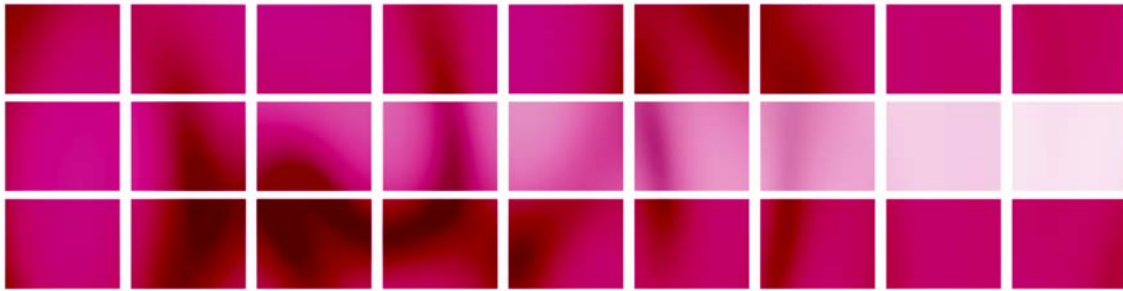


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**PRIVATISATION OF PUBLIC SERVICES AND THE IMPACT ON
QUALITY, EMPLOYMENT AND PRODUCTIVITY (PIQUE)**

***Liberalisation, privatisation and regulation
in the UK healthcare sector/hospitals***

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Country report on liberalisation and privatisation processes and forms of
regulation

The project "Privatisation of Public Services and the Impact
on Quality, Employment and Productivity" (CIT5-2006-028478)
is funded by the European Commission's 6th Framework
programme.



November 2006

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INTRODUCTION

This report focuses on the provision of hospital services in England. It traces the development of hospitals from the setting up of the National Health Service in 1948 but concentrates on the period of major reforms from the early 1980s. It also looks at what has happened to private sector provision during this period; this includes not just hospital services provided by non-profit-making and commercial organisations but also services provided to private patients in NHS hospitals.

There are a number of important factors to bear in mind in understanding the development of hospital services during the post-war period. The first is the creation of the National Health Service (NHS) itself and the aim of ensuring universal access to healthcare which is free at the point of delivery and funded by taxation. This was and remains a major political achievement and one that continues to be recognised by voters and the main political parties so much so that, although there has been considerable reorganisation of the NHS over the last sixty years – particularly over the last 25 years – there has been no real attempt by any government, Labour or Conservative to change the way the NHS is funded or to introduce more charging.¹

The National Health Service was set up with three main divisions – hospital services, family practitioner services (including general practitioners (GPs), pharmacies, opticians and dentists) and community-based services – mainly municipal-run care services for the elderly, mentally ill and mentally handicapped. This model of organisation created two important differences in health service provision that have posed serious challenges for health service reformers ever since. The first is the way that hospitals have been split off from the rest of the health service and the second is the problem of co-ordination between the centrally controlled and funded hospital sector and the long-term care provided at local level by municipal authorities.

As one analysis put it: “The hospitals (especially the teaching hospitals) were the palaces in the new service, and within the palaces the consultants sat on the thrones” (Wall, 2002). The implications of this are that key political decisions, particularly about funding, have been made in favour of hospitals to the neglect of the other elements of the NHS, particularly mental health services and long-term care. A similar point is made by Rivett: “A hospital-oriented NHS was said to be anti-GP and out of contact with the community services run by the local authority.” But it wasn’t just other elements of health care that were left in the shadow of the hospital sector. As Ranade points out the system was lopsided from the outset: “Curative, hospital-based medicine dominated at the expense of prevention, health promotion and community services, and

¹ Prescription charges were introduced by the Labour government shortly after the NHS was established and there are also charges for some services particularly dental treatment. However, there are no charges for GP consultations or the vast majority of hospital treatments.

high priority was given to the treatment of short-term episodes of acute illness to the detriment of the care and rehabilitation of the chronically ill.”

The other main challenges facing the NHS revolved around planning, management and how to provide a service which responded to local needs but which was controlled from the centre. These issues have been at the heart of debates about the NHS since the 1950s but became more urgent in the 1960s and 1970s as pressure on NHS funding began to increase. By the 1980s the NHS was to become the subject of almost permanent review and reform with no let up since Labour came to power in 1997.

Note on devolution

Health services in Scotland, Wales and Northern Ireland have been subject to UK-wide legislation for most of the post-war period although they have been administered separately with the respective Secretaries of State for those countries having responsibility for healthcare. However, following devolution of health service and other powers to the Scottish Parliament and Welsh Assembly in 2001 there are now fundamental differences in the way the three health systems are run. Both the Welsh Assembly and the Scottish Parliament have rejected important elements of the health service re-organisations implemented in England by the Labour government, particularly giving the private sector a greater role in health care.

1. THE MARKET STRUCTURE BEFORE LIBERALISATION

The National Health Service came into being in July 1948. It was a key element of the political programme of the Labour government 1945-51 which aimed to address some of the central social problems of the pre-war years and the inadequate provision of healthcare was one of these.

The setting up of the National Health Service involved the nationalisation of the hospital sector. A total of 2,688 voluntary and municipal hospitals (1,143 voluntary and 1,545 municipal) with 480,000 beds were taken over by the Ministry of Health (Rivett 1998). This left a small group of mainly charitable and non-profit making organisations under private control. These included provident associations which funded private care by offering insurance-based schemes to individuals. People paying into these schemes could be treated in private institutions but may also have been treated in private beds in NHS hospitals.

Private or “pay beds” in NHS hospitals were covered by the legislation that established the National Health Service. This is seen as a political tactic by the then Minister of Health, Aneurin Bevan, to make concessions to two of the main professional bodies – the Royal College of Surgeons and the Royal College of Physicians. The new NHS contracts for members of these bodies allowed them to undertake some private practice on top of their NHS work. The idea of pay beds in NHS hospitals was partly to facilitate this so that they could do both under one roof rather than waste time travelling to non-

NHS institutions. At the time Bevan was facing tough negotiations with the medical profession over setting up the NHS and the pay bed deal with the Royal Colleges meant they could be split away from the other main professional group, the British Medical Association representing the views of General Practitioners (Klein 1995).

Private healthcare, whether carried out in NHS hospitals or in private institutions, accounted for a very small percentage of health spending for most of the 1950s and 1960s. During this period NHS spending grew steadily and rapidly and private hospital treatment remained for the most part a privilege of the wealthy who wanted rapid treatment in better facilities. In fact, the demand for private treatment was so low that the Labour government of 1964-1970 reduced the number of pay beds in NHS hospitals not for ideological reasons but because they were being under-utilised.

However, ideological opposition to private healthcare and particularly pay beds in NHS hospitals persisted within the Labour Party and abolition of pay beds appeared as a commitment in Party general election manifestos and was taken up by the then Health Secretary Barbara Castle in 1974. The controversy over pay beds initially hit the headlines in the first half of 1974 when nursing staff at Charing Cross Hospital in London went on strike demanding the closure of private facilities at the hospital. The nurses, organised by the National Union of Public Employees (NUPE, now part of the public services union UNISON) argued that it was wrong that part of their time was taken up caring for private patients when the demands on the NHS were rapidly increasing. Following the second general election of 1974 when Labour was returned with a small majority, Castle decided to act with proposals to phase out pay beds and re-negotiate the contracts of the consultants who counted on private practice to boost their NHS salaries.

In 1974 there were more private beds in NHS hospitals (4,500) than in the private sector itself (3,500). These NHS pay beds represented just over 1% of the total in NHS hospitals while around 120,000 private patients a year were treated in them, accounting for 2% of all non-psychiatric cases dealt with. Although these are relatively low percentages there was a strong feeling in some parts of the Labour Party that it was unacceptable for the NHS to allow people to jump the queue for treatment simply because they could afford to go private. Strictly speaking private treatment in the NHS was only supposed to allow people to choose their consultant and the room in which they would stay while in hospital. In practice there was evidence that some consultants were putting their private patients ahead of NHS patients. Barbara Castle told parliament: "The issue before us is whether the facilities of the NHS, which are supposed to be available only on the principle of medical priority, should contain facilities that are available on the different principle of ability to pay. We say that those two principles are incompatible in the NHS" (Klein 1995).

Legislation introduced in 1976 specified that 1,000 pay beds should be withdrawn immediately and a Health Services Board established to oversee the phasing out of the rest of them. The number of pay beds in NHS hospitals was reduced from 3,444 to 2,533 between 1976 and 1980, the year that the Health Services Board was abolished by the Conservative government that had been elected in 1979. In fact, it was this process

of effective nationalisation by the Labour government that was one of the factors contributing to a significant growth in private hospitals from the mid-1970s. In terms of beds the sector grew three-fold from 3,500 in 1976 to 10,000 in 1986. The other factors were a combination of increasing disposable income, particularly for those on above average incomes and the rise in waiting periods for some of the more common hospital treatments.

1.1. Managerial and administrative reforms

Several post-war governments have grappled with the challenge of improving the way the NHS is run through changes to management and administrative structures. Although these changes do not relate specifically to liberalisation or privatisation of the service they are worth dealing with briefly in order to understand how hospital services have been run and the extent to which performance and productivity may have been affected by organisational change.

The main characteristics of the structure of the NHS were unchanged between 1948 and 1974. The Ministry of Health (later the Department of Health and Social Security and later still just the Department of Health) exercised central control over the primary care sector (GPs, dentists, opticians and pharmacists) and the hospitals sector. The hospital sector itself was divided between teaching hospitals with their own boards of governors that were directly under Ministry control and other hospitals which had their own hospital management committees which reported to regional hospital boards which in turn reported to the Ministry.

One of the initial intentions of the reforms introduced in 1974 was to create greater coherence between the primary and secondary care sectors and the range of services, particularly long-term care, provided by local authorities. As Ranade puts it: “The 1974 reorganisation was based on the twin principles of rational planning and efficient management, although what was finally brought into being achieved neither.” The hospital sector came under the control of a whole new structure with Regional Health Authorities given a strategic role while below them Area Health Authorities (AHAs) and District Management Teams took on the management role. It had been the intention of the then Conservative health secretary Sir Keith Joseph to restrict appointments to people with managerial experience but in the outcome was for a mixed management involving representatives of staff and the community.

The 1974 reforms pleased no one and further reorganisation took place in 1982 when the Department of Health and Social Security (DHSS) set up the NHS Executive to take on a managerial role over the primary and secondary care sectors. The idea was that this specific part of the DHSS would tackle management issues with a degree of independence from the policy making role of the Department. The specific change affecting hospitals was the removal of one layer of management with Area Health Authorities and District Management Teams replaced by District Health Authorities.

The next stage of reorganisation came in 1991 with the establishment of the first of the NHS Trusts and the “internal market”.

2. *PROCESSES OF LIBERALISATION AND PRIVATISATION*

There has not been distinct process of liberalisation or privatisation of NHS hospital services in ways comparable to other parts of the public sector where organisations were sold off or exposed to competition as they were, for example, in the electricity industry where companies were privatised and monopoly markets opened up so that individual consumers could choose which company supplied their electricity. In one sense, the market for healthcare has always been open in as far as individuals could, even though entitled to free NHS care, choose to pay for health insurance to cover private treatment or could even pay directly for treatment. In practice, it has only been a real option for the relatively well off or those provided with health insurance cover by their employers.

There has been no sale of hospitals to the private sector or long-term management contracts open to tender from the private sector to manage hospitals including their clinical services. However, there have been a number of important developments which have either led to an increase in private sector involvement in NHS hospital services or have been intended to introduce an element of competition into the system. Baggott (quoted in Ranade) talks about “creeping privatisation”, “marketisation” and “radicalism by stealth”. The key pieces of legislation or policy decisions before Labour came to power in 1997 were:

1983 – Department of Health and Social Security issues circular HC(83)18 which asks District Health Authorities to “test the effectiveness of their domestic, catering and laundry services by putting them out to tender”;

1990 – NHS and Community Care Act creates quasi-market by creating NHS Trusts as service providers competing with one another to win contracts from health authorities and fundholding GPs; and

1992 – introduction of Private Finance Initiative to fund capital projects across the public sector with the private sector often involved in the design, building, financing and operation of new facilities.

While these initiatives did have an impact on hospital services and how they were run, it is the implementation of a range of policies by the Labour government over the last six years that can most closely be described as a form of liberalisation with elements of privatisation. The 1983 competitive tendering circular definitely led to an increase in

contracting out and had an impact on the delivery of hospital services.² However, this was not about the overall ownership and management of hospitals or the delivery of clinical services. The “internal market” also affected the way hospitals were run but was not intended to nor did it lead to a significantly increased role for non-NHS providers of hospital services. PFI has certainly transformed the way hospital projects are funded and introduced more private sector involvement in the running hospital maintenance, domestic and hotel services. However, the policy was slow to be taken up under the Conservatives and was only kick-started when Labour came to power in 1997 by which time no PFI had yet been opened.

Therefore, for the purposes of this report the key date in terms of an attempt to compare the state of affairs in health services before and after “privatisation and liberalisation” is taken to be 2000 which saw the publication of the NHS plan (Department of Health 2000) and then:

2000 – Concordat between Labour government and private sector hospital groups over co-operation, in particular in increased use of private sector facilities to help reduce waiting lists

2002 – decision to supplement first NHS Treatment Centres with Independent Sector Treatment Centres – these are centres specifically run by non-NHS organisations to provide non-emergency surgery and diagnostic services

2003 – NHS and Community Care Act creates Foundation Trusts with even more independence than NHS Trusts although at the same time Labour claims that it is abandoning the Conservative attempts to create an internal market.

2.1. *Creation of the “internal market”*

One of the major NHS reforms and one which introduced an element of the market into the way the NHS operates was the responsibility of the Conservative governments of 1987-1992, first under Prime Minister Margaret Thatcher and then under her successor, John Major. This involved the creation of NHS Trusts and the internal market or at least quasi-market with the splitting of purchasers and providers. Essentially this gave GPs and health authorities the role of purchasers of healthcare while NHS Trusts, primarily based around hospitals, were the providers from whom they bought healthcare. The idea was that this would create competition between NHS Trusts and improve the cost effectiveness and value for money of the treatment they provided.

The introduction of some form of market mechanism fits in the Conservative approach to the public services and particularly the Thatcher and Major governments between

² A report for UNISON (Davies, 2005) analysed the impact of contracting out of cleaning services on the spread of infection in hospitals, highlighting the fact that the number of directly employed NHS cleaners had been cut from 100,000 to 55,000 in the 20 years to 2004 and the difficulties hospitals had had in ensuring adequate levels of performance from private contractors.

1987 and 1997. However, the Conservatives had always been cautious about health policies and there is an argument that rather than NHS reform being a central ideological aim for them, they were forced to take action as a result of increasing pressure on NHS funding during the 1980s. Health authorities were finding it more and more difficult to balance their budgets and there was a growing trend for them simply to shut down wards temporarily in order to save money. In the winter of 1987 health authorities around the country withdrew 4,000 beds from service and the media attention given to the funding crisis forced a response from Prime Minister Margaret Thatcher herself. In early 1988 she promised a wide-ranging review of the NHS. This according to one leading welfare state expert was a review that “nobody wanted: NHS professionals for fear of what it would bring, the government because it had no clear idea about what it wanted to do to the NHS, and the public who still did not trust the government with the service (Timmins 1996, quoted in Ranade 1997).

The National Health Service and Community Care Act introduced the internal market which began to operate from April 1991 with the setting up of the first wave of NHS Trusts. However, the need to create a market in healthcare was not part of the main political debate at the end of the 1980s and beginning of the 1990s that led up to the 1991 legislation and nor was the legislation seen as a way of liberalising healthcare in order to give a significantly bigger role to the private sector.

Although the impetus behind the NHS Review and the resulting White Paper, *Working for Patients*, was the perceived financial crisis of the NHS, there were no proposals for changing the way the service was funded. The emphasis of *Working for Patients* was then on organisational changes and centrally on the idea that if market forces were allowed to operate within the NHS there would be a more efficient provision of services.

Although the review was open to any organisation or individual to contribute, the key debates about reform were the work of a small Cabinet committee with support from senior civil servants and political advisers. So as Klein notes this was a significant break from the past when major NHS changes were investigated by a government appointed Royal Commission that brought together experts, including those representative of the main interests affected by the issue, who were generally expected to consider a wide range of reform options and come up with recommendations based on political compromise. Instead, *Working for Patients* was the produce of discussions of a small group influenced by the ideas of an American economist, Alan Enthoven.

The idea of NHS Trusts was that they would remain part of the NHS and their board members would be appointed by the Department of Health. However, they would no longer be under the control of the District Health Authority (DHA) and they would have to secure their income by winning contracts for work from commissioning bodies, either Health Authorities or the local doctors, GPs, who, if their practices were large enough, had decided to opt for the new fundholding status which provided them a with budget to purchase treatment for their patients.

The reforms also included a change in the way funds were allocated to DHAs. A new system allocated money based on the local population and its key health characteristics – age, morbidity etc. DHAs were then free, within certain limits, to use this money to buy treatment for local people from inside or outside the local area and either from NHS Trusts or from the private or voluntary sector. So this was a market where the consumers were organisations – DHAs or large GP practices – rather than the individuals who actually required the healthcare.

Trusts were given the freedom to directly employ staff, negotiate terms and conditions, own and dispose of their own assets, retain surpluses from these sales and borrow money from the government and private sector. Their directors and chief executives were often approved by the Department of Health on the basis of their experience of the business world rather than that of the health service or even public service more generally. In fact, a major survey of NHS Trust appointments exposed the extent to which individuals with close ties to the Conservative Party were much more likely to be appointed than supporters of Labour or any other political party with two thirds of Trust chairs revealed as having links with the Conservatives. This led the Conservative government to implement a new code of conduct for NHS appointments in 1995 (Warden, 1995).

The Trusts also hit the headlines and have continued to do so over the last 15 years for the high salary levels paid to their top managers which have increased at a much faster rate than the average for NHS employees (Health Matters, 1994).

Studies have failed to uncover any significant impact of the introduction of the quasi-market. The King's Fund, one of the leading independent health research bodies in the UK produced an assessment in 1999 (Le Grand) which found relatively little measurable impact and concluded that perhaps the incentives in the system were too weak to bring about a significant increase in efficiency and effectiveness. Another report (Soderlund) published the same year focussed on the impact of management during the first few years of the internal market when there was a significant increase in the appointment of managers from the private sector. It concluded that higher spending on top level management was actually associated with poorer productivity levels.

The one way in which the Conservative Party did try to boost the private sector was by allowing tax relief on contributions to private healthcare policies taken out by the over-60s. In fact, this was a compromise as Margaret Thatcher had wanted to introduce much broader tax relief but was prevented from doing so by the then Chancellor Nigel Lawson.

2.2. *Labour reforms*

The Labour Party won the 1997 general election with an important part of its policy on health focussing on how to improve the performance of NHS hospitals, reducing hospital waiting times and speeding up the building of new hospitals and other health facilities by attracting more private sector finance. New policies on hospital performance and waiting list reduction were centred on organisational reform of the NHS and a

different approach to creating incentives where the Conservative reforms of the early 1990s were deemed to have failed. The government's first white paper on health, *The new NHS, modern and dependable* (Department of Health 1997), made it clear that it would be moving away from the internal market system that the Conservatives had tried to establish in the early 1990s. At the same time, however, Labour decided that it would breathe new life into another Conservative policy - the Private Finance Initiative (PFI) - that had made slow progress since first being introduced in 1992.

More generally the Labour government's approach to public services was to set a range of specific targets for organisations to meet. *The NHS Plan* (Department of Health 2000), for example, set targets for hospital waiting times:

- a maximum six-month inpatient wait for elective care;
- a maximum three-month wait for first outpatient appointments;
- a reduction in the maximum accident and emergency wait to four hours; and
- 31-day and 62-day waits for cancer treatment.

By 2005-06 these targets had already been met and the government was turning its attention to tougher targets to get waiting lists down to 18 weeks or less by 2008.

2.3. *Payment by results and patient choice*

The Labour government's new attempt at introducing market forces into the health sector is by altering the ways hospitals are funded and giving patients more say in their treatment. Payment by results (PBR) was first implemented only in 2006-06 and pays NHS Trusts for the procedures they have carried out based on a national tariff system. NHS Trusts are currently "road-testing" the tariffs for 2007-2008, meaning they have been notified of the prices to be attributed to all the procedures they undertake so that they can estimate their income based on their likely level of activity in the next financial year. The "road-testing" was one of a number of changes to the PBR system that the government introduced in the light of problems arising from the first year of operation as identified by an independent review.

It is now possible for patients to choose where they are treated depending on the type of procedure they require. They can access information on hospitals, including assessments from the Healthcare Commission, information about dealing with MRSA and other information about basic hospital services (parking, telephones etc.) and decide themselves or in consultation with their GPs about where to go for treatment. The government plans that patients will have a choice of at least five providers including at least one private hospital or independent sector treatment centres.

2.4. *Foundation Trusts*

A central part of Labour's plans for the NHS hospital system has meant further degrees of independence for the Trusts that wish to apply for "Foundation" status and a greater

and officially recognised role for the private sector in delivering healthcare. Foundation Trusts can, in fact, be any organisation that meets the criteria set for the government as organisations delivering healthcare and do not have to be NHS Trusts looking for greater independence. Essentially Foundation Trusts are organisations that operate “effectively, efficiently and economically” to deliver goods and services to the NHS. They do not have shareholders and any surpluses made on their activities for the NHS have to be reinvested in the provision of those goods and services. The Health and Social Care (Community Health and Standards) Act 2003 gives Foundation Trusts a wide range of new powers to generate income which build on or extend the powers afforded to NHS Trusts by the Conservative government’s National Health Service and Community Care Act 1990. These include:

- trading in NHS and non-NHS services;
- buying and selling land and assets and retain the proceeds;
- creating commercial arms or joining existing commercial ventures;
- subcontracting clinical services to commercial companies;
- borrowing money from private lenders within a prudent borrowing regime;
- asking the secretary of state (health minister) to lower annual costs by exercising discretion when valuing the assets that are transferred to them;
- benefiting from subsidies, loans and grants from the secretary of state, including their NHS capital allocations for the next three years;
- retaining surpluses under the new national tariff system;
- controlling boundary between the NHS and charged-for health and social care; and
- having flexibility to direct or transfer staff into the private sector.

(Pollock, 2003)

Foundation Trusts have been compared to other non-profit making institutions that receive large proportions of their income from government, are important for delivering elements of government policy but are not directly controlled by central or local government. These include in particular universities and housing associations. The change from NHS Trusts to Foundation Trusts marks another shift away from central government control. The secretary of state does not have the powers to intervene in the running of a Foundation Trust in the same way as is possible with ordinary NHS Trusts (Walshe, 2003). Foundation Trusts are run by boards of governors that are elected and appointed locally and they operate within a new national regulatory framework that includes a wide range of specific standards and new systems of inspection.

As at 31 October 2006 there were 52 Foundation Trusts recognised by Monitor, the official regulatory body. Most provide acute hospital services while five are mental health trusts. According to the Department of Health these Trusts between them have an annualised total income of £10.3billion, employ around 185,000 staff and have over 1,000 people as governors including patients, members of the public, staff and representatives from Primary Care Trusts, universities, voluntary organisations and other

local stakeholders. They are also responsible for well over a quarter of acute and specialist trust provision (Department of Health 2006b).

2.5. *A greater role for the private sector – the Concordat*

The 2000 NHS Plan made it clear that the private sector would play a greater role in the provision of health services in the future and that year the government signed a Concordat with what was then the main private sector body, the Independent Healthcare Association. The Concordat set out the main potential contributions of the private as:

- using its spare capacity to provide up to 150,000 procedures to the NHS each year;
- providing management to run “failing” NHS Trusts;
- forming joint ventures with NHS organisations; and
- providing overseas clinical teams for existing NHS providers or new NHS-managed developments.

The enhanced role for the private sector is such that the Department of Health set up a Commercial Directorate in June 2003 to provide a core interface for negotiations with the independent sector. The Directorate’s objectives are to:

- ensure commercial and procurement excellence across the Department of Health and the NHS;
- promote the adoption of best commercial practices where and when they significantly improve the effectiveness and efficiency of the NHS;
- facilitate the adoption and integration of commercial innovations to improve quality of care and exploit commercial opportunities resulting from innovations within the NHS;
- develop and managing links with the independent sector; and
- provide sound commercial input to assist departmental strategic reviews and policy decisions.

In terms of the hospitals sector, the Commercial Directorate’s main project covers Independent Sector Treatment Centres that it claims provide additional capacity and choice through the provision of elective and diagnostic services

Independent Sector Treatment Centres

Treatment Centres are another part of current Labour policy aimed at reducing waiting lists. These centres are intended to increase the number of spaces available for surgery separate from hospital emergency facilities, so that planned operations can take place without the risk of being postponed because of the need for unforeseen emergency work. The government also argues that this will relieve pressure in acute hospital beds and wards and so help speed up treatment for patients admitted to emergency care. Treatment centres are run either by the NHS or commissioned by primary care trusts (PCTs) from independent sector providers. The government argues that while capacity

in the NHS has been growing fast, it has not been fast enough to meet the NHS Plan target of a maximum 18-week wait from referral to treatment by December 2008. This is the reason given for extra capacity being sought through Independent Sector Treatment Centres. Forty-four NHS-run Treatment Centres were open as of 31 October 2006. Over 304,000 patients (at the end of financial year 05/06) had been treated in NHS Treatment Centres since the start of the programme in April 2003. By October 2006 there were 21 Independent Sector Treatment sites delivering a full service and three sites delivering an interim service. The Department of Health estimates that the independent sector will be providing 5.7% of the NHS 6 million annual non-urgent procedures by 2007-08, rising to a maximum of 7.5% by 2010.

2.6. *Private Finance Initiative*

The Private Finance Initiative (PFI) was an initiative of the Conservative government of John Major in the early 1990s whose main purpose was to get the private sector more involved in the delivery of major public sector capital projects. The government was reluctant to commit to significant new borrowing that would affect the Public Sector Borrowing Requirement but was also responding to a perception that publicly funded capital projects were often delivered late and over budget. The thinking behind PFI was that all the risks associated with borrowing money and designing and building a capital project, such as a new hospital, would be handed over to the private sector, whether a single company, or as has been more common, a consortium of companies that bring together financial, design, engineering and construction expertise. In fact, the role of companies went beyond delivery of the built facility and many PFI projects have been set up as design, build, finance and operate (DBFO) arrangements with the consortium (or sub-contractors) taking responsibility not just for maintaining new buildings but for running some of the associated services such as catering, cleaning, portering and security.

Once the facility was up and running the PFI consortium would charge the relevant public authority – the NHS Trust or District Health Authority in the case of the NHS – an annual fee over the lifetime of the project, usually 25 to 30 years. While some allowance would have been made for inflation and some account taken of performance, the annual fee would have to be paid out every year. There was considerable concern among health service campaigning organisations and trade unions that NHS Trusts and DHAs would be locked into these long-term contracts irrespective of changes to the local supply and demand for health services. They also argued that the PFI system was weighted against publicly funded projects and that NHS Trusts and DHAs that were desperate for new facilities would only get the funding if they took the PFI route. A particularly controversial element of the system was the way that the Treasury set the rules for comparing PFI and publicly funded project in terms of their value for money. Anti-PFI campaigners argued that the public sector could always borrow at a lower cost than the private sector and while this was recognised in the value-for-money comparison the Treasury built in an additional factor which it claimed took account of

the tendency of public sector projects to be run behind schedule and over budget (Pollock 2002 and Gaffney 1999).

Since 1997 the government has approved 80 PFI health projects worth £16.3 billion. Of these 28 are operational, 15 are in the construction phase, 12 are being negotiated and 25 have yet to be formally advertised. In contrast, over the same period the government has given the go-ahead to six publicly funded schemes with a total value of £500 million.

3. GOVERNMENT AND OTHER STAKEHOLDERS

3.1. Government

The role of the government for most of the post-war period has been as the direct owner, controller and manager of hospital services with certain responsibilities devolved at various times to strategic, regional, area and district health authorities. Devolution of management went further with the creation of NHS Trusts from 1991 and further still with the establishment of Foundation Trusts from 2003. It has been particularly under Labour governments since 1997 that the role of government has changed shifting more towards setting strategic objectives, targets and the overall policy framework. At the same time this has meant a much greater role for regulatory bodies.

3.2. Professional bodies and trade unions

There is more than a dozen organisations covering the medical professions workers that in the first instance regulate and monitor individuals' qualifications and training within the specific profession. Among the longest established are the Royal Colleges covering Surgeons, Physicians and Obstetricians and Gynaecologists as well as Midwives and Nurses. They have been joined over the years by bodies established to represent the newer occupations – the Chartered Society of Physiotherapists and Society of Radiographers, for example.

These organisations combine their professional role with trade union type representation of their members. In the last 20 years there has been an increasing recognition of the importance of this trade union role as several of these bodies have become members of the TUC, the UK's trade union federation. The NHS, like most of the UK public sector, records relatively high levels of trade union organisation with union density at 58%, well above the average for the economy as a whole at 29%.

Several of these organisations have used their political lobbying power and industrial muscle over the years to resist NHS reforms proposed by both Conservative and Labour governments. The Royal Colleges of Surgeons and Physicians, for example, were central to the negotiations that led to the setting up of the NHS and secured the right to

continue treating private patients in NHS “pay beds”. Rivett meanwhile highlights the role played by the British Medical Association (BMA) in resisting attempts by post-war governments to rationalise the healthcare system by increasing the role of local authorities.

The largest four TUC unions all have membership in the NHS – UNISON, Amicus, TGWU and GMB. They are also the four biggest affiliates to the Labour Party and so are influential both in terms of trade union policy on health, as agreed at the annual Trades Union Congress and Labour Party policy as adopted each year at the Party conference. They have generally opposed and campaigned against any policies that they regard as leading to further privatisation or commercialisation of the NHS such as contracting out, the Private Finance Initiative and more recently the government’s policies around Foundation Trusts and Independent Sector Treatment Centres. In fact concern about these policies is such that for the first time all TUC-affiliated unions with membership in the NHS have joined with three non-TUC organisations – the Royal College of Nursing, the Royal College of Midwives and the BMA – to run a campaign (NHS Together) warning of the dangers of the government’s strategy.

The campaign produced a briefing document for MPs in July 2006 and organised a lobby of parliament on 1 November 2006. The campaign’s model press release sums up its main concerns with the following statement: “Staff morale is at an all time low. We support changes that improve patient care, but there is too much top down change that has not won the support or involvement of the staff who have to implement it. The slow down in spending is being handled badly, with real cuts on the ground. And we are very worried that the NHS is being fragmented with a rapid dash to the private sector and the introduction of competition. The government should do more to recognise the progress made by their extra money and our hard work, and should make sure that change and reform involves the staff who will have to deliver it.”

3.3. *Patients*

The first time that government officially acknowledged a role for patients within the NHS was with the 1974 reorganisation that introduced Community Health Councils (CHCs). These were statutory bodies which had the right to be consulted over any proposed changes to local health services, although their powers were very limited and even if they objected to a proposal they could only delay its implementation. They had a role as a patient’s champion and watchdog and so could support patients who felt that had been poorly treated by the health service. CHCs were also a source of information and communication both for patients about the health service and for the local health service and policy makers through surveys carried out among local patients. However, the Councils were poorly resourced with funding for perhaps two or three full-time staff and often relying on volunteers to help provide their services.

Since the 1970s the issue of patient choice, rights and protection has certainly moved up the political agenda. In the 1990s the Conservatives under John Major introduced the

concept of Citizen's Charters across the public services, including a Patient's Charter for the NHS which set out standards that patients should expect in terms of waiting times and dealing with complaints. However, these were in effect voluntary codes and didn't provide patients with any new legal rights. The issue of the rights of patients and their families and quality of treatment and care was brought home by the Bristol Royal Infirmary Inquiry. This reported in 2001 following the deaths of 29 children between 1984 and 1995 that were attributed to poor management and standards at the hospital's children's cardiac unit.

The 2000 NHS Plan included a range of measures on patient's rights and ways of achieving and measuring their satisfaction with hospital and other health services and the availability of information on hospital performance. Specifically it proposed the abolition of CHCs which were replaced in September 2003 by local patient forums under the aegis of the new Commission for Patient and Public Involvement in Health.

3.4. The Commission for Patient and Public Involvement in Health

The Commission for Patient and Public Involvement in Health was set up in January 2003 as an independent, non-departmental public body, sponsored by the Department of Health. The Commission's role is to make sure the public is involved in decision-making about health and health services in England. There is a Patient and Public Involvement (PPI) Forum, for each of the 572 NHS Trusts in England. PPI Forums are made up of groups of volunteers in local communities who are willing to help patients and members of the public to influence the way that local healthcare is organised and delivered. The Commission is responsible for submitting reports to and advising the Government on how the PPI system is functioning. It liaises with national bodies such as the Healthcare Commission on patient and public involvement issues, and makes recommendations to these bodies and the Department of Health as appropriate. The Commission gathers information and opinion from PPI Forums, channelled through its shared information system in order to ensure that the bodies it reports to are acting upon patients' and the public's views.

4. REGULATION

The description below highlights the differences regulation before and after Labour's main reforms that took shape mainly on the basis of the NHS Plan 2000. To a certain extent these are related to a process of liberalisation which involves an increased use by the NHS of private facilities to carry out certain operations. There is also the element of patient choice which means that individual patients are beginning to have the possibility of choosing where to have their operations and, depending on the nature of the procedure, this may include one or more private hospitals. However, the developments in regulation can not be traced back just to this development and there are other factors that have led to a review of regulation in the health services and a process of reform

which would have been carried out even if the government had not decided to provide a greater role for the private sector in hospital treatment.

4.1. Before 2000

The main regulatory bodies that pre-date Labour's recent NHS changes are the Audit Commission and National Audit Office whose main concerns are the monitoring of accounts of national and local public bodies and assessment of their performance them in terms of their value for money. The Audit Commission is independent watchdog covering local organizations while the National Audit Office (NAO) focuses on central government departments and agencies.

The Audit Commission's primary aim is to push for improvements to these, by making practical recommendations, spreading best practice and getting feedback from the people that use them. The Audit Commission looks at organisations' financial statements, reviews financial aspects of corporate governance, including looking at the arrangements for ensuring that public bodies act within the law and that there are processes in place to prevent and detect fraud, and at the internal arrangements that public bodies have in place to satisfy themselves that they are using their resources economically, efficiently and effectively. The Commission also responds to members of the public, or people working in public services, who want to raise issues confidentially about how those services are being run.

Although NAO operates at the national level it does undertake investigations which enable local organizations to compare the way they run certain aspects of their affairs. For example, in 2006 the NAO published a report assessing the way that NHS trusts manage their temporary staff making recommendations on good practice to show where savings could be made.

The government through the Department of Health and Parliament, via its Health Select Committee had, and continue to have, a role in monitoring the hospitals sector but this was mainly through ad hoc investigations rather than anything comparable to the ongoing regulation which is now being provided by the Healthcare Commission, the National Institute for Health and Clinical Excellence and Monitor, the body regulating Foundation Trusts.

4.2. Monitoring the professions

The General Medical Council's (GMC) main role is to protect patients by:

- keeping up-to-date registers of qualified doctors;
- fostering good medical practice;
- promoting high standards of medical education; and

- dealing with doctors whose fitness to practise is in doubt, which may ultimately involve removing the doctor from the register and removing their right to practise medicine.

The GMC is an independent charity whose governing body has 35 members: 19 doctors elected by the doctors on the register; 14 members of the public appointed by the NHS Appointments Commission; and two academics appointed by educational bodies - the universities and medical royal colleges.

Concerns about the effectiveness of regulation led the government to introduce regulations in 2002 which gave the public a greater role in the running of the Council and required it to revalidate a doctor's registration every five years. Previously doctors' qualifications were checked just once when they were admitted on to the register. However, following revelations about the GP Harold Shipman who murdered over 250 of his patients, the Department of Health launched a consultation over further reforms of professional regulation in the health services. The consultation closed on 10 November 2006 and the Department's response is due early in 2007.

4.3. *After "liberalisation"*

With the 2000 *NHS Plan*, the setting up of Foundation Trusts, the Concordat with the private sector and introduction of Independent Sector Treatment Centres, the Labour government initiated a significant new phase for the hospital sector. This meant much more independence at local level for hospitals switching to Foundation status and a much more upfront role for the private sector in the provision of services. With the Department of Health having less direct control over hospitals and more involvement of private sector organisations, the Labour government recognised that the system needed major reforms in the way it was regulated. This came at the same time as other pressures were on the health service to improve the quality of care and respond to the increasing litigation from patients unhappy about the treatment they had received or who had directly suffered as a consequence of hospital treatment. This has led to a significant increase in the monitoring and regulation of hospital activity both in the NHS and in the private sector.

4.4. *The Healthcare Commission*

One of the main new regulatory bodies is the Healthcare Commission (full title – Commission for Healthcare Audit and Inspection) which began work in April 2004, having been set up by the *Health and Social Care (Community Health and Standards) Act 2003*. The Commission took over the responsibilities of the Commission on Health Improvement, which was set up in 1999 to review and monitor standards of clinical care and governance. It has also assumed the responsibility for auditing local NHS organisations that was previously carried out by the Audit Commission and overall its main duties are to:

- assess the management, provision and quality of NHS healthcare and public health services;
- review the performance of each NHS trust and award an annual performance rating;
- regulate the independent healthcare sector through registration, annual inspection, monitoring complaints and enforcement;
- publish information about the state of healthcare;
- consider complaints about NHS organisations that the organisations themselves have not resolved;
- promote the coordination of reviews and assessments carried out by ourselves and others; and
- carry out investigations of serious failures in the provision of healthcare.

The Commission has to pay particular attention to the:

- availability of, access to, quality and effectiveness of healthcare;
- economy and efficiency of the provision of healthcare;
- availability and quality of information provided to the public about healthcare; and
- need to safeguard and promote the rights and welfare of children and the effectiveness of measures taken to do so.

The Commission's latest annual *State of Healthcare* report was published on 31 October 2006 and includes, for the first time, a view of performance of the independent healthcare sector in meeting the minimum standards required by law. The Commission's Chief Executive Anna Walker told the *Guardian* (31 October 2006) standards in the independent sector were "pretty much the same as in the NHS. It was hard to make direct comparisons and the commission wanted a change in the law to put all establishments on the same footing. But it was fair to say private and voluntary hospitals were no better or worse than the NHS." The report revealed that:

- 11% of private sector establishments (13% of acute hospitals) failed the standard which requires them to have processes to ensure monitoring of treatment and care;
- 10% (11% of acute hospitals) failed on having processes to ensure that staff are appropriately recruited, trained and qualified; and
- 7% per cent (8% per cent of acute hospitals) failed on having processes to minimise the risk of infection.

4.5. *National Institute for Health and Clinical Excellence*

The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 as an independent organisation appointed by the Department of Health to be responsible for providing national guidance in three key areas:

- public health – this includes guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector;

- health technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS; and
- clinical practice – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

In 2002 NICE created a citizen's council in to provide it with a way of consulting with members of the public about its work.

4.6. *Monitor – Foundation Trust regulatory body*

Monitor authorises and regulates the management and finances of NHS foundation trusts. It was established under section 2 of the *Health and Social Care (Community Health and Standards) Act 2003* and is a non-departmental public body. Monitor considers applications from NHS Trusts seeking foundation status and authorises them if satisfied that certain criteria are met. The terms of the formal authorisation set out the conditions under which a foundation trust is required to operate and covers such things as:

- description of the goods and services related to the provision of healthcare that the foundation trust is authorised to provide;
- limits on the amount of income that the foundation trust is allowed to earn from private charges;
- limits on the amount of money that the foundation trust is allowed to borrow; and
- financial and statistical information the foundation trust is required to provide.

Once NHS Foundation Trusts are established, their activities are monitored to ensure that they comply with the requirements of their terms of authorisation. Inspection of the performance of a foundation trust against healthcare standards is carried out by the Healthcare Commission, which will send copies of their inspection reports to Monitor. Monitor has powers to intervene in the running of a foundation trust in the event of failings in its healthcare standards or other aspects of its activities, which amount to a significant breach in the terms of its authorisation.

4.7. *The National Patient Safety Agency*

The National Patient Safety Agency (NPSA) was set up in July 2001 to try to provide a co-ordinated response to and help prevent patient safety incidents occurring in the NHS. The NPSA is trying to make sure that incidents are reported to promote an open and fair culture in hospitals and across the health service. An important element of this is encouraging staff to report incidents without fear of personal reprimand. The Agency works with patients and staff locally and nationally to investigate incidents and to try to come up with appropriate solutions. It does this by collecting and analysing information from staff and patients via a national reporting and learning system.

Since 1 April 2005, the NPSA's work also involves:

- safety aspects of hospital design, cleanliness and food (transferred from NHS Estates);
- ensuring research is carried out safely, through its responsibility for the Central Office for Research Ethics Committees; and
- supporting local organisations in addressing their concerns about the performance of individual doctors and dentists, through its responsibility for the National Clinical Assessment Service.

The Agency estimates that there are 900,000 incidents each year where an NHS patient is either harmed or nearly harmed as a result of medical errors or other safety issues.

Table 1: Regulatory Actors

Before 2000	After 2000
Government through Department of Health	Government through Department of Health
Parliament through Health Select Committee	Parliament through Health Select Committee
National Audit Office	National Audit Office
Audit Commission	Healthcare Commission
General Medical Council and other bodies regulating the health professions	General Medical Council and other bodies regulating the health professions
	National Institute for Health and Clinical Excellence
	Monitor – regulatory body for Foundation Trusts
	National Patient Safety Agency

5. ACTORS AND OWNERSHIP

There has not been a process of privatisation in the UK that has led to the sale of publicly owned hospitals to the private sector. The Private Finance Initiative (PFI) does mean that there are hospitals which are effectively owned by private companies, mainly consortia, but this applies to the hospitals as physical assets and not to the management of the hospital and the clinical services it provides. Ownership reverts to the National Health Service at the end of the PFI contract. There has been a change in the way hospitals are run in the sense that many of them are becoming more independent from Department of Health control through the creation of Foundation Trusts but this does not yet involve a change of ownership.

The four biggest private healthcare groups in the UK are BMI Healthcare, BUPA, Capio and Nuffield Hospitals. Between them they run 134 hospitals and nine treatment centres and employ around 50,000 employees, the equivalent of less than 4% of total NHS employment. In total there are around 300 private hospitals in the UK. Each private hospital is on average much smaller than an NHS hospital so the total number of acute beds in English hospitals is around 108,000, a figure that has been steady for over 10 years. The total number of acute hospital beds in the private sector is around 15,000.

Occupancy rates in the NHS average 85% compared to less than 50% in the private sector.

5.1. *Private hospital groups*

BMI Healthcare runs 49 acute care private patient hospitals around the United Kingdom with over 2,400 beds. It has a turnover of around £700 million, 10,600 employees and handles 250,000 inpatient and 750,000 outpatient visits each year. BMI Healthcare hospitals work together with the NHS providing 10 private hospitals and private wings within the grounds of NHS Trust hospitals. A new division - Amicus Healthcare - has been established to meet the specific needs of public health sector patient contracts and in the future will have its own separate staff teams working in dedicated facilities. Network Healthcare, a company quoted on the South African stock exchange has majority control of BMI, with three UK investment companies having significant shareholdings.

BUPA began as The British United Provident Association in 1947 in order to offer what it describes as a complimentary service enabling people to choose where, when and by whom they were treated. The company had a turnover of £3.6 billion in 2005 but this included UK and international health insurance and care homes, with the hospitals division accounting for £535 million. The company does not give a detailed breakdown of employee numbers. The annual report indicates that it has 27,173 full-time equivalents involved in healthcare, but this will include its care homes both in the UK and Spain. As a provident association, BUPA does not have shareholders and says that it reinvests its surpluses into improved health and care facilities such as medical equipment, the latest technology and buildings. It runs 25 hospitals and a range of other health-related services including: health insurance, care homes and health-at-work policies. In the 1980s BUPA established joint ventures with the NHS, in particular with St Thomas' Hospital, London and the National Hospital for Nervous Diseases. The company expanded rapidly during this period with a substantial hospital building and acquisition programme.

Capio Healthcare UK runs 21 private hospitals and nine NHS Treatment Centres. It also runs psychiatric hospitals, neurological services and dedicated eye unit. The Swedish owned company has more than 100 operating units across Europe with some 16,000 employees. It has just over 3,100 employees in the UK and in 2005 had a turnover there of around £250 million. Nuffield Hospitals was established in 1957 as a not-for-profit organisation and a registered charity. It has no shareholders. The company has 39 hospitals in England and one in Scotland. It employs a total of 9,311 people and in 2005 had a turnover of £524 million.

BMI, BUPA and Capio have all expressed an interest in further work for the NHS in terms of treatment centres or franchising of management at failing hospitals. Other companies on the NHS register for franchising include: Hospitalia activHealth

(Germany), Interhealth Canada, Quo Health, Secta Group and Serco Health (part of the Serco business services group of the UK).

CONCLUSIONS

There have been a number of different ways in which forms of competition and privatisation have been introduced into the public provision of healthcare in the UK. Actual direct competition with the private sector has effectively been there throughout the whole post-war period. However, for most of this period this has been marginal, providing the well-off with the option of faster treatment in plusher surroundings. As waiting lists began to grow in the 1970s so to did use of private sector treatment and a commercial sector began to develop alongside the primarily non-profit making sector. Although Conservative governments were ideologically in favour of more competition and private sector involvement they never took any major initiative to boost private healthcare or change the nature of the funding of the NHS. Their main way of encouraging private involvement was through competition for non-clinical services through the contracting out of ancillary services like cleaning, catering and portering. This was also part of the PFI project that was launched by the Conservative in 1992 and gave the private sector a much greater role in the funding and managing of capital projects in the NHS. But even here the Conservatives' support for this policy now appears lukewarm in contrast to the way it has been so enthusiastically pushed by Labour governments since 1997.

Since 2000 Labour governments have been seeking to provide greater independence for local NHS providers (Foundation Trusts) and a greater role for the private sector in providing non-emergency treatment. This has led to the introduction of a number of new regulatory bodies to monitor both public and private sector providers. The introduction of patient choice also means that in many instances patients will be able to choose where they go for treatment and one of the options could be a private hospital or independent sector treatment centre. The treatment will continue to be free to the patient whichever provider they choose. These reforms are at their earliest stages and the Labour government argues they will improve services to patients and improve efficiency in NHS providers. Some commentators argue that the changes could make it much more difficult for NHS hospitals to plan effectively and will distort the provision of healthcare particularly in areas where there are significant numbers of private sector providers looking to improve their capacity levels.

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Websites

Government and related organisations – agencies and statutory bodies

- www.doh.gov.uk – main ministry (Department of Health) website
- www.nhs.uk/ – information about the organisation of the NHS in England
- www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/PrivateFinanceInitiative/fs/en - Department of Health web pages on the Private Finance Initiative
- www.cppih.org/ – patients' forums
- www.healthcarecommission.org.uk/homepage.cfm – Healthcare Commission
- www.monitor-nhsft.gov.uk/index.php – regulatory body for Foundation Trusts

Health sector trade unions and professional associations

Affiliated to the TUC

- www.unison.org.uk – biggest public service and health service union organising nursing, ancillary, ambulance, management and administrative staff
- www.amicustheunion.org – mainly a private sector union but with significant membership among health service laboratory staff and technicians as well as engineering and craft workers
- www.gmb.org.uk – general workers' union with mainly ancillary staff in membership
- www.tgwu.org.uk – general workers' union with mainly ancillary staff in membership
- www.csp.org.uk – physiotherapists' professional association and trade union
- www.bda.uk.com/ – dieticians' professional association and trade union
- www.sor.org.uk – radiographers' professional association and trade union
- www.orthoptics.org.uk/ – orthoptists' professional association and trade union

www.cdna-online.org.uk/ – Community and District Nursing Association
www.hcsa.com/ – hospital consultants’ professional association and trade union
www.feetforlife.org/ – chiropodists’ professional association and trade union
www.sor.org.uk – radiographers’ professional association and trade union
www.ucatt.org.uk/index.htm – construction worker and technicians’ union

Other trade unions/professional associations

www.rcn.org.uk – nurses
www.bma.org.uk – doctors
www.rcm.org.uk – midwives
www.rcseng.ac.uk/ - surgeons
www.rcplondon.ac.uk/ - physicians

Main private sector hospital groups

www.generalhealthcare.co.uk/ – BMI Healthcare
www.bupa.com – BUPA provident association, international group with headquarters in UK and as a provident association (similar to a mutual insurance company) it doesn’t have any shareholders
www.capio.co.uk/ – Capio – European multinational with headquarters in Sweden
www.nuffieldhospitals.org.uk/ - non-profit making group of hospitals