2011/6/14/david-cameron-nhs-speech-in-fulls

79. The Lancet. (2011, 22 December). *Blog: Competition and health care quality – the debate continues*. Retrieved from http://ukpolicymatters.thelancet.com/blog-competition-and-health-care-quality-the-debate-continues-22-december-2011/

80. Cooper, Z., Gibbons, S., Jones, S. & McGuire, A. (2011). Does hospital competition save lives? Evidence from the English NHS Patient Choice Reforms. *Economic Journal*, *vol 121, issue 554,* pp. F228–F260.

81. Pollock, A., Macfarlane, A., Kirkwood, G., Majeed, F.A., Greener, I., Morelli C., Boyle, S., Mellett, H., Godden, S., Price, D. & Brhlikova, P. (2011). No evidence that patient choice in the NHS saves lives. *The Lancet*, *vol 378, Issue 9809,* pp.2057–2060.

82. Bevan, G. (2011). Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. *British Medical Journal.* Retrieved from www.bmj.com/content/343/bmj.d6470; Black, N. (2011). Preliminary findings on competition in healthcare should not be over-interpreted. *British Medical Journal.* Retrieved from www.bmj.com/content/343/bmj.d4731

83. Hunter, D. (2013, July). *To market! To market!* Centre for Health and the Public Interest. Retrieved from http://chpi.org.uk/wp-content/uploads/2013/07/David-Hunter-to-market-to-market.pdf

84. London School of Economics. (2012, 05 March) *Bad science concerning NHS competition is being used to support the controversial Health and Social Care Bill*. Retrieved from http://blogs.lse.ac.uk/politicsandpolicy/bad-science-nhs-competition/

85. Bevan, G. (2011). *op cit.*

86. Footman, K., Garthwaite, K. Bambra, C. & McKee, M. (2014). Quality check: Does it matter for quality how you organise and pay for health care? A review of the international evidence. *International Journal of Health Services*, volume 44, issue 3, pp 457–477; pp. 479–505.

87. World Health Organisation. (2000). *The world health report: Health systems: Improving performance*. Retrieved from www.who.int/whr/2000/en/whr00_en.pdf

88. Davis, K., Stremikis, K., Squires, D. & Schöen, C. (2014, 16 June). *Mirror, mirror on the wall, 2014 update: How the US healthcare system compares internationally*. Retrieved from www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

89. Campbell, D. (2014, 26 September). Patients neglected at privately run NHS hospital, watchdog finds. *The Guardian*. Retrieved from www.theguardian.com/society/2014/sep/26/care-quality-commission-hinchingbrooke-hospital

90. Lyons, J. (2014, 8 February). Fury as Tory Party donors are handed NHS contracts worth £1.5 BILLION under health reforms. *Mirror*. Retrieved from www.mirror.co.uk/news/uk-news/fury-tory-party-donors-handed-3123469

91. Robertson, A. (2014). "This can't go on" – Cameron hires private health lobbyist into the heart of government. *Open Democracy*. Retrieved from www.opendemocracy.net/ournhs/andrew-robertson/this-cant-go-on-cameron-hires-private-health-lobbyist-into-heart-of-governme

92. Boyle, D. (2013, 24 January). *Barriers to choice: a review of public services and the government's response.* Retrieved from www.gov.uk/government/publications/barriers-to-choice-public-services-review

93. Burge, P., Devlin, N., Appleby, J., Rohr, C. & Grant, J. (2004). Do patients always prefer quicker treatment? A discrete choice analysis of patients' stated preferences in the London Patient Choice Project. *Applied Health Economics and Health Policy, vol 3, issue 4, pp. 183–194.*

94. Which? (2005). *Which choice? Health. London: Which?*

95. Fotaki, M., Roland, M., Boyd, A., McDonald, R. & Smith, L. (2008). What benefits will choice bring to patients? Literature review and assessment of implications. *Journal of Health Services Research & Policy, vol 13, Issue 3, pp.178–184; Dixon, A., Appleby, J., Robertson, R., Burge, P., Devlin, N. & McGee, H. (2010). Patient choice. How patients choose and providers respond?. The King's Fund.* Retrieved from www.kingsfund.org.uk/publications/patient-choice; Coulter, A. (2010). *Do patients want choice and does it work*? *British Medical Journal.* Retrieved from www.bmj.com/content/341/bmj.c4989

96. Fotaki, M., Boyd, A., Smith, L., McDonald, R., Roland, M., Sheaff, R., Edwards, A. & Elwyn, G. (2005, December). *Patient choice and the organisation and delivery of health services: Scoping review. A report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO). Manchester: Centre for Public Policy and Management, University of Manchester.*

97. Fotaki, M. (2014, March). *What market-based patient choice can't do for the NHS: The theory and evidence of how choice works in healthcare. Centre for Health and the Public Interest. p.13.* Retrieved from http://chpi.org.uk/wp-content/uploads/2014/03/What-market-based-patient-choice-cant-do-for-the-NHS-CHPI.pdf; Hunter, D. (2013, July). *To market! To market!* Centre for Health and the Public Interest. Retrieved from http://chpi.org.uk/wp-content/uploads/2013/07/David-Hunter-to-market-to-market.pdf

98. Royal College of General Practitioners. (2014, 28 July). *Crisis hit GP surgeries forced to turn away millions of patients*. Retrieved from www.rcgp.org.uk/news/2014/july/crisis-hit-gp-surgeries-forced-to-turn-away-millions-of-patients.aspx; Borland, S., Levy, A. & Sinmaz, E. (2014, 24 June). The families, elderly and disabled being told they must find new GPs. *Daily Mail.* Retrieved from www.dailymail.co.uk/news/article-2666377/Struck-doctor-As-soaring-population-swamps-surgeries-thousands-told-switch-GPs.html

99. NHS England. (2014, June). *A guide to our vision and purpose.* Retrieved from www.england.nhs.uk/wp-content/uploads/2014/06/nhse-guide-vision-purpose-2014.pdf

100. Department of Health. (2008, November). *List of new hospital schemes – Prioritised Capital Schemes.*

101. House of Commons Treasury Committee. (2011, 18 July). *Private finance initiative: Seventeenth report of Session 2010–12.* p.3. Retrieved from www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/1146.pdf

102. Plimmer, G. & Neville, S. (2014 01 October). NHS Trust becomes first to buy out its PFI contract. *Financial Times.* Retrieved from www.ft.com/cms/s/0/cc4f10b2-4951-11e4-8d68-00144feab7de.html

103. Comptroller and Auditor General. (2012, 10 October). *HM Treasury: Equity investment in privately financed projects. HC 1792, Session 2010–2012. p.6.* Retrieved from www.nao.org.uk/wp-content/uploads/2012/02/10121792es.pdf

104. National Audit Office. (2007b). *The operational record of the first wave of PFI hospitals.* Unpublished Paper, cited in Hellowell, M. & Pollock A.M. ibid. p. 19.

105. Pollock, A., Price, D. & Liebe, M. (2011, 09 February). Private finance initiatives during NHS austerity. *British Medical Journal.* Retrieved from www.bmj.com/content/342/bmj.d324

106. House of Commons Treasury Committee. (2011, 18. July). *Private Finance Initiative: Seventeenth report of Session 2010–12.* p.3. Retrieved from www.publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/1146.pdf

107. Comptroller & Auditor General. (2011, 28 April). *Lessons from PFI and other projects.* Retrieved from www.nao.org.uk/wp-content/uploads/2011/04/1012920.pdf

108. Comptroller & Auditor General. (2010, 17 June). *The performance and management of hospital PFI contracts.* Retrieved from www.nao.org.uk/wp-content/uploads/2010/06/101168.pdf

109. Whitfield, D. (2012, December, amended 2014, January). PPP Wealth Machine: UK and global trends in trading project ownership. *European Services Strategy Unit, Research Report No.6.* Retrieved from www.european-services-strategy.org.uk/ppp-database/ppp-equity-database/ppp-wealth-machine-parts-1-8.pdf

110. Healthcare Commission. (2007). *Independent sector treatment centres: A review of the quality of care.* London: Commission for Healthcare Audit and Inspection.

111. Ibid.

112. Pollock, A.M. & Kirkwood, G. (2009). Independent sector treatment centres: learning from a Scottish case study. *British Medical Journal.* Retrieved from www.bmj.com/content/338/bmj.b1421

113. Slater, E. (2011, 25 May). *NHS reforms examined: £500m paid in botched NHS contracts to private companies. The Bureau of Investigative Journalism.* Retrieved from www.thebureauinvestigates.com/2011/05/25/500m-sweetener-paid-to-private-companies-to-treat-nhs-patients/

114. Royal College of Surgeons of England. (2006, 14 February). *Select Committee on Health, written evidence. Parliamentary Business.* Retrieved from www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934we41.htm

115. British Orthopaedic Association. (2006, 13 February). *Select Committee on Health, written evidence. Parliamentary Business.* Retrieved from www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934we16.htm

116. Pollock, A. M. & Godden, S. (2008). Independent sector treatment centres: evidence so far. *British Medical Journal.* Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2249623/

117. British Orthopaedic Association. (2005, 13 February). *op cit.*

118. Royal College of Surgeons of England. (2006, 14 February). *op cit.*

119. Timmins, N. (2013). *The four UK health systems.* London: King's Fund.

120. Connolly, S. (2010). *Funding and performance of healthcare systems in the four countries of the UK before and after devolution.* London: Nuffield Trust.

121. Commission on the Future Delivery of Public Services. (2011). *Commission on the future delivery of public services.* The Scottish Government. Retrieved from www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf

122. The Bevan Commission. (2011). *NHS Wales: Forging a better future: A report by the Bevan Commission 2008 – 2011.* Retrieved from http://wales.gov.uk/docs/dhss/publications/110606bevan1en.pdf

123. Brindle, D. (2013, 29 January). Has Wales found the winning formula for healthcare? *The Guardian.* Retrieved from www.theguardian.com/society/2013/jan/29/wales-found-winning-formula-healthcare

124. Cameron, D. (2010, 07 June). *Prime Minister's speech on the economy.* Retrieved from www.gov.uk/government/speeches/prime-ministers-speech-on-the-economy

125. Ramsay, R. (2001). The iron chancellor. *Variant, issue 13. p. 7.* Retrieved from www.variant.org.uk/pdfs/issue13/Ramsay.pdf

126. The World Bank. (2013). *Health expenditure, total (% of GDP).* Retrieved from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

127. Woolhandler, S. (2007). Competition in a publicly funded healthcare system. *British Medical Journal.* Retrieved from www.pnhp.org/PDF_files/BMJ_Woolhandler_Market_Failure.pdf

128. Hunter, D. (2013, July). Hunter, D. (2013, July). *To market! To market!* Centre for Health and the Public Interest. P. 5. Retrieved from http://chpi.org.uk/wp-content/uploads/2013/07/David-Hunter-to-market-to-market.pdf

129. Brown, G. (2003, 3 February). *A modern agenda for prosperity and social reform: Speech to the Social Market Foundation at the Cass Business School.* Retrieved from www.smf.co.uk/wp-content/uploads/2004/05/Publication-A-Modern-Agenda-for-Prosperity-and-Social-Reform-Gordon-Brown.pdf

130. Hunter, D. (2013, July). *op cit.* p.6.

131. Dixon, J., Le Grand, J. & Smith, P. (2003). *Can market forces be used for good? The King's Fund. pp.18–31.* Retrieved from www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/can-market-forces-be-used-for-good-legrand-dixon-smith-may03.pdf; Hunter, D. (2013, July). Ibid.

132. Dixon, J., Le Grand, J. & Smith, P. (2003). Ibid. p. 30.

133. Evans, R.G. (2005). Fellow travellers on a contested path: Power, purpose, and the evolution of European healthcare systems. *Journal of Health Politics, Policy and Law, Vol. 30 (1–2). Duke University Press.*

134. Monitor. (2014, June). *Monitor's annual plan for 2014–15. p.24.* Retrieved from www.gov.uk/government/uploads/system/uploads/attachment_data/file/321913/Monitor_Annual_Plan_2014–15.pdf; Care Quality Commission. (2014). *Quarterly performance and finance report Q1 2014–2015: Part A – Strategic measures. p.31.* Retrieved from www.cqc.org.uk/sites/default/files/CM071405%20Item%205%20%20Q1%202014-15%20performance%20annex%201.pdf

135. Dixon, A., Harrison, T. & Mundle, C. (2011). *Economic regulation in health care: What can we learn from other regulators? The King's Fund. p.3.* Retrieved from www.kingsfund.org.uk/sites/files/kf/Economic-regulation-in-health-care-paper-The-Kings-Fund-November-2011.pdf

136. Hodge, M. (2014). *Monitor: regulating NHS foundation trusts. House of Commons Public Accounts Committee.* Retrieved from www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/monitor-regulating-nhs-foundation-trusts-report/

137. Monitor. (2014, July). *About Monitor.* Retrieved from www.gov.uk/government/uploads/system/uploads/attachment_data/file/326396/About_Monitor___July_2014.pdf

138. BBC. (2013, 17 October). *Dorset hospital trusts merger plan blocked. BBC News Dorset.* Retrieved from www.bbc.co.uk/news/uk-england-dorset-24559766

139. Monitor. (2014). *Summary: Monitor's investigation and findings, and next step.* Retrieved from: www.gov.uk/government/publications/case-investigation-into-the-commissioning-of-elective-services-in-blackpool/summary-our-investigation-findings-and-the-next-steps

140. Care Quality Commission. (n.d.). *About us: What we do and how we do it.* www.cqc.org.uk/sites/default/files/documents/201202-cqc-about_us.pdf [accessed 8 October 2014].

141. Vinegar, D. (2013, 21 June). Will the CQC survive its latest crisis? *The Guardian.* Retrieved from www.theguardian.com/healthcare-network/2013/jun/21/cqc-crisis-morecambe-bay-failure

142. Public Accounts Committee. (2012). *The Care Quality Commission: Regulating the quality and safety of health and adult social car.* Retrieved from www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1779/177903.htm [accessed on 14 October 2014].

143. British Medical Association. (2013). *Doctors declare CQC not fit for purpose.* Retrieved from http://bma.org.uk/news-views-analysis/news/2013/june/doctors-declare-cqc-not-fit-for-purpose

144. The Practice. (n.d.) *Homepage.* Retrieved from www.thepracticeplc.com/ [accessed 26 October 2014].

145. North Cumbria University Hospitals. (n.d.) *Homepage.* Retrieved from www.ncuh.nhs.uk/index.aspx [accessed 26 October 2014].

146. Calkin, S. (2011, 14 June). Patients 'being coded as palliative to cut death rates', inquiry told. *Health Service Journal.* Retrieved from www.hsj.co.uk/home/patients-being-coded-as-palliative-to-cut-death-rates-inquiry-told/5031106.article?blocktitle=Clinical-Coding-News&contentID=1969

147. Woolhandler, S. (2007). op cit. p. 1129.

148. Klein, R. (2007). The new model NHS: Performance, perceptions and expectations. *British Medical Bulletin, p. 47.* Retrieved from http://bmb.oxfordjournals.org/content/81-82/1/39.full.pdf+html

149. Coote, A. (2004). *Prevention rather than cure. The King's Fund.* Retrieved from www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/prevention-rather-than-cure-making-case-for-choosing-health-anna-coote-kings-fund-1-march-2004.pdf

150. Mason, A., Goddard, M. & Weatherly, H. (2014). *Financial mechanisms for integrating funds for health and social care: An evidence review, CHE RP 97.* Centre for Health Economics, York. Retrieved from www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP97_Financial_mechanisms_integrating_funds_healtthcare_social_care_.pdf

151. Iacobucci, G. (2014). Raiding the public health budget. *British Medical Journal.* Retrieved from www.bmj.com/content/348/bmj.g2274

152. Wanless, D. (2002, April). *Securing our future health: Taking a long-term view: Final report. p.35. HM Treasury.* Retrieved from http://si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf

153. Wanless, D. (2004, February). *Securing good health for the whole population: Final report. pp. 13–14. HM Treasury.* Retrieved from http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/media/D/3/Wanless04_summary.pdf

154. Lifestyle statistics team. (2014, 26 February). *Statistics on obesity, physical activity and diet: England 2014. p.5. Health and Social Care Information Centre.* Retrieved from www.hscic.gov.uk/catalogue/PUB13648/Obes-phys-acti-diet-eng-2014-rep.pdf

155. NHS. (2014, 03 June). *Obesity.* Retrieved from www.nhs.uk/Conditions/Obesity/Pages/Introduction.aspx

156. Walshe, K. (2010). Reorganisation of the NHS in England. *British Medical Journal*, *341*.

157. Sylvester, R. & Thomson, A. *op cit.*

158. Health Committee. (2010). *Commissioning 1948–2010. Parliamentary business.* Retrieved from www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/26805.htm

159. Sippitt, A. (2014, 31 March). *How much is the "NHS market system" costing? Full Fact.* Retrieved from https://fullfact.org/health/market_national_health_service_costs_commissioning-30961

160. Paton, C. (2014, February). *At what cost? Paying the price for the market in the English NHS. p.6. Centre for Health and the Public Interest.* Retrieved from http://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf

161. The Personal Social Services Research Unit (PSSRU) state that the mean full-time basic salary of a nurse on a hospital day ward is £25,744 per year. Curtis, L. (2013). *Unit cost of health and social care 2013.* p. 235. Personal Social Services Research Unit. University of Kent.

162. The PSSRU put the average income for a GP in England at £106,100 per annum. Curtis, L. (2013). *Unit cost of health and social care 2013. p. 190.* Personal Social Services Research Unit. University of Kent.

163. The average cost of an A&E visit currently stands at £114. Department of Health. (2013). *Reference costs 2012–13.* p.9. Retrieved from www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

164. P16 of UnitedHealth Group Llc 2013 10K filing www.unitedhealthgroup.com/Investors/~/media/9202A464BDEF4EF5ACEBCBA082684FE8.ashx

165. P36 of UnitedHealth Group Llc 2013 10K filing, www.unitedhealthgroup.com/Investors/~/media/9202A464BDEF4EF5ACEBCBA082684FE8.ashx

166. Calkin, S. (13 September 2013). Exclusive: Loss-making UnitedHealth UK plans rebrand. *Health Service Journal.* Retrieved from www.hsj.co.uk/news/finance/exclusive-loss-making-unitedhealth-uk-plans-rebrand/5063267.article

167. Hansard. (n.d.). *Submission to Parliamentary Select Health Committee by UnitedHealth.* Retrieved from www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/1020/1020w238.htm [accessed 30 October 2014]

168. Button, M. & Leys, C. (n.d.). *Healthcare fraud a threat to patient care.* Retrieved from http://chpi.org.uk/wp-content/uploads/2012/06/CHPI-Healthcare-Fraud-a-threat-to-patient-care1.pdf [accessed 30 October 2014]

169. Button, M. & Leys, C. (n.d.). *Healthcare fraud a threat to patient care.* Retrieved from http://chpi.org.uk/wp-content/uploads/2012/06/CHPI-Healthcare-Fraud-a-threat-to-patient-care1.pdf [accessed 30 October 2014]

170. Naylor, C., Ross, S., Curry, N., Holder, H., Marshall, L., & Tait, E. (22 July 2013). *Clinical commissioning groups: Supporting improvement in general practice.* The Kings Fund. Retrieved from www.kingsfund.org.uk/publications/clinical-commissioning-groups

171. Hansard. (1 March 2010). *Health Services, Isle of Man, [318827].* Retrieved from www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100301/text/100301w0009.htm

172. Optum. (n.d.) *About us page.* Retrieved from www.optum.com/about.html [accessed 30 October 2014]

173. Search Google site:nhs.uk scriptswitch and results will show some of the organisations that are using the software.

174. Duedil. (n.d.). *Financial statement of Scriptswitch.* Retrieved from www.duedil.com/company/04740718/scriptswitch-limited/financials [accessed 30 October 2014]

175. GMB. (20 December 2013). *Press release: GMB on £1 billion NHS contract.* Retrieved from www.gmb.org.uk/newsroom/gmb-on-nhs-contract

176. Soteriou, M. (27 June 2012). Loophole in APMS contracts threatens primary care stability, enquiry warns. *GP Online.* Retrieved from www.gponline.com/loophole-apms-contracts-threatens-primary-care-stability-enquiry-warns/article/1138556

177. American Association for Justice. (December 2011). The ten worst insurance companies in America: How they raise premiums, deny claims, and refuse insurance to those who need it most. p.18. Retrieved from www.justice.org/sites/default/files/file-uploads/AAJ_Report_TenWorstInsuranceCompanies_FINAL.pdf

178. US Securities and Exchange Commission. (6 December 2007). *Press release: Former UnitedHealth Group CEO/chairman settles stock options backdating case for $468 million.* Retrieved from www.sec.gov/news/press/2007/2007-255.htm

179. Hodgson, P. & Ruel, G. (January 2012). Twenty-one US CEOs with golden parachutes of more than $100 million. Retrieved from http://go.gmiratings.com/rs/gmiratings/images/GMIRatings_GoldenParachutes_012012.pdf ; Rivlin, G. (1 November 2012). New study shows how golden parachutes are getting bigger. *The Daily Beast*. Retrieved from http://www.thedailybeast.com/articles/2012/01/11/new-study-shows-how-golden-parachutes-are-getting-bigger.html

180. Gaskell, S. (14 January 2009). AG Andrew Cuomo reins in health care giant United on price fixing; systemic overcharging revealed. *The Daily News*. Retrieved from www.nydailynews.com/news/ag-andrew-cuomo-reins-health-care-giant-united-price-fixing-systemic-overcharging-revealed-article-1.424992

181. UnitedHealth Group. (2013). *Annual Report*. p.77. Retrieved from www.unitedhealthgroup.com/~/media/UHG/PDF/2013/UNH-2013-Annual-Report-Summary-Form-10-K.ashx

182. Fortune. (2014). Global 500 2014. Retrieved from http://fortune.com/global500/unitedhealth-group-39/

183. UnitedHealth Group. (Last updated September 2014). *Divdend history*. Retrieved from www.unitedhealthgroup.com/Investors/Dividend.aspx

184. Office for National Statistics. (2009). *General lifestyle survey: Health tables, 2009*. Retrieved from: www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2009-report/health.xls

185. North Cumbria University Hospitals. (n.d.) *Homepage*. Retrieved from www.ncuh.nhs.uk/index.aspx [accessed 26 October 2014].

186. Interserve. (n.d.) *Homepage*. Retrieved from www.interserve.com/ [accessed 26 October 2014].

187. Amec. (n.d.) *Homepage*. Retrieved from www.amec.com/ [accessed 26 October 2014].

188. Companies in the UK. (n.d.). *Health Management Carlisle Limited*. www.companiesintheuk.co.uk/ltd/health-management-(carlisle) [accessed 26 October 2014].

189. Health Service Journal (2014, 17 February). *Patients at Wirral operated on with unsterilized equipment*. HSJ Live. Retrieved from http://m.hsj.co.uk/5068067.article

190. Plimmer, G. (2012, 12 October). Interserve sells PFI stakes for £90m. *Financial Times*. Retrieved from www.ft.com/cms/s/3938bcb6-1478-11e2-8ef2-00144feabdc0,Authorised=false.html?_i_location=http%3A%2F%2Fwww.ft.com%2Fcms%2Fs%2F0%2F3938bcb6-1478-11e2-8ef2-00144feabdc0.html%3Fsiteedition%3Duk&siteedition=uk&_i_referer=#axzz3GP9l2u8x. www.dalmorecapital.com/Pages/Dalmore-Capital-Fund.aspx

191. Seddon, N. (2010). Is the NHS getting the right treatment, *Telegraph.* Retrieved from www.telegraph.co.uk/health/7886304/Is-the-NHS-getting-the-right-treatment.html; Robertson, A., (2013, 13 May). "This can't go on": Cameron hires private health lobbyist into the heart of government. Retrieved from www.opendemocracy.net/ournhs/andrew-robertson/this-cant-go-on-cameron-hires-private-health-lobbyist-into-heart-of-governme

192. Sylvester, R. & Thomson, A. *op cit.*

193. Health Policy Briefs. (2010). *Health affairs*. Retrieved from www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=23

194. Leys, C. & Player, S. (2011). *The Plot Against the NHS*, Merlin Press.

195. Bevan, G., Karanikolos, M., Exley, J., Nolte, E., Connolly, S. & Mays N. (2014, April). *The four systems of the United Kingdom: how do they compare?* Nuffield Trust, Retrieved from www.nuffieldtrust.org.uk/sites/files/nuffield/publication/revised_four_countries_summary.pdf

Written by: Anna Coote and Joe Penny

With additional research by: Daniel Button

Thanks to: David Hunter, Ian Gough and Helen Kersley for reviewing this report, to Jane Franklin for editing the references, and to Unite for supporting the research.

Designed by: www.soapbox.co.uk
Cover image by:
www.flickr.com/photos/comedynose/3797160719

New Economics Foundation
www.neweconomics.org
info@neweconomics.org
+44 (0)20 7820 6300
@NEF

Registered charity number 1055254
© November 2014 New Economics Foundation

ISBN 978-1-908506-70-2

This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Unported License.
To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-nd/3.0/ and www.neweconomics.org/publications