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Forty years of failure Private sector contracting and its impact on the NHS

Researched and written by **Dr John Lister** August 2024

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About the author

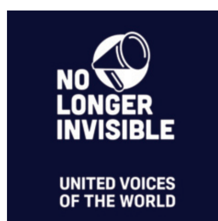
John Lister has worked as a specialist health journalist since the spring of 1984 when he was appointed as Information Director of GLC-funded London Health Emergency campaign as the drive to outsource non-clinical NHS services began. Since then he has led the development of evidence-based campaigning, delivering research and analytical reports and newspapers on NHS issues for local authorities, national, regional and local trade unions and local campaigners.

In 2004 John was awarded a PhD in Health Policy for a thesis on neoliberalism and global health systems, published in 2005 as a book by Middlesex University Press, and appointed Associate Senior Lecturer in Journalism and Health Journalism at Coventry University, where he also led a masters-level module of health policy for 20 years.

His updated book *Global Health versus Private Profit* (Libri 2013) won international acclaim. He has also organised international conferences on health journalism, and written and edited the only book on health journalism for a European audience (*First Do No Harm*). He has written and co-edited five books on the history and situation of the NHS between 1988 and 2022 (NHS Under Siege), winning a Medical Journalists Association award in 2008 for *The NHS after 60 – for patients or profits?*

In 2019 John was co-founder and remains co-editor of the evidence-based free access news website on the NHS, The Lowdown (https://lowdownnhs.info). He is a Member of Honour of the National Union of Journalists.

Cover Photo: London, UK. 31 October, 2019. More than 150 low-paid and predominantly migrant St Mary's Hospital Paddington cleaners, caterers and porters outsourced via Sodexo to Imperial College NHS Healthcare trust and belonging to the United Voices of the World (UVW) trade union take part in a coordinated series of 'five strikes in one day' involving also cleaners from the Ministry of Justice, University of Greenwich café workers, cleaners from ITV and Channel 4's offices and park attendants from the Royal Parks. The St Mary's workers are seeking the same terms and conditions as comparable in-house NHS workers and an end to outsourcing.
Credit: Mark Kerrison/ Alamy Live News



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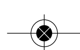

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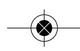

Preface – Forty years of failure – private sector contracting and its impact on the NHS

In Module 3 of the UK's COVID-19 Public Inquiry, the Public Interest Law Centre (PILC) represented the Frontline Migrant Health Workers Group (FMHWG), which included the Independent Workers Union of Great Britain (IWGB), United Voices of the World (UVW), and Kanlungan Filipino Consortium. The focus of our representations during the course of Module 3 was to highlight the systemic injustices that frontline migrant health workers faced during the COVID-19 pandemic, with a specific emphasis on the impact of outsourcing, precarious visa-related work conditions, and insufficient protective measures like access to adequate personal protective equipment (PPE).

However as we stressed in our Opening Statement to the Inquiry:[1]

> "*First, these members are working class, in low and under paid employment. The majority of the members are from ethnic minorities and so fall within the protected characteristics of the Equality Act 2010. However, the Group wishes to emphasise at the outset, that systemic issues, like outsourced employment, are applicable across the working class as a whole, regardless of ethnicity.*"

Module 3 of the Covid Inquiry focused on the impact of the Covid 19 pandemic on healthcare systems across the UK. This involved how the public and particularly the Johnson Government responded to the pandemic. It examined how the capacity of healthcare systems, particularly the NHS responded to a pandemic and how this evolved during the Covid-19 pandemic. Whilst it was essential for this module to examine a broad range of issues from the impact of the pandemic of doctors, nurses and healthcare staff, communication with patients, discharge from hospital and core decision making, the FMHWG and PILC felt it lacked an understanding of how the NHS has been stripped of finance which has been siphoned off to private contractors. That outsourcing 'strategy' has had a detrimental impact on health services – and we call for the outsourcing of jobs and services to be stopped.

On behalf of the FMHWG, lawyers at PILC asked the Covid 19 Public Inquiry to commission a report the issues of outsourcing, privatisation and the impact on health services, specifically the NHS. The aim of commissioning this report would be to provide a current and historical analysis of the impact it has had provision of health services. We argued that it would provide a comprehensive understanding of why health services were placed under such strain during the pandemic, and why private outsourcing has failed a public service.

The Inquiry refused our request. Alongside the FMHWG, we felt we had no choice but to commission this Report and provide it as evidence to the Covid-19 public inquiry ourselves.

The Impact of Outsourcing on Migrant Health Workers

One of the central arguments advanced by FMHWG was the detrimental effect that outsourcing has had on the working conditions of frontline health workers. Outsourcing is a process whereby the National Health Service (NHS) contracts out certain services—such as cleaning, portering, and catering—to private companies, rather than employing workers directly. This practice, which has been a political choice in the UK for decades has driven down wages, eroded workers' rights, and worsened working conditions. The COVID-19 pandemic served as a stark revelation of how these systemic issues manifested in life-threatening ways for migrant workers in particular, but also all workers who were employed through outsourced contracts.

This Report authored by Dr John Lister, titled "Forty Years of Failure: Private Sector Contracting and its Impact on the NHS," provides a historical and structural analysis of how outsourcing has failed the NHS and its workers. Lister's report outlines how private contracting in the NHS was ramped up following the Thatcher-era reforms of the 1980s and has since become embedded in the functioning of the healthcare system. The emphasis on cost-cutting by private firms often leads to low pay, lack of job security, and minimal benefits for workers. For migrant workers, these issues are exacerbated by their precarious immigration status, which ties their ability to work to specific visas.

FMHWG highlighted that many outsourced migrant workers were left out of key protections that directly-employed NHS workers were afforded during the pandemic. This included access to sick pay and the provision of adequate PPE. Outsourced workers have lower pay, worse terms and conditions, and a lack of

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integration into the NHS workforce, meaning they were not included in the same safeguarding measures during the pandemic. This left outsourced workers many of who are migrants particularly vulnerable to the virus.

As an anonymous witness ("IWGB Cleaner") speaking on behalf of the FMHWG puts it: "There was a stark difference in the personal protective equipment provided to in-house clinical staff and to outsourced workers. Clinical workers at the hospital had access to full PPE including gloves, aprons, masks, visors … However, there was no apparent understanding that as… cleaning staff, we also had a very high risk of exposure to Covid-19. We were only provided with surgical masks, and there were usually not enough of these to go around so we would have to reuse them… As far as I am aware, there were no checks or assessments of the hospital or of the outsourced company for compliance with health and safety regulations or IPC guidelines during the pandemic."

Alex Marshall, President of IWGB, speaking on behalf of the FMHWG at the Covid Inquiry Hearings, explained that "A lot of [outsourced] workers were making basic demands… these were frontline workers who had been doing a job and knew they were going to be particularly vulnerable, and they were asking for things to be implemented that would protect them, that would protect their families. Also, we knew that we were going into places where there were incredibly vulnerable people. We're talking about cancer wards, we're talking about antenatal wards, we're talking about old people's homes, and we were just asking for things to be put in place to ensure that we weren't spreading the virus more than you know it was already clearly spreading like wildfire."

Lack of Protection During the Pandemic

FMHWG also focused on how the pandemic exposed critical failings in the protection of outsourced and migrant workers. The FMHWG argued that many outsourced workers did not have sufficient access to PPE, despite being on the frontline of the NHS in high-risk roles such as hospital cleaning and patient transportation. In many cases, these workers had close contact with COVID-19 patients or contaminated environments but were either not provided with PPE or were given substandard equipment to use.

This lack of PPE was not just a logistical issue, which of course it was, but reflected deeper structural inequities. Outsourced workers were not fully integrated into the NHS system. As such, their safety was not prioritised in the same way as NHS-employed staff, despite the essential nature of their work. The fact that these workers were disproportionately people migrants added a layer of racial and economic injustice to their exclusion from critical safety provisions.

Many of these workers, despite working in the NHS, had to continue working even when ill, as they could not afford to take time off due to inadequate sick pay or the fear of losing their jobs. This practice of working while unwell further exacerbated the spread of COVID-19 within hospitals and healthcare settings, putting both the outsourced workers and patients at risk.

Alex Marshall gave the following account during the Covid Inquiry Module 3 Hearings: "…we were having to either choose to go into work and risk their lives or stay at home, potentially face destitution, and that is not a choice that any individual should be making, and that's a choice that should have been taken care of by the employers and the government who actually had the resources to make that decision for them."

He further explained:

> "[T]*he three different organisations [United Voices of the World, Independent Workers of Great Britain and Kanlungan Filipo Consortium] were presented with various situations, …and we responded in the best way possible. And as deeply harrowing and troubling it was to hear of these experiences, it was equally as troubling to know that we weren't unique, these weren't one-offs, that these were situations that thousands of people were struggling with, where their voices weren't being heard where they were just asking for basic protections so they could do their job, so they could continue to earn, but also so they could protect people and not spread the virus.*"

Dr John Lister's report further details how private contractors, in their pursuit of profit and cost-cutting, often failed to meet basic health and safety standards. He argues that private sector involvement in the NHS has led to a fragmented workforce where communication and responsibility for worker safety become muddled. During the pandemic, this fragmentation became deadly, as outsourced workers were left without adequate protections while performing some of the most dangerous jobs in the healthcare sector.

Precarious Work and Migrant Visa Conditions

FMHWG also argued that migrant workers in the NHS were placed in an especially precarious position due to the visa system that governs their ability to work in the UK. Many migrant health workers were reliant on temporary work visas that tied their legal

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right to remain in the country to their employment in the NHS. This meant that losing their job would not only mean the loss of income but also the potential of deportation. This visa condition created an environment of fear and insecurity, where workers felt compelled to continue working in unsafe conditions, knowing that their immigration status depended on it.

Migrant health workers were disproportionately affected by the pandemic due to the roles they often occupied. Many migrant workers were employed in lower-paid and more dangerous jobs, such as portering, cleaning, and working in COVID-19 wards. These jobs had higher exposure risks to the virus, yet the workers were often paid less than their directly-employed NHS counterparts. The combined factors of precarious visa status, lower pay, and higher exposure to the virus contributed to disproportionately high rates of illness and death among migrant health workers.

FMHWG's submissions to the COVID-19 inquiry included evidence that migrant workers were more likely to die from COVID-19 compared to other NHS staff. This was attributed to the nature of their work, the lack of PPE, and the pressures of visa-related job insecurity. The inquiry heard that many of the workers who died from the virus were in roles that involved direct contact with COVID-19 patients or contaminated environments. Despite this, their safety and well-being were not prioritised, and in many cases, they were denied access to adequate support, both during and after their illness.

Outsourcing as a Political Choice – but no economic sense

A key theme of FMHWG's arguments was that outsourcing was not an inevitable or neutral practice but a political choice that had been made over decades by successive governments. This choice, they argued, prioritised profit and cost-cutting over the welfare of workers. The privatisation of key NHS functions, including cleaning, catering, and portering, has led to a two-tier system where outsourced workers are treated as second-class employees, despite performing essential roles within the health service.

Dr John Lister's report, *"Forty Years of Failure,"* places these experiences of workers into context by tracing the rise of outsourcing in the NHS back to the 1980s. He describes how the introduction of private sector contracting was driven by an ideological commitment to neoliberal economics, which sought to reduce the size of the public sector and increase the role of private enterprise. The impact of this shift has been the degradation of working conditions for those on the frontlines with outsourced workers bearing the brunt of these changes. At the same time private companies have enriched themselves on the back of this.

Alex Marshall when giving evidence on behalf of the FMHWG at the Module 3 Covid Inquiry Hearings explained that: "…due to the fact that we were outsourced workers, we were gig economy workers, there just seemed to be no thought for this section of the workforce as to how we can keep these guys safe, and any of our complaints were made to feel like we were just being annoying, like we were just asking for too much, like they just wanted to silence us. And we saw this coming and we were raising the alarm. But, you know, these are situations that so many of these workers are putting up with day to day. There are power dynamics at play whether you're on an unstable visa or if you're an outsourced working or you are working in the gig economy that we're crying out like, look, all of these organisations are dealing with these issues on a daily basis. The pandemic was pouring petrol on a blazing inferno that's already going on for a lot of our members."

As the Report notes, the pandemic laid bare the human costs of these policies. While private companies have profited from outsourcing contracts, the workers have been left with low pay, inadequate protections, and high levels of job insecurity. The COVID-19 pandemic, in many ways, exposed the systemic inequalities that had been entrenched through decades of outsourcing, with migrant workers suffering the most severe consequences.

Conclusion

The representation of the Frontline Migrants Health Workers Group by the Public Interest Law Centre in Module 3 of the COVID-19 Public Inquiry we believe brought crucial attention to the structural issues affecting outsourced and migrant health workers during the pandemic. We highlighted the significant role that outsourcing played in leaving migrant workers without adequate protection and in precarious employment situations. The combination of outsourcing, poor working conditions, visa-related job insecurity, and lack of PPE during the pandemic created a perfect storm of vulnerability for these workers.

This Report we believe adds an important historical and analytical dimension to this discussion, demonstrating how outsourcing has consistently undermined the NHS and its workers for decades. Outsourced workers and migrant workers, who were essential to the NHS's functioning during the pandemic, found themselves disproportionately exposed to danger, underpaid, and inadequately protected.

The inquiry serves as a reminder that political choices about the structure of public services have direct, sometimes deadly, consequences for the most vulnerable workers.

We have called on the Covid 19 to urgently reconsider the issue of outsourcing in the NHS and rethink how we value and protect all workers, especially those who are migrants and perform some of the most essential, yet precarious, jobs.

Paul Heron – Legal Director
Helen Mowatt – Head of Legal Casework
Public Interest Law Centre, October 2024

The legal team from the Public Interest Law Centre who worked on Module 3 include:
Paul Heron, Helen Mowatt, Ellen Fotheringham, Juliet Galea-Glennie, Holly Ahom, Melissa Kizito and Luisa Le Voguer Couyet.

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Finally, our thanks and solidarity to the members and organisers of the Independent Workers Union of Great Britain, United Voices of the World, and Kanlungan Filipino Consortium.

The Frontline Migrant Health Workers Group are calling for:

1. End outsourcing and privatisation in the NHS and bring outsourced staff back in house at equal pay and terms. End the super-exploitation in the pursuit of profit.
2. Improve public funding for the NHS and public health. Since 2010 the health budget has grown by less than the previous average increase in spending – bringing real terms cuts as resources lag behind rising costs.
3. End 'hostile environment' policies and overhaul migration system that devalues the lives of migrants, exposes them to harm and increases the overall public health risk posed by a future pandemic.
4. End 'no recourse to public funds' conditions applied to visas. The No Recourse to Public Funds rule leaves workers living in fear of losing their jobs and open to abuse. It leaves them at the mercy of employers.
5. Overhaul sick pay system to provide access to sick pay to all employed, limb b and self-employed workers at a living wage rate. Sick pay should be paid at the full wage rate. Without this it leaves workers who are sick, either working or risks them starving.
6. Early engagement with unions and community organisations to inform decision making and understanding of needs of workers.
7. The Health and Safety Executive to have the statutory power to enforce workplace breaches and punish employers. The HSE has seen its funding and staffing cut. In 2021-22 it was 43 per cent down on 2009-10 in real terms. Staff numbers have been cut by 35 per cent since 2010 on a like-for-like basis. This must be reversed
8. Re-nationalise the National Health Service.

Chapter notes

1 https://covid19.public-inquiry.uk/wp-content/uploads/2024/09/10180704/INQ000502164.pdf

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1 Privatisation of non-clinical services

Ancillary services

From 1983 onwards ministers began the process by salami-slicing off low-profile but potentially profitable services – starting with non-clinical support ('ancillary') services, primarily cleaning, catering and laundry. Ministers argued that bringing in private providers to the NHS was a way of cutting costs, and tried to downplay the extent to which any 'savings' were at the expense of staff and standards of care.

One group of local campaigners (Hillingdon Health Emergency) aptly summed up in 1984:

> "*The important thing to realise is that privatisation is not being done to save money or to direct more finances towards patient care. The evidence indicates that it costs money rather than saves it, and standards fall drastically. Privatisation is a political move to line contractors' pockets and destroy the power of organised labour.*"

Outsourcing of services ticked four boxes on the Thatcherite political agenda:

- it reinforced the free-market ideology later known as 'neoliberalism' (minimising the size of the state and scope of the public sector, holding down taxes on the rich and big business);
- it reasserted the belief that the private sector is inherently more 'efficient' than the public sector
- it started the process of whittling down a major public service, delivering some short-term cash savings at the expense of quality;
- it offered contracts for Conservative donors and associates in the cleaning, catering and laundry industries.
- and, no less important, it undermined the power of the NHS unions, which were the most strongly organised and most combative in these sectors of the workforce. Where services had been contracted out, the support workers were no longer NHS employees, and, especially after anti-union laws had been passed, this meant the possibility of combined strike action of support staff and professionals over pay and conditions (as had happened in the 1970s and 1982) would be largely eliminated.

Even though the health unions have changed since then, with a greater unionisation of professional staff, the long term damage this split inflicted on them is still exposed each time the issue of action over pay is discussed.

Similar ideology, again accepting the claim that the private sector is more 'innovative' and 'efficient', was the main driving force in New Labour's increasingly irresponsible experiments with the use of private finance for hospital building projects from 1997, and using private providers for clinical services from 2000.

Tony Blair's party shared the belief that the power of competition (or in New Labour-speak "contestability") could improve quality and increase efficiency in health care. That is why, with extra money to spend, New Labour ministers chose not to invest directly in expanding the NHS, but instead to invest in developing new, private providers and a competitive market. They even set targets for a growing share of NHS operations to be delivered (at higher cost) by the private sector.[4]

And when David Cameron's Conservative-Liberal Democrat coalition took office in 2010, it was ideology, in defiance of the growing body of evidence, that drove both the austerity agenda and Andrew Lansley's Health and Social Care Act. This restructured and fragmented the NHS, to create and institutionalise a competitive market in clinical and non-clinical services at considerable cost, but with no detectable benefit other than to private providers.

Forcing through competitive tendering

The proposal to bring in compulsory competitive tendering to the NHS was first advocated by the Conservative Medical Society in a paper to the 1978 Conservative conference. In 1982 a draft NHS circular was drawn up, but sidelined by the pay dispute which lasted much of the year. But it was not until after Margaret Thatcher's second Conservative election victory in 1983 that the key circular **HC(83)18**[5] was issued calling for *Competitive Tendering in the Provision of Domestic, Catering and Laundry Services*.[6]

The circular clearly reflected the impact of lobbyists from the industry: it states the Government's belief that the use of private contractors "under carefully drawn

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and properly controlled contracts" could "often prove the most cost effective way of providing support services." It requires health authorities to "test the cost effectiveness of their … services by putting them out to tender (including in-house tenders)."

All District Health Authorities were given to the end of February 1984 to submit a timed programme for implementation, and told that they should not attempt to uphold any detailed requirements for staffing, or the length of time required for tasks.

Despite any other rhetoric, from the outset cheapness was the order of the day, not quality: "In no circumstances should a contractor not submitting the lowest tender be awarded the contract unless there are compelling reasons endorsed at district authority level …"

Privatisation

The government's objective was clearly to ensure that private contractors secured as many contracts as possible, and this process was immediately branded as "privatisation" by the TUC health unions of the day (NUPE, COHSE and NALGO, subsequently merged into UNISON, the GMBATU (now GMB) and ASTMS, now part of Unite) which began to step up their resistance.

They began to work with campaigners to develop publicity and information that could convey to a wider and largely uninformed public (who were mainly concerned about cuts in services) that privatisation was not just a threat to the jobs and living standards of health workers, but also a major threat to the safety and quality of health care.

Some NHS managers were reluctant to contract out services because it meant breaking up their established health care teams. Indeed ministers were forced to step in and force health authorities in Calderdale, South Cumbria and Cornwall to hand over laundry contracts to private firms. NHS management resistance was strengthened by early contract failures – a quality check in Cheltenham revealed 84% of hospital pillow cases and 73% of sheets laundered by Sunlight to be below the required standard.

Campaigners and the unions began to collate evidence of the performance and the impact of private contractors – to encourage DHAs to steer clear of failing firms, and increase the chances of threatened staff fighting back. In publicity from London Health Emergency a cockroach symbol was used as a visual reminder of the threat of plunging hygiene in hospitals.

The resistance begins

By April 1984 the first major strike against privatisation broke out at Barking Hospital in East London: it was to last 18 months, but end in defeat. The mainly women strikers were opposing the loss of jobs, the reduction of hours for many of those remaining and the increased workload required to ensure the company made a profit.

In June 1984 domestics at Hammersmith Hospital walked out on what became a 3-month strike against an in-house tender which would axe 49 jobs, cut full time staff from 122 to just 28, cut the pay for most of those remaining on part-time by 50%, and more than halve the hours for cleaning the hospital.[7] The striking staff were finally sacked in September when the Special Health Authority voted to bring in private contractors Mediclean.

The relentless squeeze on standards also divided some of the Government's own supporters: in the autumn of 1984 Gardner Merchant, a catering subsidiary of Conservative-donating Trust House Forte, pulled out of tendering for any of the NHS catering contracts to avoid reputational damage:

> " *"I have no desire to appear in the media accused of exploiting patients," said MD Gary Hawkes. "Just imagine what it would do to us if we were running the catering where there was a food poisoning epidemic like there has just been in [Stanley Royds Hospital[8] in] Wakefield.""* [9]

By the end of 1984 there was already a long and growing list of contract failures against some of the main players. This included: Crothalls (the firm that triggered the Barking Hospital strike by cutting hours of work and wages) who were fined in Croydon and Worthing and had their contract terminated in Maidstone for failing to meet standards and leaving nurses to do the cleaning; laundry firms Sunlight and Advance; and Exclusive Health Care Services and Hospital Hygiene Services, with failures in Leeds.

In some cases disputes against privatisation were victorious, and in other areas NHS managers themselves remained unconvinced of the merits of tendering.

By October 1984 two thirds of the first few domestic catering and laundry contracts that had been awarded had gone to private companies. That month trade unions in London, together with the GLC-backed campaign organisation London Health Emergency organised a 200-strong conference on Fighting NHS Privatisation in London's County Hall.[10] The message there was that the fight had to be waged equally against private contractors moving in, but also against drastic cuts in terms and conditions to win 'in-house' tenders that would also undermine the quality of services.
This was later confirmed by research in 1987, which found that costs had been reduced by 34 per cent for contracted out hospitals, and by 22 per cent of contracts

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that remained in-house. Figures from the Department of Health in 1990 showed the same pattern: the private sector had won fewer contracts but been more ruthless in cutting costs – almost always at the expense of staff jobs, pay or conditions. £81m of the claimed £110m savings on first round contracts had come from in-house contracts: the private sector had won 15 per cent of contracts but made 26 per cent of the savings.[11]

It soon became apparent that the high profits the private contract firms at first expected would not be forthcoming. A number of private contractors pulled out of tendering for NHS domestic service contracts, including Sunlight, Reckitt, OCS and Blue Arrow. The finance director of Blue Arrow declared "there is nobody making any money out of the National Health Service".[12]

Moving the goalposts

With fewer contracts and lower profits than expected the private contractors began to lobby the Government, urging ministers to "move the goalposts" to make it easier for private firms to win and retain ancillary contracts.[13] On at least three occasions health authorities which attempted to award contracts in-house because they believed that the lowest tender by private contractor was unworkable were overruled by health ministers.[14]

In March 1985 Bromley Health Authority had become so dissatisfied with the work done by Hospital Hygiene Services (HHS) that they terminated their contract after six months.

The option of dismissing unsatisfactory contractors had previously been argued by the contractors' own trades confederation the Contract Cleaners and Maintenance Association (CCMA) as one of the advantages of the competitive tendering method. But as soon as they lost the Bromley contract, HHS (whose directors included Conservative MP Marcus Fox) immediately piled pressure on health minister Kenneth Clark, who within 24 hours authorised a telephone directive to all health authorities, changing the rules in the contractors' favour.

Under the new instructions no health authority could decide to throw out a contractor, no matter how bad their performance, without prior Department of Health approval. The delays this introduced into the process gave the company under threat the chance for a short period to throw extra resources into the contract to stave off the danger of dismissal, before reverting back to its unsatisfactory ways.

But even these changes were not enough for contractors. The beginning of 1986 brought news that Maidstone DHA had finally managed to break through the bureaucratic logjam and terminate its contract with Crothall.

Once again out came a new set of directives from NHS Board Chairman Victor Paige imposing yet further restrictions on the dismissal of incompetent contractors, discouraging even the imposition of penalty payments for unsatisfactory work.

Before kicking out a failing company health authorities were now required to refer any proposed contract cancellation to both the Regional Health Authority and to the DHSS.

They were also prevented from asking contractors to specify performance rates of employees (opening the way for some of the more impossible workloads which had previously been the basis of artificially cheap private tenders.) And they were prevented from inquiring into the profit margins expected for particular contracts – and from doing their own vetting of contract firms. Health management were told to rely instead on less discerning lists drawn up by Regional Health Authorities. Regions compiling approved lists were even told to avoid "intrusive" questions on the finance and competence of contract firms.

The CCMA had drawn up an even more ambitious series of demands including the right for contractors to terminate contracts more easily, for health authorities rather than contractors to provide cleaning materials, and a reduction in the fines charged by health authorities when contractors failed to carry out their work. At the end of 1986 CCMA Secretary-General John Hall even argued that the government should abandon compulsory competitive tendering … and switch to a policy of compulsory contracting out.[15]

However one of the reasons why contractors were having problems was that health authorities feared loss of direct management control of the crucial ancillary services, and were less than impressed with the performance of the contractors already at work in the NHS.

In this context it is doubtful whether the letter from NHS Management Board Chair Victor Paige, making it much more difficult to ditch an incompetent contractor, made it easier for the firms concerned to win contracts.

Management resistance

By September 1986, the target date for completion of the tendering process, despite all of the efforts of ministers to force through private contracts the National Audit Office found that only just over two thirds (68%) of the services (by value) had even been put out to tender.

Some health authorities, notably in Wales and Scotland had simply refused. The private sector had won just

18% of the 946 contracts that had been awarded. By February 1987 according to NUPE, 79% of contracts awarded had gone in-house with only 21% awarded to private contractors.

But even where private contractors were unable to win, damage was still being done. Competitive tendering had meant many in-house bids were now undercutting the contractors, slashing more jobs, and more hours of work, and as a result further undermining the quality of patient care.

Contracting out – whether or not the private sector won the contract – was leading to plunging hygiene standards that created ideal conditions for the spread of a new 'superbug' MRSA and other hospital-borne infections.[16]

By the winter of 1987, when a massive new round of spending cuts pushed waiting list scandals onto the front pages of even staunch Conservative newspapers, significant damage had already been done to the infrastructure of support services in what were increasingly overcrowded hospitals.

Long gone were the heady days of Spring 1985 when the contractors' own trade confederation, the Contract Cleaners and Maintenance Association (CCMA)'s newsletter 'Reflections' headlined "We Are Winning," and confidently asserted that:

> "*We are currently winning over 75% of the competitive tenders in the NHS, which is well above our previous expectations. And there is no indication that this ratio will decline.*"

Instead CCMA member firms had increasingly run into financial problems, and others began to withdraw from tendering. A mere half-dozen of the 46 CCMA companies had between them cornered the lion's share of all contracts awarded.

Staffing problems and erosion of patient care

Contractors were facing enormous difficulties in recruiting and retaining staff on the inferior pay, terms and conditions they offered, which few of the old NHS workforce opted to accept. While most contractors paid similar hourly rates to in-house, they cut hours worked, reducing more staff to part-time (and saving on National Insurance), eliminated bonuses and overtime, and provided less holiday pay and little, if any, sick pay.[17]

The most notorious area for outsourcing has been **hospital cleaning**, where this experience has been replicated ever since in hospital after hospital across the country, with staff turnover in some 1980s contracts reportedly as high as 550%.

The result was a continuing churn of staff, effectively casualising the workforce, with few developing any experience or skills in doing the job properly. As the unions and campaigners had warned, the NHS ward teams, which combined ancillary nursing and medical staff with other professionals had been broken up by the separation of so-called 'hotel services' (cleaning, catering, laundry and porters) from clinical care.

This also set the pace for in-house bids: Whitbread and Hooper cited Leeds Western District Health Authority that won an in-house bid by **halving** the total number of working hours.

The National Audit Office (1987) found cost reductions had mainly come from three sources:

- Reducing the amount of service (reducing cleaning frequencies)
- Reducing labour costs, or
- Increased productivity (by making staff work harder, or in some cases such as catering using new technology).[18]

Wherever services were contracted out, the most dedicated and experienced cleaning staff, who often had been the staff best able to communicate with and support anxious patients, and supplement the level of care nurses could provide, were stripped out. Instead in came a contractors' workforce of inexperienced, under-paid and over-worked staff, required to work strictly to the specification in the contract, and no longer employed by the NHS or accountable to the ward sister or matron.

Tasks that were not in the specification, or which could no longer be done in the reduced hours of work, wound up being done by nursing staff or others – or not done at all.

Agenda for Change

The ground-breaking Agenda for Change (AfC) pay agreement, eventually signed off in 2004 replaced the antique Whitley Council system of pay grades, and covered all non-clinical and clinical staff other than doctors and the most senior managers. It was the first-ever system to be based on job-evaluation of each post, conducted jointly with the unions. For many staff it offered the possibility of upward progress through each band.

But it covered NHS staff only. As the new bandings were rolled out, and job evaluations took place in each trust, the contractors' staff fell even further behind the terms and conditions of the other staff they work with every day. In 2021 UNISON summed up the growing variety of contracts covering staff working for contractors in the NHS:[19]

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1. **Retention of Employment (RoE)**
   Although staff under the retention of employment scheme were seconded to work in private companies, they remained directly employed by the NHS trust/board and are covered by AfC bargaining and pay outcomes.

2. **Outsourced NHS staff where AfC rates have been agreed as part of the Contract**
   The NHS Contractor must 'mirror' AfC pay awards and rates. This group will have the entitlement to the nationally negotiated pay award applied as part of the terms of the outsourced contract.

3. **Outsourced NHS staff where AfC rates have been agreed but this is NOT part of the contract**
   The NHS Contractor does not have to 'mirror' the AfC pay award or pay rates. This group will have achieved this locally - often following political campaigning or an industrial dispute leading to negotiations between UNISON, the NHS Contractor and the NHS Trust. This mirroring may be time limited.

4. **Outsourced workers being paid below Agenda for Change rates**
   This group of workers are employed by an NHS contractor and they do not have a contractual right to AfC annual pay awards, and the NHS Contractor is not obliged to pay AfC pay rates. Staff could be employed on rates as low as the National Living Wage

To make matters more complicated still, support staff in hospitals that had been through several competitive tendering exercises that led to changes of contractor could be divided into several groups, each on different historical terms and conditions linked to previous employment, but none on fully equal terms with the staff directly employed by the NHS.

Cleaners' Voices

A UNISON campaign to mobilise hospital cleaning staff in 2005 brought a more in-depth focus on the 2004 Department of Health document Revised Guidance on Contracting for Cleaning, which noted in its introduction:

> "*Following the introduction of compulsory competitive tendering, budgets for non-clinical services such as cleaning came under increasing pressure, and too often the final decision on the selection of the cleaning service provider was made on the basis of cost with insufficient weight being placed on quality outcomes.*

> "*Since NHS service providers were in competition with private contractors, they too were compelled to keep their bids low in order to compete. The net effect of this was that budgets and therefore standards were vulnerable to being driven down over an extended period until, in some cases, they reached unacceptable levels.*

> "*Although improvements have been seen in recent years following the introduction of the Clean Hospitals Programme and the investment of an additional £68 million in cleaning, there remains concern that price is still the main determinant in contractor selection.*" [20]

The pamphlet Cleaners' Voices, which accompanied the UNISON campaign, focused on the contradiction between issuing strong guidance on standards of cleaning while the NHS persisted in many hospitals in contracting out this vital service to companies that were still fixated solely on profits for their shareholders, and not directly accountable to the clinical staff.

This was highlighted by the publication of the Matrons' Charter, 'An Action Plan for Cleaner Hospitals',[21] which said it was aimed at "all staff in the NHS, whatever their role," but paid no attention to the issue of contracting out.

Cleaners' Voices was structured as a response to the elitist approach of the Matrons' Charter. It set out "Ten key steps cleaners want to see to make cleaner hospitals a reality", of which number one was:

> "***Prioritise cleaning services***
> "*Cleaning staff throughout the NHS want to see hospital cleaning services made a genuine priority for NHS Trusts, from the topmost level of management downwards, including medical and professional staff. It is no good the Government saying that it is a priority when NHS Chief Executives are saying there is no more money in the pot for 'hotel services'.*

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"*Without proper standards of hygiene in wards, clinics and operating theatres it is impossible for clinical professionals to deliver high quality, hi-tech medicine.*

"*The message from cleaning professionals, loud and clear, is that it will require a complete break from the culture that has largely prevailed at management level since the Competitive Tendering of the mid 1980s, a culture which branded cleaning and non-clinical services as 'hotel services', and saw them as legitimate targets for contracts which slashed back hours of work and quality of care in pursuit of the lowest cost.*" [22]

Point nine on the staff list was bringing services back in-house:

"*Competition for contracts within this system has reduced even in-house services to the lowest common denominator. The answer isn't to produce more guidance on contracting to bring about quality services: private companies will never take responsibility when things go wrong nor will giving Matrons' powers to withhold money from poor performing contractors solve the problem. Rather than transferring risks, all we are doing by continuing with contracting-out, is losing control.*

"*Cleaning staff argue, overwhelmingly, that their services should be 'in-house' within the NHS. Bringing services back in-house must be seen as a vital first step towards restoring lost standards of care through team working. And unless staffing levels and hours of work are also raised, there is little chance that services will genuinely improve.*"

Privatisation and the spread of infection

In 2004 the Department of Health itself explicitly recognised the link between competitive tendering and the falling quality of what have remained remain labour-intensive support services. Its document *Revised Guidance on Contracting for Cleaning* noted:

"*Following the introduction of compulsory competitive tendering, budgets for non-clinical services such as cleaning came under increasing pressure, and too often the final decision on the selection of the cleaning service provider was made on the basis of cost with insufficient weight being placed on quality outcomes.*

"*Since NHS service providers were in competition with private contractors, they too were compelled to keep their bids low in order to compete. The net effect of this was that budgets and therefore standards were vulnerable to being driven down over an extended period until, in some cases, they reached unacceptable levels.*

"*… there remains concern that price is still the main determinant in contractor selection.*" [23]

In October 2004, then Health Secretary John Reid argued that one reason for the proliferation of one of the most serious Hospital Acquired Infections, methicillin resistant staphylococcus aureus (MRSA) had been the Conservative Government's decision to contract out cleaning work, with contracts going to the lowest tender.[24]

A survey showed that while just over a third (440 of the 1184 hospitals surveyed) employed private contractors, 15 of the 24 hospitals deemed 'poor' were cleaned by private contractors. This suggested very clearly that the incidence of poor cleaning was twice as common among privatised contracts.[25]

Big contract failures

In **Sussex**, a 5-year £15m contract with Sodexo for cleaning, portering and catering ended 3 years early in 2015, with services brought back in house: it was clear the trust and the company had attempted to make unsustainable savings, resulting in what management described as "inconsistencies in standards such as difficulties with maintaining cleaning standards".[26]

In **Leicestershire** a much bigger 7-year £300m contract[27] with Interserve to provide catering maintenance and support services to two NHS trusts and NHS Property Services was scrapped four years early, in February 2016. Around 2,000 staff were brought back into the NHS, and services are now delivered in-house.[28]

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Two years later University Hospitals Leicester admitted that cleaning and maintenance required significant additional investment, including an extra £2m in pay for the lowest-paid staff.[29]

Later in 2016 in **Nottingham University Hospitals** trust the failing contractors Carillion, who went bankrupt in early 2018, lost a five year £200m contract for cleaning, catering, laundry, car parking and security after just two years, amid a barrage of complaints over unacceptable standards. 1,500 staff were brought back in house.[30]

Carillion employees in Nottingham had complained from the outset of being short-staffed and lacking the right equipment to do their jobs properly: the trust argued that Carillion was employing about 70 fewer cleaning staff than required. The BBC reported some nursing staff were doing cleaning tasks themselves because they were not satisfied with the work of Carillion's staff.[31]

Subcos: privatisation as a tax dodge

As the succession of high-profile contract failures shook confidence in the ability of private companies to deliver adequate support services, interest was growing in a different, and more sophisticated way of cutting costs.

Foundation trusts and trusts began to look at ways of hiving off their support staff into 'wholly owned subsidiaries' (or 'subcos'), through which substantial savings could be made from tax, as well as from the development of a two-tier workforce in which new recruits would be on lower pay and inferior terms and conditions.

The subcos were set up at arm's length but still owned or partially owned by the trust. So support services that had been provided in-house were now provided by a separate company that will employ staff who currently work for the NHS.

As the Lowdown summed up:

> "*Trusts paid VAT on various services and consumables and could not recover it – that was the funding model. But some found that if they formed a subco, which is in legal terms a private company, then that gave an indirect and entirely artificial route to get that VAT back.*
>
> "*For many this was unacceptable tax avoidance. But the NHS management, desperate to find anything to mitigate gross underfunding, turned a blind eye. They argued that so long as the tax benefits were not the ONLY benefit then this organisational trick was acceptable.*
>
> "*So trusts, advised by their highly paid external consultants, wrote their business cases making bogus claims about 'service improvements,' or the ability to offer 'more flexible conditions' – just to pretend that tax was not the ONLY benefit.*
>
> "*In the real world, research by UNISON showed that tax changes contributed between 80 – 90% of the claimed value of benefits.*" [32]

The earliest experiment with a subco began back in January 2012 when Northumbria Healthcare FT transferred 806 staff out of the NHS, and into Northumbria Healthcare Facilities Management. The staff had been outsourced to a company owned by the trust. This early front-runner was also unusual in engaging with staff and their unions from the outset, and treating staff throughout as if they were still NHS employees: their new contracts effectively mirror changes in the national Agenda for Change pay scales. However even though the company did honour its promises to maintain the pay, terms and conditions of the outsourced staff, it took seven years for unions to negotiate an arrangement to ensure subsequent employees who had not transferred from the NHS could be eligible for the NHS pension scheme.[33]

Moreover the approach to staff of the Northumbria subco was by no means the norm. A UNISON analysis in 2018 reported that "The vast majority of trusts who have set up a subco are not offering newly recruited staff NHS pay, terms and conditions."

Other trusts began to experiment. In London Guy's and St Thomas' FT launched Essentia in April 13, as a vehicle to bid for estates and facilities contracts outside the trust.[34] Back in the North East, City Hospitals Sunderland set up CHOICE as a subco in 2013, Gateshead FT launched its own subco, QE Facilities, with around 500 staff in two 'waves' in 2014 and 2016, and County Durham and Darlington FT set up their subco in 2017. More subcos emerged as the Northumbria model was embraced.

By 2018 there were subcos in the North West (Bolton, Blackpool and Clatterbridge Cancer Centre, the South East (Southampton, Royal Surrey County Hospital and east Kent University Hospitals, as well as several each in the South West, Yorkshire & Humberside and West Midlands.[35]

By the early 2018 there was growing activity by trusts around the country, with an estimated 3,000 staff having been transferred to subcos, and a rising number of trusts lining up with plans to transfer up to 8,000 more. Labour peer Lord Hunt told the Health Service Journal:

> "*Apart from the ethics of a public body using considerable time and resources to reduce their*

VAT payments, with no benefit at all to overall NHS budgets, more worrying is the likely impact on staff.

"Whether by design or not, thousands of NHS staff are essentially being forced out of NHS employment with considerable uncertainty about their future. Long term, this is a blatant attempt to undermine national pay bargaining with Agenda for Change increasingly being confined to clinical staff only." [36]

Strike ballots

Growing anger from unions at the blatant tax dodging at the expense of their members led to a series of ballot votes to reject and fight subco plans – with some considerable success, notably Wrightington, Wigan and Leigh (where prolonged action by health unions forced a compromise deal to drop the plan, brokered by the local council, and trusts including University Hospitals Leicester to abandon plans without a fight.)

This put pressure on the regulator, NHS Improvement, to step in, and announce that there should be a pause in any current plans to create new subsidiaries, to give time for a 'consultation,' followed by new guidance.

The pause was the barest minimum period: by November the new guidance was out. It fell short of the unions' demands that trusts be required to show plans had the support of staff, and to publish their (often flimsy) business cases – although it did require each trust to produce one. Nor did it change the continued lack of meaningful engagement with staff.

But it did impose some restrictions on how trusts and FTs could proceed. It declared that all plans for new subsidiaries (and any "material" changes to an existing subsidiary) would have to be reported to NHS Improvement – where they would be scrutinised firstly by a panel and then potentially as part of a more detailed review.

The guidance restated previous requirements that "trusts should not spend money on private sector consultancy support in the development of tax avoidance arrangements as this represents active leakage from the healthcare system."[37]

This same point was picked up by the Healthcare Finance Management Association, which warned its finance director members bluntly that: "It is not appropriate for NHS bodies to establish companies simply to avoid tax, this was confirmed in the letter from DHSC which is attached in the appendix to this briefing." [38]

However there was still no action to enforce this, nor was the guidance sufficient to prevent more confrontation, with a prolonged strike by UNISON in Bradford forcing a subco plan to be dropped, and strong ballot votes for action, or even threats of ballot votes forcing retreats by other trusts such as Princess Alexandra in Harlow, Frimley FT and Mid Yorkshire.

The threat of shunting support staff into a subco has therefore not been adequately countered, and the extent to which this applies to the lower-paid non clinical staff underlines the continued lesser status of staff who fulfil these crucial roles.

Bringing contracts back in house

Colchester – a forerunner in voluntarily bringing services inhouse

What was then Colchester Hospital University Foundation Trust (now East Suffolk and North Essex Foundation Trust) decided to bring all of its estates and facilities services back in house in the autumn of 2011.

An extensive April 2012 article in the Health Service Journal by the Trust's special projects director Nick Chatten and others, spelled out the excellent reasoning behind the change:

"In reaching the decision to bring estates and facilities services in-house the board considered three main objectives:

- ***Patient focus*** *To provide the opportunity to re-engineer the service model to one more suited to meeting current clinical needs.*
- ***Future proofing*** *To deliver flexibility for future requirements, providing a greater degree of control in the process of change management at a pace set by the trust.*
- ***Financial control*** *To achieve the required efficiency savings target in 2011-12, and to establish the context in which savings could be made in subsequent years.*

"The board considered that in delivering its overall objectives, the contribution of the estates and facilities services - for which the outsourced contract cost the trust £13m each year - could not be ignored. If we got these services right they could make a significant contribution to the future success of the organisation.

"Entering a period of significant change in the NHS, the trust needed to be responsive and nimble to the challenges the changing NHS landscape would throw up; in-house support services would allow for such a response." [39]

The article continued, explaining the limitations of contracting out services:

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> *"It was increasingly apparent that the output-based specification that had been in place over the past 14 years gave the trust little control over how services were delivered and how they were aligned to support clinical care. This made it difficult for the trust to achieve added value and efficiency from the contract.*

> *"The board felt that at a time when financial pressures on the organisation were expected to increase, it was appropriate to gain greater direct control over its estates and facilities services."*

The transfer to in-house was achieved smoothly in just 16 weeks, with full involvement and support from the unions. And the benefits of bringing services back under the control of the Trust were soon obvious:

> *"It is still early days, although we are already seeing evidence of the benefits we are aiming for. We appear to be close to achieving the cost savings we forecast from the service in 2011-12. More importantly though, from a patient perspective, we saw an overall improvement in our National Patient Safety Agency audit cleaning standards scores in October and November compared with the previous four months."*

Sadly Colchester was an outlier at the time, and the focus of the Health and Social Care Act on outsourcing served to hold up progress along similar lines for many years.

In 2024 (as this report is written) the merged East Suffolk and North Essex Foundation Trust is once more an outlier – this time for trying to **contract out** the very same services that the Colchester Trust brought back in-house, even as the new Government has been elected pledged to legislate to "end the Tories" ideological drive to privatise our public services.[40]

Fighting to end outsourcing – and winning

Since 2020 evidence for trends in contracting seems to point in towards a move to bring services back in house. A number of major trusts, especially in London, have publicly announced their decision to bring out-sourced services back in-house as contracts end.
In January 2020 **Imperial College Healthcare NHS Trust** Board decided to end decades of outsourcing to private contractors, and, initially for an experimental period, in-house the entirety of its cleaners, caterers and porters within the next 2 months.

The announcement marked the end of a three month long industrial dispute between the Trust and trade union United Voices of the World (UVW) that included nine days of strike action at St. Mary's Hospital.[41]

It was the first time in recent years that an NHS Trust had been forced by strike action to end the outsourcing of a group of workers.

Over 1,000 workers, outsourced for over 3 decades to global giants such as Sodexo and ISS across the five hospitals belonging to Imperial Trust, would enjoy the same pay and terms and conditions as NHS staff.

Petros Elia, the organiser of the strikes and UVW co-founder said:

> *"Today marks a huge victory not just for these brave workers, but for all outsourced workers in the NHS. Our members were told they would never win this fight, but with the full backing of UVW and mass picketing, blockades and occupations they've won against all odds.*

> *"This is also a victory for patients. Study after study shows hospitals that outsource their ancillary staff have higher incidences of infections, including MRSA, and patient complaints are higher when it comes to hygiene and cleanliness. Cutting out profit hungry contractors will allow the Trust to put patient health and safety first."*

Just over a year later, in April 2021, Imperial announced that the experimental period of running cleaning, catering and portering services inhouse in place of contracting with Sodexo had been a success, and would continue. A report to the trust's board said:

> *"The in-house hotel services function (including portering, cleaning and catering) continues to perform well, with transferred staff responding positively to the support and guidance of the new management team.*

> *"Service delivery standards remain good and detailed data generated by auditing, undertaken*

independently of the operational team, is allowing targeted changes in areas where standards can be improved further.

"The in-house approach has also allowed more flexibility in responding to covid challenges, such as increased cleaning frequency recommended by Public Health England. Since the last report, the service has been maintained and flexed to meet the demands faced as part of the evolving response to the pandemic." [42]

GOSH victory

The second breakthrough was at Great Ormond Street Hospital (GOSH) where the Trust Board announced in December 2020 that cleaning and domestic services would be brought in-house (after decades of outsourcing) once the current contract with external provider OCS had come to an end in July 2021.

The decision followed a successful campaign from the cleaners' trade union United Voices of the World (UVW).

Outsourced to OCS, the cleaners – almost all of whom are Black, Brown and/or migrants – had joined UVW at the start of the Coronavirus pandemic in protest at what they described as "institutional racism" as they received far worse pay rates and terms and conditions than their majority White in-house colleagues, including only being given Statutory Sick Pay of about £19 a day rather than full NHS sick pay rates.

The workers also reported being overworked, left without adequate equipment and uniforms, and alarming incidents of what they described as bullying, harassment and discrimination at the hands of OCS managers. The cleaner's complaints, along with a 45-page report which laid out a comprehensive case against outsourcing, including how it contributed to higher rates of Hospital Acquired Infections and could be detrimental to the effective handling of Coronavirus, were presented to the GOSH Board in November 2020.

The Trust's initial response was to deny responsibility for the cleaners, which led UVW to serve notice of its intention to ballot for strike action. Buttressing the threat of strike action was a unanimous vote in favour of strike action in a consultative ballot of the cleaners a few weeks earlier.

UVW had also threatened legal action against GOSH on the grounds that their outsourcing arrangement amounted to unlawful race discrimination in breach of the Equality Act 2010.

Petros Elia said: "This victory is historic. It shows what we have known all along, that outsourcing is a choice, and one grounded in Thatcherite ideology, and that as easily as the NHS and other public institutions outsourced thousands of workers at the stroke of a pen 30 odd years ago, so too can they can now choose to in-house them at the click of a mouse." [43]

The Trust's own press release explained,

"Cleaning and domestic services are essential for a clean, welcoming hospital environment that's safe from infection. This decision, which has been made by the Trust Board, is the best way to secure a high quality service for the future in line with the Trust's values." [44]

However the process was delayed,[45] and in March 2022 the UVW had again to threaten strike action to ensure that cleaners who had been brought back in house the previous summer were brought onto full NHS contracts from April 1.[46]

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More trusts opt to bring services inhouse

In June 2021 Epsom & St Helier University Hospitals Trust also decided to bring catering, cleaning and portering services inhouse, rather than retain its outsourced contract with Mitie. Chief executive Daniel Elkeles said in a statement:

> "*We have pledged to support equality, and this move is central to that commitment. Some 40 per cent of our cleaning, catering and portering staff are from black, Asian and minority ethnic communities — communities already hit particularly hard by covid-19. This is absolutely the right time to welcome these teams back to the NHS family, with all of the benefits that brings.*"[47]

In March 2022 a press release from Barts Health announced that almost 1800 cleaners, porters, security guards and domestic staff were to be brought in-house.[48] Serco, who had won the contract in a competitive tender in 2017 had recently served notice that it would exercise its right to terminate early, at the end of April 2023.[49]

The press release continued:

> "*The Trust engaged with trade unions and other stakeholders to explore alternative options. The Board and its finance and investment committee agreed to pursue one that was both financially advantageous but would also improve the quality of service, be flexible in response to demand, and maximise engagement with staff.*
>
> "*Shane Degaris, deputy group chief executive, said: 'We have always considered contracted employees to be part of our wider Barts Health family. However as we developed our WeBelong inclusion strategy to end racial discrimination, we realised that the Trust had a responsibility to take practical steps to include all our employees, including the lowest-paid'.*"

In April last year it was announced that nearly 300 cleaning and catering staff at North Middlesex University Hospital, who were employed by Medirest, would be brought back in-house. They had been working under worse terms and conditions compared to colleagues directly employed by the NHS, with poorer sick pay and holiday entitlement.[50]

In each of these cases the trust board has recognised the need to pay more to ensure improving services and to reward staff who had proved their dedication during the peak of the pandemic.

The current state of play: cleaning (domestic) services

A breakdown of the thousands of trust sites and their use of inhouse or outsourced services is provided in the most recent ERIC (Estates Returns Information Collection) data.[51] They show that despite all of the efforts to force through contracting out, a significant majority of sites are currently covered by **in-house** cleaning services, with only a minority relying on private contractors.

While they do not give details of how many contracts are involved in each trust, the ERIC data reveal that of the 2,031 sites where the provision of cleaning services is shown, 1,123 (55%) made use of in-house services, with 908 (45%) outsourced.

Among the 24 Large Acute trusts the prevalence of in-house services is much more pronounced.

- Twelve (50%) of the 24 Large Acute trusts rely solely on in-house services, and five more are predominantly in-house.
- Only four of the 24 (16%) are almost or entirely dependent on outsourced cleaning and portering, of which three (Lewisham & Greenwich, North West Anglia, and Portsmouth) have been shaped by major PFI contracts. Only one trust not centred on a PFI hospital was wholly outsourced – East and North Hertfordshire.
- Two trusts with major PFI contracts combined a majority of in-house with a minority of outsourced services.

Within these 24 trusts 136 of the total of 163 separate sites giving details (**83%**) rely on in-house cleaning services, with fewer than one in five (**just 17%**) resorting to private contractors.

Laundry

While cleaning ('domestic services') has remained largely a task for manual labour, with limited scope for profit without reducing the quality of the work done, the private sector might be expected to enjoy much more success in bidding for contracts that involve capital investment – catering and laundry.

A 2018 study of official NHS statistics on laundry services[52] found:

> "*Linen Services **are in the main outsourced** with around 90% private contractors, 65-70% with one contractor, Berendsen, who were recently taken over by a company based in France called Elis. The other 10% or so is the few remaining in-house laundries.*"

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However this is not because the day to day costs of using a private provider are cheaper than in-house. In fact:

> *"A straight forward analysis of the Trusts with In-house providers or a service provided by a neighbouring Trust with an In-house laundry, shows that they are almost exclusively in the lower cost bracket, the only exception to this being those that provide to Mental Health Trusts with more complex linen requirements around patient clothing."*

The chronic lack of capital in the NHS stands in the way of in-house provision, even though it could generate income for the NHS:

> *"With the NHS facing significant challenges with finance, there is little appetite to support In-House laundry plants especially as this would incur substantial investment,* ***although where there is support, In-House laundries have proved to be a significant income source and importantly a way of keeping money in the NHS.****"*

The collapse of Carillion early in 2018 also highlights the risk of relying on external companies. The author warns:

> *"Linen provision to the NHS is almost totally outsourced and with the closure of so many In-House laundries over the last 30 years and with services overwhelmingly delivered by private companies, any problems with providers may find NHS Trusts with some very large headaches and few alternatives for the supply of their linen."*

Catering

NHS trusts' attitudes to catering, too, have been shaped around short-term views and the long-term lack of capital to invest in modern kitchens. A 2015 pamphlet *Keep Hospitals Cooking,* published by the Campaign for Better Hospital Food[53] argues the case for "the value of protecting hospital kitchens and of keeping patient and retail catering in the NHS and not contracting it out to private companies." It warns:

> *"Increasingly, hospital Trusts are deciding to close their kitchens and contract catering out to private companies providing pre-prepared ready meals. This chapter examines the role and value of hospital kitchens in more detail and finds that they are vital infrastructure for hospital Trusts seeking to improve the food they serve to patients."*

Care Quality Commission inpatient surveys show that patient satisfaction with their hospital meals is generally higher where food has been freshly cooked in a hospital's own kitchen or Central Production Unit (CPU) … than with pre-prepared meals made by private contractors that are delivered to the hospital to be reheated there.[54]

It notes that preparing and cooking fresh food in a hospital's own kitchen may also enable in-house caterers to create **cost savings**, for example by making fresh food from cheaper, fresher seasonal ingredients and being able to negotiate with local suppliers, "potentially as part of a collaboration with other public sector organisations."

In house cuts costs

Challenging the common presumption that contracting out catering reduces costs, the pamphlet shows evidence to the contrary:

> *"Trusts may be able to make short-term savings by contracting out catering to a private company and closing its kitchens, for example by making redundancies to NHS catering staff directly employed by the Trust. However, some are hospitals are showing that it might cost more to buy food from private contractors than to have it made in-house, and therefore may lead to higher catering costs in the long term.*

> *"Nottingham City Hospital, for example, saved an estimated £6 million by going back to freshly preparing and cooking food on-site after a period of contracted-out catering.*

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> "*John Hughes, Catering Manager at the trust, informally estimates that the NHS could make annual savings of £400 million if every hospital did likewise.*" [55]

More evidence is provided, to show that patients prefer food **produced in-house by NHS staff** rather than by contractors, and that bringing catering services in-house can generate income for the trust.

Nevertheless the current picture (as of 2015) was of 40% outsourced provision of catering:

> "*As many as four out of ten NHS hospital Trusts have now contracted out their patient catering to private companies, often as part of larger contracts to manage a variety of hospital services including cleaning and maintenance services. The remaining hospital trusts (six out of ten Trusts in total) either employ NHS catering staff or use a mixture of NHS and private contracted catering staff.*"

In 2017 an article in *Health Business* noted the dominant "negative discourse around hospital food" and pointed to a review of progress two years after the Hospital Food Standards Panel's report which found widespread breaches of what were meant to be mandatory standards:

> "*For example, 48 per cent of hospitals were found to be non-compliant with the Government Buying Standards, whilst only 55 per cent of hospitals follow the BDA's Nutrition and Hydration Digest.*" [56]

In 2019, an outbreak of listeria in hospital trusts supplying sandwiches supplied by the Good Food Chain[57] led to a sudden interest in the quality of hospital catering from both ministers and opposition. Both major parties declared themselves in favour of bringing catering services back in-house,[58] with Health Secretary Matt Hancock, apparently unaware of the parallel position taken by his Shadow, Jonathan Ashworth, calling for a "root and branch review," noting that "dozens of hospital trusts" had improved food quality by bringing catering back in house.[59]

However the following year NW Anglia NHS Foundation Trust attempted to move in the opposite direction, seeking to outsource Hinchingbrooke Hospital's multi-award winning catering department, which freshly cooks meals for patients and staff from locally sourced ingredients, and hand the contract to a private company reliant on bulk-processed cook-chill food from central depots.

The plan was a triumph of ideology over evidence, since any claims that privatisation might lower costs or increase efficiency were undermined by official NHS figures. These showed that the cost per patient meal was significantly HIGHER for supplying bulk-processed food from the privately-run re-heating facilities in Peterborough Hospital (averaging £5.33 per patient meal) than it was from the professionally-run in-house kitchens preparing fresh food in Hinchingbrooke (averaging £3.64, 46% cheaper).

Eventually after strong campaigning by the unions, Hinchingbrooke's catering was reprieved, although other services were outsourced.[60]

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2 The Private Finance Initiative

The Private Finance Initiative (PFI) has been given its own section in this study because it is perhaps the biggest privatisation so far in the NHS, but it does not neatly fit either into clinical or non-clinical services.

PFI has been a driver of outsourcing of non-clinical services, but through rigid index-linked contracts it has also had an impact by restricting the budgets available for clinical care, which in many PFI hospitals are the only services directly controlled by the trust boards.

The birth of PFI

In November 1992, as a recession hit the economy, Chancellor Norman Lamont delivered an Autumn Statement which unveiled what became the Private Finance Initiative (PFI). He said:

> "*…the Government have too often in the past treated proposed projects as either wholly private or wholly public. In future, the Government will actively encourage joint ventures with the private sector, where these involve a sensible transfer of risk to the private sector.*" [61]

This was a distinct change of policy from a Conservative government that since 1979 had shown little interest in investment in public sector infrastructure, and focused instead upon controlling "public spending in general and capital spending in particular."[62]

Indeed PFI was an attempt to break free from the management of the economy by the Treasury in the style often labelled as "the dead hand of the Treasury". For decades successive Conservative and Labour Chancellors had dutifully followed the advice of the Treasury, and seen it as their role to strictly control public spending, capital investment and the "public sector borrowing requirement".

This resulted in the nationalised industries being starved of funds – increasing the in-house pressure for their privatisation, in order to escape the financial straightjacket. In the NHS it resulted in a very limited capital programme, which failed to keep up with backlog maintenance as well as the requirement for replacement of very old and dilapidated premises.

The Thatcher Government tried to escape from this impasse by privatising the nationalised industries – but had baulked at privatisation of the NHS.

While it breached 11-year-old rules restricting the use of private capital,[63] PFI was clearly in keeping with the post 1980 ideological frameworks of neoliberalism (with its obsession with maximum private sector role, free markets and minimum public/state involvement).[64] Lamont's successor Kenneth Clarke was an even more enthusiastic promoter of PFI, which he famously summed up as:

> "*Privatising the process of capital investment in our key public services.*" [65]

The policy was eventually branded as the Private Finance Initiative – PFI – although the acronym was soon to be parodied in many ways, from the ubiquitous

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'Profits For Industry', through to the NHS variant 'Profiting From Illness,' and the dismissive general summary: 'Pure Financial Idiocy'.

The mainstream press shied away from much serious analysis or discussion of PFI, often arguing that it was "too complicated" for news audiences. However the idea was a simple one: instead of the Treasury borrowing money on behalf of government departments to finance new infrastructure, each project costing in excess of £5m should be put out to tender, inviting bids from the private sector.

The contracts were not just for private construction firms to build new hospitals for the NHS: this had always previously been the case.

Under PFI the same companies linked up in consortia with finance companies and support service contractors, and bid for long-term contracts to 'Design, Build, Finance and Operate' the new facilities over 25-30 year periods. During this time they would effectively lease the buildings to the public sector and provide a variety of support services, in exchange for a 'unitary charge' payment which would cover the costs of capital, the construction costs, the services, and of course a substantial profit for the consortium. The unitary charge would rise each year by an agreed basic percentage, or by price inflation if this was higher.[66]

PFI = public sector debt

These capital schemes were not investments, but new forms of public sector debt. NHS trust managers would be left in control only of clinical care, while other support services including maintenance of the hospital buildings was to be done by profit-seeking private companies.

The 1990 Act also established a new system of 'capital charges' under which NHS trusts had to pay a 6% charge on their net assets each year to the NHS Executive, which brought additional administrative costs, while contributing no extra resources in return. Its effect was to normalise the idea of NHS hospitals paying out from their core income to cover the costs of buildings and equipment.[67]

However NHS capital charges effectively recirculated within the NHS itself, while payments for PFI hospitals would flow *out* of the public sector … and in to the coffers of private companies (several of them in offshore tax havens) of which a sizeable share would be scooped out as profit or dividends.

In November 1994 Kenneth Clarke went further, and told the CBI conference that in future the Treasury would only provide capital for projects as a last resort – after private finance has been explored:

> *"The Treasury is not frightened of the private sector making money out of the initiative. We cannot expect the private sector to assume new risks without the prospect of new levels of reward."* [68]

Government capital spending fell steadily from 1992, but progress on PFI contracts was slow. By 1996 angry and frustrated CBI leaders warned Clarke that PFI could fail without more decisive action. They were angry at the bureaucratic delays and costs which were holding up key infrastructure projects – and limiting the lucrative possibilities they had scented when it was first announced.

Conservative legislation in 1996 was expected to free the logjam by giving a commitment that the government would effectively act as guarantor for any debts to PFI consortiums if one or more Trusts went bankrupt, as health ministers had warned was now possible in their new, competitive, internal market in which some trusts were likely to be 'winners' – but only if others were losers.

Despite the legislation no hospital PFI schemes were signed under John Major's Government which had invented PFI. In 1996 Sir George Young, Secretary of State for Transport, which was signing early PFI deals, wrote to then Chief Secretary of the Treasury William Waldegrave, to raise his doubts over the extent to which risks were in fact being transferred by PFI to the private sector:

> *"The 'theory' is that all is well if risk transfers to the private sector. It is difficult to see how this happens in the case of services which are free at the point of delivery, and where ultimately the Government has a statutory duty or political imperative to pick up the pieces if there is a default."* [69]

Norman Lamont, who had first launched the PFI programme, also later had doubts. In 1999 he warned in his memoirs: "I suspect that in the long run some of these projects will go wrong and appear again on the Government's balance sheet, adding to public spending. We shall see." [70]

Labour's conversion to PFI

Labour's initial reaction was to oppose PFI. In July 1993, Harriet Harman, then Shadow Chief Secretary to the Treasury, speaking in the Commons strongly questioned whether PFI was a genuine partnership, as had been claimed: "It is clear that that initiative is not about partnership. It is about the Government abandoning their responsibility to modernise our economy and our infrastructure and it is about them passing the buck to the private sector." [71]

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Margaret Beckett, as shadow health secretary, toughened up the line in 1995, summing up what had become Labour's critical response, when she told the Health Service Journal:

> "*As far as I am concerned PFI is totally unacceptable. It is the thin end of the wedge of privatisation.*"

It was not until the summer of 1996 that Shadow Treasury minister Mike O'Brien announced a change – in fact a reversal – of New Labour's policy:

> "*This idea must not be allowed to fail. Labour has a clear programme to rescue PFI*" [72]

The 'rescue of PFI' was duly included in New Labour's 1997 manifesto, sitting strangely alongside promises to scrap the NHS internal market.

The pledge to scrap the market rather predictably proved to be an empty one: but the promises to implement PFI were sincere enough. By the spring of 1998, PFI was declared to be:

> "*A key part of the [New Labour] Government's 10-year modernisation programme for the health service.*" [73]

Kenneth Clarke had openly boasted that PFI would generate new profits for the private sector. But New Labour, forgetting the criticisms Harman and Beckett had made, begun arguing that using private investment to modernise public services was a "partnership," an example of the "Third Way" as argued by Tony Blair, finding common ground between neoliberalism and social democracy.

To break the impasse in signing off PFI schemes, most notably for building new hospitals, the new Government's only legislation on the NHS in 1997 was another short Bill to facilitate PFI.

The New Labour Health Minister who pushed the new Bill through parliament, Alan Milburn, echoed the words of the Conservative peer: the Bill was intended first and foremost to give the bankers just what they wanted:

> "*[It's] about removing doubt, providing certainty, and above all getting new hospitals built.*"

A Labour peer, Baroness Jay made it even clearer who was pulling the strings and effectively dictating the legislation:

> "*…the banks concerned have seen and agreed the wording of the Bill and have made clear that it satisfies all their concerns.*" [74]

Despite its popularity with New Labour ministers (most notably with the Treasury team) PFI soon began to incur the increasingly vociferous opposition of the BMA, the Royal College of Nursing, UNISON and almost all trade unions, local campaigners in affected towns and cities, and a growing body of academics.

This was because PFI came to be associated with high and inflated costs, buildings that were too small and poorly planned, and contracting out of support services, which once more attacked standards of care and staffing levels while offering additional profit streams to the private sector 'partners'.

As soon as the 1997 Act went through Parliament the first wave of PFI contracts were signed, and after a prolonged period of standstill on any new hospital building the go-ahead was suddenly given to 15 hospital projects in 1997. Since this was before devolution, the first lists of schemes agreed included one in Wales and three in Scotland.[75]

From 1997: PFI brings more outsourcing of services

The first flurry of contracts signed for the building of hospitals funded through the Private Finance Initiative also carried the requirement that NHS support staff be transferred to the service provider in each PFI consortium – whose contract was part of the deal. Many of the subsequent PFI deals have also involved a substantial transfer of staff to private contractors.

This led to significant numbers of NHS support staff leaving their jobs rather than face an unknown future under a new private employer, while others encountered all kinds of problems once the new hospitals opened, as summarised in *The PFI experience: Voices from the Frontline*,[76] a 2003 pamphlet of interviews with staff in nine new PFI hospitals in England, Scotland and Wales. Among the recurrent themes were:

- Cuts in staffing levels, and substantial increased workload for those remaining
- Cleaning and portering staff no longer being part of the NHS team
- Cleaning staff dissatisfied with the work they could do in the available time
- Cleaning staff in several trusts also required to serve meals without adequate hygiene provision
- Lack of proper staff accommodation,
- Support staff denied the use of their fridges and kettles, and obliged to use high priced catering
- Two-tier workforce, with contractors' own staff and new recruits on lower pay: transferred NHS staff on (more expensive)

TUPE protected terms and conditions discriminated against for overtime and on shift patterns, hoping they will leave.

Fears of similar problems led to a courageous 10-month strike by hundreds of support staff in Dudley Hospitals[77] against being transferred to a private contractor, which was eventually concluded by the signing of a TUPE-plus agreement in 2001.

No evidence for PFI value for money

The arguments in favour of PFI have always been heavily dependent upon theoretical assumptions, generalisations based upon unclear core data that could not be verified, and taking the word of accountants.

For example the Arthur Andersen report *Value for Money Drivers in the Private Finance Initiative*, published in January 2000,[78] was for years almost the only so-called "objective" analysis that was cited by ministers seeking to back up their claims that PFI did in fact represent good value (the Andersen report even claims much better value) than a publicly-funded alternative.

It was impossible to explore the detail of the Andersen claims, because the Full Business Case documents which they claimed their figures were based upon were never identified – there was not enough detail even to indicate the types of project involved (whether hospital, road or prison). The validity of their key finding was that the budgeted costs of 29 actual PFI projects appeared to show an "average saving of 17 per cent" over the projected costs of the schemes had they been publicly funded.

This was frequently challenged, not least on the basis that **half** of all the "savings" reported in the study came from just **one** scheme, making the 17 per cent "average" unrealistic. An equally serious flaw in the argument was that 60 percent of the claimed "savings" were based on the highly contentious (and now largely disproved) notion that "risk" was being transferred from the public to the private sector. But only one such "risk" is identified, (construction cost overruns) accounting for less than 1% of the total, leaving the bulk of this claimed saving undefined.

In other words ministers and their advisors wanted to be given some form of evidence to support their planned policy – and were not at all choosy about the quality or credibility of that evidence.

An irritated Lib Dem spokesman Matthew Taylor pointed out in the Commons on June 21 2001:

> "*The Government always quote the Arthur Andersen report because it is the only one to support their position. The survey was based on expected savings, rather than delivered savings.*"

And after the Andersen report had been effectively discredited (not least because of the company's involvement with the collapse of US energy company Enron in 2001) ministers turned instead to using an equally inadequate 2001 report by PricewaterhouseCoopers, *Public Private Partnerships: A Clearer View*. This replicated many of the same flaws of the Andersen report – but was if anything even less impartial.

PWC at that time described itself as "The market leader in project finance and privatisations …" and as "Financial Advisers on all the best Public-Private Partnerships." In fact the company boasted of its involvement in more signed PFI deals than any other consultancy firm in 2000, with 90 signings of projects valued at £8.276 billion.[79]

Its report was based on interviews primarily with managers and senior staff involved with 20 different projects – all selected by PWC. Indeed despite the many times it was cited by ministers the report offered no hard evidence at all to support the claim that PFI represented value for money.

Eventually a number of PFI deals were signed which covered only the costs of the building, and left staff employed by the NHS but managed by the private sector, under "retention of employment provisions"[80] although a majority of PFI deals came with a long-term commitment to use of contracted out support staff.

However they were set up, PFI deals in the NHS seemed to deliver an unrivalled profit stream. In 2006 researchers from Manchester Business School calculated the extra cost of financing new hospitals through PFI at £480m a year, as private equity providers enjoyed a 58% return on their investment.

The researchers also questioned the longer-term affordability of PFI schemes, some of which consume upwards of 10% of a Trust's income. Unlike capital charges, the payments to PFI consortia represent a net flow of cash and capital out of the NHS and into the coffers of banks, building firms and their shareholders.[81]

Treasury refutes Anderson and PWC claims

In 2011 a Treasury Select Committee report on PFI concluded:

- The use of PFI has the effect of increasing the cost of finance for public investments relative to what would be available to the government if it borrowed on its own account.
- The substantial increase in private finance costs means that the PFI financing method is now extremely inefficient.

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- There is no convincing evidence to suggest that PFI projects are delivered more quickly and at a lower out-turn cost than projects using conventional procurement methods.
- We have received little evidence of the benefits of these arrangements, but much evidence about the drawbacks, especially for NHS projects.
- Owing to the current high cost of project finance and other problems related to PFI we have serious doubts about such widespread use of PFI.[82]

In September 2011 the Health Service Journal reported that "60 hospitals face 'collapse' over PFI deals", having admitted that their "clinical and financial stability" was at risk because of the spiralling costs of PFI contracts. The hospitals at risk include the Oxford Radcliffe and Nuffield Orthopaedic Centre, Worcester Acute Hospitals, Portsmouth, Buckinghamshire and North Bristol.

Bailing out the PFI schemes

PFI cost starts to weigh heavy

By 2012, twenty years after the PFI policy was first announced, Treasury figures revealed that 17 NHS Trusts in England had already paid out at least the full cost of building their new hospitals – but still faced years of increasingly heavy payments under the Private Finance Initiative (PFI).

Between them the 17 Trusts had already paid out more than £3.2 billion for hospitals which were costed at £1652m: but they still had a total of £14.2 billion to pay off between them.

Six Trusts had already paid more than double the cost of the hospital, but still had years to pay. Four trusts had paid more than three times the capital cost – and Wycombe and Amersham Hospitals Trust topped the 'bad value' league table, having shelled out more than FIVE TIMES the cost of its £45m hospital, while still having another £354m to pay – the total payments stacking up to almost 14 times the cost of the building.

Almost as shocking was the Birmingham & Solihull mental health unit, which had been built for £18m, and had already cost £58m, but would eventually cost £247m under PFI. Also costing more than ten times the original cost was the £158m Norfolk & Norwich Hospital, which had paid out £460m, but had another £1.2 billion still to find.

In all 20 Trusts in England faced outstanding PFI bills of more than £1 billion – a total of £40bn – headed by the £5.7 billion for the (£1m per bed) Barts project, followed by Coventry's University Hospital (£3.4bn to pay), Central Manchester (£2.5 billion to pay) and the Oxford Radcliffe Hospitals, whose two schemes added up to liabilities of £2.4 billion.

The Treasury figures also showed that in England alone PFI hospitals worth £11 billion had already cost £8.1bn, and would cost another £62.6bn before they were paid off – an overall average of 6.4 times the original cost.

These bald figures help explain why PFI has kept raising its head as a major problem for successive governments: the deals were unbelievably expensive, and rotten value for money – and the consequences could mean cuts in services and staffing levels.

Some of the more recent schemes had caused the swiftest crisis: Mid Yorkshire Hospitals' £311m scheme has only been open a short time, but was already creating a massive debt crisis, with the Trust needing to save £2m a month. Peterborough health managers were wrestling with the soaraway cost of 'unitary charge' payments on the £289m PFI-funded City Hospital and the £25m City Care Centre which came with it, with payments of £3m a month, but scheduled to rise each year until the final payment of £60m in 2043.

Bailing out PFI

In February 2012 the Department of Health announced that it would make £1.5 billion available - in grants not loans - to seven hospital trusts in England with the heaviest PFI debt, to enable them to make PFI payments.

But to qualify for the cash Trusts would have to pass four tests on their debts, services and productivity savings. The hand-out was part of a bid by Andrew Lansley to buy the government's way out of problems on PFI while leaving PFI schemes (and the hefty profits they offer to shareholders) still intact – and diverting attention from the Health & Social Care Bill.

But far from unpicking PFI, Lansley, following the lead of Chancellor George Osborne, had been busily signing new PFI deals since taking office, compounding the long term financial problems of more and more Trusts.

PFI-driven bankruptcy

The impact of PFI also came dramatically to the fore centred on two South East London first wave PFI hospitals, the Queen Elizabeth Hospital in Woolwich, and the Princess Royal Hospital in Orpington. These had been merged into a single giant, debt-ridden South London Healthcare Trust, bringing their cumulative debts and soaring costs with them. The two hospitals had cost a total of £214 million to build, but were set to cost the NHS and taxpayer £2.6 billion to repay over 30 years.

By the time Secretary of State Andrew Lansley invoked the "unsustainable provider regime" in July 2012 the

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South London Healthcare Trust had a cumulative deficit of £207 million.[83]

Interestingly the draconian powers wielded by the Trust Special Administrator (TSA) who was brought in to propose a way forward were not deployed to challenge or force any renegotiation of the disastrous PFI contracts, which even the TSA admitted saddled the Trust with capital costs far above the NHS average. In fact all the concessions were made by or on behalf of the NHS: the plans drawn up included not only writing off the back debts, but a hefty annual subsidy to underwrite some of the excess cost of each scheme until the contracts are paid off – bringing the bail-out cost to more than £600 million.

The TSA, desperate to find some assets to plunder in order to minimise the cost of the bail-out, also seized on the idea of closing down and selling off two thirds of the neighbouring – but unrelated – Lewisham Hospital. This triggered local outrage and a succession of very large protest demonstrations, lobbies, and meetings.

A legal challenge was mounted jointly by the campaigners and Lewisham council, which early in 2013 eventually overturned this aspect of the TSA proposals, on the grounds that the Administrator, by taking action in an adjacent Trust, had exceeded even the sweeping powers he had been given.[84]

Lewisham Hospital had been saved, but it was merged into a new trust with the QEH, while the Princess Royal was taken over by King's College Hospital FT: as a result both organisations have remained chronically challenged financially.

Carillion collapse

Early in 2018 Carillion, the multinational construction and services company abruptly collapsed after years of mismanagement, handing out excessive dividends to investors, and having run up debts of £7bn, more than its annual sales of £5.2bn.[85]

As well as having been a leading player in PFI projects in the NHS and schools, Carillion had run a failed Independent Sector Treatment Centre,[86] and won (and then lost) a major contract with Nottingham University Hospitals for support services.[87, 88]

Carillion's collapse halted work on two major PFI hospitals (Royal Liverpool and Midland Metropolitan in Smethwick). In each case the public sector had to step in, take over the contracts, effectively rebuild much of the work that had been done, and pick up a hefty additional bill for the remaining work – effectively doubling the initial cost for completing each hospital, and delaying them by several years.[89]

This fiasco effectively marked the end of PFI – leaving an unresolved hiatus in capital investment, in which cynical promises of public funds to build up to 48 "new hospitals" conflict with the desperate shortage of capital to build or repair anything.

PFI keeps coming back for more

In June 2022, 30 years after Conservative Chancellor Norman Lamont first announced the policy, the New Statesman magazine published a study of hospitals funded through PFI (Private Finance Initiative) between 1997 and 2018, and headlined the fact that some had been spending more on PFI annual payments than they spent on clinical supplies.[90]

Tucked away in a table at the end was a list of Trusts with PFI contracts, beginning with those paying 10 per cent and more of their income on their PFI 'unitary charge' covering the cost of the building, support services, and interest in 2019.

Top of the list was Sherwood Forest Hospitals FT, forking out a painful 13% of income, followed by St Helens and Knowsley Teaching Hospitals and University Hospitals Coventry and Warwickshire. North West Anglia (Peterborough and Hinchingbrooke hospitals) and Great Western Hospitals (Swindon) are each on 11%, with Dartford and Gravesham, Portsmouth, Barking Havering and Redbridge and Dudley Group on 10%.

Also on 10% was the Norfolk and Norwich Hospital, built in 2001, which will not make its final payment until 2037. The trust paid £66m unitary charge in 2019 – equivalent to 10 percent of the Trust's income.

Mid Yorkshire Hospitals (Dewsbury, Wakefield and Pontefract) were recorded as paying £53m in 2019, which the researchers calculated as 9 percent of Trust income. However £53m was considerably (25%) more than the most recent Treasury figures expected the Trust to be paying in 2019.[91]

According to the Treasury, the total cost of the PFI contract covering Pinderfields and Pontefract hospitals, which cost £311m to build, should have been £1.6 billion by the time of the final payment … in 2043: and the Trust had still got most of that (£1.2 billion) to pay, with annual payments set to rise to £73m in 2041. The New Statesman figures for actual payments suggest this total cost would be much higher.

Even more worrying, these payments were always set to increase each year – by 2.5% or inflation, whichever is the higher. So the soaring rate of inflation had been driving up the unitary charge payments in every trust with large PFI contract.

If the calculations were right, and the Mid Yorkshire charge was £53 million in 2019, it would be at least £57m in 2022: so another 10 percent increase would see it leap by £5.7 million into 2023, £4.3 million more than expected. This was another hefty extra burden on the Trust going forward, as finances get tighter than ever.

Each inflated figure becomes the basis for the following year's calculation, and so on, so the impact will be considerable and long-lasting.

With unitary charges for NHS projects adding up to at least £2.3bn per year, the total extra headache for 100 or so trust finance chiefs added up to an extra cost of upwards of £170 million in 2022, at a time when budgets are already squeezed till the pips squeak.

Far from PFI being a device to stabilise costs and transfer risks to the private sector, all of the costs and risks remain firmly in the public sector, while the profits flow not just out of the NHS but all too often out of the country, to shareholders in tax havens.

Meanwhile the Guardian revealed that nearly half a billion pounds a year (almost £1 in every £5 spent on hospital PFI charges) was creamed off in interest payments. In four trusts almost half of their payments were interest paid to private companies and shareholders.[92]

So PFI is the rip-off that just keeps on taking: as the NHS faces a tightening financial regime its private sector 'partners' just keep laughing all the way to the bank.

Worse to come

However there could be even worse to come: a recent report by Nick Timmins for the King's Fund flags up the looming dangers awaiting NHS trusts as the first PFI contracts begin to near the end of their life – a phase barely considered when the contracts were drawn up over 20 years ago.

While the theory was that the maintenance component of each PFI contract would ensure that the building would be handed over in good order when the final payment was made, the reality is there is little incentive for consortia to spend out on maintenance in the final years. As Timmins warns:

> *"…while the promise of high-quality maintenance was there, it is the reality that is causing the current angst. As the National Audit Office has noted, with dry understatement, 'measuring the condition of an asset can be a subjective process.'"*[93]

The naivete of NHS managers who so often got stitched up as they signed the initial PFI contracts is now matched by the inexperience of their successors faced with the fight to ensure proper maintenance is done in the final few years:

> *"While there is plenty of guidance on managing the end of a contract, and some central support, the fact remains that these exit negotiations are still being done by individual hospitals and others, usually by people who have not done this before and are likely only to do it once, while the PFI industry has always been more concentrated and hence more expert. To the outside eye, this looks like a less than balanced equation."*

Billions more could be at stake across the 100-plus PFI hospitals and health facilities if the NHS gets this wrong, and the PFI consortia are allowed to get away with it.

The large excess sums that have been, and continue to be spent on PFI and the associate support service contracts clearly represent a major lost opportunity for more positive decisions on how the money could have been better spent – not least in bringing services back inhouse, and improving the terms and conditions of NHS staff. The money was there to build a much more robust and resilient NHS that would have much better withstood the pressures of the Covid-19 pandemic – but instead of investing in the NHS, the money flowed out of the public purse, and into the profits of the PFI consortia.

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3 Outsourcing of clinical services

Part 1: 1979-1997

Charges for care: eye and dental checks

The Conservatives had pledged in their 1979 manifesto not to increase prescription charges from the 20p per item level set by Labour. But within six months they more than doubled the charge per item to 45p. In April 1980 the charge went up another 55% to 70p, and by December 1980, when it went up again to £1, patients had suffered a five-fold increase in just 18 months.

The break-neck pace of increase continued, reaching £2.60 in April 1988 and £5.75 in 1998 – almost 28 times the cost 20 years previously.[94]

The prescription charge has always been the epitome of an ideological rather than a practical measure. Over 95 per cent of prescriptions are dispensed free of charge:[95] and comparing the total current income from charges of just £670 million (payable only in England) with NHS prescription drug costs of £11.9 billion shows that it is not a serious attempt to cover costs. It is a token gesture, forcing sick people – irrespective of their ability to pay – to stump up hard cash for their treatment.[96]

But the continued presence of some charges in the formerly free NHS did open the door to more and higher charges, and still plays two useful roles for governments favouring privatisation.

- Firstly each increase in prescription charges increases the pressure on low-paid workers to avoid going to the doctor, and for those unable to afford several items on a prescription form to choose one or more which they will do without. It is a crude, regressive (and ultimately short-sighted) way of managing demand.
- Secondly the introduction of fees for eye tests and dental check-ups, alongside the linkage of other dental treatment fees to (75 per cent of) the cost of the treatment, began to blur the distinction between an NHS charge and a private service. This distinction became harder when the eye tests were increasingly only done in High Street opticians' shops, and NHS dental charges were 'capped' at costs that were and are unaffordable for many on low wages.

From 1980 the government looked for opportunities to scrap free eye tests, eventually doing so in the 1988 Health and Medicines Act – which also abolished the free dental check-up.[97]

Free NHS spectacles were withdrawn from all but children and those defined as statutorily poor by the Health and Social Security Act of 1983: and from 1985 the limited range of NHS frames was halted, and 'free spectacles' took the form of vouchers, which often needed topping up as the costs of frames and lenses have increased.[98]

These measures, hotly debated at the time, and since, laid the basis for the subsequent complete privatisation of all but secondary care in ophthalmology, and today's situation in 2024 in which High Street opticians are effectively directly referring their customers for NHS-funded cataract operations in private clinics. The imposition of check-up fees and increase in charges for dental treatment also began the long-running saga of semi-privatised dental services in which whole areas are no longer served by NHS dentists, and many more areas have NHS dentists that insist they cannot take any additional patients.

Of course the costs of spectacles or dental treatment also act as a deterrent: when the New Labour government reinstated free eye checks for over 60s in 1999 they noted estimates that as many as 500,000 people may have been deterred by the initial fee of £10 or more.[99]

'Community care' – the first health care market

Until the late 1980s thousands of NHS long-stay specialist beds for older patients (geriatric beds) provided care for patients free at point of use. All of these have since closed, to be replaced by largely private sector provision of home care services and a mix of for-profit and non-profit private provision of nursing home care: this is still probably the biggest area of privatisation in the NHS.[100]

In 1987 there were 127,616 acute hospital beds (handling emergency and elective care) plus another 52,273 geriatric beds, giving a 'general and acute' beds total of 180,889.[101] 20 years later geriatric bed numbers had

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been cut by over 60% and acute beds by 20%, to leave a total of 122,374. Since 2010 the category of 'geriatric beds' has disappeared and the total of 'general and acute' beds at the last count has fallen to 101,339 (June 2024) – a reduction of 44% in 34 years.[102]

Margaret Thatcher's Government, tearing up the 'consensus' policies of much of the first 30 years of the NHS, began to shift the argument in 1981. They published a White Paper Growing Older (DHSS 1981) and a consultative document *Care in the Community* (DHSS 1981). Both centred on the drive to transfer patients and services out from hospital settings into 'the community.'

The consultative document suggested that funds for community-based services would depend upon the sale of surplus land and buildings. These discussions took place under a growing cloud of well-founded suspicion that the NHS was looking to 'community care' as a smokescreen to cover its abdication from responsibility for a growing area of care for the frail elderly and people with chronic mental illness.

The guidelines for provision of beds for the elderly drawn up by the DHSS in 1976 had been massively and systematically ignored by cash-strapped Regional and District health authorities. By 1984 a survey by Shadow Health minister Michael Meacher revealed that not one region in England was planning to meet the targets laid down for in-patients or day hospital places. Instead thousands of beds for the elderly had closed.

Despite a demographic 'explosion' which was creating a sharp increase in numbers of elderly people in the vulnerable 75-plus age group, NHS plans across the country were looking to reduce bed numbers to an average of 25% below the 1976 guideline provision – with an even bigger (50%) shortfall in the provision of day hospital places.

While the closures of geriatric beds and the shortfall in care for the elderly grabbed headlines, behind the scenes the biggest shift of policy in care of the elderly had gone through with little discussion in 1980.

The Social Security Act, endorsing a policy which began to be applied in 1979, gave DHSS offices the discretion to meet the costs of residential or nursing home care for elderly patients from the social security budget. At first only a trickle of patients from NHS hospitals were to receive care paid for in this way: but this was soon to increase to a flood.

Growing numbers of health authority and hospital chiefs spotted that this was the ideal means to shift the bill for caring for an expensive group of patients from their cash-limited NHS budgets on to social security: and they followed this by closing down the vacated NHS geriatric beds.

Business entrepreneurs with an eye to a profitable investment saw that private nursing and residential homes offered an attractive proposition; numbers of homes and places rocketed during the 1980s (nursing home places increased from 18,000 in 1982 to 150,000 in 1994: private residential home places expanded from 44,000 in 1982 to 164,000 in 1994), while NHS and local authority provision was rapidly reduced.

Entitlement

The procedure under the 1980 Act was made even speedier by a 1982 amendment to the Social Security Act. Until then Social Security officials had only been empowered to make top-up allowances to the board and lodging allowance to cover residential or nursing home fees: the new system made this an entitlement.

The process that ensued was one of rapid, unannounced and almost unchallenged privatisation. For the frail elderly, the concept of care free at the point of use and funded from taxation was rapidly disappearing.

More than half of the elderly people in residential homes were paying their own fees. Many of those who moved in to the dwindling number of council-run residential homes (which almost halved in number from 116,000 to 69,000 places over the same period) were obliged to pay for the privilege. Thirty six percent of the costs were being 'clawed back' from residents through **means-testing** – with people paying charges totalling around £1 billion a year in the mid 1980s, eight times the annual revenue from prescription charges.

But it was nursing homes which were set to become the biggest area of business growth. In 1979 it cost the DHSS £10m to finance 11,000 clients in nursing homes. By 1993, 281,000 people were receiving state-funded care in private homes, at a cost of £2.575 billion.

By the end of 1986 the Audit Commission was drawing attention to the scale of this spending, which was running out of control. Secretary of State Norman Fowler called in Sainsbury managing director Roy Griffiths to conduct an inquiry.

The resultant 1988 'Griffiths Report' (*Community Care; Agenda for Action*) proposed the transfer of responsibility for continuing care of the elderly **from the NHS** (where it was still provided free of charge at time of use) **to local government** (where it would be subject to means-tested charges). It amounted to the consolidation of privatisation and means-testing, with an end to the direct use of social security funding.

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Paying for their own care

A London Health Emergency (LHE) pamphlet (*Community Care: Agenda for Disaster*)[103] responding to the Griffiths report in September 1988 warned that

"We can hear the till bells ringing and the knife sharpening," arguing that imposition of means-testing (and thus cutting NHS expenditure at the price of increased charges on individuals, their savings and property assets) was the main driving force behind Griffiths' proposals, which were quite explicit, arguing that:

> "*Many of the elderly have higher incomes and levels of savings than in the past … **This growth of individually held resources could provide a contribution to meeting community care needs.**" (6.61, emphasis added)*

For this same reason Griffiths had little of substance to say about mental health services, which were to be left under the lead control of the NHS. It was a painful fact not lost on Griffiths that while many pensioners had savings and property assets which could be used to pay their own way, few psychiatric patients had sufficient wealth to make a similar approach worthwhile.

The Griffiths proposals implied even more wholesale privatisation, as they aimed to subject every aspect of community care services – whether residential or domiciliary – to "competitive tenders or other means of testing the market".

They would also confine social services departments to the role of 'purchaser' of continuing care. The vast majority (eighty per cent) of the government money flowing to social services would have to be spent in the 'independent' (private or voluntary) sector. There were measures to deter councils from providing their own residential care services for the elderly.

Strangely enough, however, these policies, commissioned and published by a government with a track record of attacking local authorities, were enthusiastically greeted by many Labour-led councils and chairs of social services. They seemed oblivious to the perils of what would later be described (in a rare political insight by shadow health spokesperson David Blunkett) as a "poisoned chalice", which would involve Labour councils in means-testing pensioners and forcing many of them to raid their savings and sell their houses to pay privately for care in profit-seeking private homes.

Thatcher, no fan of local authorities, had been persuaded to agree to this switch, recognising that it would bring a substantial reduction in government spending – and leave Labour councils taking the blame for failing services.

The government response to the Griffiths Report came in July 1989 with the publication of the White Paper *Caring for People*. Most of the Griffiths proposals were then incorporated into the National Health Service and Community Care Bill at the end of 1989.[104]

However the government recognised the potential disruption that could be caused if the reforms were introduced in 1991, alongside the new internal market proposals set out in the remainder of the Bill. So although the legislation was pushed through Parliament in 1990, the date for implementation was pushed back to 1993, meaning that the first new means-tested charges would be imposed comfortably after the next election.

First steps to create the 'internal market'

In January 1989 the White Paper, *Working for Patients* was launched with a lavish £1.25m nationwide press and TV extravaganza, including a video featuring

Margaret Thatcher which made clear the government was pressing forward with plans to "reform" the NHS.

Swiftly renamed 'Working for Peanuts' by staff and 'Working for Profits' by campaigners, the new plan relied heavily on the concept of an "internal market" which had been advocated in a 1985 paper by an influential figure in American health care, Alain Enthoven.[105]

Central to Enthoven's approach was the allocation to health authorities of budgets calculated on a per capita basis: the Health Authorities would then be free to buy services for local residents – either from each other, or from the private sector. His model was the US Health Maintenance Organisation, a device to regulate the ruinously expensive private healthcare sector which appeared to succeed in that objective for a few years in the mid-1990s.

Enthoven was one of the many economists, politicians and academics seeking ways of 'managing' the chaotic and ruinously expensive private market in health care in the USA. His proposals aimed to restrict the costs of private medical insurance – and therefore reduce premium payments for individuals and for corporations – through the introduction of "managed care", offering a restricted choice in the form of a defined range of funded treatments from a restricted range of "preferred providers" with whom specific deals would be done.[106]

He later went further, and argued in 2002 that excessive market freedom in the hands of health service users could undermine the market tools in the hands of the insurance companies, who would use their power to purchase in bulk as a means to hold down prices, arguing that free choice of provider destroys the bargaining power of insurers.[107]

The Thatcher proposals stopped well short of the root and branch 'privatisation' or attack on the essence of the NHS that some had feared; but it did begin to remodel the NHS itself, dividing it into purchasers and providers, in an "internal market".[108]

Purchasers

For secondary care the main purchasers would be District Health Authorities, with funding allocated on a complex formula to take account of the age profile and social circumstances of their population.

Health authorities themselves would be drastically reshaped to look more like businesses: numbers of HA members would be cut from an average 18 to just 11 – but this reduced number would include five 'executive members' (NHS managers, who had not previously had formal positions on health authorities).

Each HA would have a chair appointed by the Secretary of State, and paid £20,000 a year for part-time involvement, and five 'non-executive' members, paid £5,000 a year, also selected by ministers. Through these payments the government's control over the network of quangos through the power of patronage was strengthened.

A second type of purchaser would be GPs: bigger GP practices would be urged to take responsibility for cash-limited budgets, from which they would buy non-emergency hospital treatment for their patients – from local NHS hospitals or if they chose, from the private sector. GP budget-holders were swiftly renamed as "Fundholders" to avoid concerns that their budgets would run out.[109]

Providers

The 'providers' – the hospitals and community services – would initially be separately managed in an arm's length relationship with the health authorities, but they would increasingly be encouraged to **"opt out" of health authority control** as "self-governing" hospitals (later renamed as 'NHS Trusts' in an attempt to overcome complaints that they were effectively "opting out of the NHS").

Hospitals would be obliged to **compete against each other** for contracts from health authorities and GP Fundholders: the claim was that in this way money would "follow the patient", rewarding the hospitals which best succeeded in meeting local requirements, with an all-round extension of 'choice' and a downward pressure on costs.

The notion of competition was not popular in the NHS. Many hospital trusts were still smarting and showing the scars of the 'competitive tendering' of ancillary services, in which the lowest-priced tender had almost always been taken, and standards had fallen. There were legitimate fears that, as with the tendering exercise, the 'competition' would make only ritual nods in the direction of quality of care, and overwhelmingly centre on the issue of price: it would also lead to a further round of cost-cutting, which in turn, with labour costs still representing 70% of NHS spending, implied a fresh attack on staffing levels, pay and conditions.

Losers and winners

Competition also brings losers as well as winners. Less-favoured hospitals which lost out to rivals for major contracts would also lose contract revenue. Those determined to steal away contract income from rival hospitals might decide to concentrate on a few, potentially lucrative services, at the expense of closing others.

With health authorities already beginning to run down their provision of elderly care and mental health beds, it did not take a genius to work out the areas that were likely to be scaled down.

The proposal of GP Fundholding also brought in cash limits on primary care services for the first time. A handful of GPs were lured by the lavish cash incentives, the chance to break away from the narrow confines of services dictated by their local health authority, the opportunity to negotiate preferential deals for their patients to secure more rapid treatment at selected hospitals (opening up a two-tier service within the NHS), and in some cases the possibility of buying services from the private sector.

Another attraction for the most grasping GPs was that they would be able to retain within the practice any surplus left over from each year's budget.

One fundamental problem critics found with the introduction of fundholding was that it created a new uncertainty in the patient-doctor relationship. No longer could a patient be certain that decisions were being taken solely in his/her interests: now the financial situation of the practice, even the personal financial gain of the GP, could be seen as a possible factor underlying a decision.

The vast assets of NHS land, buildings and equipment would increasingly be 'owned' by the Trust Boards, which would have the power to sell off surplus assets, and the incentive to do so in order to minimise the new capital charges (notional rent, interest payable on half of the book value of their assets) they would have to pay each year back to the treasury.

Freedoms

There was also a suggestion that trusts would also have the freedom to borrow money from the government or from the private sector – this proved to be one of the most misleading promises, as Trusts found themselves constrained from day one by rigid cash limits.

Other promised 'freedoms' for Trusts included the right to expand private wings and numbers of pay-beds, and the right to decide 'local' pay and conditions for Trust employees – tearing up the long-established Whitley Council system of national-level agreements underpinning all grades of staff.

In return, Trusts were to be obliged only to balance their books and show a return on assets of 6% each year: any retained surpluses could be ploughed back into services. But of course any losses would also be the sole responsibility of the Trust, and the reforms carried the underlying threat that a failing Trust could go bankrupt. Ministers insisted from early on that they would not bail out Trusts which failed financially.

The Thatcher Government was not one to hold back for fear of public opinion, and the polls showing almost 75% of voters and more than half of all Conservative voters to be opposed to the reforms did not prevent the proposals being pushed through Parliament as the NHS and Community Care Bill.

Even as Margaret Thatcher herself, paying the price for the mass rejection of her Poll Tax policy, was ousted from office and replaced by John Major, the legislation was pushed through, receiving the Royal Assent in the summer of 1990. The first NHS Trusts began operations in April 1991 – with a massive package of redundancies at Guy's Hospital – and the unstable years of the internal market began.

We have become so accustomed since then to the existence of NHS trusts, and the separation of commissioners from providers within the NHS that it's hard for people now to grasp what a shock it was when NHS trusts were first allowed to 'opt out' of the control of local health authorities over 30 years ago. Much of the action running up to and following the NHS and Community Care Act of 1990 was reported for campaigners and trade unionists in issues of Health Emergency newspaper, which published 23 issues between the end of 1988 and the general election in 1997.[110]

Chaotic market

Margaret Thatcher's 'internal market' swung into chaotic action – a year after she had been bounced out as Prime Minister by a mass revolt against the Poll Tax.

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But there had been substantial resistance to the 'internal market' reforms, and as the first hospitals applied in 1990 to 'opt out' and become an NHS Trust (after a tokenistic 3-month 'consultation' period) many were met by a wave of active local anti-opt out campaigns.

Many large, angry public meetings were held. Polls revealed upwards of 70% of the public and 75% of health workers opposed to opting out.

However the Government had convinced most senior managers that there was little choice but to seek Trust status, and in December 1990 the first 57 Trusts were announced by the new Health Secretary William Waldegrave, set to opt out of DHA control in April 1991. 120 more hospitals and community units were already lining up with second wave Trust bids. 306 Fundholding GP practices, involving 1700 GPs were also launched, with more expressing an interest.

Two years of debate on market-style reforms to the NHS had triggered some outrageous plans by some local hospital managers as part of their plans for 'self government' as trusts. 'Income generation' wheezes were being hatched up in all directions: QEII hospital in Welwyn Garden City was offering business sponsors the chance to have wards not only named after them but painted out in their corporate colours.

Prioritising private patients

Even before the new legislation had passed, NHS hospitals had begun exploring the possibility of expanding their private patient activity. Early in 1990 the *Sunday Correspondent* revealed that Newcastle's Freeman Hospital (which had been forced to cut back NHS hip operations by 16% for lack of cash) proposed to use 'spare capacity' to carry out private operations on patients from Europe, aiming to under-cut the fees charged by BUPA hospitals by up to 50%.

Similar plans to increase private patient activity at ridiculously low prices were developed in East Anglia hospitals, while Harefield Hospital in North West London was also looking for a big expansion of private income as well as hoping to increase NHS workload "at the expense of other hospitals." [111]

St Thomas's Hospital management were anticipating extra overseas referrals as soon as the Channel Tunnel was completed. In Tunbridge Wells, too, the health authority allocated 13 rooms for private patients – at a fee lower than any private hospital. Great Ormond Street Hospital quoted a price for one operation £3,500 cheaper than a private hospital – leaving more profit for the private insurers.

In the five years to 1992 income from NHS private units increased by 40 per cent to £157 million, although no balance sheets to show the full financial costs have ever been published.[112]

The new Central Manchester Health Trust launched, proudly announcing a new "preferred provider" agreement with a private health insurance firm in an effort to fill unused NHS pay-beds.[113]

By autumn 1991 a new consortium had been launched involving 29 District Health Authorities and Trusts with under-used private beds, to investigate marketing 'package deals' including travel, treatment, convalescence and even car rentals for wealthy patients from Europe.

Manchester's Christie Hospital offered 26 health authorities the opportunity to buy preferential access for cancer patients, cutting the normal 6-week wait to just two weeks – by paying an extra £10,000-£25,000 per year.

The expansion of NHS pay-beds continued apace: analysts Laing & Buisson reported a staggering 84% increase in NHS private bed numbers in 1992-3; however figures showed 3,000 NHS pay beds had generated an average income of just £92 per day in 1989, while private hospitals were charging up to £400.51.

Attacking jobs, pay and conditions

The internal market brought a new level of instability and desperation to the new trust managers. Trusts were soon opting to exploit their new 'freedom' to alter staff pay and conditions, and behave more like the most tight-fisted private sector management.

Ambulance Trusts lost no time in seeking to cut back on jobs, pay and conditions, with a 33% pay cut for non-emergency ambulance staff in Lincolnshire, and hefty cuts for emergency and non-emergency staff in Northumbria – along with a 'single union agreement' signed not with any of the TUC unions, but with the management's favoured 'Association of Professional Ambulance Personnel,' which had just 40 members among 670 staff.

Almost every trust opted to discard the Whitley Council procedures that gave disciplined staff a right of appeal to the health authority.51, 52

Freelance professional staff?

As the new market opened up, in Autumn 1991 a confidential report to the NHS Management Executive from Keele University Professor Roger Dyson suggested turning staff into self-employed freelancers – with no sick pay, holiday pay, premium rates for overtime or unsocial hours and no pension rights. The savings to trusts would be so enormous Dyson suggested trusts

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could offer much higher hourly rates and voluntary redundancy payments or lump sums to lure staff into going self-employed.[114]

If this was seen as outlandish by most Trusts, it was later the basis of plans in Enfield (slapped down by the Department of Health), and in South East Staffordshire Community Trust (who also hoped to privatise portering, catering, laundry, transport services and even chiropody services).

Many Trusts did take up another Dyson idea, putting an ever-increasing proportion of their nursing and professional staff on short-term contracts, making it easier to shed jobs when cash pressures began to bite – creating a two-tier clinical workforce, with the lower tier facing much more insecurity.

And there was continuing interest in Dyson's call for a dilution of the "skill mix" in key departments, replacing more highly qualified nursing and other staff with (cheaper) staff on lower grades. Many second and third wave Trust applications drew attention to their on-going "skill mix review" as a way in which costs would be reduced.

Chiselling health managers were also still seeking savings by contracting out non-clinical services: in 1991 West Berkshire put all of its support services including admin and clerical work out to tender, a model followed by Essex Rivers Trust. In London, Parkside Community Trust management, copying the Royal Free Hospital, attempted to cut redundancy costs by "reckoning" that all trust employees had only started on April 1 1992.[115]

However trusts' bureaucratic costs were boosted by an explosion in salaries for top Trust directors, who were quick to cash in on new 'freedoms' to set their own pay scales, while – as many had predicted – the wages of most lower-paid staff continued to rise at less than inflation. The first £100,000-plus NHS chief executive was Peter Griffiths at Guy's Hospital Trust, where his package reportedly also involved two cars – one for him and one for his wife.

Rise of consultancy

The grimly familiar spectacle of costly but unworkable plans being drawn up by management consultants was already in evidence in 1990, with £200,000 (£1,000

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per page) squandered on a Price Waterhouse plan that collapsed almost at once, proposing a new 900-bed £140m hospital to replace 1,300 beds at West Middlesex and Ashford hospitals.[116]

Deloitte produced a plan to separate out the patient transport services from London Ambulance Service and put them out to tender, since unlike the emergency service there was a greater tolerance of failure and "many of the people so transported do not require an ambulance at all."

But one consultancy that could not survive the commercial market was Qa Business Services, formed from a buy-out of computer staff from West Midlands Regional Health Authority, which collapsed in the autumn of 1991 with debts unpaid and contracts unfulfilled.[117]

Competition within the NHS

Within six months of the internal market the chaos was growing. Orthopaedic patients from Exeter were jumping the queues of local patients waiting for operations in west London.

Consultants at St Mary's hospital were having to wait 4 days for authorisation from clerical staff before offering waiting list patients the treatment they needed – to ensure their health authority would pay the bill.

Bloomsbury and Islington health authority was complaining at unpaid invoices for elective treatment for patients from other districts.

The specialist child heart surgery unit at Guy's Hospital exhausted its 1991-92 contract budget for local patients with six months of the financial year still to go.

And the University Funding Council called for government intervention to prevent contracts in the new market going automatically to the cheapest hospitals – which threatened to put the teaching hospitals out of business.

Nonetheless in January 1992 NHS Chief Executive Duncan Nichol claimed that "both patients and staff are feeling the benefits" of the reforms.[118]

Cold Feet

Health Secretary Waldegrave, heralding the brave new world, began with bravado, declaring in April 1991 that: "It is essential that we let the internal market indicate what is needed in London, and we will then have to respond to those signals, which will force us politicians to take some decisions which have been postponed for much too long."

But ministers were already getting cold feet on the possible impact of the new market system, especially in destabilising services in the run-up to the coming general election: the market itself was to be heavily controlled, with instructions to health authorities to maintain a "steady state".

Additional cash suddenly became available – to increase numbers of NHS managers and admin staff to implement the extra bureaucracy in the reforms, and to avert any fresh cuts crisis in the run-up to the election.

With 82% of hospitals facing financial problems, many because they were treating more patients than expected – but not being paid extra because they had agreed to fixed price contracts, an extra £200 million was being pumped in to the NHS behind the scenes to prop up hospitals facing deficits.

The first six years

As the May 1997 election drew closer, the disruptive consequences of the 1990 Act were increasingly exposed, even though some of the wilder plans and projects had been rejected – or swiftly reined in by cautious ministers and more thoughtful NHS management who recognised the need to recruit and retain sufficient staff to maintain services.

Many trusts had been launched on false claims of financial viability and lurched on in near-permanent cash crisis. Private bed numbers had been hugely expanded, but the hoped-for bonanza of private cash had not materialised, and many were run at a loss. Contracting out had continued to erode the standard of non-clinical services. Moreover there had been an extension of privatisation into long term care of older patients, and into mental health.

The increased privatisation of long-term care as a result of the Community Care reforms had brought bitter localised and individual disputes over "eligibility" for NHS care – and the means tested charges for social services, explored in more detail elsewhere.[119]

Mental health services too had become increasingly dependent on private provision of medium secure and acute beds as the big old NHS hospitals were run down and closed without adequate alternatives in place.

Strangely almost none of these issues figured strongly in New Labour's electoral challenge – but voters were sick of the Conservatives, and Tony Blair romped home with a 97-seat majority and a promise to "rescue PFI."

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Part 2: 1997-2010

Conservative spending limits

The victory of Tony Blair's New Labour Government in 1997 came at a time of huge and growing waiting lists for care, with waits of more than a year commonplace and delays of over two years far from rare. Yet the first three years of the new government remained locked in to the limited spending plans outlined by Conservative Chancellor Kenneth Clarke, with only limited efforts to contain the waiting lists.

Only in 2000 did the policy change to one of large scale year-on-year increases in NHS spending designed to increase towards the average spending of comparable European countries.[120] As a result after 50 years of limited growth, health spending as a proportion of Gross Domestic Product rose swiftly from just 6.3% in 2000 to 8.8% in 2009.[121]

The increase in spending allowed for recruitment of additional staff, a substantial uplift in NHS pay linked to the Agenda for Change agreement finalised in 2004,[122] and the reopening of some beds and avoiding cash-driven closures. It was also the beginning of a serious drive to reduce delays in A&E (with a new target to treat or discharge within 4 hours[123] set in 2004 and achieved in 96% of cases by 2005).

Similar targets were set for elective surgery waiting times, culminating in 2005 (when the waiting list numbered 856,000) with an election commitment to reduce the maximum wait to just 18 weeks from referral to treatment.[124]

Strings attached

However the investment and the commitment came with extensive strings attached. The broad strategy was set out in the NHS Plan launched in 2000 by Health Secretary Alan Milburn.[125] It contained measures to entrench and institutionalise the market system that Tony Blair had correctly condemned as "costly and wasteful" and committed to scrap in 1997.

It also extended the scope of outsourcing well beyond the previous range of non-clinical support services, to include diagnostic services (new diagnostic and treatment centres) and elective hospital treatment as well as provision of so-called "intermediate beds".[126]

The New Labour approach was later summed up by Blair's Pensions Secretary John Hutton in a 2007 speech to the CBI[127] in which he argued that the "core" of the reform programme including "an open minded approach to who provides" – was being "built into the DNA of our public service infrastructure." [128]

But increasingly it became obvious that ministers were far from open minded; indeed they became ideologically obsessed with bringing in private companies and private hospitals as so-called "partners" – at the expense of sidelining and destabilising existing NHS providers.

Concordat

The starting point on this new trajectory to privatising clinical care came in June 2000 when Alan Milburn, having taken over as Health Secretary from Frank Dobson, proudly signed a 'concordat' with private hospitals.[129] This provided for them to treat uncomplicated NHS waiting list patients during winter and other peak periods when local NHS trusts lacked the capacity to deal with combined emergency and elective demand.[130]

This was initially welcomed by the BMA and of course by the private hospitals, but (perhaps surprisingly) criticised by the Conservatives as "hypocrisy". Conservative statements highlighted a doubling of NHS spending on private health care since 1997. The concordat was opposed by the Labour left and campaigners, who warned of the slippery slope towards greater privatisation of elective care.[131]

The problem then, as now, of course was that the funding to pay the private hospitals and the staff to deliver the treatment was taken from the trusts under the greatest pressure, and meant that there was no way for them to escape by investing in expanded NHS capacity.[132]

Indeed it was later revealed that the scheme was a double blow to trusts' finances, with treatment costs for NHS patients admitted to private hospitals a staggering 40% higher than the NHS. Hip operations costing an average £4,700 in the NHS had been charged at over £6,800 by private hospitals.[133]

The concordat was a massive boost for a flagging private hospital sector, where bed occupancy had been commonly averaging 50-60%. By January 2001 Manchester's BUPA Hospital boss Stephen Bird was delightedly reporting 100% occupancy, with the empty beds filled with NHS patients.

Booking out BUPA

At the end of 2001 a further deal was announced, in which the NHS would commission 5,000 routine operations such as hip and knee replacements from BUPA's 36-bed Redwood Hospital in Redhill, East Surrey. The deal involved the transfer of 27 NHS nursing staff from East Surrey Hospital, while all of

the consultants listed as working at Redwood hospital were NHS employees, all but one from East Surrey Hospital.[134]

No details were published on the cost of this project, but in South West London Kingston and Richmond Health Authority had calculated that to transfer 2,500 in-patient elective cases to the private sector would require 35 beds and cost £3,000 per case (£7.5m).

By contrast in Merton, Sutton and Wandsworth it had been calculated that to keep 82 NHS medical beds open would cost £2.44m. And at St George's Hospital it was calculated that for £5.6m NHS capacity could be increased by 56 beds (28 surgical, 28 medical). Giving work to private hospitals was a very expensive 'partnership' for the NHS.

NHS LIFT

The NHS Plan was soon followed by an extension of the PFI principle to primary care, with the establishment of 'NHS LIFT' (Local Improvement and Finance Trust) to fund the building of new surgeries and health centres, leasing them to GPs and Primary Care Trusts.[135]

While Milburn argued that this meant a £1 billion investment, in fact only £195m was government funding, the remainder coming from private sector sources seeking hefty interest rates and commitments that future projects in the area would also be financed through LIFT.[136] The plan was opposed by UNISON[137] and campaigners, but forged ahead regardless, although not on the scale anticipated by ministers.

Franchise management – the first failure

By 2002 the New Labour project was widening to include plans to 'franchise' the management of failing trusts to private management consultants. This ended up with a disastrous experiment with management consultants Tribal Secta[138] taking over control of Good Hope Hospital in Sutton Coldfield in 2003.[139]

Tribal's press release predicted that:

> "*Good Hope should become the flagship for building a true private/public sector partnership approach to improving performance within the NHS… Ideally we want to reach a position where franchise support will no longer be required, and it can be 'handed back' to the trust's management team in a stronger, more successful position.*" [140]

In fact Tribal undermined and weakened the existing management, ran up huge deficits, and eventually had to be bought out early in 2005 before they did more damage. The running of the hospital was handed back to the NHS (Birmingham Heartlands Hospital Trust).[141]

While the Trust was reduced to dire financial straits, losing money at £1 million per month, Tribal successfully jacked up their own fees by 48 per cent in its first year – with the Tribal-supplied Chief Executive paid £225,000 per annum, well above the standard rate.

A 2006 Audit Commission report on the franchise agreement revealed a managerial shambles,[142] with no financial strategy in place, and branded it as a costly failure. Flaws in the contract even meant the trust itself could not terminate it early or enforce penalty clauses for failure.

Shortly after the deal ended, radical cost-cutting measures – closing beds, wards and buildings, to make potential savings of £21 million a year – were needed to prevent a deficit of up to £47.5 million the following year.

All this was clearly lost on New Labour health minister Ben Bradshaw, who flatly denied that the contract had been a failure. However it was not until the experiment with privatised management at Hinchingbrooke Hospital was signed off by the Cameron Government years later that the idea was tested again … to fail once more.

Foundation trusts

2002 also brought plans to allow the best-performing trusts to opt out of NHS structures to become 'Foundation Trusts' (FTs).[143] A furious campaign began against the plan, backed by campaigners, health unions, the BMA and former Labour ministers, which culminated in battles in the Commons and House of Lords.

Although only 63 Labour MPs voted against legislation to establish FTs (while the Conservatives abstained), the autumn of 2003 saw the policy roundly defeated at Labour Conference[144] – and the scale of the opposition did substantially blunt the edge of Milburn's initial plan.

FTs were at first intended to give wide new powers and privileges to ten or a dozen of the country's top-rated '3- star' NHS hospitals, although this was soon extended to lesser two-star trusts.[145]

Former health secretary Frank Dobson and other former ministers correctly attacked the plan as a return to the type of market-style methods wheeled in by Margaret Thatcher's Government, and which New Labour ministers was supposed to have swept away after 1997.

They pointed out that the new 'freedoms' to be granted to FTs could only be at the expense of other NHS

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Trusts that were been excluded from the elite status. For example the initial plan was for FTs to be given extra freedoms to borrow, including from the private sector – but their borrowing would count against the total cash limits on the NHS, leaving other Trusts LESS capital for maintenance or new building.

FTs would be free to retain any cash raised from the sale of Trust property assets, prompting fears that some may embark on a new round of asset-stripping; Milburn had to add in a 'lock' on NHS assets. They would also be free to set up private companies that offered managerial and other services inside or outside the NHS and which could bid to run neighbouring 'failing' Trusts under the government's franchising scheme.

FTs would also have freedom to vary the pay of their staff, giving scope in some areas to offer more to recruit staff with particular skills – subject only to vague restrictions on 'poaching' staff from other Trusts. And they would even be given a guarantee of independence from legal direction by the Secretary of State – raising serious questions over the extent to which they could be prevented from using these other freedoms in ways which threaten the survival of other Trusts.

Cap on FTs' private income

However Milburn swiftly retreated from those warning that FTs would (like the first wave NHS Trusts in the Conservative reforms) seek to expand their treatment of private patients and numbers of private beds. He insisted that they would be prevented from doing so, and eventually he was forced to agree to a cap on private patient income – locking FTs in to making no more than their pre-FT proportion of income, meaning growth could only come by also growing NHS work.

Milburn insisted Foundations would remain "part of the NHS", controlled by "stakeholder" members from the local community, who would elect representatives to comprise a majority of a Board of Governors. He was keen to divert attention away from the experience of the first foundation-style hospital experiment in Sweden, where a major hospital in Stockholm was privatised by its board in 1999 – against the wishes of the local authority and the government.[146]

Campaigners responded arguing the real power would remain in the hands of an unelected management board, and the extent to which 'stakeholder' groups would be representative of the ethnic and social mix of the communities they cover was questionable. Nevertheless some of Milburn's colleagues, such as Ian McCartney, even argued that Foundation Trusts – supported as they were by the Conservative Party and Thatcherite organisations such as the Institute of Directors and the Adam Smith Institute – somehow represented "popular socialism" and harked back to the "old Labour", "socialist" values of "mutualism" and the cooperative movement.[147]

Eventually the amended legislation was forced through the Commons with a majority of just 17. The real dynamics unleashed by FTs were revealed later on by the Foundation Trust Network, which soon began arguing for an even greater separation from the NHS.

By 2005 they were demanding greater autonomy from government targets, a "hands off" approach by the regulator (Monitor), the right to provide primary care services, removal of the cap on the number of private patients they were allowed to treat, and to be allowed to "develop a reach beyond health." The Network even argued that patients' needs could be met by adopting "the Debenham model of providing branded boutiques." [148]

Freedoms in doubt

Meanwhile in autumn 2004 the extent of the autonomy on offer to Foundation Trusts was thrown into question, when Bradford Hospitals FT found itself facing a substantial deficit (predicting a £4 million deficit after just six months). This level of deficit was modest compared with the crisis situation then developing in many NHS Trusts, but the regulator Monitor immediately intervened – by calling in a firm of New York-based business trouble-shooters to sort out the trust.

The company, Alvarez & Marsal, was chosen and called in by Monitor: but the costs of flying in the team of "turnaround management consultants" (Americans, who had to be told that British healthcare is priced in pounds and not dollars) had to be paid by the Bradford Trust.[149] Their recipe for turning the finances around included axing sandwich snacks for elderly patients and dispensing with cover from security guards on the hospital car park.[150]

Ministers predictably washed their hands of the whole business. In the House of Commons Health Secretary John Reid issued a statement refusing to answer parliamentary questions on any foundation trusts, declaring that:

> "*Ministers are no longer in a position to comment on, or provide information about, the detail of operational management within such Trusts. Any such questions will be referred to the relevant Trust chairman.*" [151]

Nonetheless in the 2005 General Election the Blair Government made it clear that if they were re-elected then all hospitals would be pressed to become Foundations.

Questioning the NHS model

In 2002 a policy statement from the Secretary of State Alan Milburn, Delivering the NHS Plan, had argued that "the 1948 model is simply inadequate for today's needs":

> *"We believe it is time to move beyond the 1940s monolithic, top-down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values."* [152]

The following year this was put into practice by the establishment of a new 'Commercial Directorate' inside the Department of Health, headed by a Texan with experience of the private health sector, and largely staffed by "interims" recruited from the private sector. By 2006 it had grown to 190 people – with the single aim of maximising the NHS reliance on private providers.[153]

By 2004 Milburn had departed to follow the logic of this argument, and embark on a lucrative career with the private sector. Tony Blair's former advisor on NHS policy, Simon Stevens (who was ten years later to become NHS England chief executive) had taken over the role of setting out a full-scale scenario for a "mixed economy" in health:

> *"Government is now stimulating a more mixed economy on the supply side, to expand capacity, enhance contestability, and offer choice. Free standing surgical centres run by international private operators under contract to the NHS are a first step. Private diagnostics and primary care 'out of hours' services are next."* [154]

Elective surgery

However these harsh lessons on the limits of competition in the health care sector were not applied to other services that were still being energetically contracted out. One of the most decisive new areas for contracting out was elective surgery – as New Labour went much further than Thatcher had dared, and began to outsource clinical care.

In 2003-4 ministers were driving the establishment of 'Independent Sector Treatment Centres' (ISTCs), the coy New Labour-speak for a chain of 26 privately-owned and run units previously known as Diagnostic and Treatment Centres (DTCs). 20 NHS-run DTCs had been quietly established.

But the kernel of New Labour's plan was to allocate a substantial share of routine NHS elective surgical and diagnostic work to the private sector. This was the same private sector that routinely poached NHS-trained nursing and medical staff, and which cherry picked the patients and the procedures which offered the most hope of profits, leaving all of the costly, long term and intensive treatment to the NHS.

After the 'concordat', which proposed a greater use of private hospitals to treat NHS-funded patients, the ISTCs were supposed to be different: they were to be new units, set up and run from the outset by the private sector.

Under the original specification, they were supposed to make no demands on the local pool of qualified health workers, but bring all of the necessary staff with them. So many of the corporations winning the first bids were overseas or multinational companies.

According to the Department of Health document Growing Capacity the ISTCs were supposed to ensure "additional clinical activity, additional workforce, productivity improvements, focusing specifically on additional capacity":

> *"It will be a contractual requirement for providers to define and operate a workforce plan that makes available additional staff over and above those available to the NHS."* [155]

In fact none of this happened.

Recruit staff from NHS

By autumn 2003 ISTCs had been told that they were free to recruit up to 70% of their workforce from the NHS, potentially stripping local hospitals of staff, and lumbering them with sky-high bills for agency staff to fill the gaps.[156]

Creating a brand new element of the private sector was argued by New Labour advisors and ministers as a vital step to create "contestability" – the coy phrase for competition, which New Labour was even more committed to as a principle than Margaret Thatcher had been. Ministers were convinced competition would drive trusts to cut costs and improve quality – while all it achieved was diverting hundreds of millions out of NHS budgets into private pockets.

NHS Trusts and Foundation Trusts increasingly had to compete not only against other NHS providers, but also against private hospitals which had a much less complex and costly caseload. But the competition was even more unfair than this suggests: ISTC contracts were ring-fenced … so that only private sector providers were allowed to bid for them.[157]

The profit-seeking ISTCs would each scoop up a share of the projected 250,000 procedures a year to be diverted from existing NHS units.

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The nationally-negotiated contracts were on a 'play or pay' basis, meaning that the PCTs were required to pay the full contract price to the ISTCs over the 5-year period, even if the NHS sent fewer patients for treatment. Of the preferred bidders announced in September, five were from overseas – Canada, South Africa and the USA – and two British.

They were contracted to treat only non-urgent cases where waiting times were a problem, including orthopaedics (hip and knee replacements), ophthalmology (mainly removal of cataracts) and minor general surgery such as hernia and gall bladder removal.

The private units had no obligation to after-care: and they could fix their own terms and conditions, with some offering consultants four or five times what they'd get from the NHS.

While Ministers claimed ISTCs would be paid the same cost per case as NHS hospitals, in practice they took on only the simplest and cheapest cases, leaving the NHS with an increasingly expensive caseload. Even the ISTCs' start-up costs were subsidised.

It was also later revealed that the average ISTC treatment incurred an additional cost of 11.2% above NHS levels[158] – meaning that for every nine ISTC patients NHS hospitals could have treated ten. Their profits were guaranteed.[159]

In NHS units such as the Oxford Eye Hospital the revenue from cataract operations helped underwrite the running costs of a department delivering a full range of services: but any surplus created by DTCs would simply be pocketed as profit by shareholders.

The opposition to the plans was widespread.

Private hospital chiefs were angry that new units are being built instead of filling up their existing empty beds. Conservative shadow health minister Liam Fox said the contracts were too expensive.[160]

Almost all organisations representing health staff opposed the new private centres: UNISON warned that they would drain resources and staff from the NHS. The BMA has said that the DTCs could destabilise the NHS. The Association of Surgeons in Training warned that the centres could do lasting damage. Even the Royal College of Nursing expressed concern over staffing levels.

To make matters worse, establishment of ISTCs came after an injection of new funds into the NHS to enable it to expand its own capacity: just as some of these investments were starting to deliver, a small group of bureaucrats at national level decided with no local consultation where the new ISTCs were to be.

Only bankrupt Bristol PCTs were allowed to refuse an ISTC: other local health commissioners were given no say, while the PCTs in Oxfordshire that objected to an ISTC for ophthalmic services were roughly slapped down.

New funding system for market in clinical care

As a vital part of its new, wider-reaching marketising measures, New Labour also moved to introduce a much more complex system for financing health care providers. The most important change was originally described in the NHS Plan as "reforming financial flows," but became known (misleadingly) as 'payment by results' (PBR).[161,162]

In fact the payments had nothing to do with the 'results' of the treatment: the hospital secured the same fee whether the patient jogged out in a tracksuit or was carried out in a coffin. PBR is a 'cost-per-case' system, linked to a fixed national tariff of 'reference costs' for each item of treatment they deliver. The new system was introduced firstly for Foundation Trusts in 2004, and later rolled out across other acute hospital Trusts.

The new structure was designed with two prime objectives:

- to create a new framework within which Foundation Trusts could secure a wider share of the available contract revenue in a competitive health 'market', while Trusts less well resourced, or whose costs for whatever reason are higher than the reference price, could lose out.
- and (perhaps more important) to open up a portal through which NHS funds could be extracted to purchase care from private providers such as ISTCs.

By effectively commodifying health care at such a basic level, the PBR system fitted the New Labour objective of breaking down the barriers between the public and private sectors, and ensured that every NHS patient who chose (or was persuaded to accept) treatment in an ISTC or private hospital took the money with them … out of the NHS.

So the crisis and cash shortfalls remained within the NHS, while the private sector collected a guaranteed margin. A 2006 study by York University pointed out that there were other potential downsides and perverse incentives in the policy, which of course ministers and academics assumed would somehow take care of themselves.[163]

Choice

Ministers attempted to create the illusion that the situation was being driven not by them but by patients:

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individual patients were offered a progressively wider ‘choice’ of where they wanted to have their treatment. By the end of 2005 Primary Care Trusts were obliged to offer almost all patients a ‘choice’ of providers – including at least one private hospital – from the time they were first referred. By 2008, the NHS’s 60th year, any patient was allowed to choose any hospital which could deliver treatment at the NHS reference cost.[164]

New Labour ministers made clear that they wanted at least 10% of NHS elective operations to be carried out by the private sector in 2006, rising to 15% by 2008.[165]

However to achieve these targets could easily result in patients not being given a choice, but being told by their GP that the policy was to send them to an ISTC.[166,167]

This policy was strongly criticised, not least by the BMA, but also by studies produced by London NHS managers for Health Secretary John Reid, which warned that the plans were “problematic, unaffordable” and of “no benefit” in London, since they would have serious impact on the financial stability and viability of NHS Trusts.

The Commons Health Committee found no evidence ISTCs delivered any benefit that could not have been delivered through the NHS more cheaply.[168,169] There was growing concern that hospitals which lost out as patients chose to go elsewhere could be forced to close departments – or close down altogether: ministers and senior NHS officials said that they were willing to see this happen, arguing that it would not be their policy, but patients who made the decision.

But the new system also represented the end of 30 years of efforts to equalise allocations of NHS spending on the basis of population and local health needs: the new market system emerged as the enemy of equality – for staff, for patients and the general public.

More investment in private sector

After New Labour’s third and final election victory in 2005, a new Health Secretary, Patricia Hewitt, lost no time in speeding up more privatisation. She invited private tenders for the second round of ‘Independent Sector Treatment Centres,’ (ISTCs) to deliver a further 250,000 operations a year: but once again NHS hospitals – even Foundation Trusts – were excluded from the bidding process.

In addition another £400m worth of X-rays, scans, blood tests and pathology tests were to be hived off to the private sector. The Commons Health Committee concluded in 2005:

> “ *“The Department of Health remains committed to investing £550 million each year in procurement from the independent sector, seemingly regardless of what the local health economies decide they need,” and further noted: “The apparent contradiction between leaving it to local health economies to decide on Phase 2 schemes and the determination to spend almost £3 billion on independent provision …””* [170]

The Department of Health (DoH) no longer claimed that ISTCs were being brought in to create additional capacity. Instead the establishment of a viable private sector was seen as a means to establish ‘contestability,’ which in theory was supposed to drive up standards and drive down prices.

However the Health Committee heard that no such reduction in prices had been achieved:

> “ *Despite the changes, the Department will **continue to pay more than the NHS Equivalent Cost** for Phase 2 ISTCs. NHS providers stressed in their evidence that this was unacceptable. Bids should not be accepted unless they provided services more cheaply than the NHS equivalent. They wanted fair competition. The supposed benefits of Phase 1 ISTCs in improving efficiency in the NHS were not sufficiently proven to continue to pay a substantial premium.”*[171] *[emphasis added]*

So waiting list operations would be transferred from NHS hospitals at higher cost to private providers

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(leaving under-used NHS departments with inflated costs and a caseload of complex, chronic and costly patients the private sector did not want).

Indeed, because the services were being transferred, the DoH argued that it should also allow the transfer of NHS staff to carry out the work – permitting them to be seconded from NHS hospitals. The new contracts would almost double the number of private sector operations to be purchased by the NHS, pushing the government 's total spend in the 'independent sector' up towards £1.5 billion – two thirds of the total £2.3 billion turnover of the private medical industry in 2003.

The plan was no longer an 'internal' market – but simply a market, in which NHS Trusts would have to compete not only against other NHS Trusts, but also against private hospitals which insist upon a much more selective – and thus much less complex and costly – caseload, and have no emergencies to deal with.

So, bizarrely, NHS hospitals, under the cosh to deliver endless year-on-year 'efficiency' savings, were eventually told they would be allowed to spend taxpayers' money on advertising to attract patients.[172]

Competition – using patients to force change

Competition was to be forced by putting the responsibility on to individual patients, who would have relatively little relevant knowledge, but be offered a progressively wider 'choice' of where to have their treatment. They would not be made aware that the potential consequences of their decisions could include forcing the closure of their own local NHS hospital.

These risks were highlighted by the BMA's evidence to the Commons Health Committee, warning of

> "*...the potential risks of NHS facilities being left with more complex procedures to which a premium would not attach under the Payment by Results system, but which would inevitably be more expensive to perform: 'Current policy will see those conventional NHS centres reliant on routine work to cross-subsidise large fixed overheads become increasingly vulnerable.*"

The Committee's report notes that this threat was "particularly worrying in view of some trusts' high deficits."[173]

By the end of 2005 Primary Care Trusts (the local commissioning bodies) would be obliged to offer almost all elective patients a 'choice' of providers – including at least one private hospital – from the time they were first referred. PCTs would also be required to ensure at least 10% of elective operations went to private providers.

In early 2006 New Labour plans went even further, suggesting a long list of NHS-owned and run facilities should be handed over to private companies as part of the drive to ensure at least 10% of all NHS elective work was delivered privately, rising to at least 15% in the longer term. They included:

- A brand new state of the art NHS Treatment Centre in Birmingham, not even yet open;
- A specialist unit in the new PFI–financed New Forest hospital in Lymington;
- A huge renal dialysis contract covering much of the north of England, with dozens of NHS units handed over for private operators to refurbish and run for profit.
- NHS catheter laboratory in Rotherham and Barnsley, which could be handed over as part of a cardiology contract:
- 'Spare surgical capacity' in NHS hospitals in the South West Peninsula could be used by private companies carrying out NHS-funded operations;
- Modern NHS treatment centres, including Ravenscourt Park Hospital in NW London and the world-leading SW London Elective Orthopaedic Centre (SWLEOC) in Epsom also faced the threat of privatisation.[174]

None of the planned Treatment Centre projects were put out to public consultation, and patients remained largely unaware of the plans or their implications, making them harder to challenge.

One plan rejected

In summer 2005 Epsom & St Helier hospitals NHS Trust which runs SWLEOC placed an advert in the official EU Journal inviting private companies to bid to take over its management from Spring 2006. This decision was not taken by the Trust, but at national level by the Department of Health.[175]

However the implementation was down to the Trust, and in September 2005 plans were revealed to hand over SWLEOC to an American (New York) Hospital for Special Surgery. The UNISON Branch in Epsom & St Helier Trust worked with pressure group London Health Emergency to mount a challenge to the proposals. These were finally halted when a small group of noisy local pensioners and LHE organiser Geoff Martin managed to get in to the trust board meeting that was to sign off on the deal, and ask the decisive question: where was the business case to show the benefit of the deal to the NHS?[176]

This was met by silence from the trust chair, finance director and board members, none of whom had obviously even asked the question. They adjourned the meeting, promising to return with an answer, but in fact returned only to move on to next business – and

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the privatisation had been abandoned. SWLEOC is still a highly successful NHS-owned and run unit 19 years later.[177]

Choice agenda

From 2008 any patient would be allowed to choose any hospital which could deliver treatment at the NHS reference cost, erecting 'patient choice' as a more fundamental principle than maintaining local access to NHS hospital services, with Tony Blair stating: "Choice is not a betrayal of our principles. It is our principles."[178]

Alongside the privatisation came a renewed financial squeeze on NHS trusts, which began almost as soon as the votes had been counted in the 2005 General Election on May 5. The first cuts in hospital services began to hit the headlines locally and nationally: Lewisham Hospital in SE London revealed an £8.5m deficit and plans for ward closures.

Hewitt clearly believed that the instability her Government's policies had created was good for the NHS. In a June 14 interview with the Financial Times's Nick Timmins, she admitted that too many NHS staff feel that "change upon change has been done to them, rather than with them", but spelled out the scenario:

> "*It's not only inevitable, but essential that payment by results and these other elements create instability and change for the NHS. That is precisely what they are designed to do.*"[179]

The logic of Hewitt's position was simple: any hospital that failed to balance its books must have failed to attract sufficient patients – and patients had therefore exercised their 'choice'. Since patient choice was the main mantra of New Labour's NHS policy, those hospitals which were not chosen would be allowed to close. But there was no equivalent promise to patients whose first choice was to use good services at their local NHS hospital, but who faced being dispatched for private sector treatment to meet new privatisation targets.

Crisp provokes a crunch

July 28 2005, normally the midst of a sleepy holiday period, marked the launch of a round of restructuring and 'reforms,' unveiled in a circular to NHS managers by NHS Chief Executive Sir Nigel Crisp, entitled 'Commissioning a Patient-led NHS'.[180] Although Crisp and ministers claimed that the reforms were "to reflect patient choices" and reshaping "from the bottom upwards", the opposite was the case: the reforms were being relentlessly driven from the top, with no heed for critical views from professionals or the public.

Opinion polls and surveys confirmed that the first choice of NHS patients was the opposite of Government policy: people wanted continued access to comprehensive local NHS services in the hospitals they knew and loved. However Crisp's plan meant the Primary Care Trusts (PCTs) which held the purse strings for most health care services, and still directly employed upwards of 250,000 health workers delivering community and mental health services, would have to be broken up, and reduced to commissioning only. Their services were to be hived off to Trusts, handed over to the voluntary sector – or simply contracted out to private firms. Crisp clearly didn't care which.

The process of restructuring was designed to cut spending on NHS hospital care, diverting more patients to private providers, and encouraging GPs and PCTs to 'free up' cash by developing alternative forms of 'care outside of hospital'. Angry trade unionists pressed frustrated and befuddled Labour back-benchers to protest at Crisp's scheme, which had been hatched up by a few senior civil servants and health ministers without any wider discussion. After months of protests and pressure some of the more outlandish proposals were toned down, postponed or dropped: Patricia Hewitt even came to a UNISON seminar and apologised for having got it wrong.[181]

The Commons Health Committee, in a hard hitting report in December 2005 expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs. But Hewitt ignored the Committee's concerns, and in January 2006 published a new White Paper 'Our Health, Our Say' … seeking to push Primary Care Trusts towards "outsourcing" all of their services. It even contained a provision for local service users to petition to force their local Primary Care Trust to put any public sector NHS service out to competitive tender from "any willing provider".[182]

A month later Hewitt went further, and claimed at a press briefing that PCT staff were eager to be privatised: she asserted there was "widespread enthusiasm" from staff to move out of the NHS and work for social enterprises in primary care and, according to the HSJ:

> "*…called for 'unions and professional bodies to start to see it as something which their own members are very interested in…*"[183]

On February 16 2006 – hard on the heels of a major privatised contract failure (the shambolic hand-over of the supply of bottled oxygen to vulnerable patients at home to four profit-seeking companies, with disastrous consequences)[184] – Tony Blair personally staged a formal 'welcome' into the "NHS family" for eleven private companies eager to make profits. Blair predicted that the NHS would soon be purchasing up to 40 percent of private operations. In some areas and specialties this would mean private providers creaming off a majority of routine surgical cases from NHS Trusts.[185]

This would not only have had a financial impact, but threatened to strike a body blow at the training of junior doctors, and at medical research which is only carried out in major NHS University hospitals: but the outsourcing did not go as far as Blair and the Blairites wanted.

However a government-commissioned report, for the National Co-ordinating Centre for NHS Service Delivery and Organisation, published in early 2006, warned that patient choice, Blair's big idea, may actually reduce the quality of care.

'Patient Choice and the Organisation and Delivery of Health Services: Scoping review,' highlighted by Doctor magazine, concluded that disadvantaged patients were less likely to benefit from choice.[186] It warned that severely ill patients, unlike "consumers", were making choices under stress and would therefore, prefer a trusted clinician to decide for them. And it concludes:

> *"There is evidence that a 'choice' policy may have adverse or, at least, unpredictable consequences. Above all, there is a question mark over claims that the policy will improve equity of access to healthcare."*

The Bristol University paper also analysed previously unavailable data which showed that the introduction of an internal market into the NHS triggered an increase in mortality after heart attacks. But worse still for the Blairites, the data shows that greater competition was associated with higher death rates after heart attacks. Far from demanding choice, the data also shows that:

> *"…there is not a strong groundswell of opinion asking for choice of provider, especially as some issues such as very long waiting times have been, in large part, addressed by other reforms to the health service in the UK."*

Rationing NHS care

The spring and summer of 2006 saw panic measures in London to ration numbers of patients referred by GPs to hospital consultants. News of the privately-run, cash-led rationing scheme, which would process each GP referral through a team of bureaucrats in privately run 'referral management centres' broke with the publication of a leaked document, in which managers discussed measures that would arbitrarily restrict Londoners to the lowest 10% of hospital referral rates anywhere in England.[187]

A critical article in the *British Medical Journal* argued that the principal aim of the new centres was to "curtail demand" and underlined the lack of any evidence that the new system, which had "appeared overnight in an evidence-free zone" could deliver any positive benefit for patients. It was obvious some of the patients denied NHS elective care would 'choose' to go private.[188]

A survey by GP magazine Pulse revealed almost 70% of GPs were up against policies aimed at cutting their referrals, with some facing attempts to cut them by more than 20%, and 53% of GPs said their referrals were now going via referral management centres. A quarter of GPs had been set a specific target to cut their referrals, and one GP in three said they had had a referral bounced back because it had not been submitted in accordance with procedure.

Inviting in insurance companies

Also in the summer of 2006 ministers provoked fury by inviting private insurance companies to take over control of a large slice of the £64 billion NHS commissioning budget controlled by PCTs. The first inkling of this proposal came in a front page article in the Financial Times, headlined 'Insurers invited into NHS economy'. FT correspondent Nick Timmins concluded that:

> *"The move is likely to attract interest from the big US insurers such as United Health and Kaiser Permanente, Discovery of South Africa, BUPA, PPP and Norwich Union in the UK, and possibly German and Dutch insurance funds."* [189]

These insurance companies specialise in screening out and excluding potential subscribers with pre-existing illnesses and chronic conditions – and have no relevant expertise that could inform the commissioning of a comprehensive health care service for the whole resident population of a PCT.

It seemed the whole story was a 'kite-flying' exercise to test out public response until it was revealed that an advert had indeed been placed that week in the Official Journal of the EU, inviting companies to bid for "framework contracts" to deliver commissioning and management services to PCTs. Virtually all aspects of the PCTs' role were to be offered out to private bidders:

> *"This will include, but not be limited to, responsibility for population health improvement, the purchasing of hospital and community care, supporting local GPs develop practice-based commissioning [sic], the management and development of community health services for the PCT resident population …."*

The new arrangement would leave the PCTs with next to nothing to do other than brew the tea and open the biscuits for occasional board meetings.

However once again, as it had been the previous autumn, the advert was suddenly withdrawn, with claims of unexplained "drafting errors", and a letter from Hewitt was hastily published, attempting once again to assure an even more confused and sceptical public that there was no plan to privatise the NHS. But the very next month ministers gave the go-ahead to a fresh advert, identical in all essentials.

But even if ministers couldn't see it, the big insurers did recognise the immense risk involved in taking on an under-funded, highly pressurised health care system way out of their experience. That threatened privatisation did not happen.

Privatising NHS Logistics

But plenty more did: in July 2006 came news than an American firm was poised to take over the responsibility for spending more than £4 billion a year of NHS money, running the NHS Logistics Authority and much of the NHS Purchasing and Supply Agency in what the Times described as "the biggest privatisation yet seen in the health service." [190] Novation, the Texas-based group, was in the final stages of negotiating a deal that would make it and its German partner, DHL, responsible for buying everything from bandages to hip implants for the NHS, in contracts that lasted, with some modification, until 2019.[191]

The outsourcing triggered a strike ballot by UNISON members, with Karen Jennings, head of health at UNISON, warning: "The Government's decision to privatise is driven by pure dogma and an obsession with market-testing."

Three months afterwards, in October 2006 Hospital Corporation of America, the biggest US hospital corporation got its feet firmly under the table of the NHS in a new contract with the cash-strapped University College London Hospital foundation trust. HCA formed a joint venture with UCLH to provide an international cancer centre that would boost the hospital's private patient income.

HCA was then running more than 270 hospitals and surgical centres worldwide, including six private hospitals in London. The contract was for them to take over private patient operations on the largely unused 15th floor of the new PFI-funded UCLH tower in London's Euston Road to provide a specialist blood and bone cancer centre – aimed at international and UK patients. The extra revenue helped UCLH to pay the hefty PFI unitary charge, but in return the Trust was committed to supply staff and pathology and other services to their new lodgers.[192]

Also in October 2006 the Department of Health implementation document 'Making it Happen' stressed the need for "better partnership working with third and independent sectors".[193] In July a policy paper from the 'Third Sector Commissioning Taskforce' emphasised that:

> "*…delivering health and social care services is no longer the preserve of the public sector … third sector as well as private providers have a valuable role to play ….'* [194]

Health minister Lord Warner warned that local NHS hospitals would have to "face up to the need to reconfigure services" to enable new "independent sector providers" to enter the NHS market. The logic was simple enough: to make room for the development of a brand-new private sector, Hewitt, Warner and Blair had to slash back existing NHS services.

As they did so, more and more acute trusts and Primary Care Trusts were running into serious deficits: and in November the HSJ flagged up the enormous scale on which the NHS was using management consultants as battering rams to drive through cuts in staff and services. More than a third of acute hospital trusts (62) and a quarter of PCTs (81) were receiving so-called "turnaround support" – at huge expense.[195]

'Independent providers' enter primary care market

Primary care too was facing upheavals. In 2004 a new GP contract had completely changed the NHS relationship with GPs, and opened up a new form of privatisation. As Allyson Pollock and David Price explained:

> "*…the 60-year–old arrangements where GPs contract directly with the Secretary of State to provide care has been dissolved. In its place are four new contracting options, each of which is between the government or local health commissioners and healthcare companies.*"

> "*GPs themselves will be under contract to companies or trusts, not the state. The alternative provider medical services (APMS) contract, the fourth route that marks off this reform from earlier revisions, allows commercial companies to hold the provider contract.*"

> "*… each of the four new contracting routes and associated payment systems combine to end the open-ended commitment to provide care. Instead, primary care services are being broken up into saleable commodities under a process known in the world of privatisation as 'unbundling'.*" [196]

The new contracts allowed GPs to opt out of 'out of hours' calls, which many GPs welcomed, and hand

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responsibility to local PCTs (commissioners). These changes were brought in unevenly over a few years: the consequences, however were not what many GPs expected.

In many areas GP cooperatives had built up a great deal of expertise in organising high quality out-of-hours cover: but rather than use this expertise, many PCTs turned instead to the private sector, effectively creating large companies whose business was picking up contracts to deliver primary care.[197]

One of the first companies in this field was Harmoni, but in Cornwall the service delivered by KernowDoc was replaced by a (notoriously unsuccessful) contract with Serco. In East London, too attempts by local GPs to take back organisation of out-of-hours care were bypassed as the contract went to a private company.

As other contracts were opened up to private bids, the new entrants to the primary care 'market' were by no means welcomed locally. In North-Eastern Derbyshire the PCT's inexplicable choice of US insurance giant UnitedHealth's European subsidiary as its 'preferred bidder' to run the Creswell Primary Care Centre in December 2005 was met by uproar and warnings of privatisation:

The campaign of resistance in Creswell eventually led to an Appeal Court decision in August 2006 that quashed the selection of UnitedHealth and ordered the tender to be reopened, with the PCT required to involve and consult the local community properly on its plans.[198]

However also in 2006, a High Court judge rejected local appeals and rubber-stamped a bizarre tendering process which had allowed United Health Europe to secure a contract to deliver primary care services in a deprived area of Derby, despite having no staff, track record, expertise, or local links.[199]

The drive for outsourcing and private contractors did not stop at borders: early in 2007 Royal Surrey County Hospitals department of breast, general and melanoma surgery sent out a warning to GPs that correspondence they received would no longer be checked for errors. The hospital had outsourced transcription of consultant letters to India, and was piloting the move in order to "save time". Baffled GPs described the move as "extraordinary." [200]

Commercialising primary care

The primary care market was already estimated to be worth upwards of £150m a year to the independent sector, with almost a third of Primary Care Trusts planning to put services out to tender. By March 2007 Allyson Pollock and colleagues found that:

> "*…about 30 companies held commercial contracts to provide primary care services in England*

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through their ownership of 74 health centres and general practices, excluding out of hours contracts …. The companies comprise general practitioner owned and operated companies; international healthcare corporations, including drug companies; companies with commercial links to the drug industry and healthcare corporations; companies providing catering, cleaning, and laundry services under private hospital contracts; and some joint ventures between these." [201]

Primary care was one of the targets for a major expansion of private provision spelled out by the Department of Health's Director of Commissioning, Mark Britnell, who in January 2008 confirmed that £250m a year had been earmarked for new privately provided health centres and services. He said:

"There is a potential business here worth more than £1bn for Virgin, Assura, Boots and other private-sector providers to bid into, alongside existing G.P.s and foundation trusts." [202]

The Government also introduced a scheme in which private business could bid for Alternative Provider Medical Services contracts (APMS), where private companies take over whole GP practices.

Meanwhile Sir Richard Branson's Virgin Group declared their interest in the NHS primary healthcare market, calling on GPs to join them in establishing a network of branded clinics, with the first of six 'one-stop-shop' health centres due to open later in 2008, offering services from homeopathy to therapy alongside typical GP services.

Mark Adams, Virgin Healthcare chief executive, said that while GPs would retain their existing contracts, "…it would change the delivery model from something designed in 1946 to something that better serves today's world."

Virgin did not plan to bid for 'alternative provider' contracts, but Health Secretary Alan Johnson was planning 250 new APMS surgeries and GPs were already feeling the negative effect of these privatisations. Dr Sam Everington, former deputy chair of the BMA and European GP of the Year, had lost out to private company Atos Healthcare in a bid for an APMS practice near his own award-winning practice in Bromley-by-Bow.

Other companies eager for to get their snouts in the trough included US insurance giant UnitedHealth which had just won GP contracts in Camden and elsewhere.

Health minister Ben Bradshaw was delighted at the new private sector interest, and told the FT:

"We want to see the fullest possible range of service providers, including independent sector partners, developing innovative proposals to promote better health, improve patient access and develop more personalised care for patients." [203]

Polyclinics versus local care

In the summer of 2008 London's 31 PCTs voted to press ahead regardless with a scheme for 'polyclinics' and hospital closures that had been advocated in a major report commissioned from then Professor Sir Ara Darzi, a leading specialist surgeon and academic. Darzi's controversial plan to concentrate primary care, community and diagnostic services in new centres had been followed by a peerage to facilitate his appointment as a junior minister, with a second report rolling out similar ideas across England.

However virtually nobody in London actually supported the idea. Lord Darzi's call in July 2007 for family doctor and other services in London and elsewhere to be centralised in a new network of polyclinics triggered confusion, debate, and a massive campaign by the British Medical Association to 'Support NHS General Practice'.

Darzi's report on London's NHS[204] suggested a network of 150 polyclinics in the capital, each to cover a local population of 50,000 and employing 100 or more staff including upwards of 20 GPs and many more nurses and support staff at an estimated cost of £21m a year for each polyclinic – £3 billion-plus across the capital. The proposals ran alongside a downgrading of many of the capital's general hospitals, and eager early implementers in Haringey planned to close 75% of GP surgeries in the Borough (45 out of 60), to be replaced by just five polyclinics.

Despite a £15m campaign to promote the plans, fewer than 1,900 people registered their support – out of just 3,700 who responded to the consultation from an electorate in London of 5.6 million. There was also public suspicion that the plans for polyclinics would mean wheeling in major corporations to build and run them, and to deliver primary care services.

The normally docile King's Fund joined the growing chorus of criticism exposing the flaws in the plans for polyclinics. The Fund argued polyclinics may be more expensive, less efficient and less accessible than the traditional family doctor service.[205]

The polyclinic idea was no more popular in the rest of the country either: in the summer of 2008 a round-up of the state of play by HSJ correspondent Alison Moore noted:

"Polyclinics seem to be fast becoming the love that dare not speak its name - and the word is

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rumoured not to appear in the final Darzi review at all. While some strategic health authorities seem to be proposing something close to polyclinics and there is universal support for providing more outpatient and diagnostic appointments in the community, the word is virtually absent in regional reviews outside London.” [206]

In 2014, as the implications of the 2012 Health and Social Care Act became more apparent, NHS England decided that in compliance with competition law, all new GP contracts would be opened up every five years to bids from the profit-making, private corporate sector.

£1 billion squandered on health reforms without results

In June 2008 came a devastating report jointly produced by the Audit Commission and the Healthcare Commission: it effectively demolished the claims that it was New Labour’s privatising reforms that had improved the NHS. It argued that Tony Blair and Gordon Brown’s ‘reforms’ – including Foundation Trusts, the use of private sector treatment centres and the system of ‘payment by results’ – had cost up to £1 billion to introduce over five years, but appeared to be having little significant effect.[207]

Yet this still understated the scale of the failure: there were clear signs that the two Commissions had pulled their punches. For instance the report was curiously silent about the impact of the most expensive policy of the lot – the Private Finance Initiative (PFI) as a means to fund new hospitals. The inflated costs of PFI payments, combined with the rigid system of ‘payment by results’ needed to create the new market in health care were forcing many Trusts into financial crisis: yet PFI was not even mentioned in the 94-page report.

Nor did the report discuss the problems generated by ‘payment by results’ for specialist hospitals, whose larger than average costs were not properly reflected in the national tariff, and who remained dependent on transitional support to prop them up.

The report highlighted the continued refusal of New Labour – aping the previous attitude under the Conservatives – to ensure the systematic and sustained collection of data by the DH that is necessary to enable analysts to monitor the impact of the reforms, and notes that as a result the information is at best sketchy:

“The lack of formal monitoring of the reforms means that we have not carried out a comprehensive examination of the reforms in every single part of the NHS.”

In fact the report avoided any discussion or consultation with front-line health workers or trade unions: they only met NHS managers, hand-picked GPs, non-executive directors, and Foundation Trust governors, and held a series of interviews with “commissioners, providers and strategists based in London.” Nor did they speak to patients, not even a carefully screened selection. Instead: “The views of patients were gained through analysis of the results of the DH Choice survey.”

However the two Commissions remained unconvinced that the ‘reform’ package was cost-effective or delivering its promised improvements. The much-vaunted ‘patient choice’ policy had failed to make much impact, although as campaigners had warned, it was enough to destabilize some local NHS Trusts:

“Unsurprisingly, given that choice is not universally provided, there is no evidence from our fieldwork that choice policy has so far had a significant impact on patient pathways or that it has led to an improvement in the quality of services offered.

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> "*We did not find endorsement of choice as a mechanism for changing patient flows. In those trusts or units that are on the cusp of financial stability, a small activity change as a result of choice could have a significant impact on the viability of a service or of an organisation.*"

The report also published figures from a London survey which showed that the prospect of going to a private hospital for treatment was the least popular of 16 possible factors cited by patients. Primary Care Trusts had often been struggling against the odds to press-gang reluctant patients into treatment at new private (Independent Sector) Treatment Centres (ISTCs) – when their choice was to remain in the NHS:

> "*Some health economies reported that, despite a significant effort from PCTs, their local ISTC was still underutilised. Some PCTs cited that there was little local appetite for independent sector providers, with the majority of patients choosing to be treated at the local NHS hospital, even if it had longer waits than the ISTC.*"

The two Commissions echoed the arguments of critics and campaigners that the total activity carried out in ISTCs was a minuscule proportion of the NHS caseload – with a best case figure of just 105,604 cases in 2007-8, equivalent to just 1.79% of the elective activity of the NHS.

The previous year ISTCs had carried out just 4 percent of cataract operations, and 7 percent of hip procedures: such small levels of activity – at costs 11% above the NHS tariff – made it "difficult to draw any conclusions about the impact of ISTCs."

The report also backed up campaigners who had argued that ISTCs were merely "cream-skimming" the easiest and most profitable cases:

> "*Among our fieldwork sites, there was a belief that the ISTCs have cherry-picked cases and have left the potentially more complicated and expensive cases to the local NHS. … In addition, due to the lack of facilities such as intensive care, the costs of any complications resulting in a patient being readmitted as an emergency will be borne by NHS providers.*"

The report by the two Commissions was far from perfect: its authors and the two organizations commissioning the work did not begin as critics of the reforms. They avoided some important issues. But despite these limitations the report showed that health workers and campaigners had been proved right: the NHS had improved thanks to record growth in spending, backed by targets to reduce waiting times.

And, as the report states, these were "substantially delivered without using the system reforms."

'World Class Commissioning'

If the concept of polyclinics was ambiguous in relation to private sector involvement, the concept of World Class Commissioning was completely up front, if heavily disguised behind a barrage of barely readable jargonised rhetoric aimed more at bamboozling and boring people into submission than developing any credible argument.

It was designed from the outset to promote outsourcing and develop a functioning market in healthcare. The idea was coined by Mark Britnell, Director-General for Commissioning and System Management for the NHS in England from July 2007 until September 2009, when he jumped ship and left his £253,000 a year post to join multinational consultancy firm KPMG.[208] While at the Department of Health Britnell led the development of three major initiatives to develop private sector involvement and a competitive market in the NHS: World Class Commissioning, the creation of a 'Cooperation and Competition Panel', and reforms to primary care and community services.

World Class Commissioning began in 2007, spelling out 11 'competencies' against which the Primary Care Trusts (PCTs, which were the commissioning bodies for England's NHS) were to be judged. Britnell himself later told the Commons Health Committee that he did not think anybody really disagreed with them, and the Committee itself seemed to agree, concluding that:

> "*Ridiculous though the term is, much of the World Class Commissioning initiative is unexceptionable.*"[209]

However competencies 6 and 7 (Prioritise investment, and Stimulate the market) proved to be really contentious, since the stimulation of the market at local level in the NHS meant creating competition for the NHS providers, and that became the priority for investment.[210]

The PCTs were obliged both to divest themselves of the community health services that they were still providing, in many cases either to a non-profit community interest company or 'social enterprise', or to a for-profit private sector provider, and ensure sufficient openings were created for private sector providers to gain at least a toe-hold.

To prod them further and faster along this path, PCTs (which collectively controlled a massive £75 billion in NHS commissioning budgets) were encouraged to commission advice from any of the 14 giant private

sector corporations. This included four big American health insurers and care managers – Aetna, Humana, UnitedHealth and Health Dialog Services – who had been included in a new 'Framework for Procuring External Support for Commissioners' (FESC). Also included in the 'approved' list of 14 firms were UK-based private companies including BUPA, Axa PPP and Tribal, along with KPMG and McKinsey.

The Department of Health warned SHAs that they would be measured on the number of PCTs that were making use of advice from the FESC framework. As the Commons Health Committee later noted:

> *"The FESC framework was designed, in part, to provide a route through which commissioners could use longer-term outsourcing."* [211]

Urging PCTs to effectively contract out commissioning in this way was a qualitative step change in privatisation. Health Minister Ivan Lewis claimed that the FESC organizations were "already known and trusted": but one thing all 14 companies had in common was that not one of them had any experience of commissioning or providing a comprehensive and universal health care system like the NHS.

Over two years later the Health Committee could not get any clear answers from the Department on the cost of the FESC scheme. Even less information was available on the total cost of external consultancy support commissioned by PCTs as they struggled to meet the competencies of World Class Commissioning while at the same time in many cases implementing cuts in services, exclusion of certain treatments or drugs, and cuts in staffing as they struggled to balance the books.

An idea of the quality of advice on offer can be gleaned from the fact that one of the private companies wheeled in was management consultancy Ernst and Young (later rebranded as EY), who produced a briefing document on primary care recommending that more patients must be persuaded to "switch" between GPs, creating a "competitive tension" between them. They advised NHS Primary Care Contracting that "a high level of patient 'churn' was essential to ensuring healthy competition". The fee charged for this information was never disclosed.[212]

UNISON was highly critical of World Class Commissioning in evidence to the Public Accounts Committee in 2009:

> *"The assumption that has been built into the system is that the NHS is unable to improve itself and services need to be subjected to market-testing and competitive tender in order to produce better results. […]*

> *"The stated reason for the introduction of WCC was a perception that the quality of commissioning in the NHS was not up to scratch. However, NHS commissioning will not improve if responsibility is handed over to private sector commissioners. The Framework for procuring External Support for Commissioners (FESC) potentially does exactly that. […]*

> *"Given that these same companies are also hoping to secure a bigger piece of the healthcare market it is counter-intuitive to suppose that they will pass on any acquired knowledge and then move on."* [213]

Cooperation and Competition Panel

The Panel was set up in 2009 to allow private sector providers to raise complaints that they had been unfairly treated, and that a local area had not been sufficiently opened up to competition between would-be providers.[214] In other words the Panel was from the outset a bent umpire, with the task of shifting the goalposts to ensure that the private sector gets what it wants. It continued in this role until 2014, when its functions were taken over by the regulator Monitor.[215]

The Panel it saw its role as responding to any private sector complaints against potential mergers of NHS providers, and against what they saw as unfair procurement policies, "collusion", or "price fixing". As such, despite its misleading title, the Panel was transparently biased against cooperation, collaboration or planning between different sections of the NHS.

Its launch prompted warnings from foundation trusts that it risked "fragmenting" the NHS[216] – as indeed foundation trusts themselves did when they were established, and all market-style reforms have done since the 1980s.

Professor Chris Ham, a former advisor to Tony Blair's government, branded the guidelines as "written by a neo-liberal economist on speed", and criticised its "one-eyed" focus which undermined integration of services and regarded almost any collaboration between providers as "collusion".[217]

The Competition Panel's total opposition to any form of 'price fixing' might even question the Department of Health's policy of establishing a national tariff for treatment costs, warns Prof Ham.

Although the word 'cooperation' is included in its title, there was no sign from the Panel of any commitment to cooperate: and where it is mentioned it is cooperation in the creation of a competitive market. The Panel was single-mindedly focused on driving through a competitive system. Its policy documents endlessly

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reiterate claims for the benefits of competition, despite the total absence of any evidence to support them:

> "*In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients.*"[218]

None of these alleged benefits was supported by even a shred of evidence, anywhere in the world. But the Panel went on to make even more extravagant and absurd claims for the merits of competition against planning:

> "*choice and competition in the NHS can be expected to:*
>
> - *improve quality and safety in service provision;*
> - *improve* ***health and wellbeing;***
> - *improve standards and* ***reduce inequalities*** *in access and outcomes;*
> - *lead to better informed patients;*
> - *generate greater confidence in the NHS; and l provide better value for money.*"

This list was pure fantasy: indeed not even the most fundamentalist of free-market ideologists would dare to claim that markets can "improve health" or "reduce inequalities" – that's not what markets are supposed to do.

Having spelled out its clear, fundamentalist, completely biased free-market approach, the Panel's guidelines went on to claim that:

> "*'The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients (i.e. service contestability).*
>
> "*Where the process of competition is dampened, or otherwise hindered, by a merger, the benefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost.*"

The Panel proved to be an effective background threat, forcing the pace of outsourcing and constraining any instincts of trust management to self-preservation by obstructing new rival organisations that threatened their finances, and wider services, by cherry picking parts of their elective caseload.

The Panel's potential influence came in addition to the use of implied decision-making, allowing spurious denials that PCTs were being compelled to outsource services. Asked at UNISON's Harrogate Health Conference in 2009 about the way in which PCTs in NHS East of England were seeking to rule out a retention of services within the NHS, Health Secretary Alan Johnson insisted that:

> "*There is no deadline, there is no blue print and there is no time scale, and there is no forcing people into doing this. The option must always be there for NHS services, so I will take this up with the East of England.*"

However an initial query from UNISON to the East of England Strategic Health Authority produced a claim that the decision was taken by the 'NHS East of England Management Board' in September 2007. But no such body existed in September 2007.

A Freedom of Information request eventually secured the grudging admission that the decision had NEVER been formally taken by East of England SHA. Primary Care Trusts had clearly been misled into believing that they were implementing an SHA decision to do what local communities and NHS staff were urging them not to do.

Transforming Community Services

'Transforming Community Services' was the general process of driving through the separation of community health services from PCTs in England. An extensive 100-page document setting out a process for separation and possible privatisation of PCT services was published by the Department of Health in January 2009, but despite the warm words in the introduction, ministers and PCTs alike made no attempt to publicise it or discuss the unpopular policy with health workers or the wider public.[219] PCTs could use any of the following routes to deliver services:

- Arms-length provider organisations – PCTs could continue to deliver services through their own arms-length provider organisations.
- Integration with other NHS organisations – this could involve "vertical integration" to link up with a hospital trust through merger or joint

management, or "horizontal integration" with other PCT services.

- Community Foundation Trusts – a hypothetical solution that never materialised in reality.
- Integrated care – links with local authorities to become part of joint health and social care organisations, or new organisations such as care trusts or Integrated Care Organisations – possibly in partnership with the private sector.
- Non-NHS bodies – this could involve some or all service provision being transferred to a social enterprise, or direct privatisation with private healthcare organisations brought in to deliver services: the contracts should be open to "any willing provider". [220]

No profits, but behaving like businesses: social enterprises

Social enterprises, which were promoted as a way of separating community services from the NHS, are 'third sector' organisations, standing in theory between for-profit private sector providers and the charitable, voluntary sector. They can be not-for-profit businesses which retain surpluses rather than distributing them to shareholders as profits. However according to the DoH in 2007, just 2% of third sector organisations had budgets in excess of £5m, meaning that even the smallest PCT community services turnover would have been off the scale of the third sector.

Social enterprises are all outside the NHS, so would retain the scope some time after they had transferred NHS staff on their existing terms and conditions to invoke "economic, technical or organisational" reasons for changing their contracts.

More than eight out of ten (84%) of Social Enterprises were also small organisations with budgets of below £1 million a year, and more than a third were tiny, with budgets of less than £50,000. More than half employed fewer than 25 people and in two thirds of social enterprises volunteers outnumbered paid staff.[221]

PCTs were obliged by the NHS to consider requests from 'staff' for their services to be transformed into a social enterprise under the 'Right to request': but the formula was deliberately vague on how many staff, and at what level, are required to make the request in order for it to go ahead.

This left the possibility of a tiny group of managers effectively hi-jacking the remainder of a provider arm workforce into a Social Enterprise that few, if any, of the other staff actually want or support. The trade unions were largely excluded from any involvement in such 'requests', and there was of course NO equivalent trade union 'right to request' that managers drop unpopular proposals for a Social Enterprise, or any right for staff to appeal against a scheme or demand a ballot on whether a scheme should go ahead.

In Surrey for example 84% of NHS community staff had voted in 2006 AGAINST their management's plan to set up the much-touted Central Surrey Health as a "social enterprise"[222] – it was launched anyway.

Preferred provider

The change of Health Secretary from Alan Johnson to Andy Burnham in the autumn of 2009 brought a welcome change in policy on outsourcing. In place of putting clinical as well as non-clinical contracts out to tender from "any willing provider," and the onus being on the commissioner to show why the contract had not gone to the private sector, Burnham, responding to lobbying by the unions, announced that the new policy would be for the NHS to be the preferred provider. And, where NHS services were failing, the provider would be given at least one chance to improve services before commissioners went out to tender for an alternative.[223]

And, despite angry protests from the private sector and from one-time Labour secretary of state Alan Milburn, Burnham was able to win cabinet support for this line until the general election less than a year later.

After the banking crash – McKinsey's plan for cuts

Despite public denials and a refusal to publish the report, New Labour health ministers were known to have commissioned management consultants McKinsey in 2009 to investigate how £20 billion of 'savings' could be squeezed from the NHS by 2014.

The news of this document and a summary of its content was first leaked by the *Health Service Journal* in September 2009.[224] An HSJ editorial reminded its readers that the document had been in circulation for over a year, with customised versions for the Strategic Health Authorities.[225]

A National Audit Office report to the Commons Health Committee in 2011 explained that the challenge was more complicated because despite receiving no real terms increase in funding from 2011 to 2015 the NHS was certain to face significant additional demand for services arising from the age and lifestyle of the population – as well as the need to fund new technologies and drugs. It warned of the scale of the challenge:

> *"To keep pace, the NHS needs to make efficiency savings of up to £20 billion by 2014-15. The Government has asked the NHS to do this whilst simultaneously driving up the quality of services it provides and the outcomes it achieves."* [226]

Part 3: 2010-2020

Cameron and Lansley

David Cameron and the Conservative Party won the largest number of seats in the 2010 election, but fell short of a majority. The Liberal Democrats, led by Nick Clegg, seized the opportunity for power by joining a coalition, in doing so sacrificing many of their central policy positions. The coalition remained in power until 2015.

The Conservatives took all the key jobs including Chancellor and Health Secretary, and from the outset the NHS was hit by a combination of austerity and market-style 'reforms' that had not appeared in either the Conservative or Liberal Democrat manifestos.
The unprecedented austerity squeeze (that has not yet been relaxed after 14-years of real terms cuts in NHS spending as population increases and proportion of elderly have increased) cut public services – especially local government – but also brought growing inequality. This in turn brought a visible decline in public health, the first ever decreases in healthy life expectancy, and a steady increase in pressures on the NHS.

Under-funding also left the NHS increasingly lacking both capacity and capital to expand services or even repair crumbling buildings. This has been used to justify the NHS making greater use of private sector 'spare capacity' – and seeking private investment to fill the growing gaps.

Eager to underline the fact that the first plans for austerity had been laid by New Labour, Health Secretary Andrew Lansley triumphantly published the national level McKinsey report in July 2010[227] – making rather less noise about the fact that many of the plans it contained were to be rolled out under the coalition.

The 'report' proved to be no more than a series of Powerpoint-style slides conveying a series of assertions on possible 'savings' with no discussion of their impact, knock-on consequences or possible disadvantages, and little if any supporting evidence. The London version was even more extensive, and equally ridden with assertions.[228,229]

The £20bn savings target was embraced from the outset by NHS Chief Executive Sir David Nicholson, who warned, on the basis of the economic crisis, that NHS trusts and commissioners should be prepared "for a range of scenarios, including the possibility that investment will be frozen for a time." [230]

In what became known as the 'Nicholson challenge' he told NHS leaders to "plan on the assumption that we will need to realise unprecedented levels of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over three years." [231]

George Osborne's first Spending Review in 2010 did indeed set a £20bn savings target for the NHS – requiring year-on-year efficiency gains of 4 per cent for the next four years – a level of savings never previously (or since) achieved.

Top-down reorganisation

Within weeks of the 2010 election Health Secretary Andrew Lansley published a controversial White Paper 'Liberating the NHS.' It proposed a massive top-down reorganisation, and sought to expand competitive market that had been begun by New Labour, replacing traditional cooperation and planning with competitive tendering.

The White Paper 'Liberating the NHS' tore up both Conservative and Liberal Democrat manifesto promises, and set out plans for the wholesale top-down reorganisation of the NHS, a change so far reaching David Nicholson later claimed it would have been "visible from space".[232] It was followed swiftly by the Health and Social Care Bill, which eventually received the Royal Assent in 2012 and took effect from April 2013.

The new Bill proposed to abolish all 150 Primary Care Trusts (PCTs) which held budgets to buy services for their local population, and scrap regional planning, with the abolition of Strategic Health Authorities. It also proposed to lift the restrictions on the private sector income that foundation trusts could generate, to allow them to make up to just short of half their income from private contracts.

150 Primary Care Trusts were to be replaced by 211 new Clinical Commissioning Groups (CCGs), notionally headed by GPs, while a new NHS Commissioning Board, (soon renamed NHS England) would head a network of bureaucratic and secretive Local Area Teams reporting upwards to NHS England but not outwards or downwards to local communities and the wider public.

Competition and outsourcing

Section 75 – later reinforced by powerful regulations implemented on the eve of the Act coming into force – was the controversial heart of the Bill. It set out far-reaching requirements for Clinical Commissioning Groups (CCGs) to put services out to competitive tender. The initial draft of the Bill brought back the

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notion of opening to bids from "any willing provider," – although one of the most common cosmetic amendments to the Bill was to delete every instance of "willing" and insert "qualified."

The Foundation Trust regulator, Monitor, was given wide new powers to regulate the NHS as a whole and, in the amended Bill, to enforce both competition and integration of services.

The competition rules brought completely new players into the regime of competition in the NHS: the Competition Commission and the Office of Fair Trading (both since superseded by the Competition and Markets Authority) began ruling on mergers of trusts,[233] and obstructing collaboration between trusts to improve patient care[234] – on the grounds that it impeded competition.

No benefit

Lansley's proposals also flew in the face of evidence that the NHS market had done nothing to improve patient care. In 2010 the Commons' Health Select Committee declared it to be a costly failure:[235]

> "*Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately.*"

The Committee's summary concludes:

> "*In conclusion, a number of witnesses argued that we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser/provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished.*"

Conservative MPs' views on the legislation began with uncritical and largely uninformed support for Lansley's White Paper and for the massive and complex 400-page Bill that followed soon afterwards. This changed to uncertainty in the face of mounting opposition to key parts of the Bill, and then dogged determination to force it through.

A few Liberal Democrat MPs at first stood out against aspects of the Bill, only to be talked round after forcing a delay for a brief 'listening exercise' in the spring and summer of 2011, which changed little of substance. By February 2012 David Cameron had to deny stubborn rumours that he and other leading Conservatives wanted Andrew Lansley "taken out and shot" for his handling of the Bill.[236]

The coalition's focus on pushing through the legislation temporarily diverted attention and energy from outsourcing, but soon after the Act was passed in 2012 a new wave of outsourcing and spending cuts began.

New commissioners, new wave of outsourcing

The new shadow Clinical Commissioning Groups, often led by a handful of maverick GPs or (behind the scenes) by management consultants, began drawing up ever more far-reaching and irresponsible plans for contracting out services many of which ignored the potential impact on local NHS trusts if the contracts – and the funding – were won by private sector bids.

Contracts to outsource Musculoskeletal (MSK) services, and these potentially destabilise local NHS trauma services and therefore the viability of A&E departments. Elsewhere a variety of other services – care of older people, cancer care, end of life care, and a range of community health services such as specialist community nursing, community therapy, podiatry, early supported discharge and intermediate care – were being put out to tender, with a combined value of billions over 5-10 years.

In July 2011 Andrew Lansley reeled off a list of eight services that the Bill would open up to private sector competitive bids. It read like a roll-call of the services that had been most neglected and run-down by cash-strapped PCTs looking for cuts: musculo-skeletal services for back pain, wheelchair services, adult 'talking therapies' for mental health, ulcer and wound care, continence services, and others equally regarded as a soft touch for cuts.[237]

From April 2012 patients receiving one of eight types of community and mental health services in England would be able to be choose to access their care or support from a private health provider or voluntary or charitable organisation, not just the NHS.

However competition, prioritised over co-operation in a market-driven NHS, had not been proven to improve patient care. Even David Nicholson complained

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that the new laws promoting competition were hampering efforts to improve services, citing the blocked merger of the two trusts, and examples of GP practices not being allowed to federate.[238]

In 2013 the deputy chair of Monitor complained that the new competition arrangements were "a bonanza for lawyers and (management) consultants" and could lead to scandals. He made his remarks ahead of a proposed[239] merger of two hospitals which was supported by local doctors but opposed by an unidentified local private hospital.

The merger, called for by the NHS hospitals themselves "to ensure the sustainability of services," was eventually blocked by the Competition Commission on the grounds that it would reduce "patient choice"[240] David Locke QC, an expert in NHS contract issues, told the BMJ: "This shows the conflict between running the NHS as a public service and running it as a regulated market".[241] The lengthy battle over the merger is estimated to have cost the NHS (and thus the taxpayer) almost £2 million in consultancy and legal fees.[242]

A Lansley lie

But, despite the lack of evidence, Lansley placed competition at the heart of the Health & Social Care Act and section 75, the HSCA regulations on competition, represented a lie by Lansley. He had originally promised GPs that it was "absolutely not the case" that Clinical Commissioning Groups (CCGs) would have to put services out to tender, and Earl Howe had promised those concerned about the regulations that there would be "no legal obligation to create new markets". But the legislation showed these promises to be untrue yet again.

After the passage of the infamous section 75 legislation Professor Martin McKee, in an article in the BMJ, lamented that the NHS was now at the mercy of lawyers, including some of the peers who had supported the Act:

> *"The future of healthcare in England lies in the hands not of politicians and professionals but of competition lawyers. Clinical commissioning groups …will think twice before invoking the wrath of one of the large corporations now moving into healthcare. With legal and contracting teams many times larger than those available to the commissioners, it is they who will be the ultimate arbiters of the shape of healthcare."* [243]

There were expensive challenges from the private sector over the awarding of contracts and anecdotal reports of CCGs allowing contracts to remain with private firms[244] because of the fear of the legal costs of not doing so.

Despite the expense and the perverse consequences of the new system, there seemed to be no political will to abandon the English NHS market and use the billions that would be freed up for patient care instead.[245] But of course having an NHS market in place – whatever the extra cost – is necessary to enable more privatisation of the English NHS.

Privatisation gathers pace

In February 2012 Circle took over the management of Hinchingbrooke Hospital in Cambridgeshire, having somehow convinced the East of England Strategic Health Authority that it could deliver an astonishing level of savings in the course of a ten-year £1 billion contract. A subsequent highly critical National Audit Office report highlighted this:

> *"Circle's projected savings of £311 million over ten years are unprecedented as a percentage of annual turnover in the NHS. If delivered, Circle's proposal will make savings of over 5 per cent recurrently each year over the ten-year life of the contract. An essential element of the projected savings is an assumed annual 4.3 per cent efficiency saving from year four onwards. However, Circle's bid did not fully specify how it would achieve these savings. […] No fee is payable if a surplus isn't achieved."* [246] *p8*

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Circle's smooth-talking boss, former Goldman Sachs banker Ali Parsa, had tried to create the impression through acres of tame media coverage that Circle was some kind of benevolent workers' cooperative, while in fact it was controlled by profit driven private equity and hedge funds. Far from being a new type of company handing control to the workers, Circle was hostile to trade unions – and ran a management

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regime that made staff equally hostile to Circle, creating a chronic staffing shortage.

The hospital was facing a £10m gap between income and costs in 2012-13. To make matters worse, commissioners had decided stroke patients that had previously been sent to Hinchingbrooke would be treated at Addenbrooke's Hospital in Cambridge instead – further reducing income. And Circle's hopes of raising more income for Hinchingbrooke by capturing 5,000 more patients from a 30-mile radius flew in the face of Cambridgeshire and Peterborough commissioning plans to reduce the tariff and cut referrals for hospital treatment.

The NHS workforce that Circle attempted to manage at Hinchingbrooke, and forced to wear Circle Hinchingbrooke branded uniforms while still NHS employees, was three times larger than the grand total of 568 people then working for the whole Circle group. Although small in NHS terms, with up to 310 beds, a busy A&E, and a mix of emergency and elective admissions, Hinchingbrooke as a hospital was more than ten times larger than Circle Health's extravagant, tiny private hospitals in Bath and Reading – which had scraped through financially only on the strength of treating NHS patients in otherwise empty beds.[247]

The company's vacuous 16-point "improvement plan" was better at spending money than saving it – promising "Michelin-quality" meals and a new "value-for money entertainment system" for patients, "fairer car parking", and even hinting at improving nurse staffing levels.

The Commons Public Accounts Committee towards the end of 2012 investigated the basis on which Circle had secured the contract, and warned:

> "*The company has not achieved the savings it expected in the first few months of operation and it has already parted ways with its Chief Executive, only 6 months into the project. We are concerned that Circle's bid was not properly risk assessed and that Circle was encouraged to submit overly optimistic and unachievable savings projections. While some financial and demand risk has been transferred to Circle, the NHS can never transfer the operational risk of running a hospital leaving the taxpayer exposed should the franchise fail.*" [248]

The uncertainty over the Hinchingbrooke contract was even greater since Circle would only be paid a share of any surplus the hospital made. The company was already heavily dependent upon the NHS: despite having lost two NHS Treatment Centre contracts its main current income streams were still coming from the NHS.

Circle's two extravagantly expensive and tiny (30 bed) private hospitals had run up six years of losses, mitigated only by treating NHS-funded patients, and its business plan to expand the private hospitals was dependent upon building a workforce by poaching consultants, nurses and other staff trained by the NHS.

Behind the hype, overall control of Circle was firmly in the hands of a separate for-profit company, Circle Holdings, 95% owned by city interests, including some of the world's biggest hedge funds. In six years they had already funnelled £140m into the company – but had received no return on this investment.

Commissioners ordered to contract out

The Circle contract was followed by a succession of contracts going out to tender, not least in response to instructions from the Department of Health in 2011 for each PCT to open at least three out of a list of eight community services to "any qualified provider" by September 2012.[249]

But while these contracts were often relatively small in value (all eight services together were only worth around £1 billion nationally) some larger contracts were also being awarded.

Serco, a large-scale multinational company with a finger in many pies, was named in March as preferred provider for a £140 million, three-year contract to deliver community services in Suffolk, including community nursing, specialist nursing, community hospitals, speech and language therapy and specialist children's services. In October as Serco took over approximately 1,400 NHS staff were transferred to the new service (named Suffolk Community Healthcare) under TUPE regulations, retaining their terms and conditions, including their NHS pensions, holiday entitlement, maternity and sick leave arrangements, pay and length of service.[250]

Also in March Virgin Care won contracts worth £500 million to run community health services in South West and North West Surrey (including prison healthcare and sexual health, seven Surrey community hospitals, community nursing and dentistry, health visiting and physiotherapy, diabetes treatment and renal care.)[251] There were more contract wins for Virgin in West Sussex and Buckinghamshire.

In July Virgin Care won a £132m three-year contract to deliver children's services in Devon, including mental health, learning disabilities and school nursing. However the decision, by NHS Devon and Devon County Council, was challenged by the mother of children who depended upon the services. She argued that the commissioners had failed to assess the impact

that shifting the services to the private sector would have on service users. In October a judge found that commissioners had initially failed to meet their duty under the Equality Act 2012 to assess the impact of the move on children with learning disabilities and disabled children. Nevertheless the judge ruled that (in part because PCTs were about to be abolished so there was little scope to go back and do the process again) even though the decision had been unlawful, it could still go-ahead, regardless.[252]

Richard Branson's Virgin Care also incongruously netted contracts to deliver sexual health services in West Sussex (where there appears to have been no consultation on the deal) and Buckinghamshire.

In North Yorkshire Assura (75 per cent owned by Virgin) had also won a Competition Panel ruling that the NHS trust could be in breach of competition rules if York Hospital retained more than 40% of community referrals for musculoskeletal treatment.[253] The panel called for further measures to ensure the maximum possible number of patients were referred for treatment outside of the NHS.

In September a report from corporate finance advisers Catalyst caused a stir by forecasting that the private sector could expect to win business worth around £20 billion from the NHS in the next few years by taking over GP surgeries and setting up new community health clinics.[254]

However the report also argued that the market for services outside hospitals was an estimated £20 billion, implying that to win contracts worth that much the private sector would need to scoop close to 100 per cent of the work. Focusing on the limited resources available for the NHS to expand as necessary, Catalyst insisted:

> "*Landmark contracts awarded to Circle, Virgin Care and Serco demonstrate increasing recognition from the public sector that leveraging the private sector's ability to invest capital and use more efficient delivery models is necessary for the government to reduce costs while improving the quality of healthcare.*"

Fast track to fragmentation

In early October 2012 Andy Burnham used his Labour Conference speech to highlight a survey that showed 396 separate contracts for community health care, worth a total of £250m, were due to be signed that week, in "the single biggest act of privatisation ever seen in the NHS." The new Act, he said was "a fast-track to fragmentation." [255]

One example in the survey was rural Lincolnshire which "will soon have BMI Healthcare Ltd, Global Diagnostics Ltd, InHealth, Kleyn Healthcare Ltd, SG Radiology & Associates Ltd and VanScan Ltd all competing to offer patients diagnostic tests" alongside the existing NHS provider.[256]

Labour's survey data showed that more than a quarter of the contracts were being forced on health chiefs by new rules making them pick at least three from a sample of eight services to put out to tender, so some were having to tender for services they were already delivering satisfactorily. The full report, entitled Cameron's Great NHS Carve Up was published by the Socialist Health Association in March 2013: it noted that commissioners would be forced to open up a further 39 services in a major expansion of Any Qualified Provider tendering in community services.[257]

But even as contracting took off to the highest level yet seen, failures were beginning to become visible. In February 4,700 patients of a privatised GP practice in Camden were left without primary care after the company, The Practice (which had bought the business when UnitedHealth had walked away from its experiment with GP services), pulled out. There was also an inquiry in north west London into the failure of Care UK, one of the larger private providers, to process 6,000 X-rays at what was supposed to be an Urgent Care Centre.[258]

In July 2012 the 52-bed private BMI Meriden Hospital, Coventry, which had been bolstering its finances by treating NHS patients, was exposed as having ordered its doctors make NHS patients wait months for operations – even if there was no waiting list – in the hopes of persuading them to pay privately. The hospital was charging self-pay private patients upwards of £8,500 for a hip replacement, but was only receiving £5,485 for NHS referrals.[259]

Growth – and decline – of private sector

2013 saw another big increase in NHS spending on private contractors. Department of Health and Social Care (DHSC) *Annual Report* figures show spending by NHS commissioners on private providers of clinical services rose each year, from close to zero in 1997 when John Major's Conservative Government finally fell,[260] to just over £2 billion (2.8 percent) under Tony Blair in 2006 (when separate figures were first published)[261] and almost £9 billion (7.6 percent) by 2016,[262] and £9.2 billion in 2018.

The most substantial jump prior to the Covid pandemic was a near 25 per cent (£1.6bn) increase in 2013/14 as the 2012 Act took effect.[263] By the end of 2013 160 NHS contracts potentially worth a total of £6 billion were out to tender.

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However after an initial surge in growth the share of NHS spending on private providers flat-lined in 2016/17, and declined slightly to 7.3 percent in 2017/18.

Hostile Environment 2014-2024

In 2014 a new Immigration Act involved the NHS in an extension of the 'Hostile Environment' which Home Secretary Theresa May had established in 2012, notionally to make life miserable for "illegal" immigrants, but in fact fostering racist hostility to all who might appear to be immigrants. The new legislation, which took effect from 2015, expanded the pre-existing – and widely ignored – regulations requiring 'overseas visitors' to be charged for using the NHS.[264]

It broadened the group of people who were subject to charges, introduced a new £200 'immigration health surcharge' for anyone seeking visas to enter the UK, and allowed NHS Trusts to charge up to 150% of the cost of treatment in secondary care.

NHS Trusts were now in theory required to question everyone's eligibility for care upfront – but of course it was people of colour who were always the most likely to be checked, potentially blocking or delaying their access to care. The new law, subsequently further toughened, struck a major blow at the notion of the NHS as a universal service, covering all who need care, and funded not from user fees but from general taxation.

As the 'Patients, not Passports' campaign explained, this undermined the patient-healthcare provider relationship, not least because it soon became clear that NHS Digital was systematically sharing patient data with the Home Office for immigration enforcement purposes.[265]

The Hostile Environment, later coupled with the racist and xenophobic messages that were central to the campaign for the Brexit referendum, served to deepen the staffing shortages in the NHS, and widen the divide between the professional, clinical staff and the lower-paid non-clinical staff, many of whom were employed by private contractors rather than the NHS.

From 2017 the Hostile Environment was officially renamed the "compliant environment," but tightened as a set of policies to prevent migrants without leave to remain from accessing housing, healthcare, education, employment, bank accounts, welfare or drivers' licences. The policies were primarily implemented through the 2014 and 2016 Immigration Acts.

Charges for NHS care for certain migrants, at 150% of the cost to the NHS, and patient data-sharing between the NHS and the Home Office for the purposes of Immigration Enforcement significantly deterred irregular migrants from seeking healthcare, even in emergencies.[266]

But this political climate also increased the sense of vulnerability of staff from Black, Brown and minority ethnic communities, especially when they were at the front line of delivering health services at the peak of the pandemic. In August 2020 the Migrants' Rights Network ('MRN') alongside the Kanlungan Filipino Consortium ('KFC'), the3million and Migrants at Work (MAW') launched a survey aimed at workers who were either migrants or people of colour, who worked in the South of England, London or the West Midlands found that:

- 76% of respondents said that they felt they were putting their own health at risk by continuing to work during the COVID-19 pandemic, with 54% of those believing that they were more likely to contract COVID-19 in their line of work
- Despite concerns in relation to their own health, 38% of respondents had the additional pressure of being concerned that they would lose their job if they didn't go to work.[267]

Of the health and social care staff surveyed,

- 62% said there had been a shortage of PPE resulting in 43% of our survey respondents having to undertake physical examinations of patients or home visits with insufficient protection
- Of those who had been symptomatic during the COVID-19 pandemic (42% of our respondents), 39% were not able to access a coronavirus test.

The combination of Hostile Environment and uncaring private sector employers unwilling to go beyond bare legal minimum support for NHS outsourced staff put patients and other NHS staff at risk, as well as the outsourced staff themselves and their families.

Bullied into tendering

By April 2014, despite denials by ministers and the regulator[268] it was increasingly clear that many of the tendering exercises and private contracts were the result of fears of falling foul of the new competition rules in the Act. An HSJ survey found that almost 30 percent of CCG leaders said they had opened NHS services up to competition – or were currently doing so – only because they feared they would fall foul of competition rules if they did not.

Although only 20 per cent had experienced formal challenges to commissioning decisions or arrangements under competition and patient choice regulations, more than half (57 per cent) said they had experienced informal challenge or questioning.[269]

This pressure increased: a year later a similar survey found 43 per cent of commissioners said their organisations were inviting competition for contracts where they would have chosen not to but for concerns about the controversial competition rules, while the proportion who had experienced informal challenges had jumped to 75.7 per cent.[270]

Moreover given the mounting financial pressures on CCGs,[271] the two surveys showed that far from delivering more efficiency, the competition rules had brought increased commissioning costs, obstructed desirable service change and hindered plans for the organisational future of local providers, such as mergers.

Serco flops

From the end of 2013 two of the companies that appeared to be setting the pace early on ran rapidly into mounting problems. The website 'NHS For Sale' has collected together some of the story as contracts that seemed to promise profits collapsed along with the over-optimism of the companies' sales pitch.[272]

Among the bidders for the highly controversial £800 million plan to contract out all of the services for older people in Cambridgeshire and Peterborough Clinical Commissioning Group at the end of 2013[273] was Serco. But at that same time the company was coming under fire for performance failures and facing possible fines in its flagship Suffolk community services contract,[274] and heavy criticism from the Care Quality Commission for failures in its contract to deliver out of hours GP services in Cornwall,[275] as well as allegations of bullying,[276] and that performance data records there had been altered.[277]

In December 2013 Serco announced that it would be pulling out of its contract for running Braintree hospital in Essex before the end of the contract. In March 2014 the contract was handed back to the Mid Essex Hospital Trust – nearly a year early.[278]

The company's other major contract with the NHS for community care in Suffolk had struggled from the outset – not least being unable to recruit and retain staff – and wound up losing money, worsened by fines for performance failures.[279]

By August 2014, the company announced that it was withdrawing from the NHS clinical services market altogether, having made an £18 million loss on its three NHS contracts,[280] and in June 2015 it walked away from its out of hours contract in Cornwall 17 months early, after failing to reach the required standards.[281]

Circle pulls out

In January 2015 Circle, which had won the contract to manage Hinchingbrooke Hospital on ridiculously exaggerated claims of potential efficiency savings, threw in the towel less than three years into its 10-year contract, and just before publication of a highly critical Care Quality Commission report. Circle's failure proved beyond doubt that private sector expertise in running small scale elective-only hospitals is completely useless in the face of the complexity of running even one of the smallest NHS general hospitals.

In almost three years in control, Circle's failure ever to balance the books meant the company had made not a penny in profit, and survived only on NHS cash handouts and some of Circle's own money to prop up the budget.[282]

By July 2014 Hinchingbrooke was one of 19 "seriously indebted trusts" referred by the Audit Commission to health secretary Jeremy Hunt for closer scrutiny.[283] Circle's failure to retain staff led to sky-high chronic spending (almost double the average for Foundation Trusts) on "interim staffing" – locums, bank and agency staff. In the 2013 NHS Staff Satisfaction Survey, Hinchingbrooke came out worse than the NHS average for two thirds (19) of 28 Key Findings and in the lowest 20% of trusts for almost half. Hinchingbrooke was among NHS trusts where staff were most likely to have experienced bullying or abuse from colleagues. Its staff turnover rate was almost 50% higher than the NHS average.[284]

Circle also ran in to, and created problems in Nottingham, where a team of NHS consultant dermatologists resigned in December 2014 after the service was contracted out to Circle, refusing to transfer to the payroll of the struggling private hospital chain.[285] The Notts consultants had warned that they would not work for Circle, which had become notorious for the bullying regime at Hinchingbrooke; but they had been ignored.

The resignations left Nottinghamshire's main hospital trust with no specialist dermatologists, putting access to adult services at risk. Circle had to recruit overseas locums, some being paid £300,000-a-year, but who were not qualified to teach. By July 2015 the contract had been described as "an unmitigated disaster" for the trust.[286]

Bedford Hospital refuses Circle deal

In November 2014 Bedford Hospital Trust decided not to sign a contract that would have made it a subcontractor to Circle in the provision of musculoskeletal (MSK) services.

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Circle had become the first company to be given prime contractor status when it was awarded the £120m 5-year contract for integrated MSK services covering Bedfordshire, Luton and Milton Keynes in August 2013, with a contract that commenced in April 2014.[287]

However Bedford Hospital, which (along with Luton Hospital) was supposed to be integrated into the new system complained of a 30 per cent reduction in elective referrals in the first few months of the contract. The trust chief executive warned of the risk its income from MSK would no longer support its consultant surgeons. The reduction in income undermined the Trust finances and its ability to retain all seven of the trauma surgeons it employed.[288]

A year later Bedford Hospital management spelled out some of the problems and delays in treatment that continued to dog the new 'integrated' service, arguing:

> "*A new system and new pathways are likely to have teething problems. Yet the musculoskeletal contract in Bedfordshire is now 18-months-old and still there are delays in patient referrals of up to 46 weeks, contrary to the claim*[289] *that 100 per cent of patients are triaged within 24 hours of referral.*"

Worse still the Trust contrasted the drop in NHS referrals with the growth in referrals to the private sector:

> "*Secondary care referrals may have been reduced at Bedford Hospital, but the nearby private hospital is thriving with simple MSK surgery.*" [290]

However there had been significant delays as a result of the way the triage hub managed patient referrals:

> "*Between mid July 2014 and mid July 2015 more than 200 patients referred to Bedford Hospital had delays from the triage hub receiving the referral from the GP to the referral being sent to the hospital of between seven and 46 weeks.*"

The Trust also pointed to CCG overspending on the contract in year one, and argued that commissioners needed to consider the effect on the whole health system before awarding a contract:

> "*If a prime contractor model erodes the viability of essential services such as trauma because they become clinically and financially insupportable, have we got it right for the NHS?*"

However Circle held on to the contract, despite facing a continuing series of complaints about delays and inadequate care provided.[291]

BUPA backs off

Concerns about potential damage from an MSK contract in Sussex to core non-elective services were also, unusually, raised by potential external contractors, no doubt concerned with the reputational damage they might suffer if an imprudent contract was implemented.

In February 2015 BUPA and Surrey-based social enterprise CSH withdrew from a 5-year £235m contract to take over elective MSK services for West Sussex that they had just been controversially awarded by Coastal West Sussex CCG.[292]

A PriceWaterhouseCooper report revealed that the loss of this volume of elective orthopaedic work was likely to cost Western Sussex Hospitals NHS Trust £13.4 million, force the closure of A&E services in both of the local general hospitals in Worthing and Chichester, and cause them problems attracting and retaining staff.

No such concern appeared to trouble health managers at Coastal West Sussex CCG, who insisted they still intended to "shake up" the way musculoskeletal services are provided in the county.

Staffordshire cancer chaos

In March 2014 CCGs covering a population of 800,000 in most of Staffordshire and Stoke on Trent embarked on what the Financial Times described as "the biggest and most wide-ranging outsourcing of services so far" when they invited tenders for two contracts to provide frontline cancer treatment in district hospitals and care for the terminally ill, with a combined value of £1.2bn.

The two lots were a £687m contract to provide cancer services across Staffordshire; and a £535m deal to provide end of life and care for older people in the county.

As in Bedfordshire (above) the services were to be run on a so-called "prime provider" model, in which the CCGs would effectively abdicate their commissioning role and hand a long-term contract to one company or healthcare trust to oversee the programme, and employ a number of subcontractors to provide care. Macmillan Cancer Support, the charity, had been eagerly promoting a privatised model in working, with four CCGs to shape care services.[293]

The whole process was run with no consultation and minimal information divulged, even to local GPs, who the CCGs claimed were "leading" the exercise. There were rumours that among the usual suspects considering a bid for the contracts were Virgin Healthcare, Circle, Care UK, Cancer Partners UK, Capita and other leading private providers.[294]

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Highly unusual, however was that most of the important aspects of the contract – including contractual commitments, benchmarks, standards and performance management – would be decided not by the commissioners but by the prime contractor, in the first two-year phase AFTER the contract had been awarded.[295]

A sketchy Memorandum of Information was leaked, which was vague in the extreme on exactly what the "transformed" new services might look like, giving no assessment of likely numbers of patients, the scale of services required, or how they are supposed to work. However it did agree in advance that the "Prime provider" would be free to choose which services to "disinvest" from – with no opportunity for local people to challenge.

Carte blanche for cuts

The 'Prime Provider' would effectively have been given carte blanche to close whatever services they chose, with no possibility of further discussion. There was no provision for penalties for failing to deliver, and no suggestion of a fall-back arrangement if a contractor went bust, or simply walked away for lack of sufficient profit.

To make matters worse the Prime Provider would need to show how their fee for managing and providing Cancer Care Services could be 'self-funding' whilst ensuring that the services were still value for money and affordable – and on top of that deliver cash savings:

> "*…the prime provider **will be expected to release savings** to the Commissioners reflecting their respective financial positions which will vary between commissioners.*"

This inevitably meant that less of the budget for cancer care would be spent on cancer care, in order to guarantee the 'fee' (profit) of the Prime Provider.[296]

The whole ugly mess was summed up by campaigner Professor Wendy Savage of Keep Our NHS Public as an example of:

> "*…groups of GPs, with no training in epidemiology, oncology or commissioning, making plans to spend millions on an untried system with private companies, who have no experience in cancer care, eagerly waiting to make profits from these sick patients.*" [297]

There was a powerful campaign of opposition, making it very clear that any private sector-led bid would face ongoing hostility, but it was the lack of potential profit that seemed to deter the numbers of private potential bidders that backed away.

Bidders exit

By November 2014 the HSJ was able to list the bidders still showing interest in the two contracts, with Interserve Investments, CSC Computer Sciences, and UK Optum (a subsidiary of UnitedHealth) seeking the cancer care contract, and Virgin Care, CSC Computer Sciences, Health Management, Interserve Investments and Optum bidding for the end of life contract.[298]

Despite strong initial denials from the CCGs that the services were being earmarked for privatisation, by May 2015 commissioners had made it known that they did indeed favour a consortium led by a private provider.[299]

But the private sector was not so keen. In June 2015, in the midst of a series of setbacks and embarrassments for the private sector and a 63,000-strong public petition opposing the privatisation of cancer care, the Financial Times summed up the situation:

> "*Private sector companies have walked away from a £687m contract to provide cancer care for patients in Staffordshire, raising concern that it is priced too tightly to provide good quality healthcare.*" [300]

The FT noted that Optum had been among the latest firms distancing themselves from the contract, leaving only Interserve, with no experience of delivering or commissioning clinical services as "the only remaining contender," leading a consortium that included the Royal Wolverhampton Hospitals NHS Trust and the University Hospitals of North Midlands NHS Trust.

By July one of the two NHS trusts in that 3-way consortium pulled out, warning that the contract would require a 10% increase in cancer patients being treated, without any extra money.[301] At the end of 2016 there was a brief flurry of interest in reviving the contracts,[302] but in the summer of 2017 the project was finally abandoned after the surviving consortium failed to convince the CCGs that they could meet the required evaluation criteria and deliver with the resources available.[303]

King's Fund critique

Also in February 2015 a King's Fund report concluded that the coalition Government's flagship legislation on health was "damaging and distracting", and warned "historians will not be kind in their assessment" of its record on NHS reform.[304]

It argued that instead of streamlining the NHS, the 2012 Act had reorganised it into a "bewilderingly complex… Heath Robinson construct," where leadership was "fractured" between many bodies, creating a "strategic vacuum," and commissioning was "fragmented."

While it refused to accept accusations that "mass privatisation" took place because of the Act, brushed aside the evidence for this that had been published, and asserted such claims "were and are exaggerated", the report did admit that section 75 and associated rules on competition created uncertainty about whether contracts should be put out to tender.

Moreover it stated that there was "no evidence" that competition had brought about "sufficient benefits" to outweigh its "transaction costs."

Cambridgeshire calamity

December 2015 brought the final collapse of one of the largest attempts to put a major NHS contract out to tender, as the Uniting Care Partnership handed back its five-year contract to provide older people's care to Cambridgeshire and Peterborough Clinical Commissioning Group – just eight months after it went live. The £800 million deal (drastically reduced from the original £1 billion plan) was belatedly declared to be "financially unsustainable".

Unions demanded a full public investigation into what caused the dramatic collapse of the contract, as both the commissioner and lead provider remained silent over what had gone wrong.[305]

The saga began back in 2013 when Cambridgeshire and Peterborough CCG (CPCCG) attempted to establish the largest potential privatisation to date. They claimed that only by offering ALL older people's healthcare to private sector bidders could they deliver the "innovative" services needed, "joined up" with social care. The controversial contract – to be delivered through the largely untested model of "outcome based contracting" – included bold promises to reduce nearby hospital admissions by 20%.[306]

The plan was complex, linking not only services in the community and outpatient care, but also hospital care, including accident and emergency. The CCG had made no attempt to negotiate these changes with local NHS providers, despite the fact that the local trust delivering community health services, Cambridgeshire Community Services, was already delivering high-quality care.

To raise suspicions further, the initial shortlist of bids — and every succeeding list — included a majority of private sector providers.

The huge underlying assumption behind the entire procurement exercise was that a new contractual arrangement for Older Peoples Services could achieve the impossible: an expanded service, improved quality of care, new services (none of them costed) and seamless 24/7 health & social care – all for not only

no extra costs, but while delivering year-by-year savings despite rising demand and caseload.

And this linked to the related assumptions that the private sector might be more efficient in delivering these services or had a track record of success in the community contracts it had won already, and could be relied upon to deliver on promises.

None of these assumptions was in fact supported by the evidence. It was enough to look at the fiasco of the Serco contract in Suffolk, and their prematurely abandoned management contract at Braintree Hospital to see that this assumption was false.

Nevertheless private firms like Virgin, Care UK and UnitedHealth initially submitted bids, triggering a huge public backlash – including a successful legal challenge by local campaigners demanding CPCCG publish more detail on the plans. Fairly soon several

private bidders including Capita, Circle, Serco and Interserve pulled out, citing "affordability concerns" (a polite way of saying the deal could not offer any guaranteed profits).

Short-lived contract

The 'Uniting Care Partnership' (joint venture established and owned by Cambridgeshire and Peterborough Foundation Trust and Cambridge University Hospitals FT) eventually won the contract, after a bidding process that cost the CCG over a million pounds (and the NHS hospital trusts considerably more). After a costly and protracted procurement, 1,400 staff transferred from Cambridgeshire Community Services Trust to Cambridgeshire and Peterborough FT – causing further costs and disruption in the local health economy.[307]

But eight months in, as unions and campaigners had predicted, the 'Partnership' admitted they couldn't deliver the promised outcomes for the money on offer, either.

There had been problems from the start: rows with neighbouring hospitals; complaints from GPs that the new service was worse than the old (award-winning) NHS provider Cambridge Community Services. Patients were unimpressed when the much vaunted "integrated" one phone call service turned out to be run by an ambulance trust based in a completely different part of the country. But it seems clear that what finally killed off the plan altogether was drastic underfunding, that not only wiped out any hope of profit, but also made it impossible for NHS services to break even.

An aftershock of the Cambridgeshire failure was the welcome disbanding in 2016 of the notorious 'Strategic Projects Team' (NHS's East of England commercial advisory unit with a string of failed projects to its name. These included the franchising of Hinchingbrooke Health Care Trust, the Staffordshire cancer and end of life contracts – which were was paused following the collapse of the Cambridgeshire contract[308] – and an abandoned project for Hinchingbrooke-style franchising George Eliot Hospital Trust.).[309]

Brexit and its consequences

The narrow majority vote for Brexit in the 2016 referendum has been followed by a rightward shift in successive Conservative Governments, reflected in even more repressive attitudes to legal and illegal migration and asylum seekers.

Theresa May, the originator of the 'hostile environment' policy[310] took over as Prime Minister, succeeded on the right by Boris Johnson – who in turn was strongly backed by the even more right wing and jingoistic European Research Group in leading a purge of more moderate Conservatives. Johnson's subsequent removal has seen the Party continue to evolve in a rightward direction under Liz Truss and Rishi Sunak.

The consequence of this has been an increase in overt racism that has made the environment hostile for large numbers of people. It also means that NHS staff, many of them migrant and Black and Minority Ethnic workers, for whom such measures must have been especially difficult and stressful, found themselves required to check people's immigration status, and possibly levy the up-front charges (up to 150% of the cost of treatment in secondary care) that had been introduced earlier, before they can offer healthcare.

The impact of these developments has been a chronic downturn in numbers of applications from health professionals in EU countries to work in the NHS,[311] the departure of many European nationals who had been playing useful professional roles in the NHS, and long-running problems recruiting and retaining qualified staff to fill stubbornly high numbers of vacancies.

Six years later a Nuffield Trust study suggested that lasting damage has been done:

> "*… there is significant evidence suggesting that Brexit is now having negative effects. The worst-case scenarios have been ameliorated by agreements with the EU, planning and preparation for medicines disruption, and an easing of migration rules for non-EU staff. However, problems are distributed unevenly, with some medical specialties for example affected disproportionately by migration slowdowns. In most cases these problems seem likely to continue – potentially even being worsened if the exit and trade agreements are disrupted in the coming months.*"[312]

This meant the NHS has had to turn for recruitment to other continents[313] – hampered time and again by increasingly restrictive immigration policies. Worryingly, desperate NHS managers have also been recruiting from 'red list' countries, where health care resources are already dangerously limited and overstretched. The Guardian in 2023 reported

> "*…a 'significant increase' in hirings from countries on the World Health Organization's support and safeguard list, or 'red list',*[314] *countries such as Nigeria, Pakistan and some other Asian countries. … nurse registration from those non-EU countries had gone from about 600 a month before 2020 to close to 1,000 a month in 2021.*"[315]

Overseas recruits now need a health and care worker visa, which is tied to their contract of employment:

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they need to show proof they are to be employed or engaged by a UK health and care sector employer that has been approved by the Home Office. This can put migrant workers in a vulnerable position that can be exploited by unscrupulous profit-seeking private companies.

Care workers need to earn at least £23,000 per year, and are no longer allowed to bring dependent relatives with them.[316]

And for migrant workers on temporary 'no access to public funds' visa conditions there can be serious problems should they fall sick.

Privatisation of mental health capacity

Provision of mental health services for NHS commissioners and providers has been a major growth area for the private sector, especially since 2010. This has continued, despite repeated revelations of scandals and the recognition among NHS professionals that private care is often of poor quality and long distance from patients' homes, lacking in continuity with community and social care, and with perverse incentives resulting in longer average length of stay.[317]

The lack of capital as well as revenue to expand NHS provision has been the main driver of referrals to private beds. According to the Competition and Markets Authority the market for mental health services was worth a total of £15.9 billion in 2015, 27 per cent of which was for hospital services. The private hospital sector had grown in the previous five years, while NHS capacity had been cut by 23 per cent.[318]

In 2017 a Nuffield Trust analysis of Department of Health figures showed funding for independent sector mental health service providers had increased by 15 per cent in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services had actually decreased, by 1 per cent.[319]

By 2018 private sector analysts LaingBuisson estimated 30 per cent of England's mental health hospital capacity was in the private sector.[320] Their report noted: "robust revenue growth for independent mental health hospitals in recent years," although "pressure on prices had meant some diminution in profit margins." The main driver was "the long-term trend towards NHS outsourcing of non-generic mental health hospital treatment, which shows no sign of abating."

And by 2022 LaingBuisson calculated that while private sector beds had increased from 9,291 in 2010 to 10,123 in 2021, the number of mental health beds in the NHS had dropped from 23,447 to 17,610 – a fall of 5,837 (25 per cent).[321]

The same report also revealed that "independent" mental health care providers were in fact dependent on the NHS for 91 per cent of their income, on which their typical profit margins were a very healthy 15%-20%.

At the beginning of 2024 the Financial Times reported that spending on private "out of area" beds had reached record levels, "to the detriment of financially stretched trusts and patients."[322] A massive 95 per cent of all "inappropriate placement" days were at private providers rather than NHS trusts, up from 73 per cent in 2017.

CAMHS care

Private sector penetration has been most dramatic in child and adolescent mental health (CAMHS). Figures given in parliament in November 2018 showed that the private sector spend had grown by 27 per cent over 5 years, from £122m to £156m,[323] and the Guardian in 2019 revealed that no less than 44 per cent of the £355m NHS spending on CAMHS care was going to private providers.[324]

NHS figures in August 2022 revealed that 60 per cent of children's psychiatric intensive care beds, for the most acutely ill children, were provided by the private sector. A majority of inpatient care for under-18s was outsourced, with independent operators looking after 55% of all the children and young people who were hospitalised.[325]

But the quality of care provided by the private sector was often poor. CQC figures showed that more than 33 per cent of children's beds in the private sector were rated "requires improvement" compared to 12 per cent of NHS-run beds. Four per cent of private beds were rated "inadequate," compared to three per cent of NHS units.[326]

The Financial Times points out the unique focus of private mental health provision compared with the private hospitals dealing with elective surgery:

> "*Unlike other segments of the public health sector, the 50 mental health trusts that provide services to patients across England tend to rely on private providers for specialised care that is often complex and expensive. This outsourcing can be costly for the NHS trusts already facing severe financial strain. It can also have damaging effects on patients sent far away from their home and loved ones for treatment.*" [327]

The private sector domination in mental health has been most complete in the provision of "locked ward rehabilitation", in which a massive 97% of a £304m market was held by private companies in 2015. The largest of these was the (now merged) Cygnet/Cambian

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(20-30%), with substantial involvement also of the Priory Group with 10-20% and Huntercombe with 5-10%.[328]

In 2017 the merged Cygnet was operating 2,400 beds across 100 sites, with over 6,000 staff. In the summer of 2018 Cygnet also took over the Danshell Group, operating 25 units with 288 beds for adults with learning difficulties.[329]

The increased proportional spend on private providers has made them even more dependent on funding from the NHS to prop up their balance sheets. The largest private mental health provider, the Priory Group, received 52% of its income of almost £800m from the NHS, and another 38% from social care – a total of 90%. The group has since been sold by US private equity company Acadia to the Dutch private equity company, Waterland, for £1.08 bn.[330]

A BMA report in 2019 noted that the private sector is more remote for most patients than NHS services and explains why it costs more:

> *"An extensive study of mental health rehabilitation by the CQC (Care Quality Commission) last year found that stays in private beds cost twice as much as in the NHS because they last twice as long. It found the annual cost of rehab was £535m and that private beds were on average 30 miles away from patients' homes but just nine miles away in the NHS."* [331]

Private sector inroads

By the end of 2019, the *Financial Times* was highlighting the extent of privatisation of mental health provision, noting that one in every eight (13%) inpatient beds in England was provided by American companies, while in some areas, the proportion of US-owned mental healthcare facilities was much higher.

The FT quoted research by Candesic, a healthcare consultancy, which showed mental health patients in Manchester had a 50:50 chance of being admitted to a privately-owned hospital, and a one in four chance of the bed being provided by an American-owned company. In Bristol, North Somerset and Gloucestershire, no less than 95 per cent of mental healthcare beds were owned by private providers, and three-fifths owned by US companies.[332]

The FT also quoted Laing Buisson estimates that of the £13.8bn spent by the NHS on mental healthcare in 2018, including non-hospital services, £1.8bn went to the private sector.

Candesic estimated about a quarter of NHS mental healthcare beds in England were provided by the private sector, with 98 per cent of the private facilities' earnings coming from the health service. But it noted profit margins were under pressure "owing to funding cuts and a rise in costs — particularly staffing, forcing a reliance on more expensive agency workers."

The report followed criticism by the Care Quality Commission of the care provided by the Priory's Ellingham Hospital, in Attleborough, Norfolk, finding it "inadequate" and conditions, which included wards for children and adolescents, "unacceptable". Two of the 53 facilities owned by the Priory in England had already been rated inadequate by the CQC and a further six as requiring improvement.[333]

Kept waiting for mental health care

The increased toll of mental illness during the pandemic, and the continued rundown of NHS beds and capacity have led to a significant crisis. Even NHS England has been forced to acknowledge that 1.4 million people are on the waiting list for care, and estimates an additional eight million people would benefit from care, but do not meet current criteria.[334]

Partly as a result of efforts to move mental health services into the community, NHS bed numbers fell from 23,208 in September 2011 to 18,179 in September 2019, before the pandemic began. NHS capacity remained relatively unchanged during the pandemic, even increasing slightly to with 18,493 beds in September 2021.[335]

However in December 2021 a shocking report in the Independent revealed the "desperate" situation facing mental health services. Based on leaked data, Rebecca Thomas reported hundreds of patients with serious mental health problems were winding up in A&E, with many waiting over 12 hours for treatment, because mental health hospitals across the country were full to overflowing. Almost all mental health hospitals in London had been at "black alert" during October and November 2021, meaning their beds were nearly 100 per cent full. Referrals to mental health crisis services had increased by 75 per cent since Spring 2020.[336]

In May 2021 84% of trust leaders told NHS Providers that the amount of time children and young people were currently having to wait to access treatment for services was increasing compared to waiting times six months earlier. 78% of trust senior managers said they were extremely (47%) or moderately (31%) concerned about their ability to meet the level of anticipated demand for mental health care amongst children and young people for the next 12-18 months.[337]

The Commons Library also revealed that while 60% of people experiencing a first episode of psychosis should have access to early intervention care within

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two weeks of referral, the national average has fallen back – from 75% achieving this two years earlier to 62%, and the target was not being met in 20 of the 95 CCGs for whom data was available.

Pushing up the price of care

A report in the FT in January 2022 noted that, despite a sharp increase in need, the private sector was cutting beds for children, with about 325 beds removed in the past five years, leaving just 1,321 beds for child and adolescent mental health services (CAMHS) in England.[338] The HSJ flagged up fears that mental health budgets could fall as a share of NHS spending in 2022-3, and trigger new cutbacks.[339]

Recent years have seen the quality of care in a number of hospitals run by private companies, particularly in the area of CAMHS, castigated by the CQC. The two leading companies, The Priory and Cygnet Healthcare, have both had to close wards as a result of damning CQC reports. St Andrews Healthcare, the leading not-for-profit in the sector, has had severe limitations put on its services due to CQC reports. As a result it has significantly scaled back its CAMHS services, with plans to sell its Mansfield site to Nottinghamshire Healthcare NHS Foundation Trust.[340]

With the NHS so reliant on the private sector, there are fears that any reduction in beds will mean the private providers will try to raise the charges the NHS pays, which already range between £500 and £1,300 per bed per day.

Reports, as this report is written, of the serious financial instability of a leading private sector provider (now owned by private equity interests) underline the problems of the NHS becoming any more reliant on the private sector.[341]

Unfortunately the prolonged austerity-driven squeeze on mental health funding has also contributed to high-profile failures in several public sector providers.[342] However despite its growing profile the private sector has done nothing to show that it has any positive alternative to offer as NHS England calls for a review of the quality and safety of services.[343]

Patient transport services

There has been a long catalogue of failures of privately-provided patient transport services (PTS) (non emergency ambulance) ever since cash constraints first prompted NHS bodies to look for savings at the expense of quality by cutting back on them[344] or separating them from the main NHS ambulance service.

Case studies of many of these contract failures are available from the NHS Support Federation's website NHS For Sale,[345] and collated in the study of PTS privatisation published by UNISON, also in 2017.[346]

Since then there have been further failures, the Essex-based Private Ambulance, which collapsed creating problems for three London trusts as well as trusts in Hertfordshire and Bedfordshire; and the American-owned ERS, which stopped providing a service to Barts Health in London and also ran services across the east of England and Yorkshire.

Barts opted to take their PTS service back inhouse in October 2017, and by December had concluded that it was cheaper than the contractor, and the service would remain inhouse.[347]

In 2019, commissioners in Herefordshire and Worcestershire caused anger when they opted to end 30 years of PTS provision by West Midlands Ambulance Service. WMAS had been the first ambulance trust ever to receive an 'outstanding' rating from the CQC, and had just been confirmed as winner for another year.[348] The commissioners turned instead to a private company E-zec, whose services in Bristol had been strongly criticised by the CQC.[349]

E-zec also had a 10-year contract for providing non-emergency patient transport in Bath and North East Somerset, Swindon and Wiltshire, where patient complaints in the previous three months revealed transport had failed to turn up for an end of life patient, whilst another palliative patient had been wrongly refused the service.[350] A quick google search revealed that in Suffolk E-zec had been missing three of their four performance targets every month.[351]

The UNISON report draws clear conclusions from the frequently negative experience of attempting to contract out PTS services:

> "*There is little if any actual evidence about the outcomes achieved by privatisation of PTS or its overall value within the care system, just as there is little or no evidence of any evaluation of the impact of the years of using competition for services as a policy lever. However, there is a wide consensus that if there have been any benefits from the recent trend in privatisation of PTS these are more than outweighed by the loss of opportunity to have a better more integrated service of which PTS is one part.*

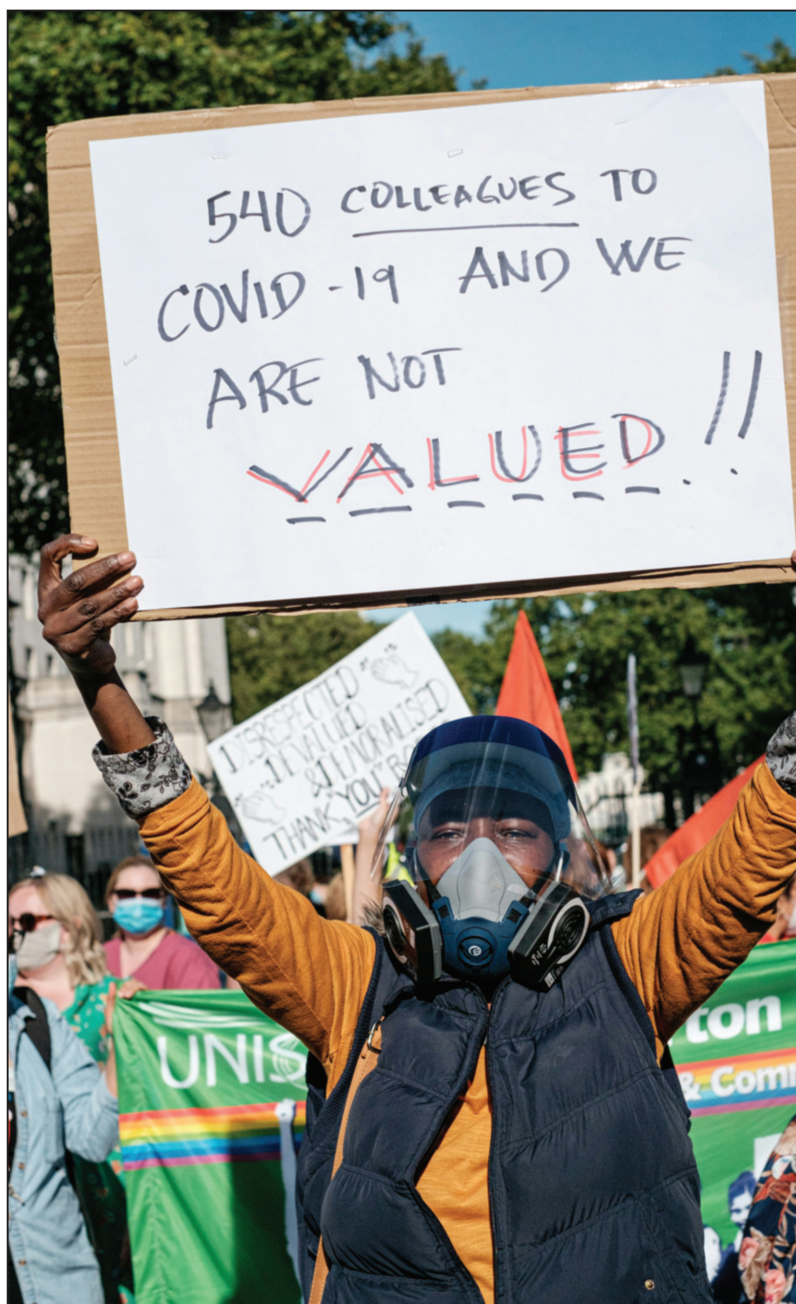
> "*The report raises serious questions about the process of commissioning by Clinical Commissioning Groups (CCGs) and challenges its value in service improvement. This research shows how poor outcomes have their source in the policy of markets and competition and the inability of the*

commissioning process and commissioners to find suitable solutions." [352]

Outsourcing leaves emergencies-only NHS

The March 2017 report 'A year of Plenty' by the Health Foundation warned that private providers were growing at the expense of NHS trusts. An increased proportion of NHS beds were taken up with emergency cases, which meant that more of the potentially profitable elective services were going to private hospitals, forcing the NHS into becoming an "emergency only" service.[353]

NHS providers had received just £650m out of £2bn of extra funding in 2015, compared with £900m of additional funding that went to pay for care provided by non-NHS bodies. NHS trusts had also found themselves reliant on using private sector beds in order to avoid falling further behind on elective treatment targets and facing cash penalties. The Financial Times in June 2020 estimated NHS work already accounted for "more than 80 per cent of Ramsay's revenues, and around 40 per cent for BMI/Circle and Spire." [354]



NHS Professionals

NHS Professionals was formed by the government in 2001 to provide temporary staff to the NHS without incurring the added costs of privately-run agencies. In 2004 it was established as a special health authority, meaning it was independent but could be "subject to ministerial direction". But in April 2010 NHS Professionals became a company, wholly owned by the Secretary of State for Health, after the government failed to find a buyer.[355,356]

It supplies doctors, nurses and other staff to about a quarter of hospitals at much cheaper rates than those charged by profit-making NHS staffing firms and saves the cash-strapped NHS £70m a year that would otherwise go to private firms.

Nevertheless in November 2016, after Theresa May had replaced David Cameron as Prime Minister, the government decided to sell a majority share of NHS Professionals, even though it was making a healthy profit and doing useful work for the NHS.[357] Staffline, one of the employment agencies hospitals use to find stand-in staff, was thought to be among those bidding to buy NHSP.

In July 2017 the Labour Party asked the National Audit Office to look into why Jeremy Hunt, the Health Secretary, was selling a profitable and effective company which was supplying staff to more than 100 hospitals around the UK, and which – on the government's own estimates – was saving the taxpayer around £70m a year.

Better still, it was receiving no central funding from Whitehall, and was putting any surplus it made back into the NHS. But for some reason ministers were believed to think it worthwhile to sell a 75% stake in the firm for just £50 million. Justin Madders, the shadow health minister argued:

> *"Nurses hired through private sector companies are 15-30% more expensive than through NHSP, with a significant proportion of that extra cost going directly to those companies rather than the staff supplied."* [358]

Madders asked the NAO to "examine the business case that has been produced [by the DH] to ascertain

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a better understanding of what additionality the private sector can bring to what on the face of it is already a successful organisation."

In the September 2017 the joint campaign[359] succeeded in halting the proposed sale/privatisation of NHS Professionals. Health minister Philip Dunne announced the government had decided to keep it under public ownership, after concluding none of the offers "reflected the company's growing potential and improved performance". [360]

The arrival – and departure of Centene

In 2017 Centene first came to public attention in England's NHS, when it was brought in by Capita to support the development of "a new integrated healthcare model" in Nottinghamshire.[361]

Centene is one of the larger providers of 'managed care' in the USA, with 27 million subscribers.[363] In 2017 it was offering advice on the "integration of systems and pathways" based on the experience of its US parent company, which, they said, provided "a portfolio of services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals".

In the US Centene aimed to save money by avoiding costly readmissions to hospital, using "person-centred innovation and technology" to make sure patients who have chronic conditions adhere to their treatment. Its 2024 website has removed much of the rhetoric that was then clearly visible, and which all seemed to fit with the mood music of NHS England's 'Five Year Forward View'.

Centene at that time also had 90% ownership of Ribera Salud, the controversial Public-Private Partnership in Valencia in Spain, which began as a scheme to design, build, operate and deliver clinical services in a new hospital, but expanded to cover the building of several hospitals. It then won a contract to assume all risks for delivering health care services for 20% of the Valencia population.

In 2017 it was a "health management group operating in both private healthcare, and the fully integrated Accountable Care System sector," and owned and managed the largest private hospital in Spain, Hospital Povisa de Vigo. The company also had "controlling and noncontrolling interests in primary care, outpatient, hospital and diagnostic centres in Spain, Central Europe, and Latin America."[363]

Farewell Salud

In November 2016 the Spanish newspaper El Pais had reported that Ribera Salud was under police investigation for allegations of fraud, including overcharging, and issues with sub-contracting.[364] And in 2017, when the right wing lost control of regional government in Valencia, the new regional government promised to roll back the privatisation.[365]

They pointed to significant problems with a lack of oversight of the "concessions" given to Ribera Salud, with no effective control, nor checks on the quality of its service, nor in any financial matters.[366] From 2018 some of the contracts were to be ended as they expired, and Centene was effectively excluded from the operation.[367, 368]

It was through its links with Ribera Salud (which had admirers in the NHS Confederation, who were eagerly searching for ways to reduce spending)[369] that Centene was brought in by Capita on a short term £2.7m contract to advise in Nottinghamshire. This enabled Centene to become one of six contractors initially approved in 2017 by NHS England to help roll out 'integrated care' models across the country.[370,371]

Moving in on England

In 2016 Centene had bought a majority stake in 'The Practice' – a company running a number of GP surgeries – and bought Beacon UK, a mental health service provider, which was renamed to Simplify Health.

In 2018 Centene recruited Samantha Jones (formerly NHS England's director of 'new care models' from 2015 to 2017, and one-time chief executive of Epsom and St Helier University Hospitals and West Hertfordshire Hospitals trusts) to head its British operation, subsequently launched as a subsidiary company, Operose.[372]

Early in 2020 Centene Corporation expanded its stake in the UK health market, buying a 40 per cent shareholding in a transformed, private equity-owned Circle Health[373] around the time Circle acquired BMI Healthcare,[374] the UK's leading private hospital group with 47 hospitals, 2,400 beds and turnover in excess of £900m.[375]

This enabled Circle, as the new owners of England's largest private hospital chain, to pick up the biggest slice of the £2bn-plus NHS contract that effectively block-booked almost 8,000 private hospital beds in the first year of the Covid pandemic: Circle's share of that contract, £468m, boosted the company's revenue in 2020 by more than 50%.[376]

It appeared that a major American takeover of health care in England – long feared by many campaigners – was seriously under way, although the lack of any Centene press release boasting of the takeover did

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seem uncharacteristic for a company seeking expansion of markets and profits.

Into primary care

In February 2021 the Guardian broke the news to the wider public that:

> "*One of the UK's biggest GP practice operators has quietly passed into the hands of the US health insurance group Centene Corporation …. The merger is expected to create the largest private supplier of GP services in the UK, with 58 practices covering half a million patients.*"

Operose Health had taken over the privately owned AT Medics, which had been set up in 2004 by six NHS GPs and seven years later was running 37 GP practices across 49 sites in London. Operose was already operating 21 GP surgeries in England.[377]

While the objections against the highly controversial expansion of Operose into primary care were continuing, at the end of March 2021 the HSJ revealed that Operose UK boss Samantha Jones had been appointed as one of a new expanded team of health advisors to Prime Minister Boris Johnson. Jones was to be "expert adviser for NHS transformation and social care delivery". It seemed as if the Centene star was still rising.[378]

Change of course

Instead, just months after it had forked out another $700 million to take complete control of Circle, Centene in December 2021 revealed that it was "reviewing" its overall strategy, focusing on maximising its profits per share, and, as part of this, considering the possibility of "divesting" itself of all its "non-core" business, including international businesses worth around $2 billion per year[379] out of the corporation's $126bn turnover.[380]

There was also a setback for Centene when, in June 2022 a BBC Panorama under-cover investigation into the services delivered by "the UK's biggest chain of GP practices." It revealed that Operose Health with almost 600,000 NHS patients, was using less qualified (and of course cheaper) Physician Associates instead of GPs to see patients, without adequate supervision.[381]

The long drawn-out review led to Centene selling off Circle with its private hospitals in August 2023 to PureHealth, the United Arab Emirates largest healthcare provider, for $1.2 billion,[382] and in December 2023 Centene completed the divestment of all its health care investments in England by selling off its subsidiary Operose, and with it once again selling its GP practices, mainly in London.[383]

This marked the end of what the Financial Times saw as an attempt by Centene to open up a "seamless pathway" potentially enabling Operose-run GPs to refer to its own chain of hospitals.[384]

When Operose was put up for sale The London Press, quoting Victor Chua of Mansfield Advisors, a healthcare consultancy, explained why the strategy had failed to deliver:

> "*Centene has found it difficult to make Operose profitable because many Operose sites are in generally less affluent areas where recruiting GPs has been difficult. There was no natural cross-sell between the Operose GPs and the Circle Hospitals, which serve a different demographic, and the geographic overlaps are limited.*"" [385]

Even the biggest of the private corporations to seek to take over a slice of the NHS has proved itself an unreliable 'partner' for the NHS, and concerned only for the bottom line on their balance sheets.

Court action against the NHS

2018 brought a flurry of frustrated private contractors seeking to sue NHS commissioners for axing their contracts. First Virgin recovered a undisclosed settlement out of NHS commissioners in Surrey for not renewing the firm's 3-year contract.[386]

Circle also threatened to sue the NHS, even though the company itself had decided to pull out of bidding for a contract to continue running an "independent sector treatment centre" in Nottingham. The Greater Nottingham Clinical Commissioning Partnership had put the contract (to run one of the largest elective treatment centres surviving from the New Labour period) out to tender at just £50m per year, a reduction of over 25% on the previous year. In Circle's view Nottinghamshire health chiefs were at fault, for not offering enough money to guarantee a large enough profit for the private equity fund that had bought up the company.[387]

In the summer of 2019 the company failed in their High Court challenge. Circle had claimed Nottingham University Hospitals Trust could not possibly treat NHS patients for less money, and that bringing the contract back in-house would be "unrealistic" and "not in patients' interests". The Court disagreed, and decided that the contract should go to the Trust, as originally proposed.

This meant that all services at the Treatment Centre would return in-house, ending the stream of profits Circle had enjoyed for the previous eleven years. The decision also meant that Circle lost the right to run their exclusive private hospital in the same building – which had treated no NHS patients.[388]

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Jobs for the nerds

The establishment of 'Integrated Care Systems' has intensified NHS top-down pressure to increase spending on private sector management consultants, and on providers of data and digital services and apps.

The pressure to bring in expertise from private contractors and consultants was linked to the 'Health Systems Support Framework' (HSSF) established in 2018 by NHS England, which was supposed to facilitate swifter and wider use of the private sector to help steer ICSs, and direct them in how to spend the funding allocated.[389]

The HSSF followed on from the management consultancy framework contract, put in place by NHS Shared Business Services in 2018.[390] It involved 107 companies, and included the 'Big Four' (PwC, Deloitte, EY and KPMG) along with the top three strategy firms (McKinsey, Bain and Boston Consulting Company) as well as 'a number of boutique firms'.

The framework selected companies that were pre-approved for work on ten different 'lots.' Consultancy.uk reported:

> "*As well as reducing costs, these frameworks can also streamline and harmonise the hiring processes across NHS bodies – as lengthy tender processes are reduced by having a list of preferred suppliers in place – and across the full spectrum of operations, covering everything from audit services and construction consultancy to catering, facilities and management consulting.*"[391]

The initial shortlist of half a dozen companies to advise on technical aspects of creating 'integrated systems' was massively expanded into a huge catalogue of organisations and (mainly) private companies that were all pre-approved to offer advice under the HSSF.

The initial list of around 80 providers[392] grew to around 200 companies accredited by NHS England to provide support under dozens of topic headings, many of which concerned data and digital transformation.[393] At least 30 of the firms were US-owned, offering expertise drawn from operating the notorious American health insurance market. NHS England explained that:

> "*…the Framework provides a quick and easy route to access support services from innovative third party suppliers at the leading edge of health and care system reform, including advanced analytics, population health management, digital and service transformation.*"[394]

However the more money that is spent on management consultants, questionable apps, digital quackery and the US interpretation of "population health management," the less is left to fund the core NHS business of delivering safe and high quality care for sick patients.

Most plans for digital systems still take no serious account of the needs of millions of people who for a wide variety of reasons are 'digitally excluded' from fully utilising the latest ideas.[395]

Some elements of the HSSF were re-tendered by NHS England in 2019 as a 4-year £700 million framework contract, which was explained as a means to help establish Integrated Care Systems:

> "*The Health Systems Support Framework (HSSF) was established to provide a mechanism for ICS and other health and social care organisations to access the support and services they need to transform how they deliver care. It focuses on specialist solutions that enable the digitisation of services and the use of data to drive proactive population health management approaches across Primary Care Networks (PCNs) and integrated provider teams.*"[396]

However we assess the value for money of the advice, data and the apps obtained through the HSSF, it was certainly welcomed by the private corporations that were looking for quick and easy ways to secure NHS contracts. Private companies may well be the main people mourning the eventual demise of the HSSF after its four-year span was complete.[397]

Mixed signals – but privatisation continues

January 2019 brought the publication of NHS England's Long Term Plan, followed at the end of February by the launch of "a broad process of engagement" seeking to "build the case for primary legislative change." The proposals did, indeed seek to remove some of the objectionable elements of the 2012 Act, notably section 75, and the associated regulations which compelled Clinical Commissioning Groups to put services out to competitive tender, and as such favoured the private sector.[398]

However removing competition is not necessarily the same as rolling back the scope of outsourcing. This was underlined by NHS England's insistence on driving through highly contentious large-scale contracting-out and privatisation of scanner services in Oxford, even as they launched their "engagement process" on the proposed legislation.

The first (of a series of eleven) major 7-year contracts for PET-CT scanner services had just been secretly awarded in Oxfordshire by NHS England to a private company, InHealth. This led to immediate, furious

opposition from consultants, campaigners, and MPs of all parties.[399] NHS England responded with only the most meaningless concessions, trying to fob off opposition by conceding that the service could be run by the staff at Oxford University Hospitals Trust. At the same time they raised the stakes by threatening legal action against anyone raising concerns about clinical standards and care.[400]

Oxfordshire campaigners reacted angrily to a misguided Guardian headline[401] that claimed there had been a "u-turn," by NHS England, insisting:

> *"We believe that the current proposed 'deal' will lead to a worsening of service across the region. This is direct privatisation of a part of our NHS. We demand a halt to the process."*

They were not alone. Oxfordshire Conservative MPs, along with local Liberal Democrat and Labour MPs, all wrote to question both the decision and the way it had been arrived at. Banbury's Conservative MP Victoria Prentis wrote to NHS England chief Simon Stevens expressing "extreme concern" that patient care would suffer.[402] But the strongest condemnation of the plan came from Oxford University's Professor of Oncology Dr Adrian Harris, who asked:

> *"If the proposed service is so excellent, why did NHSE mislead the local Oxford CCG … telling them that they couldn't discuss it and wouldn't review the tender, when there was no reason for it not to be openly discussed?"*

No reinvestment

Professor Harris pointed out that all "profits" from scans from private patients and funded trials would go to the private company, not to the hospital, where the staff and scanners are: "so no reinvestment for our benefit from our work." It also meant a 2-tier system, with patients further away being scanned in hospital car parks "with poor access machines", whereas Oxford patients would be seen at the Churchill Hospital centre.[403]

Noting that "doctors in Oxford have made it clear that they do not wish to be involved with this service, which they think has a significant number of potential disadvantages for patients," Prof Harris also asked: "Where are they going to send the scans, as there are no other PET-CT reporters working in these hospitals."

In the event NHS England toughed it out, and the contract held. There has been no similar resistance elsewhere, possibly because the contractors and trusts have learned from the errors they had made and avoided plans that would trigger a local response.

However the Oxfordshire experience was no exception: the Long Term Plan specifically called for large-scale networks to provide pathology and imaging services, and with no NHS money to invest this was almost certain to mean turning to the private sector. Both the PET-CT fiasco and the first big pathology network that was tendered in South London and the South East made it obvious that this strategy involved handing even more major contracts to 'partnerships' with private companies.[404]

Indeed some really big, long-term private contracts were being drawn up: in the Bristol, North Somerset and South Gloucester area NHS commissioners had decided to put all adult community health services out to tender, as a single ten-year, legally binding contract. NHS England did nothing to intervene or question the policy.[405]

In the summer of 2019 work began on building a new £100m 138-bed private hospital on the site of Birmingham's Queen Elizabeth Hospital as part of a 'partnership' agreement between University Hospitals Birmingham Trust and US hospital giant HCA. HCA financed the construction, planning to use 66 beds for private patients, leasing the rest to the Trust.[406]

South West collapse

However not all of the new 'partnerships' with the private sector proved durable. In June 2022 the Rutherford Community Diagnostics Centre in Taunton, the first to be run as private/public partnership with the NHS, went bust after eight months.[407]

In 2021 Somerset NHS Foundation Trust had contracted Rutherford Diagnostics, with its partner Philips Health UK to provide the centre, which was to be available to private medical insurance and self-pay patients in the South West as well as NHS patients.

It was the first of five new community diagnostics centres across to be set up across the UK by Rutherford Diagnostics and Philips Health UK. Rutherford Health had since 2015 built a network of oncology centres (known as the Rutherford Cancer Centres) in South Wales, Northumberland, Liverpool, and Thames Valley, offering an extensive range of advanced cancer treatments including high-energy proton beam therapy (PBT), radiotherapy, chemotherapy, immunotherapy, diagnostic imaging, and supportive care services.

However the heavy level of capital investment required (over £240 million) had not been met by a corresponding level of private patients: and the numbers slumped further as a result of the Covid-19 pandemic.

Rutherford had attempted to sell its spare capacity to the NHS, but the NHS had wanted to include surgical

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services, which are the main bottleneck in cancer waiting times, and the centres could not deliver this. The contracts that had been signed were not enough to bridge the financial gap, and the company went into liquidation.[408]

The partnership between Rutherford Diagnostics Ltd, which owned the Centre, and Somerset NHS Foundation Trust, which had been based on a five-year contract with an option to extend to ten years, was over in just eight months. The Trust swiftly made a new deal with Alliance Medical to run the renamed Taunton Diagnostic Centre.[409]

Somerset Foundation Trust chief executive Peter Lewis has said a partner was needed because the Taunton Diagnostic Centre's capacity is greater than the trust could use, with some private work likely to be carried out there as well. But it's hard to avoid the impression that in these ventures the NHS has become the partner facilitating the private sector.

The rise and rise of management consultants

As the Lowdown has reported, consultancy firms had a field day in the Covid pandemic – but even before that had been doing very well from the NHS, with their role behind the scenes increasingly institutionalised.[410]

Management consultants have played a key – and lucrative – role in most of the big reorganisations of the NHS going back at least to 1974.[411] After steering New Labour towards increasing reliance on private providers of clinical care in the 2000s, a major McKinsey report commissioned by New Labour shaped many of the cost-cutting policies of NHS trusts and commissioners which aimed to generate £20bn of 'savings' after the 2008 banking crash.[412]

From 2010 the incoming Conservative-led coalition in turn employed McKinsey to help construct Andrew Lansley's large and disastrous Health and Social Care Act.[413] In 2016-17 the King's Fund found that management consultants were being used to support the drawing up of Sustainability and Transformation Plans in 33 of the 44 areas.[414]

In 2018 the Department of Health and Social Care's own privatisation unit, Shared Business Services (run as "a unique partnership with digital experts Sopra Steria")[415] was working to streamline the recruitment of consultants to work at local NHS trust and commissioner level. In 2018 they set up a 4-year 'Framework agreement' which listed 107 pre-approved companies who could simply be hired, without a tender process, to steer the policies and decisions of NHS commissioners and providers.[416]

In North West London firms including McKinsey were employed again and again from 2011 in the long running fiasco of the 'Shaping a Healthier Future' project (at a combined consultancy cost of over £80m) before it was axed. McKinsey veteran Penny Dash was subsequently installed in 2020 as the chair of NW London's 'integrated care system'.[417]

England's NHS spent an estimated £300m on consultancy in 2018/19, despite evidence that management consultants in health care "do more harm than good."[418] In a blatant example of squandering tax payers' money, NHS England paid PA Consulting over £200,000 in 2019 for a 35-day "function mapping exercise" … to work out what NHSE itself was responsible for.[419]

Vision of £563,000

In 2020 Health and Social Care Secretary Matt Hancock's Department brought in a team from McKinsey for six weeks, at a cost of £563,000, to help define the "vision, purpose and narrative" of the new body to replace Public Health England after he had announced it was to be axed.[420]

But the pandemic was a real money-spinner. In August 2020 consultancy.uk reported that 16 consulting firms had been awarded coronavirus contracts worth £56m.[421] By January 2021 Health Minister Helen Whately (herself a former McKinsey employee)[422] admitted that 2,300 management consultants from 73 different companies (more than number of the civil servants in the Treasury) were working on the (lamentably poor) Test and Trace system, with £375m spent on consultancy for that project alone.[423]

These consultants were being paid an average of £1,000 per day. Deloitte alone had 900 employees at work in test and trace, and the *Daily Mail* estimated a total of almost 3,000 (2,959) consultants and contractors were advising the government on the pandemic.[424] In

October 2020 Sky News revealed that a 5-person team from Boston Consulting had been paid £25,000 per day helping to "mastermind the creation of the contract tracing systems." [425]

At no point has any serious value for money audit been carried out to demonstrate the cost-effectiveness of management consultants, or the way in which their increased authority has come at the cost of undermining the confidence and authority of NHS management. It seems as though the more contracts they win, the more entrenched their power and influence becomes.

As the North West London experience proved, once consultants have been brought in they "keep getting rehired" – despite their failure to complete projects or improve the efficiency or quality of services.

The Babylon saga

In 2013 Ali Parsa, former investment banker (and former CEO of Circle Health as it plunged into its disastrous attempt to manage Hinchingbrooke Hospital), established a new venture, Babylon Health.

It was focused on the development of digital technology and artificial intelligence (AI) in healthcare, seeking "To put an accessible and affordable health service in the hands of every person on earth."

Babylon's first smartphone app (an AI chatbot) was launched in the UK in February 2015. By asking a series of questions, Babylon's app could answer medical queries and put the user in-touch (virtually) with a GP.

In the UK, the company offered a private service via its app, charging £59 for a GP appointment, £48 for an Advanced Nurse Practitioner, £48 for Physiotherapist, or £45 for a Mental health Practitioner or Pharmacist.

Babylon's primary target in the UK was access to NHS patients. The company began a contract with NHS England for its 'GP at Hand' app in 2015, launching the service in London. Thousands of patients registered with the service and business in London with GP at Hand boomed from 2015 to 2020, especially after Matt Hancock was appointed Health and Social Care secretary in June 2018: the next month he revealed that he was actually a subscriber to GP at Hand and found the service "brilliant."[426]

Babylon claimed its app was able to provide clinical advice to patients that was "on par" with doctors, sparking criticism from GP leaders. The RCGP wrote to Hancock warning that GP at Hand:

> "…*could result in a 'two-tier' primary care service where healthier patients, with less complex medical conditions, can get an online appointment quickly and conveniently, while those with the greatest clinical need, such as those with frailty, multimorbidity or poor mental health, find it more difficult to access timely care when they need it.*"[427]

In October 2018 the Advertising Standards Authority told Babylon not to advertise its GP at Hand service until it corrected factual errors used in its promotion: in particular it had to make clear that patients signing up to GP at Hand had first to deregister from their existing family doctor.

In March 2019 figures obtained by GPonline suggested that more than one in four NHS patients who registered with Babylon GP at Hand quit the video consultation service within just over a year.[428] Two months later an independent evaluation report on GP at Hand by Ipsos MORI and York Health Economics Consortium with Prof. Chris Salisbury confirmed suspicions that GP At Hand was predominantly recruiting younger, fitter, more affluent patients. It therefore implicitly conceded that by allocating enhanced resources to them the NHS was effectively draining resources from care of more vulnerable patients and older people with greater and more complex health needs.[429]

Nevertheless the following month GP at Hand was publicising plans to extend its service to Birmingham, and striking a deal with the chief executive of University Hospitals Birmingham, Dr David Rosser, to explore using Babylon's services, including video appointments and digital triage, in the hope it might help divert pressure from its severely strained hospitals.[430,431]

Babylon's rise

Babylon Health planned to expand its virtual GP service to Manchester after its reported success in attracting over 60,000 NHS patients in Birmingham and London.[432]

IN 2020 Babylon Health announced a 10-year partnership with Royal Wolverhampton Trust that aimed to use technology to transform the way patients access healthcare.

However its diagnosis software had also come in for criticism. An anonymous NHS doctor tweeting under the name @DrMurphy11 had tested the Babylon app repeatedly, highlighting failures in its ability to detect potentially fatal health conditions.[433]

By June 2022 there were worrying signs that the app and the service centred on it could not cope with real life demands, even of such a selective cohort of patients. Ali Parsa said that the company needed to be "very cautious" about expanding its business in the UK, be-

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cause as it "lost money on every patient." The company was paid for one or two visits per year to a GP for the age cohort registered with its service, but "in reality, people use us six to seven times a year and we actually lose money on every member that comes in" As a result the company was "overwhelmed with demand" for GP services in the UK.

The company had opened seven practices in London, but despite the emphasis on digital-first and video consultations, there had been a big rise in demand for face-to-face consultations, forcing the company to open two new clinics in London.[434]

Babylon's fall

Later that same summer Babylon has announced it was ending its partnerships with two large hospital trusts in the midlands – Birmingham and Wolverhampton – arguing that they were "no longer economically viable."[435] The company's chief financial officer, Charlie Steel said Babylon could not "continue to fund the NHS forever," as it reported losing money.[436]

In the Autumn of 2022 the company withdrew from its GP at Hand service from Birmingham, where it had only opened in 2019, leaving around 5,000 patients to find a new GP.[437]

But in the meantime Babylon's attempt to launch on the New York stock markets had proved disastrous: between October 2021 and June 2022, Babylon's market capitalisation had fallen more than 90%, giving the company a market value of about $334 million, and its share price had fallen from around $11 in October 2021 to around $1 by June 2022.[438] In November 2022 its Birmingham operation was forced to close in November as part of a strategy of 'winding down' unprofitable NHS contracts.[439]

By March 2023 Pulse reported Babylon had indefinitely suspended out-of-area patient registrations for GP at Hand, telling patients they must live in Central Fulham – where the practice was based – to successfully register for the service. Babylon said it had imposed the new restriction to ensure it could continue to be able to provide care and access to its existing patients.[440]

Babylon itself went bankrupt in the summer of 2023, but in September it insisted its GP at Hand operation would not been impacted by the sale of the UK business, and was expected to continue to provide care to 100,000 NHS patients in London. Administrators Alvarez & Marsal confirmed that Babylon's clinical services business had been sold 'solvently' to US digital health business eMed.[441]

GP at Hand was 'rebranded' as eMed GP at Hand: but that was not the end of the sorry story.

Despite claiming that all was well with its UK business,[442] in March 2024 eMed announced a large-scale redundancy consultation, said to be affecting "mainly GPs", with as many as 150 clinicians affected.

eMed confirmed that it had launched a redundancy consultation, but refused to confirm or deny the number and told Pulse it was not only GP jobs at risk, although an anonymous GP insisted it was "mainly GPs" to go.[443]

Private sector stung by promise

The Labour Party's 2019 election promise to "end and reverse privatisation in the NHS in the next Parliament" triggered a tetchy response from the private hospital chains, which had been happily filling their otherwise empty beds with NHS-funded patients.

The Independent Healthcare Providers Network (IHPN) claimed that "over 40" new NHS hospitals would be needed if a Labour government prevented private hospitals from delivering care for NHS patients, and warned that waiting lists for specialist care could treble in three years.[444]

They went on to claim the private sector performed 11.2% of all non-urgent care, which they say was 436,000 operations a year. The IHPN's chief executive David Hare argued that this proved the "vital role" private providers play.[445]

The IHPN calculations were wide of the mark in almost every respect.

According to the main market analysts Laing & Buisson, there were 197 private hospitals licensed to take acute patients, with 9872 beds between them, averaging just 50 beds per hospital. The private sector is set up to deal with only a limited range of services, with no scope to treat any emergencies.[446]

9872 beds are the equivalent of around 20 district general hospitals with 500 beds – not 40. But many of the private sector hospital beds are under-occupied, and provide only a limited range of elective procedures, so it's not at all obvious they would all need to be replaced. By contrast the NHS has just over 100,000 general and acute beds, mostly in full service general hospitals.[447]

Moreover the NHS in England delivered 8.8 million elective admissions in 2018-19: so 436,000 operations is equivalent not to 11.2% of all non-urgent care, but just under 5%.

Some commentators argue that private hospitals are "only paid the standard NHS tariff" for the publicly-funded patients they treat: but private hospitals don't

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do the standard type of NHS work. They accept only the least complex cases, while the NHS has to accept all comers.

Immediately prior to the pandemic, despite the fact that a decade of austerity had almost doubled the NHS waiting list since 2010 (to 4.6 million) the private hospital sector was facing problems of stagnation at the end of 2019. A gloomy IHPN blog warned:

> *"Private healthcare finds itself at a crunch point. Low (or no) growth across local and international markets, spiralling costs, falling medical insurance subscriptions and 'intelligent consumerism' continue to challenge the sector."* [448]

Department of Health and Social Care Annual Report figures confirmed that the private sector had good reason to be concerned. While the private market had not grown, the flow of funds from the NHS to private hospitals had also slowed to a relative trickle.

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Part 4: Privatisation and the pandemic

Massive extra spend on private providers

After a decade in which the amount spent by the NHS on private providers of clinical services had risen each year from 2006, from just over £2 billion to almost £9 billion by 2016, the private sector share of NHS spending had risen from 2.8% to 7.7%.

This had flat-lined in 2016/17, and declined to £8.7 billion (7.3%) in 2017/18. NHS spending on 'independent sector providers' did increase to £9.7bn in 2019/20, but clearly not enough to cheer the IHPN and its members.

The first year of the Covid pandemic changed all that, with a massive 25.6 per cent leap in NHS spending to £12.1bn in 2020/21.[449] The major factor in this was the pandemic-driven contract signed in 2020, to pay for a big increase in numbers of NHS patients to be treated in private hospitals – effectively bailing out and rescuing the private hospital sector. However, as researchers CHPI subsequently discovered relatively little of the extra capacity was actually used.[450]

So it was no surprise that the biggest-ever increase in spending was followed the year after by a 10% reduction in 2021-22, to £10.9bn, with the private sector share of total NHS spending falling back from 7% to 6%.[451]

Supply chain – privatised chaos

Months after the arrival of the Covid-19 pandemic, huge numbers of UK health and care workers still lacked adequate personal protective equipment (PPE). Nursing Notes reported that Covid-19 had killed 209 health and care workers in the UK as by May 14 2020, and many of these deaths were "avoidable with proper PPE."

The failure to protect health and care workers was a disaster in its own right, and the privatisation played a role in this preventable catastrophe, by creating a system which was both chaotic and bureaucratic – both fragmented and sclerotic.

Such was the chaos that it led the General Secretary of the United Voices of the World, sourcing their own PPE masks for UVW members working as outsourced cleaners and porters because the private company who employed them failed to do so, and NHS hospitals in that initial phase were prioritising clinical staff.[452]

Media coverage had highlighted PPE shortages, but little had been said about privatisation. NHS Supply Chain – the organisation at the centre of this problem – had been created in 2018, 12 years after the privatisation of NHS Logistics. It was technically a part of the NHS, headed by the Secretary of State, but this status was merely a fig-leaf for a needlessly complex web of contracts with private companies who answered to shareholders first.

Immediately upon its formation NHS Supply Chain outsourced two major contracts for IT and logistics, and then broke up and outsourced the whole procurement system, by delegating eleven supply areas to various contractors.

> *The parcel delivery company DHL was put in charge of finding wholesalers to supply ward based consumables, including PPE kits.*
> *Unipart was given control over supply chain logistics, including the delivery of PPE. The stated rationale for this approach – an almost obsessive drive towards greater outsourcing and greater fragmentation – was 'efficiency savings'.*

The end result by early 2020 was a heavily privatised, convoluted, and fundamentally dysfunctional system that put layers of corporate red tape between doctors and nurses who need PPE in order to work safely, and the companies making these supplies.

The Government's failure to react to Covid-19 shouldn't be downplayed, nor should the inherent complications of procuring PPE during a pandemic. But while the Government was outsourcing NHS procurement, it was also losing its handle on the reins of NHS governance.

That's why in the early stages of the pandemic, when experienced businesses across the UK were lining up to help provide PPE, many found no one in Government willing to take their call. When the UK needed decisive leadership, all it had was a disparate network of private companies acting independently and with ineffective oversight.

The public rightly expected the Government and the NHS to take responsibility for essential, life-saving tasks. But instead of accountable, coordinated leadership, we had a chaotic mish-mash of independent private contractors which severely undermined the national effort to protect NHS and care staff.

This flawed system, offering few, if any, real advantages over in-house NHS provision, created a range of risks that helped turn the pandemic into an utter disaster. This system's 'just in time' ethos – devised by logistics companies in order to win contracts, maximise profits and enrich shareholders – took priority over public health.

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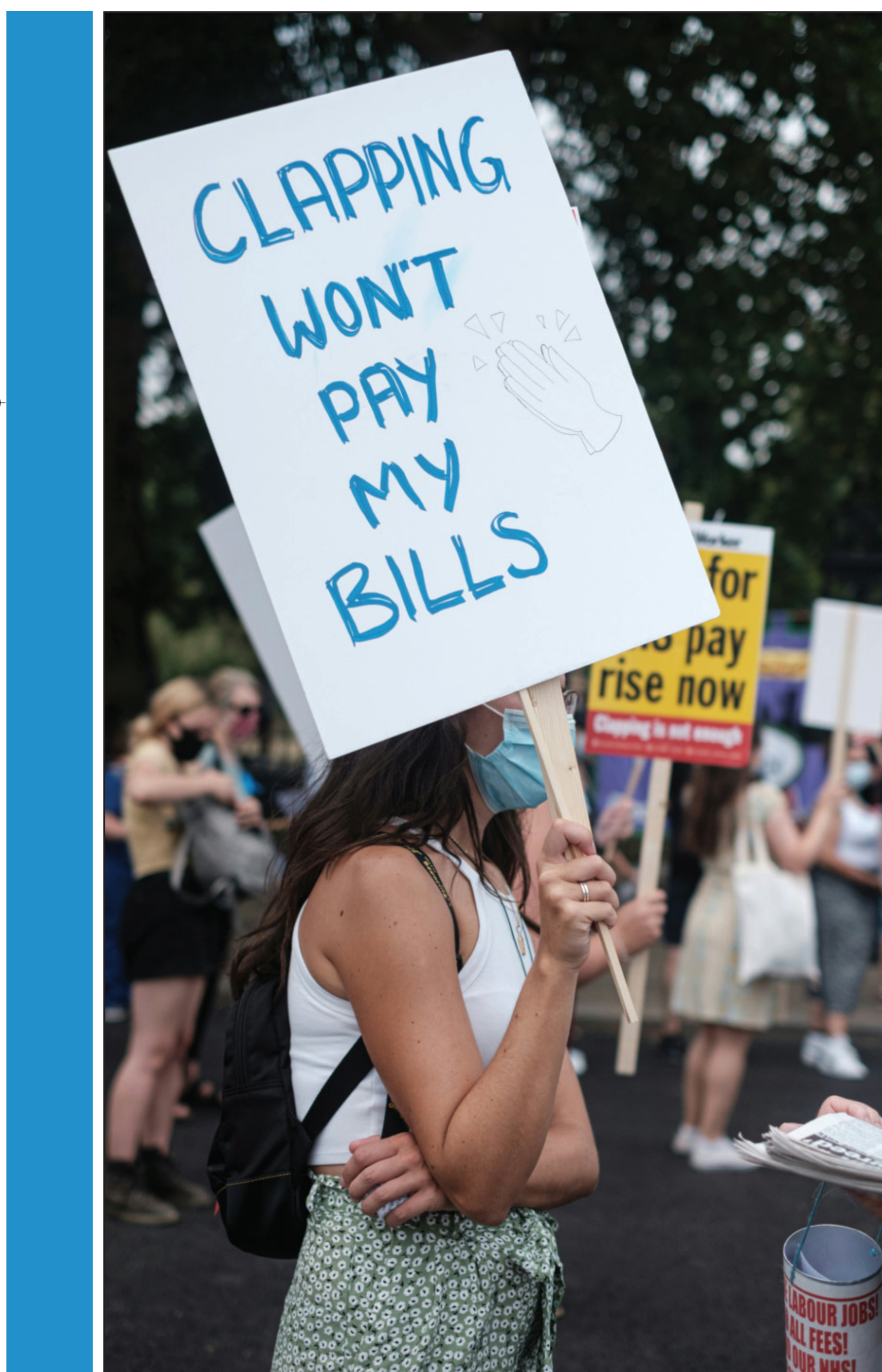
A May 2020 pamphlet exploring the detail of the privatised NHS Supply Chain concluded:

> *"The companies involved in the supply chain vary in terms of their track records and philosophies. Their cultures and approaches range from the fairly innocuous to the truly scandalous. But they are all part of a system which puts the profits of companies above the well-being of patients and the smooth functioning of our NHS – a system so convoluted that it's almost impossible to trace the source of problems and hold decision makers accountable; a system that puts cost-cutting above the safety of the nation."*[453]



Petros Elia (General Secretary of the UVW at the time) said when sourcing their own masks for UVW members

> *"Whilst there's a chance they can reduce the transmission of COVID-19 every worker and person should be given them. If UVW can source and distribute 2000 masks with no special connections and limited resources, then what excuse do our government and employers have for failing to do so? That UVW had to step in really highlights the utter incompetence and callousness of both employers and government."*

Fragile NHS

The supply chain was by no means the only weakness the NHS faced as it was plunged into the pandemic early in 2020.[454] After a decade of real terms cuts in funding the NHS was short of 100,000 staff, and had amongst the lowest hospital bed numbers (including ITU beds) in Europe. NHS Providers estimated that the NHS was underfunded to the tune of £35 billion a year by 2019. Targets were routinely missed and waiting lists had risen.[455]

The Westminster government were complacent and woefully slow to react. The Prime Minister, Boris Johnson was described as "missing in action" from the start and did not bother to attend the first five meetings of COBRA (the emergency committee convened in crises). One senior adviser was quoted as saying that Johnson "didn't work weekends" and "didn't do urgent crisis planning." Rumour had it that during that crucial early period Johnson had been closeted in Chequers in order to meet an urgent publishing deadline on a promised book about Shakespeare.[456]

The government failed to follow WHO advice (seen as only for 'developing countries') and rejected public health measures that other countries were taking as "…only appropriate for low and middle-income countries."[457] As a result, hospitals were soon overwhelmed by Covid patients. In order to free up beds hospital patients were discharged back to care homes without being tested, leading to very high death rates among the elderly

The lack of early testing meant front-line NHS and social care staff had to isolate unnecessarily, leading to acute staffing shortages, and many elderly patients were discharged into care homes without being tested, with devastating results.[458]

Needing urgently to set up a 'test and trace' system, the government could have reinforced local public health networks, already in place but much weakened by the preceding decade of austerity.

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Instead, they chose to ignore them, passing over local structures (including 44 public health laboratories) and ignoring GPs – whose community connections should have made them an obvious choice for running test and trace – and (unlike Germany, for instance, which employed 400 local authorities and public health teams)[459] turned instead to the private sector.

It outsourced the system to private companies with no relevant healthcare experience, who had to set up a parallel system from scratch. Thus 'NHS Test and Trace' had little to do with the NHS, and was largely delivered by outsourcing giants like Serco, Sitel and Deloitte, commissioned directly by a small army of 2,500 management consultants working in the Department of Health and Social Care.[460]

Inefficient test and trace

The resulting centralised model was not efficient. One study showed that local public health teams typically had contact rates of over 90%, compared to just 60% for services run by Serco,[461] while the public systems received only a fraction of the billions handed to private sector.

In an incongruous twist, the contract with Deloitte (the lead consultancy) did not oblige them to share test results with Public Health England (PHE) or with local authorities, so GPs weren't told which of their patients had Covid.[462] Hospitals, GPs and local public health teams were understandably frustrated at being excluded, and few were surprised when test and trace proved to be a very expensive failure.[463] The Public Accounts Committee concluded that there was no clear evidence that it had made "…a measurable difference to the progress of the pandemic, despite the 'unimaginable' cost of £37 billion over two years."[464]

The majority of the spending was on testing: the National Audit Office in December 2020 found that of the £15 billion of funding confirmed before the November Spending Review, around £12.8 billion (85%) was assigned to testing and £1.3 billion to tracing. An additional £7 billion allocated in the November Spending Review, was also largely for mass testing, formally referred to as 'Operation Moonshot'.

Test and Trace involved many different private and public contractors. The NAO found that, by the end of October 2020 Serco had signed contracts valued at £277 million for contact tracing and managing some of the testing centres. At that point, the total spend on Test and Trace was £4 billion.[465]

The criticism of the private sector's role in filling in for what should have been a publicly-provided service is therefore mainly that it lacked any appropriate experience or expertise, and therefore inevitably delivered

an ineffective and inefficient service. The ideological preference for private providers, and a resulting poorer service, has in this instance cost not only money but quite probably lives.

As with test and trace, the emergency procurement of stocks of PPE was taken largely out of the hands of the NHS and anyone with any expertise. Many contracts were not put out to tender and campaigners and public interest lawyers are still struggling to gain a full picture how much was spent on what, and what was the eventual result.

The government set up a fast track 'VIP lane' for PPE providers, and contracts worth billions were awarded to companies who too often had little or no relevant experience of making PPE or medical grade equipment. 47 companies were awarded contracts totalling £4.7 billion after being fast tracked by ministers, MPs, peers and officials. In February 2022 the government quietly reported that it had written off £8.7 billion of tax payers' money spent on PPE, either because it was faulty or because it was not used by its expiry date.[466] The government was also heavily criticised for overpaying for equipment.

This study will not go in detail through this grim period, in which the NHS was the victim of ill-considered policies and unwise decisions by government. Some of the issues have already been discussed by the Covid Inquiry, and in many cases follow-up inquiries are still going on.

But we will briefly highlight the contrast between this woeful incompetence and indifference on the one hand, and the highly successful and efficient vaccine roll out, which was implemented and administered by the NHS, without any scandals or impropriety.

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Lowest paid staff at highest risk

While all this took place, the advice about PPE changed 40 times in 6 months – suggesting that the guidance was tailored to suit what was available rather than the scientific evidence. Health care workers were understandably terrified of catching Covid at work, and in hospitals, hospices and the social care sector desperate staff improvised PPE and accepted donations from local businesses, schools and veterinary practices. Many, including 1500 doctors, logged reports of inadequate PPE.[467]

Hundreds subsequently described being unsupported, threatened, or even disciplined for highlighting the shortages, although NHS trusts denied this.[468] One of the smaller trade unions representing mainly Black and Minority Ethnic workers, United Voices of the World resorted to sourcing their own PPE.[469] So while ministers and civil servants floundered, a small union (UVW) sourced 2,000 masks for their members. The Independent Workers Union of Great Britain (IWGB) also did the same, while members of, Kanlungan, actually made their own PPE for their members.

Many front-line workers were poorly paid, with contracted out staff sometimes on zero hours contracts and inferior conditions, and of course they could not work from home. The added risks of being in the lower tier of a 2-tier workforce could prove deadly, as the proportionally higher death toll tragically proved.

Just twenty one percent of NHS staff are from ethnic minority backgrounds: but non-white ethnicities accounted for 75.8 per cent of deaths linked to Covid-19.[470] Many fell into other risk categories in addition to poverty, including co-morbidity, ethnic minority backgrounds,[471] and living in crowded accommodation. Most could not live on statutory sick pay of £97/week if they got Covid or came into contact with it, and so couldn't afford to self-isolate.

UVW, IWGB and Kanlungan fought against this two tier system. As stated they bought, or made their own PPE for their members. Additionally IWGB brought a case to to the High Court highlighting the poor health and safety conditions for precariously employed workers. They won their case against the Government, but there needs to be a more systemic approach in this area.[472]

The NHS's pain was the private sector's gain

The UK slumped into the long-threatened second wave of Covid-19 infections in the autumn of 2020. There were grim warnings of increased demand on NHS beds and intensive care units, combined with the usual increased 'winter pressures', a funding gap of £1 billion,[473] and a death toll forecast to rise as high as 75,000 by Christmas.[474] The private hospital sector's future appeared rosy.

Not only had many private hospitals increased their share of NHS-funded elective surgery and cancer treatment during the first peak of the pandemic, but they had also begun to cash in on increasing numbers of self-pay and privately-insured customers seeking to jump lengthening NHS waiting lists.[475]

The big, lucrative deal with NHS England in March 2020 to block-book up to 8,000 private acute sector beds through to the end of May at a total cost of almost £1.6 billion[476] – guaranteed "cost recovery for its services, including operating costs, overheads, use of assets, rent and interest, less a deduction for any private elective care provided".[477] This meant the private hospitals, and their lenders and landlords,[478] were cushioned against the impact of Covid-19 on their core business, even while NHS hospital trusts were struggling financially.

Bad times?

Many private hospitals had been forced to cancel operations for at-risk groups, while their overseas patients were kept away by travel restrictions. The NHS was likely to suspend many of the elective operations that had for years been filling otherwise empty private beds.

Private hospital firms, most of which were under pressure to service extensive debts, were also fearing a reduction of self-pay patients, whether they were worried by fears of catching the virus or feeling the impact of the growing economic downturn.

To make matters worse, most private hospitals depend upon sessional work of surgeons and anaesthetists whose core employment is in the NHS, and who were increasingly under pressure to work extra hours to help deal with Covid patients on NHS wards.

Good Times?

But the NHS headed towards the threatened second wave of Covid infection with inadequate funding[479] and lacking the capital required to reconfigure and refurbish buildings to cope with the need for social distance and infection control. However the private hospital sector was revelling in a succession of lucrative contracts to treat NHS patients, and celebrating what seemed to be an increasing prospect of a long-term role filling the gaps in NHS capacity that had been created by a decade of under-funding.

Details began to emerge of the first round of contracts signed by the NHS.[480] The Health Service Journal pointed out that in many cases these contracts "paid for staff and equipment to be transferred to NHS hos-

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pitals as opposed to paying for ward space in private hospitals,"[481] and Spire Hospitals confirmed this analysis.[482] This was because most private hospitals are small (averaging just 43 beds) and separate from the main NHS acute centres, and because the private hospitals are primarily staffed with nurses, with relatively few doctors,[483] most of whom work on a part-time sessional basis while employed by the NHS.

However as the Covid pandemic progressed, local deals saw NHS hospitals transferring whole departments and specialist operations to nearby private hospitals: in April, Norfolk and Norwich University Hospital transferred its entire chemotherapy service – with up to 300 patients using the service each week – to Spire Norwich Hospital, which had not provided a chemotherapy service prior to the outbreak of COVID-19.[484]

- University Hospitals Manchester transferred cystic fibrosis services, followed by operations for breast and lung cancer, to Spire Manchester;[485]
- hundreds of Walsall patients needing urgent cancer treatment were switched to Spire Little Aston;[486]
- Leeds Teaching Hospitals Trust specialities such as stroke rehabilitation, neurosurgery, cardiology, vascular, ophthalmology, cancer surgery and general surgery were provided in Nuffield Health and Spire hospitals;[487]
- almost 500 Worcester patients received urgent treatment including cancer care at Spire South Bank,[488]
- and in the east of London around 7,500 patients from Barking Havering and Redbridge University Hospitals – ranging from patients recovering from Covid through to cancer and other urgent treatment and routine surgery –were sent for treatment at Spire Hartswood.[489]

What pickings for the private hospitals?

As the specific examples reveal, there was no widespread use of private hospitals for Covid patients: but nor was there any large-scale resort to treating NHS elective patients in the private hospitals. While there were some stories of the contract being successfully utilised and delivering value for some trusts, the block-booking contract itself was vague in its specification. The lack of information on how many of the potential 8,000 beds had been used, or what other support might have been received, made it impossible to gauge whether or not the NHS had received value for money.

By mid-June 2020, with none of the first contract details yet in the open, the Guardian revealed that the Treasury had blocked an NHS England plan to extend the deal with the private hospitals into 2021, at an estimated annual cost of up to £5 billion.[490]

Treasury objections centred on doubts over how many of the block booked beds were being used, and the Guardian noted: "NHS England has refused to disclose how many patients have been treated by private providers since March, even though they collect this data each day." It quoted vague claims by private hospital chiefs and NHS England that they had treated "tens of thousands of NHS patients" during the pandemic.

On July 31 an NHS England letter to trusts and commissioners urged them to include use of private hospitals as part of their plans to restore previous normal levels of treatment of elective and emergency patients, and referred to "£3 billion NHS revenue funding for ongoing independent sector capacity."[491]

End of the gravy train?

However a week later the BBC reported this as a scaling down of the contracts: "NHS England has an-

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nounced it is to end the deal that gave it access to more than 90% of private hospital beds, staff and equipment." Instead:

> "*…it plans to move towards local agreements with the private sector, in what it describes as the 'next phase of the response to coronavirus'.*" [492]

In mid-August Spire Healthcare Group announced that a variation of the initial NHS block booking contract was going to give private hospitals more scope to increase their own private patient caseload:

> "*The variation will allow Spire Healthcare to undertake a phased transition back to normal business, by providing NHS elective care to reduce waiting lists, whilst increasing private activity in its 35 English hospitals. The NHSE Contract, and subsequent variation, is expected to remain in place until at least the end of October 2020 but will have a definitive expiry date at the end of December 2020.*

> "*The most significant variation is to guarantee that a certain minimum capacity in each hospital will be made available for privately funded patients (PMI and self-pay). NHSE will continue to cover cash costs, in line with the original contract. In return, Spire Healthcare, along with other private providers, will commit to a minimum private rebate (a deduction from the NHSE reimbursed costs commensurate with the amount of private care provided), with additional incentives agreed for the private providers for exceeding that minimum rebate subject to delivering NHSE activity.*"

> "*Private activity has been building steadily since the de-escalation phase of the NHSE Contract was triggered on 15 May.*"[493]

A new deal?

At almost the same time the Independent broke the story that a massive new "framework contract"[494] was being offered, through which private hospitals could more simply be contracted to take on NHS waiting list patients:

> "*…the health service could spend up to £10bn of taxpayers' money buying operations and treatment in the private sector over the next four years to reduce waiting times.*" [495]

However questions remain unanswered on how many private beds were actually booked – and used – by the NHS at local and national level, and at what cost. Statistics from NHS England[496] revealed that only 2,300 of the undisclosed total of private acute hospital beds block-booked by NHS England were being used in early September.[497]

According to Healthcare Markets the private sector was benefiting two-fold: not only were the private hospital firms celebrating strengthened ties with the NHS and the prospect of sharing £10bn revenue from waiting list contracts over the next four years, but conventional private hospital activity was also recovering to pre-pandemic levels, with private cancer treatment exceeding 2019 levels.

Even better news for the private hospitals was that – as Health Secretary Matt Hancock admitted on BBC Radio 4's Today Programme – England's NHS had been reduced to fewer than 100,000 general and acute beds – down from 109,000 in 2010.[498] And by no means all of this reduced number could be fully utilised, because of the need for post-Covid infection control measures and social distancing.[499]

The NHS had fewer beds than ever and a soaring waiting list; and fewer than half of patients were being treated within the target maximum of 18-weeks from referral. So with the prospect of thousands more operations being cancelled in the winter after a disastrous summer,[500] it was good news all round for the private hospitals, who would win out whether patients went private or stayed in the NHS queue.

Private sector links

Meanwhile the extent to which NHS England saw the future in a permanent alliance with private hospital chains was underlined when NHS England Chair Lord Prior formally opened a new £7.5m private day hospital in Stourbridge for Australian-owned hospital firm Ramsay Healthcare.[501] The local news report referred to unspecified "health chiefs" who said:

> "*Stourside Hospital will provide a hub and spoke model to Ramsay's existing West Midlands Hospital in Halesowen, and that will support the strong partnership between West Midlands Hospital and The Dudley Group NHS Foundation Trust to deliver joined up healthcare services.*"

In October NHS England chief executive Sir Simon Stevens took time out to give a keynote speech to the virtual summit meeting of the Independent Healthcare Providers Network (IHPN).[502]

Of course the private sector was delighted at the renewed and strengthened prospects of 'partnership' with the NHS. The summit also heard from former deputy CEO of NHS England Dame Barbara Hakin, who said private hospital firms would have to decide how much capacity they want to commit to the NHS and what type of treatments they are best placed to

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provide, insisting: “I think there’s a huge will to make this happen.”

NHS Providers deputy CEO Saffron Cordery also spoke of a “sea-change” over the past few months in relations between the sectors and the crucial need for these partnerships to continue.

IHPN CEO David Hare commented:

> *“IHPN members hugely welcomed the opportunity to hear from Sir Simon and it is a clear indication of the importance he places on talking to independent healthcare leaders and hearing views from those ‘on the ground’ in the sector.”*[503]

He went further, arguing that “barriers are coming down across the healthcare system.”

> *“The private/public divide has been a feature of policy thinking over far too long a period and I think there is an opportunity now to see the healthcare system as one.”*

It is quite understandable for NHS management to seek any means to maintain continuity of elective services, especially urgent services for cancer and cardiac patients during the Covid crisis. However, institutionalising the long-term use of limited NHS funding to commission beds and services from private hospitals will inevitably leave the NHS chronically dependent upon private providers, while lining the pockets of the private hospital sector and its investors.

The private hospitals, staffed with NHS-trained doctors and nurses, and fishing from the same limited pool of qualified staff as the NHS, could coin in the cash from NHS-funded elective services and private patients. But the underfunded, under-bedded, understaffed NHS was left as the only provider of emergency treatment, maternity care – and all the more complex, costly and long-term care for all the elderly, young, and poor patients the private sector has always avoided.

The virus had turned out to be terribly profitable.

Part 5: Privatisation after peak Covid

No private fears on white paper

The publication of a new NHS White Paper in the spring of 2021 proposing the establishment of Integrated Care Systems (ICSs) with statutory powers did not create much interest from the private sector who appeared convinced that the new proposals will essentially make little difference to core contracts and flow of NHS funds into the private sector.

David Hare, chief executive of the Independent Healthcare Providers Network said that despite the attempts in the Cameron coalition Government’s 2012 Health and Social Care Act to make it compulsory:

> *“…the reality is that competitive tendering has always been a minority sport in the NHS, with just 2% of NHS contracts by value let by competitive tender in recent years, so the impact risks being overstated.”* [504]

Indeed the bulk of the clinical contracts won by the private sector since 2012 had been relatively low value community health contracts. Back in 2019 findings from IHPN Freedom of Information requests to England’s CCGs showed the proportion of NHS contracts awarded through competitive tendering had fallen from 12 per cent of all contracts in 2015/16 to 6 per cent the following year, before recovering partly to 9 per cent in 2017/18.[505]

However the value of these contracts as a percentage of CCG spending on clinical services had fallen from 3% to just 2% over the same period. NHS Providers had also found while the private sector had won many more community health services contracts than the NHS, the 21% of contracts won by NHS trusts represented 53% of the contracts by value.[506]

Laing-Buisson boss William Laing even conceded the White Paper could mean that contracting out of com-

munity health services might "grind to a halt," affecting firms like Virgin Care, Serco and Mitie. But it was unlikely to have much impact on the big money contracts – mental health, elective care and diagnostic services where the NHS lacks sufficient in-house capacity.

> *"The government's new policy probably won't make much difference in most market segments because the NHS uses the independent sector mainly to do things it can't do itself."*

Private management were also pleased to see the White Paper retained 'patient choice' and included "...clearer rules on the circumstances and processes around the operation of Any Qualified Provider."

Virgin Care sold off

In December 2021 came news that Virgin Care, the company which had been launched in 2008 to compete for NHS and social care contracts all over the country, especially in primary care, community health care, children's services, sexual health and urgent care, had been handed over to venture capitalists Twenty20 Capital, and rebranded as HCRG Care Group.[507]

Virgin Care had at one point seemed to be one of the most successful private firms in scooping up contracts after the 2012 Health & Social Care Act. It won £2 billion of contracts in five years from 2013-2018.[508] It had even felt bold enough to sue and win £2m in damages from a group of Surrey NHS commissioners who had dared to terminate a contract.[509]

Virgin Care was Twenty20 Capital's seventh transaction in 2021, and its fourth acquisition in the health and social services sector. The company's website boasted that it was looking for "significant returns in 2-5 years."[510]

Not all of Virgin Care's contracts would necessarily be transferred to Twenty20. Bath and North East Somerset council and CCG, for example, who awarded Virgin a 7-year £54m per year contract for health and care services in 2017 – had just controversially agreed to extend it for another five years.[511]

Virgin Care's local managing director had as a result of this contract even more controversially been listed as a member of the 'Partnership Board' running the 'Integrated Care System' that would be in charge of the NHS across Bath, North East Somerset, Swindon and Wiltshire from the following April.[512]

But council leader Kevin Guy warned that the November deal had not been fully signed off, and might not be: the impending sale of Virgin Care to a firm of venture capitalists had not been disclosed to council officers during the negotiations.

Virgin Care's boss Dr Vivienne McVey, staying on as chief executive under HCRG, insisted that only the owner and name of the company had changed, and "everything else remains the same."[513] But it was not clear how many commissioners would accept health and care services being taken over by a firm called Twenty20 Capital.

Delivery Plan

NHS England's 'Delivery Plan' in early 2022 was supposed to enable the recovery of acute services from the after-effects of the pandemic, but in fact it accepted that waiting lists could rise as high as 14 million before they fell, and that long waits would not be eradicated until 2025.[514]

The Plan was focused above all on the need for long-term reliance on the "capacity" of the private sector. Quite apart from any ideological objections to funnelling public money to profit-seeking private providers, and the cost of paying above NHS tariff prices to make it profitable for private hospitals to treat NHS patients rather than a growing number of 'self-pay' private patients, there are practical problems with this scenario for the NHS.

Firstly, the private sector cannot bridge the gaps in capacity that have been opened up in the NHS by the decade of austerity and bed cuts and the impact of Covid.

The most recent official statistics on bed numbers, to the end of 2021, showed 11,400 of the 100,000 general and acute beds that were technically 'available' were not being used.[515] There was no capital to enable trusts to reopen beds that had remained empty since the Covid pandemic first struck.

The combination of beds still unused, and beds filled with Covid patients left over 25,000 NHS front-line beds (one in four) out of action for either emergency or waiting list patients.

But the whole of the private acute hospital sector according to Laing Buisson comprised just 8,000 beds, and many of them were not affordable, not available or not suitable for high volumes of NHS elective care. And even if EVERY available bed was block-booked, it could only compensate for less than a third of the capacity that had been lost to the NHS.

Plus diverting large numbers of NHS patients from NHS hospitals to private hospitals often several miles away would in many cases mean also dispatching teams of NHS staff to deliver the operations, since the private sector is not staffed up to work in such intensive fashion. This would mean taking staff out of multidisciplinary teams in NHS hospitals (where they can be

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on call to cover emergencies) making trusts much less efficient.

Any further expansion of the private sector would also mean increased recruitment from the same limited pool of staff trained by the NHS – effectively robbing one department to staff another.

Danger warning

The BMA also warned of the potential dangers of excessive and continued NHS use of private hospital capacity:

> "*…we are concerned that the UK Government's plans … risk embedding a longer-term trend of outsourcing NHS contracts and funding to ISPs (independent sector providers) in England, rather than sustainably increase NHS capacity. We have consistently opposed the outsourcing of NHS contracts to the independent sector, on the basis that it threatens the clinical and financial viability and sustainability of the NHS.*" [516]

Spending extra money to deliver the least complex operations in private hospitals, would also mean that there were fewer resources available for the NHS to treat the older and more seriously ill patients that the private sector does not see as profitable. Waiting lists for more complex conditions were likely to go up, even as treatment for more straightforward cases speeded up. This was a new 'inverse care law,' prioritising the cases that have least serious needs.

The outlook was also gloomy for improvements in emergency services and for mental health, neither of which were included in the Delivery Plan.

The other problem which the NHS England guidance did not address was that the private hospitals are not equally distributed across the country, but focused on prosperous populations and areas, so mainly located in London and the south east of England. So any recovery strategy dependent upon private rather than NHS capacity will inevitably offer a raw deal to other parts of England, which have consistently lost out over the past decade as austerity has widened social inequalities and stalled and even reversed the historic trend towards increased life expectancy.

Task force

At the end of 2022 the first meeting of Rishi Sunak's newly constituted Elective Recovery Task Force once again tried to kick start (or "turbo-charge") a fresh increase in NHS use of private hospitals. The body was well stuffed from the outset with advocates for the private sector,[517] and its conclusions seemed to have been decided in advance:

> "*A new taskforce, bringing together independent hospital leaders and NHS officials, will examine how to significantly expand use of the private sector and give patients more choice over where they receive treatment.*" [518]

This body apparently "ordered" the NHS:

> "*…to 'turbo-charge' use of the private sector*[519] *to help clear record waiting lists. A Downing Street summit on Wednesday will work on plans to maximise use of all available hospital capacity – regardless of who provides it – as* ***pressures on the NHS*** *mount.*" [520]

This was of course welcomed by the private hospitals' lobby group, the Independent Healthcare Providers' Network (IHPN), which is quoted in the government press release that states openly that the role of the taskforce is to increase privatisation:

> "*Experts will focus on how the NHS can utilise existing capacity in the independent sector to cut the backlog. The independent sector has been used to bolster NHS capacity and ease pressure at critical times for nearly 2 decades …*" [521]

However the Telegraph does tacitly concede that private sector referrals might not be such an attractive prospect for patients, especially those with mobility problems, when it reports

> "*Patients will increasingly be offered surgery hundreds of miles away in an expansion of schemes that have seen NHS patients in Devon offered knee and hip operations at private hospitals in Surrey.*" [522]

Mr Sunak is quoted saying he was "comfortable" with the NHS making more use of private hospitals "if that's what it takes to get patients quicker and better care". Patients will also be given "as much choice as possible", "including options to travel to a hospital further away for faster treatment."

Again the word 'choice' is used and abused. Polling from the Health Foundation had confirmed that the choice that most patients expressed when asked was to be able to access timely, safe care from a properly staffed NHS hospital close to their home:

> "*89% support giving patients more choice over where they are treated, for example, the option of being treated in a hospital in their local area if there is a shorter wait.*" [523]

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Why NHS management aren't convinced

The NHS understanding of the limitations of the private sector as a means to reduce waiting lists was made clear in evidence to the Commons Public Accounts Committee from the Health Foundation, NHS Confederation and NHS Providers at the end of 2022.

The NHS Confederation, representing NHS commissioners and providers, pointed to the profound limitations of using the private sector:

> *"The independent sector is being commissioned to take on more procedures to tackle the waiting lists in the NHS. Whilst this is welcome as it can alleviate the pressure on the NHS, the independent sector will not have the capabilities, workforce or capital to take on the cases which are more complex in nature and acuity.*

> *"The NHS will likely be left with the more complex and costly procedures to carry out because of the expertise and infrastructure needed. People on waiting lists, many of whom have been waiting several months, have deteriorated in their health and will need more complex care than they did when they first joined the waiting list. Due to this, these patients will not have the choice to use the independent sector, and this further complexity of care means health inequalities worsen."* [524]

The Confed goes on to point out that both the NHS and private sector are recruiting from the same pool of qualified staff, so the growth of the private sector undermines the NHS. And it highlights the lack of capital for investment to expand or to maintain and rebuild or replace ageing hospitals and clapped out equipment as factors limiting NHS capacity.

NHS Providers, representing trusts and foundation trusts, also highlighted the financial constraints and fears of a majority of trust managers that they lack the resources to achieve the targets set for them by NHS England, as well as the problems and limitations of using private providers:

> *"Trusts have mixed views about the use of the independent sector in tackling the waiting list. Firstly, private sector provision is not uniform across the country and therefore access to the independent sector isn't always available. There is a concern that a reliance on the independent sector could further widen health inequalities as independent sector provision is more likely to be present in affluent areas. [...]*

> *"The role of the independent sector is limited ... Independent sector provision largely covers high volume, low complexity cases as most independent sector providers do not have intensive care capacity. Therefore, independent sector provision can only really accommodate low risk patients."* [525]

The submission from the Health Foundation helps to answer a question often misunderstood by campaigners: how much NHS care is privately provided, and whether its role is growing: the answer seems to be that private hospitals have a growing share of a reduced market:

> *"Before the pandemic, ISPs [Independent Sector Providers] delivered around 12 per cent of total NHS-funded planned treatments requiring hospital admission and 7 per cent of outpatient treatments. As of March 2022, the share of care delivered by ISPs was higher than it was before the pandemic. For care requiring hospital admission, the volume of ISP provided care grew by 9 per cent, equating to an increase in share from 12 per cent to 16 per cent. At the same time, the total number of NHS and ISP provided treatment was 14 per cent lower."* [526]

Health Foundation survey data also shoots down one of the private sector's favourite arguments for patient choice to use providers outside the usual area. In fact the overwhelming choice was to be offered local treatment:

> *"89 per cent support giving patients more choice over where they are treated, for example, the option of being treated in a hospital in their local area if there is a shorter wait."*

Moreover there was a clear majority (81% of those surveyed) in favour of waiting lists to be prioritised by the urgency of the condition – favouring the NHS and its resources – rather than length of time on the list.

The Health Foundation submission also noted that while there are 250 ISPs providing elective care at Independent Sector Treatment Centres (treating only NHS patients) and private hospitals, ISPs tend to be narrowly focused on particular treatments (one in four, 23 per cent covering only ophthalmology). And it concludes with a key question that has subsequently raised by the Public Accounts Committee:

> *"The independent sector… is responsible for a higher proportion of admitted treatments than pre-pandemic. Given activity levels are not where they need to be and the public's scepticism, this requires further scrutiny.*

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"Could the increased proportion of treatments being delivered by the independent sector be helping to limit waiting list growth, by delivering care that otherwise could not be delivered by the NHS?

"Or does this represent displacement of activity from the NHS to the independent sector?

"In the context of value-for-money concerns about the use of the independent sector raised by NHS England, and the ongoing disruption to elective care being caused by COVID-19, this is important."

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Concluding summary
40 years of experience of privatisation

This study has worked through a long list of actual examples of why the private sector has proved an unsuitable and deeply unreliable 'partner' for the NHS in either clinical or non-clinical care.

Over the past 40 years private providers, who have no responsibility to patients or the public, but only to shareholders, have dipped in and out of various services, and cherry-picked services and patients based entirely on the level of available profit, while leaving the NHS with reduced resources to deal with the health needs of the population.

Many private providers have proved themselves time and again to be poor employers, at best only partially concerned with the wellbeing of patients, the NHS or even their own staff, and often willing to endure strike action in the hopes of deterring union members from accessing their full entitlements. This was shown most recently in the series of disputes over £1,650 Covid bonuses that were paid out to all NHS staff, but which many contracted staff had to fight for.

Outsourcing is still a live issue in some trusts, although some of the biggest London trusts have come to the conclusion that services function better and more flexibly when staff are all part of the NHS.

Time and again when outsourcing has been posed, either through traditional outsourcing, or the possibility of social enterprises, or trusts attempting to establish "wholly owned subsidiaries," NHS staff have shown through ballot votes and resistance that they are well aware of how much they stand to lose. Private sector staff are equally well aware of what they are missing out on.

Too many Government Ministers and NHS managers, having taken the propaganda of the private sector (and from the New Labour years) too seriously have been sadly unaware of the contradiction involved in their expecting profit-seeking companies to act as honest 'partners' of the NHS and deliver services that don't prioritise profit.

Perhaps they may be enlightened by the relatively recent statement from the CEO of Spire Hospitals who explained one of the reasons why Spire and other private hospitals are not the solution to the NHS waiting list problems. He said Spire is aiming to focus on private work, and to limit income from the NHS to no more than 30 per cent of its income.

Meanwhile it is worth also reminding Government Ministers and NHS managers that the private sector does not have a magic wand or any technological fix to reduce the number of hours needed to deliver safe, effective cleaning services, catering, or portering.

Equally, there is no spare pool of qualified staff to allow the private hospital sector to expand without damaging NHS. Increasing the work in the private sector damages the capacity of the NHS. And in the case of ophthalmology, the training of the next generation of specialist doctors and the ability to deliver timely treatment for patients with more complex needs are threatened by the private sector cornering an ever-larger share of a limited budget to deliver the simplest (cataract) operations and screening to patients with the least needs.

If the NHS spends the same amount of money but brings in private providers, the net result is less money for services, or fewer staff and fewer hours worked – because profit must take its share.

If the NHS tries to keep services intact and at the same time outsource to private providers, it will inevitably cost more, because profit must take its share.

Either way the NHS loses resources, becomes dependent upon private sector that will only ever want to take over minority of services, and if profits can be guaranteed.

Outsourcing/privatisation is an ideological policy that has been adopted by both of the main political parties in Britain, and imposed most vigorously in England, while devolved governments have reversed most of the marketisation imposed upon them by Westminster up to 2000. As an ideological policy, outsourcing has continued despite the widespread evidence of its failure to deliver the promised combination of reduced prices and improved quality, and the copious evidence that it has wasted hundreds of millions and reduced the quality and flexibility of services.

Opposing privatisation and outsourcing is not ideological or party political. It is practical, logical, and evidence-based. It provides for a better public health service for all. Moreover bringing all staff into one, NHS, team is the best and only way to tackle inequalities at work, and all of the negative aspects of the 2-tier workforce created by outsourcing and privatisation since 1984.

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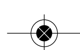

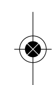
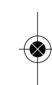
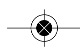

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