

Healthcare and the Economy 1

Business and the NHS

October 2011



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Executive summary

- Helping people to get better or cope with illness is what the public perceive to be the function of the NHS.
- The major changes in the proposed Health Bill are to NHS structure around commissioning arrangements, clinician involvement and strategic direction.
- The NHS is a complex machine in which there are many shapes and sizes of components – representing the diversity of suppliers, providers and players - that function together as the NHS. Take any one away and the machine doesn't work – or can't do the work that it is designed to do.
- All but the public sector are independent organizations (independent contractors, charities, social enterprises, for-profit and not-for-profit), essentially privately run businesses that are owned by individuals or accountable to trustees rather than the state. Whoever provides the NHS service it is still the NHS and still free at the point of delivery.
- In the light of this picture of diversity and eclecticism, it may not be helpful to polarize the current debate to one of public versus private or independent sector.
- The NHS already spends £1 in every £4 in the independent sector when the broader and more accurate description of 'independent' is applied i.e. technical support, medical kit and supplies, diagnostic services, independent contractors (GPs, pharmacists, optometrists and dentists).

"...there has been such a clamour from sectional interests in the field of national health that we are in danger of forgetting why these proposals are brought forward at all... consideration should now be given... to the requirements of the British people as a whole."

Anuerin Bevan, 2nd reading of the NHS Bill, 1946¹

For well over a year now there has been a vigorous public debate taking place about the NHS, the Health and Social Care Bill and the need for efficiencies. Claim and counter claim have been made; speeches and pauses have come and gone and opinion, myth and truth have intermingled leaving many inside and outside the NHS confused and anxious.

It is vital, as we think about the future of healthcare delivery in England, to rise above the politics and look at the evidence. The waters have become so muddied in the past year that it has become difficult to see what is being proposed, have an accurate picture of healthcare services and have clarity on meaning. Rational debate seems to be trumped by emotion and prejudice at a time when the country needs to hear the facts about the challenges that we face, not least around the rising demands on the healthcare system. There is no doubt that the NHS is an imperfect system for healthcare delivery but it is one which has for 63 years reassured us that none of us have to worry about medical costs. This is a privileged position and one only has to travel to a developing nation to realise how fortunate we are. The universal service is not up for negotiation, but times have changed. Demands on healthcare mean that we spend proportionally ten times what we spent in 1948 on the NHS and this trajectory is unsustainable. We owe it to the public who fund the system to focus on determining the best way to provide services. Therefore the debate must not be hijacked by scaremongering or vested interests but be informed by evidence and experience to ensure that we have a clear understanding of purpose.

This short paper seeks to inform the debate by setting out:

- 1. What we mean by healthcare and what the NHS covers.**
- 2. What the proposed NHS structure looks like and how it is funded.**
- 3. The diversity of services vital to the delivery of healthcare.**
- 4. The true picture of NHS spend in the independent sector.**
- 5. Conclusions.**
- 6. A glossary of terms used in the debate.**

1. <http://hansard.millbanksystems.com/commons/1946/apr/30/national-health-service-bill>

1 What we mean by healthcare and what the NHS covers

Healthcare (*noun*)

The organised provision of medical care to individuals or a community.

Although it can be sometimes difficult to judge where healthcare ends and social care begins, for the purpose of this paper we will focus on the provision of medical care. The wider care industry, although vitally important, increases the complexity of the discussion excessively.

Healthcare has two components: firstly helping people stay healthy, and secondly making them better, or helping them cope with illness. Public perception, especially where the NHS is concerned focuses on the latter, so this paper will do the same, although long term planning on the macro level urgently needs to incorporate illness prevention.

The delivery of healthcare is typically categorised into two main sectors: the primary and community sector (which includes general practice and community services such as nursing, physiotherapy, dentistry and the like), and the secondary or institutional sector (which includes highly specialized ‘tertiary’ care undertaken in centres of excellence, such as organ transplantation) that is delivered in hospitals. In addition there are other sectors such as those dealing with mental illness and ambulance/patient transport services. It is an impressive range of services which are provided by a network of organisations and people who have a common purpose: improving our health.

Since 1948 the NHS has been “A service comprehensive in scope, including medical and allied services of every kind”², covering care for everything from traumatic road traffic injuries to diabetes, maternity to medicines. Although dental, optical and pharmacy charges were brought in after the first few years, the other significant change has been the scope of treatment available. As diagnostic and medical discoveries have expanded, so has the range of illnesses that can be treated and the demand for care for what could be termed as ‘variations on normal’ or ‘diagnostic drift’ has increased. A few areas, most notably Croydon where the ‘Croydon List’, was first produced in 2006 by the Primary Care Trust³, have dared to withdraw treatments of “low clinical value” from NHS provision (e.g. hysterectomy, orthodontics and tonsillectomy). But overall the increase in scope, combined with a growing and ageing population mean that the proportion of Total Managed Expenditure by the Treasury on health and related social care now stands at about 23% and is rising.

2. Ministry of Health and Department of Health for Scotland. Report of the inter-departmental committee on medical education. London: HMSO, 1944.
3. <http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/lowclinicalvalue/Pages/lowclinicalvaluetool.aspx>

2 What the proposed NHS structure looks like and how it is funded

Most people think of the NHS as GPs and Hospitals. It's a little more complex than that. Taking the current NHS reform proposals as our first reference point, for an individual wanting to access healthcare, how is it going to be organized? To the best of our knowledge the new structure looks like the plan in Figure 1 (NHS Flow diagram, opposite page), which shows the access point for people as well as the different structures and oversight for delivering that care. The complexity derives from the proposed changes to the way services are commissioned. In this paper we are particularly interested in the services on the ground, actually delivering patient care, rather than the regulatory, commissioning and accountability structures. In terms of accessing services, there is no proposed change. The public will still receive healthcare from the usual range of professionals in the community with choice being offered when requiring investigation, surgery or specialised assessment. There may be an increase in choices of where to be referred for investigation, but the 'Any Willing Provider' policy that encouraged new market entrants, now changed to 'Any qualified provider' pre-dates this Health Bill.

The colouring in the diagram shows that there is combined involvement of the public and independent sectors (including charities, for-profit and not-for-profit) at every point for patients. This involves a wide range of different types of service and an equally wide range of types of relationship and degrees of integration, ranging from "fully embedded" services to conventionally out-sourced "supply chain" relationships.

The original white paper in July 2010 made much of the role of the public involvement body (Healthwatch) implying that there would be the opportunity for patients to refer local commissioning decisions to the national Healthwatch body if they were thought to be unfair. Fair provision of services would be enhanced by having a locus for overarching strategic reviews of the NHS. However this is notable by its apparent absence from the proposed landscape. The current mantra of localism should not prohibit a considered overview of what NHS services are required and can be afforded nationally. We already have the National Institute for Health and Clinical Excellence (NICE) advising on national availability of medicines, treatment standards and guidance, but the service planning seems to be missing. If we are to avoid postcode lotteries, the emphasis on local freedom to design services should follow a national strategic plan that has calculated

demand, demographics, training requirements and necessary services.

There has been controversy over the rewording of the role of the Secretary of State. The reason given for changing the duty from 'provide or secure the provision of services' to 'ensure that services are provided' is to prevent the Secretary of State from micro-managing the service. Professor Chris Newdick⁴ points out that NHS bodies already have the delegated authority to resist micro-management and the existing structures could be clarified to reinforce them.

It's worth noting that the increase in complexity of commissioning arrangements is a fundamental change, although the desire to put clinicians in the 'driving seat', i.e. having a greater say in what and how services are provided, is not new, having been the thinking behind the Conservatives' GP fund-holding in the 1990s and Tony Blair's health white paper in 1997. Added into the commissioning arrangements is the greater involvement of Local Authorities who oversee social care and have an interest in public health. This too is a nod back to the twenty years (1968-1988) of the Department of Health and Social Security (DHSS) which oversaw health, social care and welfare and public health. The new lines of authority between the different agencies are still not entirely clear, with Clinical Commissioning Groups now becoming concerned that their promised powers might be watered down. Many GPs have welcomed the increased commissioning role, but have been less than enthusiastic about taking responsibility for budgets. Public funding has previously allowed clinicians to be removed from most of the financial implications of their decisions, which have been borne by managers. The ramifications of this change could be considerable, with questions at all levels being asked about priorities and affordability. Against a background of an economic crisis caused by over-spending these are difficult conversations but they can't be avoided.

4. <http://www.reading.ac.uk/law/about/staff/c-newdick.aspx>

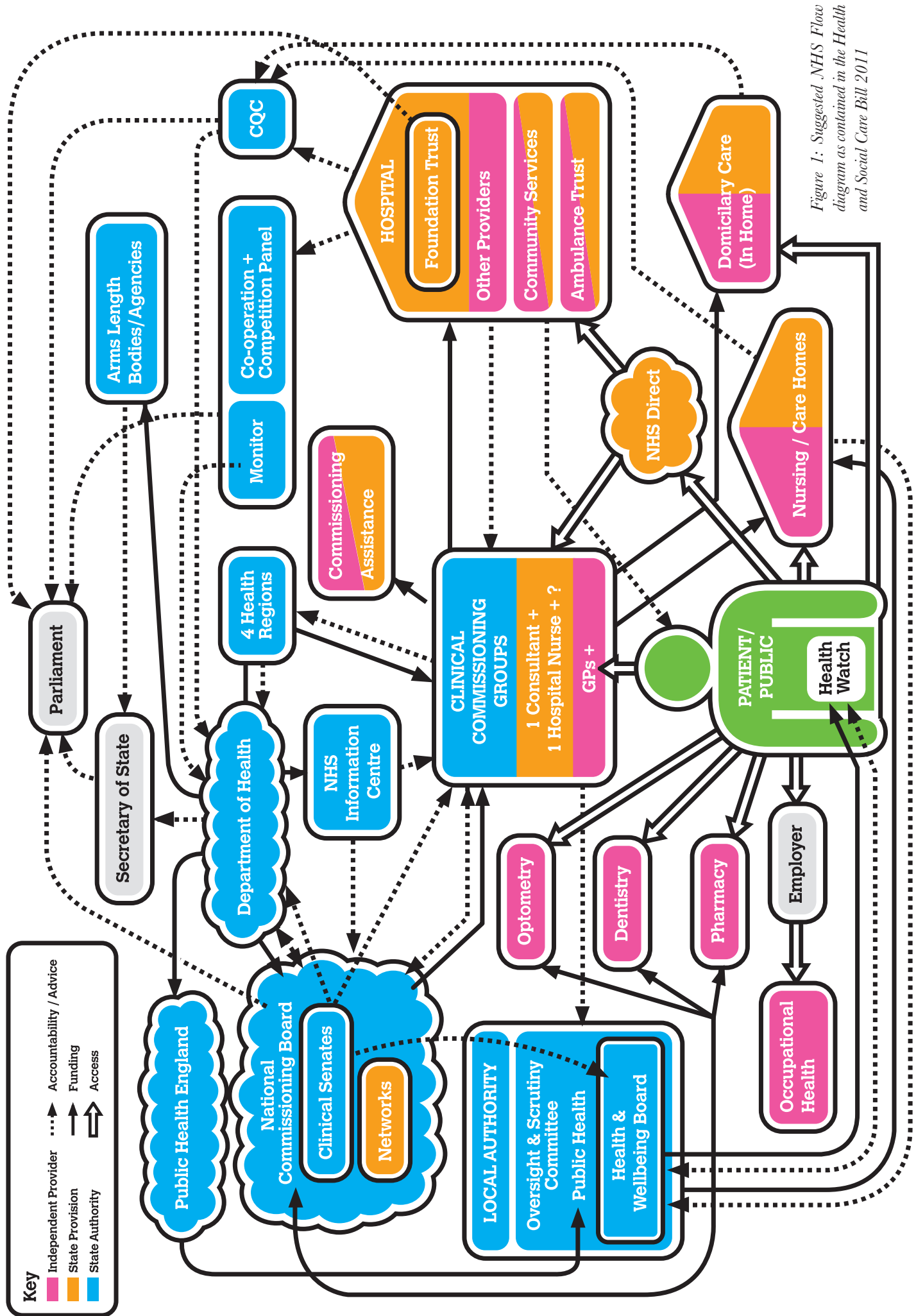


Figure 1: Suggested NHS Flow diagram as contained in the Health and Social Care Bill 2011

2 What the proposed NHS structure looks like and how it is funded

Funding

The NHS is funded through income tax and a proportion of national insurance. No changes to the way the NHS is funded have been proposed. Cuts to the NHS are being reported regularly. These fall into two categories.

Government budget: The NHS budget is one of two government budgets that have been ring fenced. The overall allocation to the NHS has increased in real terms, although because of inflation the Institute of Fiscal Studies have suggested that this might not be true beyond 2012.⁵ The Treasury has asserted that it will meet its commitment to a real terms increase.⁶

Efficiency savings: What has been dubbed the “Nicholson Challenge”, after the NHS Chief Executive David Nicholson, follows his 2009 public statement, that between 2011 and 2014 the NHS needed to make “efficiency savings” of up to £20bn to “deal with changing demographics...and cost pressures in the system”⁷. It is about doing more for less as demand is rising. Some NHS Trusts however have responded by cutting jobs and services at an alarming rate, arguably making short-sighted decisions to plug the gaps in their budgets instead of undertaking the essential redesign of services that is required to ensure demand can be met. This is disappointing as the evidence shows that were managers to take fraud more seriously⁸, educate patients about self-care for minor ailments⁹ and review supplier-led demand then significant savings could be found.

5. <http://www.ifs.org.uk>

6. <http://www.guardian.co.uk/uk/2011/mar/24/budget-2011-nhs-spending-power-cut>

7. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099700.pdf

8. <http://www.2020health.org/2020health/research/Stealing-the-nhs.html>

9. <http://www.pagb.co.uk/selfcare/movementforselfcareinpractice.html>

3 The diversity of services vital to the delivery of healthcare

Delivering healthcare to 53million English patients requires a network of organisations that has increased in diversity over the lifetime of the NHS but which has always been pluralist in nature. Both primary/community and institutional care include public sector, independent for-profit and not-for-profit and voluntary/ charity organisations contributing to and providing services. It is a salient point that the public often do not know who is providing their care, and according to polling are unconcerned by the nature of the provider. Their focus is on quality, convenience and recovery.

The public sector is well understood as the part of the economy providing basic government services. All but one of England's Acute Hospital Trusts are operated by the public sector and most clinical staff working within them are employed by the state. Buildings also belong to the state unless the Hospital Trust has been rebuilt through a Public Finance Initiative (PFI) deal, where just like domestic mortgages, the company who built or funded the PFI owns the bricks and mortar until the loan is paid. Charities that provide services are sometimes in receipt of government contracts and public funding, such as the British Pregnancy Advisory Service, or may be self-funded (through donors and fundraising) such as Macmillan Cancer Care.

Despite the recent political emphasis, there are only a few social enterprise companies that deliver services including nursing, dentistry and general practice to the NHS. They apply market-based strategies to achieve a social purpose and can be not-for-profit or for-profit.

All contributors to the NHS except the public sector are independent organisations, essentially privately run businesses (including self-employed individuals) that are owned by individuals or accountable to trustees rather than the state. A for-profit business or social enterprise will have a duty to long-term shareholder value, but otherwise the financial discipline is the same as for charities and not-for-profits. A service has to be provided to a minimum quality and safety standard within budget, with arguably both more freedom and discretion on the one hand, and external scrutiny from the regulators, parent company (if they exist) and investors compared with the public sector.

Ownership is distinct from funding. Some or all of a provider's funding may be from the state, and it will in any event have to comply with state-set standards and regulations, employ its own staff and takes full responsibility for its day to day running. Subject to any industry or state "fail-safe" arrangements, it can go out of business, with real financial loss to its shareholders/owners or trustees.

Primary / community healthcare

Primary care includes the different disciplines of general medical practice, pharmacy, optometry and dentistry. The majority of GPs are self-employed whilst also receiving the benefits of an NHS pension and payments to help fund their practices. Practices run like small businesses and make a profit. Likewise dentists, pharmacists and optometrists in the community are nearly all self-employed or employed in a private business. Known as 'independent contractors' to the NHS they all sign up to a code of practice and contracts that set out what is expected of them. It is up to the practitioners to decide how much of that profit is ploughed back into the practice to improve staffing or facilities. Most practices are run by GP partners but some have handed over the practice management to companies offering management support such as Virgin Healthcare. Strict laws have governed advertising by these professionals, which means superiority cannot be claimed.

In 2010, other community clinicians such as nurses, community matrons and other allied health professionals such as e.g. podiatrists, who used to be employed by the primary care trust (PCT) were required to separate from it. In 85% of cases they moved to be employed by the local NHS Hospital Trust (so remaining firmly part of the public sector), with the others becoming involved in social enterprises, community businesses or other independent organizations. Under the previous government, the 2008-9 NHS Operating Framework required there to be separation between the PCT commissioning and provider functions, ostensibly to ensure that in-house providers were not given favourable treatment when it came to making provider decisions. However the desire to remove any "conflict of interest" is limited – to insist that your GP can diagnose an illness but not treat it is nonsense.

3 The diversity of services vital to the delivery of healthcare

In this text we've kept to a dual categorisation of services – primary or secondary – but increasingly there are other services being provided in the community that were once the preserve of secondary care i.e. NHS hospitals. So it is now possible to have blood tests, CT and MRI scans, screening and physiotherapy in the community and more complex clinical services delivered in the patient's own home, such as chemotherapy, post-discharge care and end-of-life care. More and more of these options are being enabled by independent providers who have contracts with the NHS.

Secondary healthcare

Secondary care is still the term used to refer to the care that is provided within hospitals, however as mentioned above, this is changing. So whereas for example all surgery used to be undertaken in a hospital, now some minor surgery can be done at your GP practice; and heart pacemakers can be fitted from which readings can be taken remotely, so the patient no longer has to travel to the hospital for check-ups. Tertiary or specialist centres are those which offer more complex surgery and tests. As doctors become ever more specialized in their particular area of expertise, we should expect fewer (but probably larger) tertiary centres for any particular intervention.

There are different types of hospital. 167 Acute NHS Hospital Trusts provide a range of services, 89 of these have become Foundation Trusts which means that they are run by local managers, staff and members of the public and given greater operational and financial freedom (which they generally have yet to take up, such as setting local pay rates and the ability to borrow). In many respects they are becoming more akin to independent charities than state institutions, the latter still taking their orders from Whitehall. All of these are currently in the public sector in terms of their management, employment and estate (unless they have a PFI contract) apart from Hinchingsbrooke Hospital which should be moving to independent sector management (the contract has yet to be signed). In terms of technical and supporting services there is a diverse range of services that are provided by the independent sector to each Hospital Trust that enable it to function (See below and Figure 2 – Typical NHS Hospital and associated services), and an increasing number of services which the NHS provides to private patients. Likewise many hospital doctors do both public and private work. There is no limit to how much a hospital doctor can earn from their private practice, even while on paternity/maternity leave.

Publicly (i.e. tax-payer) funded work may also be done in

hospitals owned by the independent sector (Independent Sector Treatment Centres or ISTCs). These may be one of the ~170 Private Hospitals in England who now list services on the NHS "Choose and Book" system, or one of the smaller number (about 30) of "stand-alone" ISTCs established by the last government. Latest figures show that about 15,000 people a month are using independent sector providers through the Choose and Book system.

In addition to the acute hospitals described above there are also 54 Mental Health NHS Trusts which provide health and social care services for people with mental health problems, both through primary and secondary care services. The independent sector providers provide some 15% of NHS mental health services overall and 28% of complex NHS mental health services and have done so for many years. 38 Mental Health NHS Trusts have Foundation Trust status.

Two other categories of NHS Trust worth mentioning are Care Trusts and Ambulance Trusts. There are now only two Care Trusts in the country (there were 10) which combine social, mental and primary care services. These are both in the public sector, as are the 11 Ambulance NHS Trusts. The latter perform the majority of the emergency responses but there are many private ambulance providers with NHS contracts who undertake non-emergency patient transport.

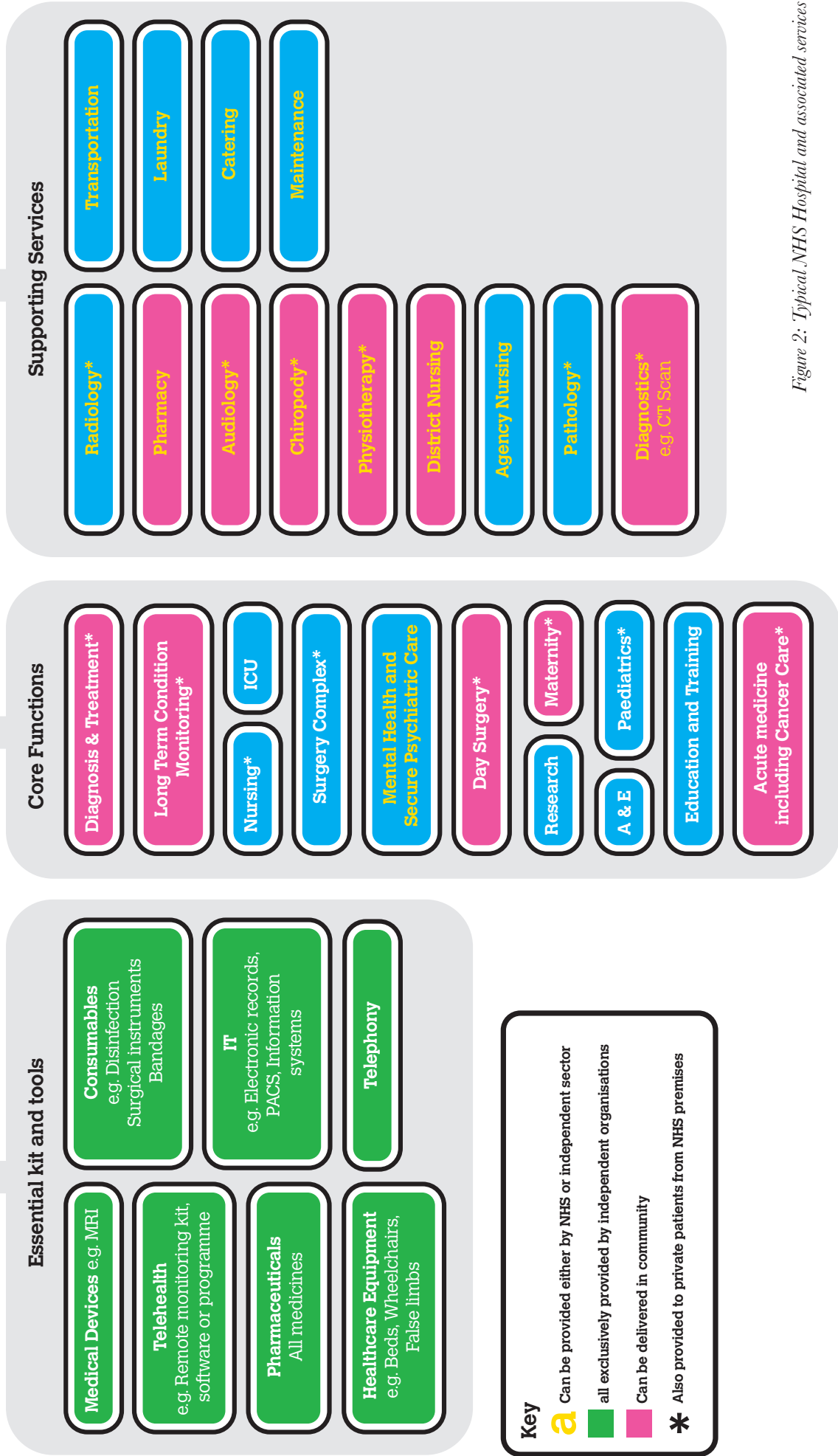
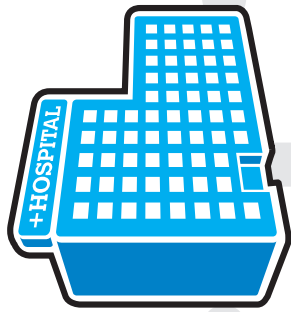


Figure 2: Typical NHS Hospital and associated services

3 The diversity of services vital to the delivery of healthcare

Employment

The NHS census states that there are now 1.4m NHS employees¹⁰ delivering services but this is inaccurate as it includes 39,000 GPs who as we've already mentioned are mostly self-employed and therefore fall in to the category of independent providers. In fact the total number of people delivering healthcare can only be estimated, as there are so many different organizations involved in ensuring that we receive all the detection, diagnosis and treatment that we need. There are in addition at present some 45,000 clinicians (all types) who, either full or part time, deliver NHS care from independent providers. Many work in both the independent and public sectors.

Technical work vital for the delivery of healthcare

Every medicine that is used in the NHS is produced by the independent pharmaceutical sector. Likewise medical equipment from complex MRI scanners to the basics of beds and needles is all produced by small through to large private businesses and bought by the NHS. Some expensive equipment is leased but again the sources are business and charities, not the public sector. Pathology and diagnostics provision is split between private and public. A more complete list of examples of essential kit and supporting services is in figure 2. As technology advances it has the potential to enable diagnostics to be undertaken in mobile centres or at local facilities, at reduced cost and greatly increased convenience for patients.

10. <http://www.bbc.co.uk/news/health-12819538>

4 The true picture of NHS spend in the independent sector

The previous sections highlight that the involvement of charities, not-for-profits and for-profit businesses is integral to the functioning of the NHS. It's often quoted that only £1 in £20 of NHS funding is spent in the independent or private sectors. However that is when these sectors are narrowly defined as the private hospitals and independent treatment centres that were largely brought in to help reduce waiting lists, offer patient choice and give value for money through productivity and innovation.¹¹ The proportion of independently run hospitals, independent treatment centres and diagnostic organizations undertaking activity is small. Yet this is a very narrow definition.

Defining the independent sector

As we have seen above, independent and private sector involvement extends way beyond the clinical treatment services provided by both for and not-for-profit businesses. It includes the technical support services without which a doctor could not operate; it includes all the kit necessary to be able to admit a patient onto the ward and monitor them; it includes every piece of diagnostic equipment, every box of medicine or latex gloves; it includes most GPs, optometrists, dentists and pharmacists who all contract to the NHS without being employed by it; it includes many procedures that detect or diagnose illness. When you begin to analyse the diverse and complex components that need to be in place before a patient can receive care you find a lengthy supply chain of different providers who contribute to the health professional being able to do their job.

11. <http://www.guardian.co.uk/politics/2005/jul/02/society.publicservices>

4 The true picture of NHS spend in the independent sector

General	
PCT purchase of healthcare from non-NHS bodies, excluding Local Authorities and other (includes ISTCs, other private sector and voluntary sector)	£4,699,015,000
NHS Trust purchase of healthcare from non-NHS bodies	£199,563,000
Foundation Trust purchase of healthcare from non-NHS bodies	£240,000,000
Social care	
PCT purchase of social care from independent providers:	£391,703,000
Primary care	
Spend on G/PMS, APMS and PCTMS:	£7,404,594,000
Non-GMS services from GPs:	£124,236,000
PCT spend on Contractor led GDS and PDS contracts	£2,620,452,000
PCT spend on Trust Led GDS and PDS	£37,331,000
PCT Expenditure on Pharmacy	£1,992,796,000
PCT spend on General Ophthalmic Services:	£467,552,000
Clinical supplies	
PCT prescribing costs	£7,946,018,000
Foundation Trust Drug costs	£1,887,800,000
Non-clinical supplies	
PCT spend on Consultancy	£261,147,000
Trust spend on Consultancy Services	£142,868,000
Foundation trust spend on consultancy	£141,600,000
SHA spend on consultancy	£52,744,000
PCT spend on auditing	£42,733,000
Trust spend on auditing	£26,306,000
SHA spend on auditing	£2,547,000
Foundation trust spend on auditing	£14,900,000
Foundation trust spend on hospitality	£3,800,000
Foundation trust spend on publishing	£1,500,000
Foundation trust spend on insurance	£18,300,000
TOTAL	£28,719,505,000
TOTAL NHS SPEND IN ENGLAND 2009/10	£100,200,000,000
% TOTAL OF NHS SPEND	28.67

Table 1: NHS spend on Independent Sector

References

NHS Foundation Trusts:
Consolidated Accounts 2009-10 http://www.monitor-nhsft.gov.uk/sites/default/files/0295_0.pdf P44

NHS (England) Summarised
Accounts 2009-2010

Local Spending Reports -
NHS Trusts 2009/10 dh_120816

Local Spending Reports - Strategic Health Authorities
2009/10 dh_120815

NHS Funding and Expenditure
www.parliament.uk/briefing-papers/SN00724.pdf

Table 1 shows the bigger picture of the NHS spend on services provided by the independent sector. The actual spend is around 28% of NHS funding being spent on non-NHS services and it has been this way for many years. This is closer to £1 in every £4 being spent in the independent sector. And that doesn't include personal spending in the dentistry, optometry and pharmacy settings or the exponential increase in personal spending on cosmetic surgery, which would increase the overall percentage spend in the independent sector.

5 Conclusions

This short paper aimed to set out the picture of healthcare services as they are currently configured, map out the proposed pathways contained in the Health and Social care Bill and come up with some clearer definitions of terminology, some of which are in the body of this paper and some of which are in the glossary.

We've set out what is clearly a complex machine in which there are many shapes and sizes of components – representing the diversity of suppliers, providers and players - that function together as the NHS. Take any one away and the machine doesn't work – or can't do the work that it is designed to do. Whoever provides the NHS service it is still the NHS and still free at the point of delivery.

Reflecting on this diversity, it's interesting that public perception of what is in the NHS 'family' does not match the reality. GPs are seen as part of the NHS even though they are self employed business men and women, whereas hospital consultants are often seen as independent individualists even though they are usually fully employed by their hospital trust or medical school. The mix of public and independent partnership is also a challenge to public awareness: an NHS owned hospital can have facilities run by a private company who built it, with the clinical services provided by NHS employees, and the ancillary services by a mixture of public and private staff.

In the light of this picture of cooperation and collaboration, it seems unhelpful to polarize the current debate to one of public versus private or independent sector. Looking at the partnerships at all levels there is a symbiotic relationship; remove the independent sector from the NHS and it would fail at every level.

One theme that begins to emerge is of more opportunities to have routine care in or close to home. This chimes with the political mantra (including pre-coalition) of care closer to home. The political parties need to be careful however. Specialist care is increasingly being shown to be safest when there is a critical mass of experience and activity – and this will mean care further from home for patients requiring complex treatment.

6 A glossary of terms used in the debate

Cherry-picking

This is where an organisation picks the best possible circumstances, clients or products in order to maximise profit and efficiency. In the NHS, this term has been applied to the independent sector providers of care who are accused of “creaming off” the easiest, most profitable patients. In order to do this they would have to be in control of referrals, but they are not. Either NHS commissioners or patients themselves chose where they are treated. The actual range of procedures that the independent sector is allowed to do is determined by the NHS, not by the providers themselves. In many cases these are routine procedures, a deliberate decision by the former government to help reduce waiting times. However this is not the case in mental health; in 2009-10 the independent sector saw more patients with learning difficulties and mental illness¹² than the public sector.

This term is also sometimes applied to describe a perceived risk of destabilisation of other NHS services by the removal of volumes which allow for wider cross-subsidy. To verify this would require an accurate internal accounting evidence base that (we are told) usually doesn't exist. If the real issue is being unable to cross-subsidise, then the problem is lack of appropriate payments for other types of treatment or other NHS commitments e.g. training.

Some say that the root of the problem is having competition in the NHS. The implication is that it is the independent sector which introduces the competitive element. However the entire NHS internal market would have to be abandoned (that allows NHS Trusts compete with each other for patient contracts) and any offering of choice would have to be withdrawn to eliminate all risk of more easy cases going to one provider than to another. We would then be back to a monopoly with all the problems that having no alternative brings.

Competition

‘Taking part in a contest which results in winners and losers’. When there is competition in a system, players in the system are challenged to improve the quality and quantity of what they do and how they do it. It doesn't rule out collaboration between competitors. Collaboration is not the opposite of competition - monopoly is the opposite of competition. However the competition and the possibility of failure has to be real to ensure that risk-

taking remains measured and reckless behaviour to attract business isn't vindicated by the knowledge that the state will bail out the hospital or other suppliers.

Depoliticisation

‘To remove from political influence or control’. The hope to take responsibility for public services away from the elected representatives who oversee how tax-payers money is spent is possibly utopian. History has shown that change in the NHS has always been politically driven. Politicians keep the NHS accountable for what it does and what it spends - they have to – it's tax payers money. Arguably they have not done this well as productivity has been going down year on year for much of the past 15 years. Both NICE,¹³ established in 2000 to assess new medicines and produce guidelines for treatment and the Independent Reconfiguration Panel (IRP),¹⁴ established in 2003 to provide advice to the Secretary of State for Health on contested proposals for health service change in England have provided valuable advice at arm's length from politics on healthcare and facilities. Other arm's length bodies provide advice. However these could be the limits to which depoliticisation is practicable.

General practitioners

Doctors who specialise in family or general medicine are called GPs. About 95% of GPs are self-employed and are known as ‘independent contractors’ to the NHS. Others who fall into this category are the majority of Pharmacists, Dentists and Optometrists. GPs have a contract with the NHS however which gives them a certain predictable income and an NHS pension as well as the ability to deliver services. They usually own their own buildings but get grants from the NHS to employ staff and improve their premises.

If GP-led Clinical Commissioning Groups come into being and they become responsible for holding much of the NHS funding, to reassure the Treasury they will become statutory bodies. Statutory bodies are organizations with the legal authority to take action in respect of a particular area of life, in this case, spending on healthcare.

12. Hansard (2011), 2009-10 Purchase of healthcare from non-NHS bodies. 28 Mar 2011: Column 192W.

13. <http://www.nice.org.uk/aboutnice/>

14. <http://www.irpanel.org.uk/view.asp?id=0>

6 Glossary of terms used in the debate

Privatisation

Privatisation is the incidence or process of transferring ownership and control of a business, enterprise, agency or public service from the public sector (the state or government) to the independent sector (businesses that operate for a private profit) or to private non-profit organizations. This begs the question, who actually owns the NHS, so who could transfer the ownership? It is owned by government and is controlled by the Department of Health (who own the NHS logo and letters as registered trademarks) under the Secretary of State (SoS) for Health. It is essentially another government department. It is supposed to be self-financing by mandatory payroll deductions but it is still annually subsidized by the taxpayer to make up for shortfalls in revenue. The SoS remains responsible for the NHS.

For the NHS to be privatised, control would have to be handed over to a private organisation. This is not happening.

According to the OECD and the World Health Organisation, the term 'privatisation' can also include other policies such as 'contracting out' that is, the process by which activities, while publicly organized and financed, are carried out by private sector companies, e.g., street cleaning, rubbish collection, council housing.

This already happens in the NHS. Thousands of contracts are held by independent providers for everything from cleaning to CT scans, patient transport to Macmillan nurses, day surgery to complex mental health treatment.

These contractors are still accountable to the same standards and regulations as directly employed services, but do not have the benefits that come with NHS employment or ownership e.g. an NHS pension. In the actual provision of services, the expected rise up to 2010 in treatment undertaken by the private sector on behalf of the NHS (from 3% to 10%) hasn't happened. The Confederation of British Industry (CBI) puts the contribution at about 5%.¹⁵

Some independent providers also have responsibility for post-graduate training e.g. GPs, pharmacists, optometrists, dentists. Some view privatisation to occur when a service has to be paid for out-of-pocket. This already exists in the NHS. Hospitals have private wings, dentists offer the chance to top-up payment for fillings, pharmacists can charge for vaccinations. This does not change the ownership of the NHS. It simply offers diversity and choice to patients. There are no plans to increase this in the current Health Bill.

The independent sector that is growing in terms of receipts of NHS funding is the 'supply chain'. There are several reasons for this. As more medical technology becomes available, the proportional costs of purchasing it are rising. Also more companies are offering diagnostic services e.g. MRI, pathology at more convenient locations or cheaper rates which are increasingly being preferred over an often inflexible NHS alternative. Thirdly, development of IT and medical technology mean that new ways of communicating and monitoring enable patients to do more for themselves and need fewer face-to-face consultations with NHS staff.

15. [http://www.cbi.org.uk/ndbs/press.nsf/0363c1f07c6ca12a8025671c00381cc7/e085125c16f8cb1b802573ec003991a3/\\$FILE/CBI%20ISTCs%20report.pdf](http://www.cbi.org.uk/ndbs/press.nsf/0363c1f07c6ca12a8025671c00381cc7/e085125c16f8cb1b802573ec003991a3/$FILE/CBI%20ISTCs%20report.pdf)

2020health.org's vision: Creating a healthy community

2020health is an independent, grass-roots Think Tank with a passion for health and technology.

We create innovative, realistic solutions that drive equality and efficiency and put patients in control.

We consider the cultural and economic effects of health policy as all policy should reflect the shared values of society.

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“2020health provides an invaluable forum for those who are interested in development and reform of the Health Service. Its meetings are always stimulating and thought provoking.”

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