THE lowdown

Health news, analysis and campaigns.
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Informing, alerting and empowering NHS staff and campaigners

Hidden costs will weigh down six trusts that get new hospitals

Unite has hailed victory in the long-running Lincolnshire health visitors' dispute, which is coming to an end with the vast majority of the workforce being upgraded onto the grade 10 pay scale.

John Lister

The infamous promise of "40 new hospitals" by Prime Minister Boris Johnson has not only been shown to be misleading, but the six trusts that will get new hospitals will be saddled with hefty extra payments.

Even though the extravagant rip-off funding through PFI has now been brought to a halt, trusts will have to pay an annual "dividend" payment of 3.5 percent each year for the capital investment they receive and on the increased value of their assets, according to a Health Service Journal report.

Although there would be no requirement to pay back the initial funding, the 3.5% payments would continue indefinitely as an added financial burden to the trust.

The £2.7 billion that will be allocated to the six trusts for rebuilding and upgrading their hospitals is part of a £3 billion "health infrastructure plan". But far from being generous, it is less than a third of the £10 billion called for in the Naylor review of estates two years ago.

Meanwhile the 21 trusts planning 34 new hospitals (including a number of community hospitals with few if any acute beds) get to share £100m of "seed funding," and offered only the vague hope that their business plans might be accepted some time after 2025.

£20m per year interest payments

The increased costs facing trusts can be considerable: the *HSJ* takes the example of the West Hertfordshire Hospitals Trust, which is seeking around £400m to rebuild its crumbling general hospital in Watford, despite complaints from elsewhere in the area that the site is inaccessible.

The trust has told staff that **"The money is not a free gift but is a bit like an 'interest only mortgage' — we will make an annual dividend payment on the sum provided but we won't be asked to repay the principle sum. The extra cost pressure due to capital charges would be around £20m per year."**

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Nuffield Trust analyst Sally Gainsbury told the HSJ: "While 3.5 per cent looks high compared to prevailing interest rates at present, a more significant problem is the fact provider incomes have become so squeezed that many already struggle to cover their staff costs, let alone generate a return on their physical assets to reflect the costs of that investment."

The West Herts Trust has a backlog maintenance bill of £65m, and already has to pay interest on £195m of government loans accumulated over recent years to prop up its flagging budget, and is struggling to meet a target of reducing its deficit this year to £27m.

An extra requirement to find at least £20m per year is likely to force more desperate cost-cutting measures, even when the new building is eventually opened.

Backlog and borrowing

Of the other trusts promised new hospitals, Barts Health already has accumulated loans of £149m and a £65m deficit; Leeds Teaching Hospitals has a relatively small deficit but £89m of loans; Princess Alexandra Hospital in Harlow has £66m of loans and is projecting a deficit of £27m; University Hospitals Leicester has a massive £209m of loans already in place, and expects to meet its control total deficit of £49m. So none are strongly placed to pay out the additional costs of the new buildings.

Senior policy adviser at NHS Providers, David Williams, told the HSJ:

"This shows that capital and revenue are closely related, not isolated funding streams. Trusts need both adequate, multiyear capital investment and sustainable revenue settlements to maintain services at the appropriate standard."

IN THIS 16-PAGE THIRD PRE-ELECTION, END OF YEAR ISSUE

NHS is on the table!

Leaked documents confirm NHS has been on agenda of US trade talks

John Lister

Drug prices, and the length of patent protection that keeps the price of branded drugs high, have been at the centre of a series of meetings between British and US trade delegations as Theresa May's government began preparations for a US trade deal after Brexit.

451 pages of official British government notes revealing this and other aspects of the discussions were leaked to the Labour Party last week.

They led to reinforced accusations by Jeremy Corbyn and other Labour leaders that (as Donald Trump had said on his visit to Britain in the summer), the NHS was "on the table" in trade talks. Corbyn has argued that ministers had been discussing "selling it off" to the Americans.

The *Daily Mirror* took a similar view, describing "a bombshell press conference" in which "Mr Corbyn first showed heavily-redacted government documents, obtained by campaigners, relating to months of trade talks between the US and the UK. But he then dramatically held up a second bundle - the uncensored versions."

The *Guardian* reported Labour's argument that "We have now got evidence that under Boris Johnson the NHS is on the table and will be up for sale. He tried to cover it up in a secret agenda and today it has been exposed."

The current government may have tried to suppress the embarrassing content, but attempts to question whether the documents were genuine were derailed when former minister Liam Fox, who was present at the early meetings, confirmed they were.

The documents span a period before Johnson took office, and the *Financial Times* among others was keen to play down their significance. Their correspondent Jim Pickard argued that out of the 451 pages there only seemed to be a few relevant paragraphs:

"On page 41 it says that the US is not keen on warning labels on food.

"On page 43 it repeats the US desire to improve the "media narrative" on chlorine-washed chicken.

"On page 119 there are some words hinting at the US desire for longer drug patents.

"That's pretty much it....quite thin material when you boil it down to the essentials."

So what are we to make of the evidence, now we can now comb through it online?

Missing out on content

It's clear the *FT* missed a lot of interesting content. In the first meeting (page 24) there is a discussion of the movement of professionals across borders and recognition of their qualifications – and this includes nursing:

"Nursing was the other profession that the US was interested in. Nursing in the US was very closely coordinated with Canada and Ireland. The relationship with Canada was particularly close and Canada had adopted the US exam. A compact between 25-30 states meant that nurses were able to move between those states. The US were interested to know if it would be really problematic for the UK to act in this area – they were sensitive to the particular sensitivities with the health sector in the UK."

In the second meeting the US ambition to lengthen the life of patents that protect the higher prices of branded drugs was discussed:

"The US said there is a lot of conversation on drug prices and looking at what other countries pay and this is causing angst. There are worries that the US is not getting a good deal in pharmaceutical industries." (pp48-49)

State Owned Enterprises

In the third meeting the discussion moved on to a discussion of State Owned Enterprises (SOEs), in which the US trade delegation "probed UK position on our 'health insurance' system" (p49).

While it's clear the main US concerns in this regard are with the many large SOEs in China, the discussion clearly shows a determination to restrict the freedom of governments to protect or subsidise these enterprises:

"The US tends to be more aggressive in trying to discipline other nations' subsidy programmes. The US business community became interested in SOEs a few years ago, which drove this position further. The US stated that SOEs are particularly positioned to potentially disrupt trade flows, and so are keen to have tougher rules for SOEs than for private business." (p50)

It's interesting that in this discussion the US asked if the UK had concerns about their "health insurance system."

The British did not point out that the NHS is not an insurance system, but a health service funded from taxation. Nor did they insist it had to be off the table. Instead they replied that more discussion should take place 'further down the line':

"the UK has an advanced competition law regime and strong corporate governance rules, and we believe we are compliant with international best practice. Wouldn't want to discuss particular health care entities at this time, you'll be aware of certain statements saying we need to protect our needs; this would be something to discuss further down the line when we come to consider what entities would count as 'enterprises'. (p52)

"The query about 'health insurance' was likely a fishing expedition to check the tone of our response."

The Lead Negotiator comments on this query, noting that:

"The query about 'health insurance' was likely a fishing expedition to check the tone of our response. We do not currently believe the US has a major offensive interest in this space – not through the SOE chapter at least. Our response dealt with this for now, but we will need to be able to go into more detail about the functioning of the NHS and our views on whether or not it is engaged in commercial activities …" (p53)

Extending patent protection of profits

The Fourth meeting included a lengthy discussion of patent issues. The document flags up as "Key Points to Note" the connection with the NHS:

"This session provided the UK with an opportunity to provide a comprehensive overview of our approach to patent policy and highlight how this is intricately linked to the UK health system." (p119)

An introduction from the UK delegation argues:

"The pharmaceutical sector has an annual turnover of £48.2 billion, it employs over 100,000 people from 2,000 businesses, and it is closely integrated with the UK's national health system." (p121)

The discussion on how the two systems work concluded with an upbeat suggestion that agreement is getting close:

"We have reached a point (for Patents in Pharmaceuticals/Health) where beyond specific policy details in niche areas, we are awaiting the clearance to negotiate and exchange text to really take significant further steps. There is however significant scope to discuss patents in other areas at future sessions, in particular: Technology and Agriculture/Chemicals." (p132)

Data and algorithms

In addition, as the *Times* has pointed out, the leaked documents, most especially from the fourth meeting in July 2018, also revealed that a "top priority" of US negotiators was establishing a "free flow" of data (p22), and emphasising US opposition to any requirement for American companies to disclose encryption methods or algorithms underlying their systems.

Alan Winters, director of the Trade Policy Observatory at Sussex University, told *The Times* that clauses on data sharing and algorithms that US negotiators want inserted into a deal could be used to capture data from Britain's 55 million NHS patient records, which city accountants EY have estimated could be worth £10 billion a year.

According to the Times report:

"The arrangements could see UK data swept back to servers in America and mined by algorithms written in Silicon Valley to develop new diagnostic tools and medical devices that would then be sold back to the NHS."

The UK NHS could wind up "unable to analyse its health data without paying a royalty to Silicon Valley to use an algorithm," and "Once the algorithm has been written and copyrighted by an American company, if the NHS tried to do the same in the UK it could be sued."

What is striking throughout the leaked papers is the eagerness of the British delegation to fit in with the ambitions of the Americans, knowing that especially after an acrimonious no-deal Brexit a US trade deal might be the nearest to a substantial deal on offer.

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No stand taken

Despite the subsequent protestations of ministers after the unredacted documents were publicised, at no point in these meetings does anybody from the British delegation insist that the NHS would not be "on the table".

However it's also clear that the US delegation's interest in the NHS is almost entirely focused on drug patents (and protecting higher prices) and on free flow of data.

Boris Johnson's ministers are no doubt quite willing to "sell off" the NHS to American corporations, and the "ratchet" clauses in free trade agreements would potentially restrict options to bring privatised services back in-house.

However there is no evidence so far that there are any potential American buyers lining up to take over a deficit-ridden, under-funded and under-invested service.

Campaigners want to keep it that way: and there is no doubt – despite the denials all round – a Johnson government would be the most amenable to striking a deal with the US which would impact on the NHS with potentially disastrous consequences.

What are the main parties offering?

Election manifestos are not the place to find detailed health policies, but they do give an insight into how the parties are responding to calls for credible plans to solve the crisis in our health service. Here is a quick round-up on where the three major parties, plus the Green Party, stand on some of the central issues of concern for the NHS and social care.

Funding

The general consensus of opinion (think-tanks, BMA, IFS etc.) is that the NHS needs at least 4% per year over the next five years to maintain the current level of service, but to make any meaningful progress on its major problems, including staff shortages, mental health provisions and waiting times, the NHS will need funding growth of around 5% a year over that same period.

The Labour Party has pledged to increase expenditure across the health sector by an average 4.3% a year, the Green Party has pledged 4.5%, the Liberal Democrats have pledged 3.8%, and the Conservatives have pledged around 3.1%. The figure for the Conservatives spend has been calculated by The Health Foundation as no total health budget was published by the Conservatives.

The Green Party pledge most, but an analysis by The Health Foundation of the three main parties, concludes that only the Labour funding promise will enable improvements in care to take place, whilst the Liberal Democrats pledge will maintain current levels of care. Planned funding under the Conservatives, however, is not enough to maintain the current levels of care.

Staffing

The NHS has a staffing crisis with an estimated 100,000 vacancies. The policies of the last Conservative Government, including the axing of the nursing bursary and Brexit, have fueled this problem.

All four parties aim to reinstate the bursary in some form, although only the Labour Party promises to reinstate bursaries for nurses and other allied health professionals.

The Conservatives and the Liberal Democrats only plan to fund bursaries for nurses doing training in areas with staff shortages and in certain regions. The Green's pledge is not specific.

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One of the key promises of the Conservative manifesto is the pledge to deliver 50,000 more nurses, although the manifesto is unclear as to the timescale for delivery. The figure of 50,000 nurses includes retaining 18,500 nurses who might otherwise have left, so the actual figure for additional nurses is 31,500. The recruitment of additional nurses will be 12,500 from overseas and 14,000 through new undergraduate students and 5,000 would be degree apprenticeships.

The viability of recruiting so many overseas nurses given the brutal immigration policies from the Johnson and May governments has been questioned, however. The Conservatives plan to increase the NHS surcharge payable by people from non-EEA countries from £400 to £625 per year and extend it after Brexit to people from EEA countries - another move that will make the UK a less attractive location for healthcare staff. Plus there is the issue of the £30,000 minimum salary for migrants and how this will be applied to healthcare staff.

In contrast, both Labour and the Liberal Democrats promise to develop ethical recruitment policies for overseas staff. In addition, the Lib Dems note that they will also maintain freedom of movement.

Recruitment and training of staff is expensive and Full Fact has raised doubts over the minimal £879 million allocated by the Conservatives to funding the extra nursing staff and reinstating the bursary for student nurses — with a minimum of £5,000 per year.

Full Fact argues that the full cost of employing 50,000 Band 5 nurses could be as high as £2.6 billion per year, far more than the almost £900 million allocated.

The Conservatives promise of 6,000 extra GPs also grabbed attention, with the related promise of 50 million more appointments each year. The promise had already been made by Matt Hancock – and exposed by *Pulse* magazine as another misleading claim, including 3,000 trainees along with 3,000 qualified GPs in the total.

Labour has a number of policies in its manifesto to target the staffing crisis. As well as the restoration of bursaries, there is also a plan to increase the number of health visitors and school nurses and expand the number of GP training places by 5,000 per year.

Labour promises NHS staff a 5% rise in pay in

2020 followed by year-on-year above inflation pay rises. The party says it will enshrine safe staffing levels into law; Wales and Sotland have already done this.

The Liberal Democrats pledges include action on the pensions crisis, GP numbers and a workforce strategy. The Health Foundation notes, however that "the manifesto acknowledges that [the workforce crisis] will require investment in recruitment, retention and making the NHS an attractive place to work. Yet the funding promised [by the Liberal Democrats] falls short of the amount needed for workforce training, despite chronic staffing shortages."

Infrastructure

The NHS's infrastructure is crumbling and disintegrating – 50% of GP surgeries are not fit for their current purpose, according to the BMA, and recent data shows that £6.5 billion is needed to complete the backlog of maintenance needed in hospitals and clinics.

Back in 2017, the Naylor report estimated that £10 billion would be needed to make the NHS fit for purpose and deliver the plans that had been drawn up around England to improve the NHS. The plan was for the NHS to raise at least £6 billion of this itself from land and property sales.

What do the main parties promise for our crumbling infrastructure? Well the Conservatives highly publicised promise of 40 new hospitals, was almost immediately exposed as a sham. We now know that the promise is just £2.7 billion for six upgrades to currently existing hospitals. The funding for the remaining '34 hospitals' only consists of £100 million to develop business proposals.

Furthermore, as the bill for backlog maintenance of NHS infrastructure is around £6.5 billion, the £2.7 billion for six projects just scrapes the surface of the problem.

Since the Naylor report in 2017 hospital trusts have been ramping up their sale of land and assets, but as the maintenance bill keeps rising, this approach appears to be having little impact on spending on infrastructure.

Labour promises to invest £15 billion in infrastructure to bring capital spending up to the international average and to halt the sale of NHS land and assets driven by the Naylor review.

The Liberal Democrats have promised to spend £10 billion and the Greens will focus funding on the construction of new community health centres, bringing health services closer to people's homes.

Social Care

Social care is in crisis with demand rising and real problems with attracting and retaining staff. Years of austerity has led to major cuts in services and serious problems in access to care. This has also had a knock-on effect on the NHS as patients well enough to leave hospital can not due to a lack of care packages.

The three main parties have all pledged more money for social care. But an analysis by The Health Foundation, found that none have pledged enough to meet the growing demand or improve pay for social care staff. The estimate is that an additional £12.8 billion is needed for social care to bring it back to levels of access seen in 2010/11.

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Out of the three main parties, only Labour has set out any concrete proposals for reform, with a headline pledge of free personal care for the over-65s. The plans also include building a 'national care service' and a life-time cap on social care costs. They will plow in an additional £11.1 billion for social care by 2023/24, according to the Health Foundation analysis.

The Liberal Democrat plans, which according to the analysis by The Health Foundation amount to £2.9 billion in additional spend by 2023/4, include establishing a cross-party convention to agree a long-term funding model for health and social care and introduce a cap on the cost of care.

The Conservative manifesto says the least of any of the parties opting just to say they plan to "build a cross-party consensus on long-term social care funding." Their additional spend is just £1.1 billion.

Several Conservative policies, including Brexit and the minimum salary level of £30,000 for migrant workers, will actively exacerbate the problems in social care. These policies will block new recruits to care work and leave nursing homes and domiciliary care companies struggling to keep services running.

Privatisation and restructuring reform

The NHS has been in a state of reorganisation for many years now - the Health and Social Care Act 2012 ushered in competition, privatisation and major changes to the way the NHS is organised.

The failings of the tendering system and the forced competition between NHS organisations have made it unpopular throughout the NHS. It has disrupted the planning of healthcare and wasted precious resources.

The Labour Party and the Green Party pledge to repeal the H&SC Act and so end competitive tendering and privatisation across the NHS. Labour promises that all integration of care will be delivered via public bodies.

In contrast, the Conservatives and Liberal Democrats only promise to make changes to the legislation in the 2012 Act that will end compulsory tendering and competition between NHS organisations. These are the changes that NHS England proposed in the January 2019 Long-Term Plan.

The years of top-down restructuring of the NHS that began with the 2012 Act will carry on, according to the

Conservative manifesto, as it pledges to continue with the restructuring set out in the Long-Term Plan.

Organisations put in place under the 2012 Act, such as the CCGs, are now being merged and integrated under plans for Integrated Care Systems (ICS). It is likely that NHS outsourcing will continue due to pressure on capacity and the structure of the proposed integrated care provider contract. These plans confirm a U turn on key elements of the Lansley reforms (H&SC Act 2012) but do not block the possibility of further NHS privatisation.

Labour too would introduce new NHS legislation, but to reinstate the duty of the health secretary to provide care to all citizens, which was removed under the Coalition's reforms in 2012.

Public Health

Under the last Conservative government, the responsibility for public health was transferred to local councils and funding was cut. By 2020/21 funding for public health will have been cut in real-terms by 25% on 2015/16 levels or around £1 billion. This has had a major impact on service levels, particularly in more deprived areas.

Labour promises to address the shortfall in funding with an increase of £1 billion in spending on public health. The Liberal Democrats also promise to make good the shortfall but without mentioning a figure. Both these parties appear to appreciate the importance of public health services to our society and people's well-being.

They both outline a number of pledges, many focused on food and drink, including minimum unit pricing for alcohol, extending the Soft Drinks Industry Levy to juice and milk-based drinks and approaches to regulate junk food advertising and sales.

The Conservative manifesto, on the other hand, does not address this issue in much detail, instead it says they will "invest in preventing diseases as well as curing them" and try to "empower people with lifestyle related conditions to live healthier lives."

Waiting times

In November this year, data from the NHS showed that key targets for cancer, hospital care and A&E have been missed for over three years. The delays for hospital care and in A&E hit their highest levels since both targets were introduced.

Less than 75% of people who went to A&Es in England in October were treated and then discharged, admitted or transferred within four hours – the smallest proportion since the target was introduced in 2004. In September 2019, 4.42 million patients were on the waiting list, the highest number ever and 76.9% of cancer patients starting treatment within 62 days - below the 85% target.

All these problems can not be addressed in isolation and are inextricably linked to funding of both the NHS and social care.

As already outlined, the Conservatives funding plan does not provide enough money and no plans have been put forward to solve the problems of social care.

So although the manifesto lists pledges for waiting time reductions, in reality there will not be sufficient funding to have any impact.

Labour plans to introduce free prescriptions and annual dental check-ups for all, and to not let NHS data be exploited by international technology and pharmaceutical corporations.

Mental health services are in crisis at present due to lack of staff and funding, with high waiting times and a lack of sufficient infrastructure and beds. Children and adolescent services are particularly badly hit.

Mental health is discussed in all four manifestos, with all four parties, Labour, Green, Liberal Democrat and Conservative, pledging to treat mental health and physical health with the same urgency, however as already discussed this will only happen if funding is sufficient.

Other pledges

All the parties have a number of other pledges relating to healthcare.

Labour plans to introduce free prescriptions and annual dental check-ups for all, and to not let NHS data be exploited by international technology and pharmaceutical corporations.

Following the considerable media coverage of possible drug price rises under any post-Brexit trade deal with the US, it is interesting that Labour plans to establish a government generic drug company, so if fair prices are rejected for patented drugs, the provisions of the Patents Act, compulsory licences and research exemptions can be used to secure access to generic versions. Labour also plans to plant an 'NHS forest' to ensure the organisation can become carbon neutral.

Both Labour and the Liberal Democrats have pledged to make PReP for HIV prevention available on the NHS.

The Conservatives announced an extension of the Cancer Drugs Fund into the 'Innovative Medicines Fund' and a doubling of investment in dementia research and speeded up trials. However, Brexit has already led to a significant 'brain drain' of academics and researchers from UK universities.

The charity Alzheimer's Research UK has already warned about the negative effect of Brexit on research into dementia, with a loss in funding - dementia research in the UK has benefitted hugely from EU funding over recent years - and the loss of researchers and collaborations with European researchers.

And finally the regular battle over car parking fees should get a mention - Labour will scrap them for all: but the Conservatives will end hospital car parking charges only for those in "the greatest need" plus staff working night shifts.

Hillingdon Hospital set to crumble for six more years

Hillingdon Hospital is the local hospital for Boris Johnson's Uxbridge constituency: but it exhibits all the signs of the crisis caused by years of under-funding.

Hillingdon is one of many trusts facing large and escalating backlog costs for maintenance, but is not one of the six trusts singled out for new or rebuilt hospitals. Instead it is one of the 21 trusts included in the 'fake forty' announcement of 'new hospitals' while only receiving a share of a minimal £100m in "seed funding" to develop a business plan.

This means Hillingdon will get no significant additional investment to address the crumbling buildings until at least 2025.

£192m repair bill

Yet the most recent Annual report emphasises the scale of the bill for repairs and new equipment – which was estimated at £191.6m in 2017 (although the official NHS tally of backlog maintenance was much smaller at £109m in 2017-18 and only slightly lower for 2018/19 at £107m), and how pressing the backlog pressures are:

The Hillingdon Trust's 2018-19 Annual Report admits that:

"The estate has suffered from underinvestment over an extended period and many building fabric and services are failing or are beyond economical repair and their design life cycle.

"A recent survey highlighted that 81% of the Hillingdon estate and 51% of the Mount Vernon estate has a condition that is 'operational but major repair or replacement will be required soon' or worse.

"… The survey also revealed the immediate need to invest significant capital over the next four years to prevent the condition of the estate deteriorating further therefore compounding the overall backlog cost.

"The Trust recognises the condition of the estate has a direct impact on the ability to provide a safe environment for patients and the importance of a clean, safe environment for all aspects of healthcare should not be underestimated.

Unfortunately the condition and age of the estate makes it difficult to meet modern standards and this has the potential to cause infection control issues if not addressed appropriately."

The Trust also has a recurrent underlying financial deficit and reported a final deficit in 2018-19 of £25.9m: but this was after receiving £24.5m of "central cash support" to prop up the budget, which is expected to continue this year, and adds to an accumulation of loans adding up to almost £60m.

The pressures on the trust have also meant a growing number of delays in elective treatment, with only 51.7% of allergy patients and 55.8% of pain management patients being treated within 18 weeks, well below the 92% target. There are also delays in Paediatric Dermatology, Rheumatology, Gastroenterology and Trauma and Orthopaedics all of which on less than 72%.

Circle buys out major UK hospital chain

John Lister

Circle Health, the company best known for its disastrous failure to run Hinchingbrooke Hospital, one of the smallest NHS general hospitals, and its unsuccessful court challenge to losing its contract to run a treatment centre in Nottingham, is buying up the largest private hospital chain in Britain, BMI Healthcare.

This will take Circle from a small scale business that had never made a profit, and was valued at £75.2m when it was taken over and delisted from the Stock Exchange in 2017 by hedge funds Toscafund and Penta Capita, to a major company with a combined annual revenue of nearly £1 billion, with 54 hospitals and over 2,600 beds.

BMI, which was previously owned by South African private health corporation Netcare, is being taken over for an undisclosed amount, as Netcare pulls out of the British private health care market after thirteen years.

Plummeting performance

Toscafund first took over a substantial share of Circle in 2015 shortly after the firm pulled out of the Hinchingbrooke contract. Financial deficits were rising and performance was plummeting as a result of the company injecting its private sector "know-how" into a previously successful hospital, alienating staff, and forcing increased reliance on more costly agency staff.

As Circle pulled out, Hinchingbrooke received the CQC's worst-ever rating for levels of care, and "inadequate" ratings for safety and leadership. The company threatened legal action against the CQC and tried to prove there had been a "Labour Party plot" to force it out of the contract, but eventually gave up.

One familiar feature of both for Circle is dependence on NHS-funded patients: Circle's own small private hospitals in Reading and Bath have always been heavily dependent on income from treating NHS-funded patients, as are BMI hospitals – where NHS work accounts for 42 per cent of revenues.

Until this year Circle's most profitable business was its NHS contract to run the Nottingham Treatment Centre, Europe's biggest treatment centre, which provides NHS-funded services including gynaecology, cardiology and respiratory medicine along with diagnostic testing and treatment for cancer.

However in May Deputy High Court judge Sir Anthony Edwards-Stuart ruled that the CCGs sending patients to Nottingham could go ahead and hand the 5-year £320m contract to Nottingham University Hospitals Trust from July. Further legal action by Circle, seeking damages from the CCGs which withdrew their contract, has not yet been dealt with by the courts.

The big question for the new expanded Circle after the takeover is completed this month is whether the new company can buck the trend of declining margins from privately insured patients and restricted NHS budgets which persuaded Netcare to pull out of the British market, and deliver increased profits.

If not, how long will Circle's proprietors, Toscafund and Penta, both noted for their focus on profitability, continue to pump in the funding to keep the business afloat?

Piecing together the puzzle on privatisation

John Lister

The election period brought a debate on the extent of NHS privatisation – with some, especially on social media, eager to over-emphasise of exaggerate the inroads that have been made by the private sector, and others trying to argue that it is a side-issue.

The first early blow in this contest was struck ahead of the election by a London School of Economics blog from David Rowland, a former head of policy for three national regulators of health professionals, now working for the independent think tank, the Centre for Health in the Public Interest (CHPI).

Entitled ***Flawed data: Why NHS spending on the independent sector may actually be much more than 7%***, the blog takes a critical look at the details provided each year in the Department of Health and Social Care's Annual Report and Accounts. This document is the source of the "settled view of the media that around 7% of NHS expenditure is spent in the independent sector."

Rowland helpfully brings together the equivalent figures going back to 2013/14, the first year after the implementation of the Health and Social Care Act which pressurised Clinical Commissioning Groups to put services out to tender and invite private bids.

But surprisingly he does not comment on the significant (almost 25%) increase in the level of NHS spending on independent sector (private) providers the year after this legislation took effect, far higher than the total increase in spending that year, of just under 10%.

Rowland's focus is on the overall percentage of total NHS spending, which appears to increase by a much smaller amount (from 6.1% to 7.3%) although this is almost a 20% increase in share of spending in a year.

Indeed he effectively ignores this increase, and argues that over the six years the share of spending has remained "remarkably stable," since the figure then rises above and falls back to 7.3% – although this, as noted the change over 6 years is a 19.7% increase, and 7.3% of £125 billion is a large sum.

Rowland's objection to the way the figures are presented by the Department are set out clearly, and some points are quite obvious: for example he highlights the £1.3 billion spent in 2018 by trusts on sending patients to private hospitals – a figure that has more than doubled since 2013/14 and clearly should be included in spending totals.

It is also fair for him to point out that almost all of the money paid to local authorities has been for them to commission nursing care and social care that is in practice delivered by the private sector. This spending was £2.8 billion in 2018-19, although the blog does not appear to go on to separate out this spending in the alternative table.

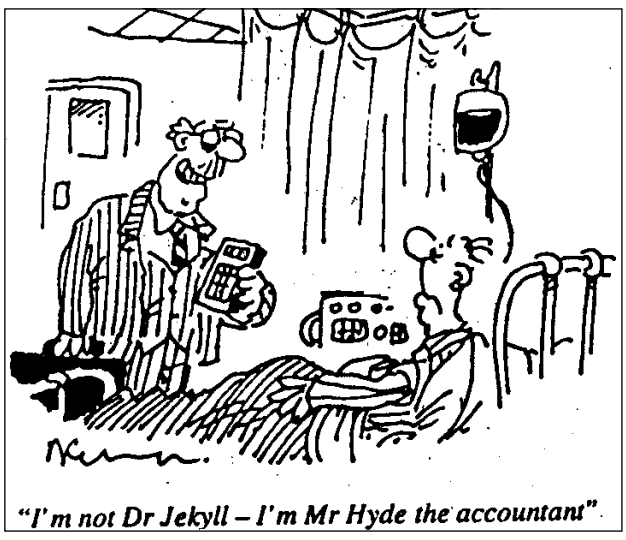
If GP and dental spending are deducted, Rowland's figures show £13.5 billion was spent on private providers in 2013-14, rising to £18.4 billion in 2018-19, a 36% increase

Rowland also argues that many voluntary sector organisations and not for profit companies are to all intents and purposes private sector providers, although again the implications of this are not worked through in the final figures.

We can also agree that a very large share of pharmacy and ophthalmic services have been effectively privatised, with Boots, Lloyds Pharmacy, Specsavers and Vision Express cashing in on NHS contracts.

But much more controversial is Rowland's argument that General Practice and General Dental services should be similarly bracketed as independent sector (i.e. private sector) spending – effectively regarding all GPs and all NHS dentists as the equivalent of Virgin Care or The Practice, and ignoring NHS dentistry. The case for this is not clear, and while campaigners will continue to fight to remove for profit companies from GP services the extent to which the relatively small corporate sector in GP services can be singled out from the total budget is not clear.

Before moving on to present his alternative breakdown of spending Rowland also quite reasonably



"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

questions the sense of comparing private spending with the total of Department of Health Spending, rather than NHS England's actual spending on health services.

This does have the effect of appearing to minimise the level of private spending. Obviously if this was to be changed, the comparison would need to be changed for each year to ensure consistency, so it would make a one-off difference, but then the benchmark would remain the same.

Having made these points Rowland notes:

"On this basis, we find that in 2018/19 £29 billion was spent by NHS England on the independent sector, which is around 26% of total expenditure. This percentage of the NHS's expenditure on the independent sector has stayed fairly constant for the past six years."

With a nod to those of us who object to including all GPs in the private sector, he adds:

"If General Practitioners are excluded from this calculation, the figure is £21 billion, or around 18% of total expenditure on the independent sector."

In fact the inclusion of the large sums spent on GP services and the smaller, but significant sum spent on General Dental services skews all of the sums, and diverts from the significant growth in the share of NHS spending on private providers.

Indeed if GP and dental spending are deducted, Rowland's figures show £13.5 billion was spent on private providers in 2013-14, rising to £18.4 billion in 2018-19, a 36% increase, and rising from 14% of NHS England spending in 2013-14 to 16% (almost £1 of every £6 spent) by 2018-19.

This is useful information for campaigners. It's a shame it is so complex a process to get to it that few will make use of it.

Concentrations of privatisation

However modest the overall percentage of spend on private providers might be, we know that within certain services the concentration of private provision is much higher than the average.

This imbalance is highlighted by a new report researched by the Nuffield Trust for the Institute of Fiscal Studies. Recent trends in independent sector provision of NHS-funded elective hospital care in England does exactly what it says on the cover: but it begins with the Department of Health figures we have just seen criticised.

The motivation for the IFS commissioning specific NHS research appears to be this "neutral" body's wish to question Labour's election manifesto and commitments:

"Labour has vowed to 'end and reverse privatisation in the NHS in the next parliament', signalling an ambition to end – or at least significantly reduce – the role played by private providers in treating NHS-funded patients."

Its key findings show that while emergency care remains almost exclusively provided by NHS hospitals, there has been a significant privatisation of the provision of NHS-funded elective care, from "almost none" in 2003-4:

"ISPs [independent sector providers] account for a small, but growing, share of NHS inpatient activity. They provided 609,549 NHS-funded elective episodes in 2017–18 (6% of all NHS elective activity) ….

"Wider NHS activity has increased substantially over the last 15 years, with ISPs accounting for one-sixth of this growth.

"The NHS is becoming increasingly reliant upon ISPs for some types of elective work. For example, in 2017–18, ISPs conducted 30% of all NHS-funded hip replacements, 27% of inguinal hernia repairs and 20% of cataract procedures. Replacing this capacity within NHS providers would therefore require careful planning.

"In some cases, ISPs have provided additional capacity for the NHS, while in others they appear to have been used as an alternative provider of care. 82% of the growth in hip replacements between 2003–04 and 2018–19 was accounted for by ISPs."

"The NHS is becoming increasingly reliant upon ISPs for some types of elective work. In 2017–18, ISPs conducted 30% of all NHS-funded hip re-placements, 27% of inguinal hernia repairs and 20% of cataract procedures.

The researchers argue that the private sector is important, but a relatively minor player in the provision of NHS elective care: "It is important to note that while volumes have increased at ISPs, this increase still only represents a small part of the growth in NHS activity over this period."

Between 2003–04 and 2017–18 NHS-funded elective episodes at NHS hospitals increased by 3.2 million, an increase of 48.8%, while total NHS-funded elective episodes increased by 3.8 million, so one-sixth (16.1%) of the extra operations were by private providers.

But in some specialties the private sector played a bigger role: "by 2017–18, ISPs accounted for 19.6% of all NHS-funded cataract surgeries, 27.3% of inguinal hernia primary repairs and 30.3% of hip replacements."

On hip operations the private sector had the lion's share of the increased caseload, with NHS hospitals increasing by 5,101 compared with 23,354 additional procedures (82.0% of the total increase) by ISPs.

The study offers no explanations or discussion. The extent to which this was due to New Labour's policy of subsidising "independent sector treatment centres," with contracts for which only the private sector could bid, is not discussed, but the graph shows most of the

Continued page 10

continued from page 9

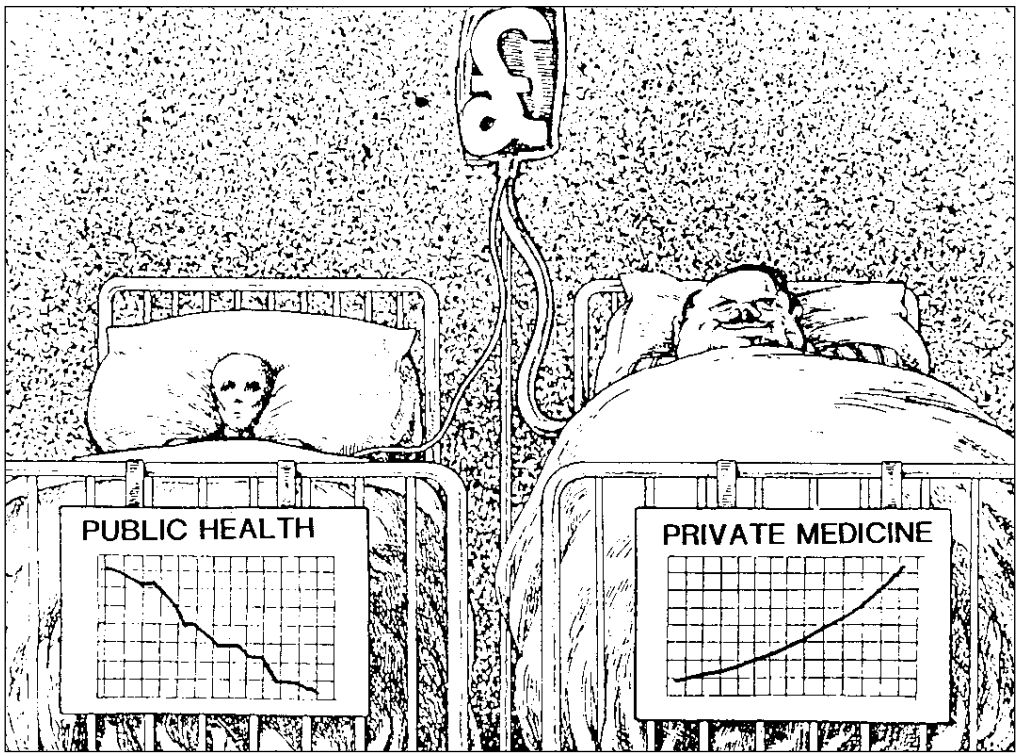
increase in private sector share of hip replacements had taken place by 2010.

The researchers point out that the pattern is "even starker" in the case of hernia repairs, where private sector caseload grew by 13,478 over the period, and NHS hospital volumes actually fell.

The paper concludes by noting the geographical variation in the level of private provision of elective treatment, with 40% of hip replacements being done by private providers in the South East and East Midlands, compared to just 11% in London.

But it offers little discussion on the reasons for the shift of activity to private providers, or the geographical differences: one possible factor is the high levels of NHS bed occupancy linked with increased pressure on emergency services, along with potential financial consequences of failing to deliver performance targets for elective care.

It appears that the IFS would be happy for us to conclude that while privatisation is a significant factor in these specialist elective services, the scale of the private sector role is great enough to mean there is 'no alternative' to continued substantial reliance on private hospitals to deliver NHS-funded treatment.



Corbyn claim justified: Nuff said?

The third approach, taking another distinct view is a short report from the Nuffield Trust entitled Privatisation in the English NHS: fact or fiction?

Written by Nuffield Trust policy wonks Helen Buckingham and Mark Dayan it makes no reference to David Rowland's blog, or to the Department figures, but annoyingly asserts a different figure:

"Around 22% of the English health spending goes to organisations that are not NHS trusts or other statutory bodies."

This figure is not explained, referenced, or linked in with the published statistics. The authors go on to state that:

"this includes many services that the general public would regard as being within the health service. For example, almost all the GPs, dentists, pharmacists and opticians who treat NHS patients are private businesses, and have been since the inception of the NHS in 1948."

They then go on to discuss private (Virgin) and non-profit providers delivering community health services, private and voluntary sector providers of 'talking therapies' and the right of patients seeking elective treatment to choose from a list of providers including private hospitals.

They do however concede that "Much of the inpatient provision for people with a learning disability or mental health problems and high levels of need is privately run."

They go on to discuss the extent to which privatisation has grown in recent years, and argue that:

"Adding together all non-NHS providers, looked at as a proportion of spend to adjust for the generally increasing budget, the purchase of private health care has been both significant and relatively stable, at between 20 and 22% for the last nine years.

"Regardless of whether we include charities or not, private spending is actually proportionately lower in 2018/19 than it was in 2015/16."

However the authors accept that Jeremy Corbyn's claim that 'privatisation has doubled since 2010' is focused "primarily on areas such as hospital and mental health care, rather than 'primary care' areas like GPs and opticians," the authors admit – perhaps surprisingly for some readers – that:

"his claim that it has doubled is correct in cash terms, although the context is that health spending overall has risen by a third. But even in terms of proportion, we do see a notable expansion in private spending in these areas."

They note that, private spending has effectively "flatlined for the last three years:"

"This may reflect that while the 2010 to 2015 coalition government had several initiatives to increase competition and private provision, there have been no more major moves in this direction since."

They note the debate in which some campaigners have argued that moves towards "integrated care systems" (ICSs) will inevitably increase the role of private providers, but also note the comment of David Hare, the chief executive of the main lobby group for private providers working with the NHS, who has said that he does not expect his members to take on ICS contracts.

The Nuffield paper pulls up short of the "nothing to see here, move along" school of thought promoted by the Health Service Journal.

Like Rowland's blog and the IFS study it can help us build a picture of what is happening, although it is not sufficient to do that in itself.

It's up to campaigners and trade unionists to identify an approach that is credible and focused on the main issues – and one that recognises how much of the NHS remains a public service, under public ownership, and how hard we need to fight to defend it.

"Adding together all non-NHS providers, looked at as a proportion of spend to adjust for the generally increasing budget, the purchase of private health care has been both significant and relatively stable, at between 20 and 22% for the last nine years.

Private sector in the NHS market: **A catalogue of failures (2013-19)**

The history of outsourcing in the NHS is marked by a catalogue of significant failures. The set up and performance of these contracts is opaque. The private providers are not subject to the same scrutiny as the NHS and yet profit-led companies are entrusted with the care of millions of NHS patients.

At this election all the parties are queuing up to remove all, or parts of the handiwork of the coalition government, who instituted a seismic experiment in NHS outsourcing and competitive tendering in 2013.

Since then over £25bn NHS clinical contracts have been advertised and around 40% of that value has been awarded to the private sector.

Following this policy is now a long trail of contract failures across a wide range of NHS services. We list dozens of examples below, to show the scale of the outsourcing under this policy and to contribute towards a national appraisal of the impact that has been dodged by government.

Private firms providing care to NHS patients are conflicted, between on one-side, the need to keep down costs and generate a financial return, and on the other, the demands from the NHS to provide the best care they can and to maintain a constant service.

Repeated failures show that these motivations cannot be reliably reconciled. Profit-led companies have been tempted into compromising care on many occasions, to the detriment of patients. Companies have walked away from numerous NHS contracts when profits decline, leaving the NHS to pick up the pieces.

The risk to patients and services of outsourcing care is higher the more it is used. However, a Boris Johnson government is very likely to continue with it, even if the current tendering rules are changed.

In fact, the pressure on the NHS and the decades of cuts in bed capacity mean that all parties would have to stomach continued outsourcing in the short term as in some areas the NHS is heavily reliant upon it. Over 30% of mental health inpatient care is provided by the private sector and 70% of adult social care staff work in the independent sector.

Of course, some dispute whether outsourcing is privatisation at all, often because there is no Thatcher-style share sell off, but academic definitions are clear and include outsourcing alongside many other tactics employed by governments in a patchwork of privatisation strategies.

It is a long road back to a publicly provided NHS. It would need both steps to hardwire public provision right across health and social care and a huge investment in raising NHS capacity.

And if we don't take these steps? Then either through cock-up, circumstance or design the steady privatisation of our NHS will continue.

Community Services

The term 'community services' covers a wide range of services provided in the community, including many services that would previously have been provided in a local hospital.

In July 2019, the private maternity service One to One Midwives gave pregnant women just a couple of days notice that it was withdrawing the services it provides to the NHS. The company entered insolvency proceedings soon after. This left about 1,700 pregnant women, some due to give birth within weeks, having to find new midwives. The company, which provided midwifery services to women in Essex and the north-west of England, said the contracts did not pay enough to make the service financially sustainable.

This was the second midwifery company to collapse – Neighbourhood Midwives, which provided midwifery services to women in the south-east, closed in January 2019.

In May 2019, Concordia Specialist Care Services terminated a contract to provide community dermatology services in Essex two months early with just five days notice. The original contract was for five years, but the CCG announced in October it was being cut to two years and ending in July 2019. The cut in contract time followed a CCG inspection of the services the company provided in Fryatt Hospital, Dovercourt. The inspection found "standards of hygiene and cleanliness in a number of areas did not comply with national standards, medication was out of date, specimens were inappropriately stored in a medication fridge and Concordia staff were unaware of how to access organisational policies".

Virgin Care won a seven-year £280 million contract in March 2015 to provide services for the frail and elderly in East Staffordshire. Under this fixed-price contract, Virgin Care was to be the prime provider and could sub-contract the work to other organisations. The contract was dogged by contractual and financial issues.

In October 2017, Health Services Journal (HSJ) reported that Virgin Care was demanding £5 million more from the CCGs. As this was not provided by the CCGs, Virgin Care terminated parts of the contract. Then in April 2019, Virgin announced that it is to leave the contract entirely in April 2020, three years early. The reason given is that Virgin and the CCG were unable to come to a new financial agreement. Virgin stated that it is not able to run the service on the money provided by the CCG and it is not prepared to make up the shortfall.

The quality of service provided by Serco was investigated in Suffolk, where it was awarded a £140 million contract in October 2012 to run community services.

The company was criticized for failing to meet key response times. In January 2014, a report from Serco to the council's health

Continued overleaf

continued from page 11

scrutiny committee showed that Serco was not hitting three of its key performance indicators in community health response times.

For example, it failed to meet urgent four-hour response targets - for nurses and therapists to reach patients at home 95% of the time (only achieving 89.3% in November 2013). Before Serco took over, the target was achieved 97% of the time. In September 2015, Serco relinquished the contract and an NHS consortium including Ipswich and West Suffolk Hospital Trusts took over the running of community services.

In 2014 Healthcare at Home was bombarded with complaints over its home delivery of essential prescriptions to NHS patients. The largest issue was its failure to deliver all medications - some life-saving - on time. Problems emerged after Healthcare at Home switched from using an in-house delivery service to Movianto: an American logistics firm operating throughout Europe. When Movianto's IT systems failed many patients were left without deliveries.

Mental Health Services

The NHS has a large number of contracts with private providers for mental health services, both residential and in the community. The last few years have seen a succession of highly critical reports by the Care Quality Commission (CQC) on residential mental health services with many rated "inadequate" and others closed completely or to new patients.

In September 2019 the CQC published a report on residential mental health, noting that it had found 28 mental health units run by private companies to be "inadequate" in the past three years. The Royal College of Psychiatrists is so concerned about the poor standards of care that it has written to the secretary of state urging him to commission a public inquiry led by a high court judge.

The CQC has rated 16 independently run mental health units as inadequate so far in 2019 and it rated four others in the same category in 2018, and eight in 2017.

In November 2017, a CQC report found that nearly three-quarters of private clinics were failing to hit regulatory standards of care. The report was based on inspections of 68 independent services providing residential detoxification services over the last two years.

Hospitals run by the Huntercombe Group have received particularly critical reports after inspections by the CQC. In December 2018, an inspection by the CQC of the company's hospital for children and adolescents in Norwich found serious concerns. The CQC took immediate action to protect those using the service, including enforcement action to remove the registration for the hospital. The Huntercombe Group then closed the service and the patients had to be found places elsewhere.

Earlier issues with the company's hospitals, include in September 2017, Watcombe Hall, being closed indefinitely after the local NHS hospital raised concerns about the number of young patients being admitted from the unit suffering from malnutrition and dehydration and in 2016, the company's hospital in Stafford was placed in special measures and told to urgently improve in 24 areas.

Cygnet, a specialist mental health provider that operates more than 150 facilities across the UK, which between them have more than 1,000 beds, has been repeatedly criticised by the CQC. From January to September 2019, mental health units run by the company have been found to be inadequate by the CQC six times.

In November 2019, the CQC ordered that the Cygnus Acer Clinic in Derbyshire must stop admitting new patients due to serious concerns over patient safety, including a huge shortage of trained staff. In 2019 there were two serious incidents, one of which resulted in a patient taking their own life by hanging.

In September 2019 the CQC published a report on residential mental health, noting that it had found 28 mental health units run by private companies to be "inadequate" in the past three years.

In October 2019 an inspection report on Cygnet's Newbus Grange hospital in Darlington, noted how the CQC had found a patient with "unexplained injuries", and there were opportunities for patients to kill themselves and staff asleep while on duty. The unit was put into special measures and its 10 patients moved elsewhere.

In July 2019, the CQC downgraded the hospital at Godden Green to "requires improvement". In June 2019, HSJ reported that multi-agency investigation had been launched into Cygnet's 65-bed hospital in Maidstone, whose 15-bed male psychiatric unit had had a "disproportionate" number of safeguarding alerts for patient-on-patient attacks.

The Priory, one of the country's leading provider of mental health services owned by the US company Acadia, has been the subject of several reports of failures in care in recent years, including patient deaths.

In July 2019, the CQC placed two of the company's hospitals in special measures – Priory Hospital Blandford in Dorset and Kneesworth House in Royston, Hertfordshire. The hospitals were found by the CQC to be unsafe and uncaring and rated them both as inadequate. The hospitals have been given up to six months to show improvement or face closure.

Earlier in the year in February, the Priory's hospital for children with learning disabilities in High Wycombe was closed, following a CQC report that gave the unit an overall rating of 'inadequate'. The hospital had only opened in April 2018 and catered for children aged 13 to 17 with learning disabilities and/or autism.

In 2018, two of the company's hospitals - Southgate, North London, and Roehampton – were rated "requires improvement" overall by the CQC.

In 2016, an inquest ruled that the death of a 14 year old Amy El-Keria at a Priory hospital in 2012 was as a result of months of serious failings at the hospital, including staff failing to pass on the fact that she had spoken of wanting to end her life.

Also in 2016, the family of 17-year-old Sara Green, who died in the Priory Royal in Cheadle in 2014, called for the company to have its NHS contract cancelled. In March 2016, the Priory and Solent NHS Trust admitted liability for the death of 15-year-old George Werb, who had been a patient at the Priory Hospital Southampton.

In June 2019, St Andrew's Healthcare's hospital in Northampton was rated "inadequate" by the CQC. The watchdog had found that adolescents were kept in unsafe seclusion rooms for excessive amounts of time and without beds, blankets or pillows. It was reported that some patients had been in seclusion for years and earlier in 2019 the BBC's Victoria Derbyshire programme was given footage of a teenager reaching their arm through a door hatch to enable contact with their parents during a visit to the hospital.

Surgery/ Diagnostics

A private hospital run by BMI Healthcare that treats up to 10,000 NHS patients a year, put their safety at risk according to a report by the health watchdog. The Care Quality Commission (CQC) rated Fawkham Manor hospital in Kent as "inadequate" - the worst possible ranking. Staff told the CQC that financial targets were prioritised over patient safety at the hospital, where NHS patients make up almost half the caseload.

In Somerset, dozens of people were left with impaired vision, pain and discomfort after undergoing operations provided by the private healthcare company Vanguard Healthcare under contract with Musgrove Park Hospital, Taunton. The hospital's contract with Vanguard Healthcare was terminated four days after 30 patients, most elderly and some frail, reported complications, including blurred vision, pain and swelling.

In a very similar set up in Devon, 19 NHS patients had the outcome of their cataract surgery reviewed after at least two had problems with their eyes following operations at a private hospital. The problems emerged on the first day of operations conducted under a contract to perform cataract operations between the NHS's South Devon Healthcare Foundation trust, which runs Torbay hospital, and Mount Stuart hospital, owned by Ramsay Healthcare.

Circle was the private provider involved in the privatisation of Nottingham's dermatology service, which in June 2015, was described by an independent report as "an unmitigated disaster". Once part of a national centre for excellence at Queen's Medical Centre, it is now much reduced, with some patients sent to a centre in Leicester. When Circle won the contract, several consultants refused to transfer from NHS contracts, leaving the dermatology service with few consultants and Circle had to employ locums.

In June 2013, the NHS temporarily stopped referrals to BMI Healthcare's Mount Alvernia hospital, in Surrey, following a Care Quality Commission report which found serious failings on patient consent, care, cleanliness, staffing levels and service quality monitoring. The report noted some staff had told inspectors breaches had been caused by initiatives designed to "save money" or for "logistical and financial reasons"

The Care Quality Commission (CQC) rated Fawkham Manor hospital in Kent as "inadequate" - the worst possible ranking.

Emergency care and ambulance services

One of the most controversial failures in recent times has been the Coperforma contract in Sussex for non-emergency patient transport. This four-year contract worth £63.5 million was awarded in 2015 by seven CCGs. Coperforma replaced the NHS's South-East Coast ambulance service (SECamb) on 1 April 2016; it was then just a matter of days, before problems with the contract hit the headlines.

By mid-April local and national press were reporting on a service in chaos, with crews not turning up to pick up patients leading to missed appointments and patients languishing for hours in hospitals awaiting transport home. Patients included those with kidney failure with appointments for dialysis and cancer patients attending chemotherapy sessions. The GMB union representing the ambulance crews said it was an "absolute shambles". Finally, in October 2016, Coperforma were forced to give up the contract.

In September 2017, the private ambulance company, Private Ambulance Service contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration. The business, which ran 126 vehicles and employed 300 people, took over the contract in April 2017.

In September this year SSG UK Specialist Ambulance Support Ltd, the largest firm providing 999 emergency and non-emergency transportation for the NHS, was put into administration.

The company provided services for ambulance trusts all across the country including South central, East of England, North East and London.

■ More examples on other parts of the NHS can be found at *https://www.nhsforsale.info/*

Australia's private health insurance system stuck in "death spiral"

John Lister

A mounting crisis in Australia's heavily subsidised private health insurance industry has even caught the attention of the Daily Mail. The situation offers a grim warning to any Tories with aspirations to undermine the NHS.

Australia currently spends the equivalent of £96 billion per year on health, to cover a population of just 25.2 million. Its universal tax-funded health care system, Medicare, was introduced in 1984, and lasted until 1996, resulting in a sharp decline in private health insurance from 70% of the population in the 1950s to just 30% in 1998.

As the European Health Management Association pointed out "In essence the Medicare system was proving too good for the private sector, so the government subsidised the private sector to allow it to compete better with the public sector."

Government-funded

Right wing Liberal governments tried to turn the tide, and brought in a 30% government-funded rebate for people taking out health insurance, initially costing $600m a year, and from 1997 imposed a penalty tax on high earners who failed to take private insurance.

From 2000 this penalty was coupled with a surcharge of 2% on private insurance policies for every year above 30 a new higher-paid subscriber was aged when they took out a policy.

Since then the private sector has expanded, along with the public sector subsidy, despite the increased cost of private provision: one analyst argued that $2.5 billion spent on subsidising private insurance in 2004-5 could "open and operate an extra sixteen 500-bed hospitals."

The latest calculations show that the public subsidy to private health care has mushroomed to $9 billion a year, with government-funded rebates increased ten-fold to $6bn, plus another $3bn on private medical services for patients. 60% of all surgical procedures are performed in private hospitals.

Less healthy pool

However premiums are arising faster than wages or inflation. And as a result people are dropping out of health insurance cover, especially younger and healthier people, leaving an increasingly older and less healthy pool of subscribers, which increases costs and pushes premium payments even higher.

Analyst Stephen Duckett of the Grattan Institute argues private health insurance is facing a "death spiral" and "politicians need to rethink whether or to what extent taxpayers should continue to subsidise the industry."

Duckett raised the sharp question back in February "Is it time to ditch the private health insurance rebate?" He pointed out to the comparison with failing industries:

"Over recent decades we have learnt that propping up industries in the face of consumers turning away from their products is not a long-term proposition. Private health insurance is no car industry, but it's not a sunrise industry either. Yet it receives a greater subsidy than manufacturing at its subsidised peak at the end of the 1960s."

He now says "future reforms to PHI should be made based on a clear view of the desired role of private health care given that it functions alongside a universal publicly funded scheme, Medicare. To what extent is private hospital care a substitute for public hospital care? To what extent is it a complement to the public system?

"If the purpose of private health care is to complement the public system – providing services, facilities and amenity beyond those considered necessary for public funding – then the argument for public subsidy is weak."

The Grattan Institute is not against private medicine, but has blamed "greedy" private sector doctors for "excessive" private hospital costs and "egregious" bills for specialist care, with some patients facing bills at more than twice the official Medicare Benefit Schedule fee.

The latest calculations show that the public subsidy to private health care has mushroomed to $9 billion a year, with government-funded rebates increased ten-fold to $6bn, plus another $3bn on private medical services

Saving private healthcare

It notes private patients stay in hospital 9 per cent longer than public patients with similar conditions, and has put forward recommendations identifying $2bn in possible savings a year, declaring if the changes are realised, it could "save private health care in Australia".

Earlier this year more searching questions were asked on the value of private health insurance for older Australians after a 78-year old woman who was privately insured was told by private hospital in Hobart she was "too old" to be admitted and that it was "outside of [hospital] protocol" to treat her.

More than half of over 65s in Australia have private insurance. But ABC reports Erin Turner, the CEO of independent consumer advocacy group CHOICE Australia, who argues that in many cases, the public health system would be better equipped to suit patients' needs.

"It's particularly good in emergency scenarios and you have access to great quality doctors and trained professionals," she said.

In April the health minister brought in a restructuring of health insurance policies into different levels – bronze silver and gold, with discounts for young subscribers: but this still complex and expensive system, with its high additional out of pocket costs has not been able to stop the drift out of health insurance among younger people.

The Guardian now reports that the Australian Healthcare and Hospitals Association is now calling for a Productivity Commission review of the healthcare system asking the question of whether the private insurance system should be saved.

Lost in translation: Trust spouts jargon but misses the message

John Lister

Shrewsbury and Telford Hospitals Trust is facing a major inquiry into what is already Britain's biggest-ever scandal over maternity services, investigating the deaths of as many as 800 babies. Huge questions are being asked over its management culture, staffing levels and the safety of patient care in its A&E, most recently a CQC waraning letter over inappropriate treatment of mental health patients.

The Trust has also recently received Matt Hancock's rubber stamp of approval to press ahead with a controversial £312m plan to downgrade emergency services in Telford's Princess Royal Hospital and 'centralise' acute services on the Royal Shrewsbury Hospital 16 miles away.

So we might expect Shrewsbury and Telford Hospitals Trust to be dusting down its long-standing, controversial "Future Fit" plan, drawing up Strategic Outline and Outline Business Cases, beefing up its clinical strategy (since arguments for the concentration of services at Shrewsbury are heavily based on staffing) – and almost obsessively focused on patient safety and practical issues.

But the Trust's November Trust Board papers show us things are very different.

Future Fit appears to have been discarded within two months of being approved, and replaced by the mumbo-jumbo of a 'Hospital Transformation Programme'.

Senior managers are spouting half-understood Japanese jargon arising from its links with the Virginia Mason Medical Centre in Seattle, whose website proudly proclaims that its management mixes "basic tenets of the Toyota Production System with elements from the philosophies of kaizen and lean."

So now baffled staff in Shrewsbury and Telford have to deal with a 'Kaizen Promotion Office,' and a battery of obscurely written documents that insofar as they tell us anything make clear that there are a lot of "Gaps" – not least in understanding the kaizen approach which they think they have adopted.

According to the Transformation Programme, for example, despite six years of discussion on reorganising hospital services, which was endlessly claimed to be based on clinical criteria, **"The Trust currently doesn't have a clinical strategy".**

A Trust Board document from 'Director of Transformation and Strategy' Bev Tabernacle-Pennington also warns of a problem with the Trust's wider "strategy and vision" – admitting that even leaders attending a workshop "were not clear on these, and could not articulate the main drivers for our strategy work."

There is also concern over **"the overlap and lack of understanding about the many work streams and how these currently work to address the Quality deficits identified to date."**

If even the leaders don't understand what the Trust is trying to do, imagine how bemused other staff must be at what's going on.

They may not be impressed or enlightened by news that "The improvement methodology has been utilised to test the sustainability of the plans put in place by the ISG's for example the use of Genba walks."

Our management team have become really keen on those Japanese management techniques

Despite six years of discussion on reorganising hospital services, "The Trust currently doesn't have a clinical strategy"

But worse, the document admits that work on "Human Factor" – the most important part of kaizen and lean, the focus on empowering staff at all levels to intervene to eliminate or address human error and maximise quality and safety – is not included in the Trust's strategy. If this is true then all the efforts are being wasted.

Worse still there are no plans for engagement with staff on Human Factor to explain it and make it real, or roll out any proposals, and – in a Trust embroiled in a safety scandal – no focus on patient safety.

There is also a lack of "workforce modelling", and doubts whether the 'Out Of Hospital Programme' would be adequate to carry through the downgrading of services at Telford and relocation in Shrewsbury.

To put the tin lid on it, the Director of Transformation and Strategy admits that even the financial modelling on the plan they have been arguing for since 2013 is "yet to be completed:"

Campaigners already knew there was management talk of a "gap" of upwards of £100m between the allocated funding of £312m and the likely actual cost of the hospital upgrade.

The 'Hospital Transformation Programme' team understandably try to look on the bright side, and assure us that even though they don't really know what they are doing, they do have "a number of enthusiastic individuals" … and propose to set up still more confusing meetings, including a "Transforming Care Partnership Board."

And there are also plans to pay city accountants Deloitte for six weeks consultancy to help "form plans" and "advise" all the managers and staff who can't make head or tail out of the Japanese jargon and the directionless Trust Board.

People expecting a new hospital to be built, or services to be improved are advised not to hold their breath waiting.

THE lowdown

In our first year we pledged to:

- establish a regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally.

To go into a second year we need **YOUR HELP**

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Our editors and main contributors are **Paul Evans** of the NHS Support Federation and **Dr John Lister** (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) who have almost 60 years combined experience between them as researchers and campaigners.

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.


THE lowdown

Health news, analysis and campaigns. NUMBER 11, October 12 2019

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

Private GP service sets sights on further NHS expansion

Paul Evans

Babylon health plans to expand its virtual GP service to Manchester after its reported success in attracting NHS patients to use its GP at Hand business.

The private company, which offers fast GP appointments by video has attracted over 60,000 NHS patients in Birmingham and London and if its plan is accepted will be up and running in Manchester by early 2020.

The CCG backed the expansion to three major cities, under current regulations patients who sign-up for GP at Hand are all registered with Babylon Health's GP practice in Hammersmith & Fulham in West London; so it's this CCG that will be required to give approval for the expansion to Manchester.

Problems for CCG

Babylon's expansion in this way has led to major financial problems for Hammersmith and Fulham CCG as it is responsible for thousands of new patients registered on GP at Hand whether they live in their area or not.

The CCG eventually gave approval for the expansion to Birmingham, with the proviso that no more than 2,600 patients be registered in the area in the first three months.

However, changes announced in late September by NHS England and NHS

The app will see you now ...

New contracts for 'digital-first' GP providers will probably require them to set up a physical clinic in the area

Improvement will change this and have a significant effect on the way Babylon Health operates from June 2020 onwards when they come into force.

The new contracts will remove patient registration and mean that once 1,000 patients are registered in a CCG area by a provider outside this area, then the provider will be issued with a new APMS contract covering that area.

Financial burden

This means the patient list is divided up and no single CCG bears the financial burden of thousands of extra patients registering.

GP at Hand has approximately 60,000 patients living outside Hammersmith and Fulham, and these patients will now have to be divided into 17 different lists in areas where GP at Hand has more than 1,000 patients.

Other changes mean that in the areas where the new contracts are issued to the digital-first GP providers they will probably be required to set up a physical clinic in the area.

There is also a proposal that new digital primary care providers should be required to set up in areas lacking doctors and primary care access is poor.

Figures obtained by GPonline suggest 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.

A successful Mental Health Summit on September 28 organised by campaigners including Keep Our NHS Public and Health Campaigns Together has now published video and reports as part of a drive for more concerted campaigning.

IN THIS ISSUE

WHO WE ARE – and why we need YOUR help to sustain The Lowdown - Back

FAKE FORTY 4 pages of background & analysis on promised new hospitals 7-10

BLUE on BLUE Shropshire's Tory MPs row over Telford hospital downgrade 10-11

PFI R.I.P.? A closer look at the new Health Infrastructure Plan 11

https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

Help us keep The Lowdown running in 2020

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it far and wide.

On the website we will gratefully acknowledge all of the founding donations that enable us to keep this project going into a second year.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*