



Amicus response to 'Health Reform in England: update and commissioning framework'

Amicus is the UK's second largest trade union with 1.2 million members across the private and public sectors. Our members work in a range of industries including manufacturing, financial services, print, media, construction and not for profit sectors, local government, education and the NHS.

Amicus is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. Amicus has members in primary care, mental health and acute NHS Trusts.

Executive Summary

- Government reforms of the health service have been underpinned by a process of transferring healthcare assets and services from the public sector to the private sector. This also underpins *Health Reform in England: update and commissioning framework*.
- Fragmenting healthcare services between multiple providers will lead to a reduction in the quality of services and the quantity and range of services that are available in a locality. The result will not meet the stated aims of the Government to develop high-quality services delivering individualised care.
- The fragmenting of services between multiple providers and the increased development of competition will further divert vital resources away from frontline services.
- The transfer and recruitment of staff outside of nationally agreed frameworks is likely to result in a bearing down on staff numbers and their terms and conditions to reduce costs. This will work against the drive for high-quality services locally and nationally.
- The fragmenting of services and their division between multiple providers will increase health inequalities.

Amicus Case in Detail

Introduction

1. Government reforms of public services currently taking place are dominated by a process of service and asset transfer from the public to the private sector and the introduction of competition. This process has assumed many guises. Amicus believes this agenda also underpins the Government reforms of the NHS with a process of commercialising and privatising the NHS taking place. *Health Reform in England: update and commissioning framework* is a critical step in this process and aims to fragment healthcare provision between multiple providers outside of the public sector.

1.1. The *Health Reform* document is firmly located within the context – and therefore must be considered – in the wider reforms to the NHS taking place. This has included:

- a) The use of Private Finance Initiatives (PFI), Public Private Partnership (PPP) and Local Improvement Finance Trust (LIFT) schemes;
- b) The creation of Foundation Hospital Trusts;
- c) The development of Independent Sector Treatment Centres;
- d) The introduction of Payment by Results and Practice Based Commissioning and the embedding of competition between different services;
- e) Management contracts awarded to the private sector to run ‘failing’ hospitals;
- f) Private companies’ involvement with primary care - running premises and the direct provision of care;
- g) Privatisation of services, for instance the recent announcement to sell NHS Logistics to DHL/Novation and awarding oxygen supply services to the private sector.

1.2. Amicus is not opposed to change, believing a future high-quality health service lies with a reformed NHS - but one which is integrated, properly and publicly funded and publicly owned. The Government policies outlined above have been chipping away at this. Amicus believes the continued expansion of the above policies, alongside the introduction of the large scale proposals contained within the *Health Reform* document, will fundamentally change the character of the NHS to the detriment of patients in the long-term.

1.3. Amicus was deeply concerned by the Secretary of State Patricia Hewitt’s recent assertion that there should be no ‘arbitrary’ limits on the types of healthcare providers. This opens the door for extensive third and private sector provision of healthcare services¹. Concerns specific to large scale service delivery by the third sector are raised below. However, it should be clearly understood that in Amicus’ view the overwhelming majority of health care contracts will be won by the private sector with the third sector acting as an outsider for this agenda. Discussing public service provision being passed to the private and voluntary sectors, Neil Cleavelly, director of Information and Policy at the National Association for Voluntary and Community Action states that “...in reality the private sector

¹ Secretary of State Patricia Hewitt, speech to the IPPR, 19th September 2006.

is well placed to win most of the work...”². This raises quite serious concerns for Amicus which are also outlined below.

1.4. Amicus believes competition, and commercialising and privatising the NHS do not deliver the quality, individualised care and reduced health inequalities that Amicus supports. Amicus is therefore opposed to the document *Health Reform in England: update and commissioning framework*.

Fragmented multi-provider healthcare threatens the quality and quantity of healthcare services

2. The *Health Reform* document envisages PCTs mainly having a commissioning role rather than directly providing care. Provision of the majority of healthcare services would be fragmented between multiple providers outside of the public sector. Amicus’ believes this will damage the quality and quantity of services.

3. Rather than the development of a single, integrated healthcare system the *Health Reform* proposals deepen and widen the competition between different providers and services to secure their income stream and to employ qualified staff. Placing public services, not-for-profit organisations and private sector companies and other for-profit organisations in competition against each other undermines collaborative working practices and good communication across services.

4. In addition to further undermining collaboration, Amicus fears that fragmenting services and creating a lucrative market for potential healthcare providers to enter (and exit) will have a detrimental impact upon the continuity of care that patients and users receive.

4.1. Private sector and other for-profit providers who take on a healthcare service that does not secure the expected financial returns may cut their losses and withdraw from the provision of that service.

4.2. In a PSI over view of the delivery of health care globally by multi-national firms a trend emerges of acquisition and sale of healthcare clinics by firms to develop their core business, and to support their own business needs. If there is full implementation of the *Health Reform* document there is no reason to think that such business drivers would not lead to the sale and acquisition of clinics based on business, and not patient, need as has happened elsewhere in the world³.

4.3. Lack of secure long term funding and the unreliability of patient income streams may make not-for-profit organisations providing a healthcare service increasingly vulnerable to take-over by large private sector firms who wish to enter the healthcare market or strengthen their position relative to other providers.

4.4. In these instances the loss or change of service provider will be a break in the continuity of care for patients and users which could be extremely detrimental for the individual(s) concerned.

² Neil Cleeveley, the director of information and policy at the National Association for Voluntary and Community Action, Public Finance Magazine (www.PublicFinance.co.uk), 1st September 2006.

³ Public Services International, *Forces and Reactions in Healthcare: A Report on Worldwide Trends*, 4th April 2005.

5. Amicus agrees more healthcare should be delivered to people in community settings and within and close to their own homes if they choose. James Strachan, former chair of the Audit Commission, warned in January 2006 that removing key sections of hospitals “makes it very difficult for [an] A&E department to run itself because it’s lost some of the underpinning surgical divisions which it needs to function”⁴. Movement towards regional ‘super-centres’ for Accident and Emergency departments is already being pushed ahead with closures and the ‘downgrading’ of facilities occurring. This trend will be accelerated further with the hiving off of elective procedures increasing under the proposals within the *Health Reform* document. This clearly runs counter to the Governments’ stated aims of choice and care being delivered closer to patients’ homes.

6. Amicus agrees delivery of healthcare should be best value, but contests that this is what is being proposed. Amicus believes that by fragmenting healthcare services and locating them outside of the public sector the financial drive will be to deliver the *cheapest* healthcare. Amicus fears that - amongst other concerns - this will lead to a reduction in the amount of staff training provided. It is unclear from the *Health Reform* document where the responsibility, obligation and cost of initial and on-going developmental training will lie. Financial pressures within the NHS have already led to a significant reduction in training places for health visitors, for example. Amicus has found that financial constraints have also led to a cutting of training budgets in the mental health sector⁵.

6.1. The separate service provider locations of routine and complex surgery leave concerns over the training of future practitioners and surgeons. The British Orthopaedic Association (BOA), the British Medical Association (BMA) and the Royal College of Surgeons (RCS) clearly stated the location of routine operations with ISTCs was having a serious impact on the local training of practitioners when the first wave of centres were reviewed⁶.

6.2. A further dwindling of developmental training for staff will add to difficulties in retaining staff and hamper staff ability to innovate service provision for the benefit of users. A reduction of initial training will have a cumulative impact over several years leading to further understaffing difficulties in healthcare.

7. Third sector organisations are already involved in the delivery of some healthcare services, and constructively work alongside NHS provision in many cases. However, the delivery of services by the not-for-profit sector is currently on a relatively low scale given the total size of the NHS. Amicus does not believe that such organisations have the long-term funding or the infrastructure in place that is necessary to deliver public services on a large scale. For example, in supporting and meeting the training, supervision and development requirements of large numbers of community practitioners and health visitors.

8. Amicus remains deeply concerned at the advert in the *Official Journal of the European Union* inviting companies to tender for the commissioning function of PCTs. This has been followed by David Nicholson in *HSJ* stating that he ‘expected’ private sector tendering to be used across the whole of the NHS⁷. It has since been revealed that multi-nationals and large firms such as McKinsey, UnitedHealth, Bupa, Humana, Discovery and

⁴ James Strachan, BBC interview, 3rd January 2006 found at http://news.bbc.co.uk/1/hi/uk_politics/4550984.stm.

⁵ State of Mental Health Services – Amicus Survey Report, August 2006.

⁶ House of Commons Health Committee Report, Independent Sector Treatment Centres, Fourth Report of Session 2005-06, paragraphs 83 – 85.

⁷ David Nicholson, *Health Service Journal*, 14th September 2006.

Tribal Group have all concluded the first stage of the Department of Health's bidding process⁸. This would mean multi-nationals and large private firms exercising up to 80% of the national health budget through taking on the commissioning function of PCTs, and being placed in the driving seat of choosing service providers and the range of services available.

8.1 This not only represents a substantial outsourcing of the NHS but also opens up a 'democratic deficit' in health services at a local level. This is especially the case when considered alongside the proposals contained in the Governments' 'Stronger Local Voice' document⁹. Amicus believes the outsourcing of such functions and the provision of services renders strategic healthcare decision making processes more opaque as increasingly functions and providers fall under 'commercial confidentiality'. The restriction of information this results in reduces the local and national accountability of services, democratic oversight and the full assessment and evaluation of services that will enable future development¹⁰.

Vital resources diverted away from frontline services

9. Awarding healthcare services to private and other for-profit providers will result in a portion of taxpayers' money leaving the health service to benefit individual shareholders rather than being invested in frontline healthcare services.

10. For-profit companies will 'cherry pick' routine and simpler healthcare services that are cheaper to provide and more profitable. PCT direct provision will therefore be for patients who require complex and expensive care. This has already begun to occur in respect of Independent Sector Treatment Centres. A BMA study found that patients are significantly more likely to be rejected for treatment from ISTCs than the NHS. The impact has been a distortion of the case-mix of patients the local NHS sees – substantially so in some specialisms. There is a tendency of ISTCs to perform only straightforward elective procedures on patients without co-morbidities¹¹. The 'cherry picking' of patients and procedures in order to increase profits will escalate if the Government proceeds with opening large swathes of services to tender.

11. Large private sector companies can afford to initially offer PCTs a loss-leading contract to provide healthcare services and push any other potential provider aside. This enables them to establish a monopoly position for future commissioning rounds and increase their price. This will unnecessarily increase the cost to the public in future representing wasted resources.

12. ISTCs were engaged to deliver particular elective procedures on a privileged basis and are provided with a minimum guaranteed income – paid up-front for a contracted number of procedures in contracts worth £2.5 billion. A large amount of public funds turned into instant profits for companies who receive money for operations that are not

⁸ *Health Service Journal*, 21st September, 2006.

⁹ See Amicus response to 'A Stronger Local Voice: a framework for creating a stronger local voice in the development of health and social care services', September 2006.

¹⁰ Difficulty in obtaining information has already been experienced in relation to ISTCs making evaluation difficult, see the House of Commons Health Committee Report, Independent Sector Treatment Centres, Fourth Report of Session 2005-06.

¹¹ BMA Health Policy and Economic Research Unit, *Impact of Treatment Centres on the Local Health Economy in England*, December 2005.

performed¹². Despite this wastage the *Health Reform* document contains the same proposal – PCTs encouraged to guarantee minimum incomes, length of contracts, provide financial supplements and help with capital investments to incentivise new services to be developed. This is likely to lead to a large amount of money leaving the health service when added up across the country. Amicus believes that this does not represent the best value for money method of developing new and innovative services. Simply engaging and properly working with health sector staff can deliver service development and innovation.

13. Expanding competition and the private health sector has generated a raft of associated costs which the NHS has had to absorb. These costs include the annual PFI charge and the additional layer of bureaucracy – for example, data clerks and managers - that operating Payment by Results necessitates. These costs will escalate with the full implementation of commissioning and fragmenting services between different providers as more bureaucracy is required to manage such a system.

The impact on staff terms and conditions will affect patient care

14. High-quality public services require sufficient funding and resources, with motivated, respected and fairly paid staff. This is the foundation of providing responsive, individualised care. Patients need to have time and space to develop relationships with health workers to discuss their options and be fully involved in decisions about their care. This requires services being designed and resourced to allow staff sufficient time to spend with each individual patient. Amicus does not believe that this will be the outcome of the breaking-up of health services between multiple providers outside of the public sector.

15. The outsourcing of services from the NHS means that staff will be removed from nationally agreed frameworks leaving providers free to bear down on terms, conditions and pensions to reduce costs. For-profit providers who wish to maximise their profit margin and smaller third sector providers struggling with unreliable income streams both have an incentive to keep costs low. For example, the US firm, Kaiser Permanente, that the Department of Health has developed links with, has a business strategy to use fewer and lower graded staff¹³. This will clearly have a damaging impact on the quality of care experienced, reducing the available staff time for each individual.

15.1. A reduction in staff numbers, and staff terms and conditions will work against the drive for high-quality services locally and nationally. De-moralised, over-stretched and under-resourced staff will find it difficult to deliver service changes, innovations and developments that users may wish to see implemented.

15.2. The understaffing of healthcare disciplines also results in time being focused on those with conspicuous needs. This results in those without conspicuous needs not receiving earlier support and intervention to their detriment. This situation already exists in some very understaffed disciplines. The *Health Reform* document does not recognise this and Amicus fears it will worsen under the proposals within the document.

Competition and breaking-up services will increase health inequalities

¹² The *HSJ* have reported that ISTCs are performing less than 60% of procedures they need to on average per year. To perform the total number of procedures they are contracted to perform by the end of their contracts would require a huge upsurge in the number of referrals to ISTCs, *Health Service Journal*, 21st September 2006.

¹³ A. M. Pollock, *British Journal of General Practice*, August 2006.

16. Amicus believes that if healthcare services are located with providers whose driver is a wish to lower the costs of provision universal access to services will be eroded through a reduction in the range of services available and increasingly through an introduction of 'top-up' charges. This has already begun to occur in cash-strapped PCTs. For example, Queen Charlottes and Chelsea Hospital in London recently began charging £4,000 for a maternity scheme that guaranteed one-to-one care during pregnancy and childbirth. Amicus supports the position of The Royal College of Midwives who believe that this level of service should be available to all women, not just those who can afford it¹⁴. In Oxford patients have to wait until a hernia is extremely serious and painful before receiving treatment on the NHS. Patients who wish to receive treatment before reaching this stage have to pay for private treatment. A recent Royal College of Speech and Language Therapists (RCSLT) survey found that departments were being hit hard by the financial pressures operating in the NHS, leading to a lack of support in place for some people recovering from strokes and no new NHS admissions to children's SLT services in the Vale of Aylesbury

16.1. The gap in health inequality has continued to widen, with 4 out of 5 of the PCTs spearheading the initiative to reduce health inequalities not on track to meet their targets¹⁵. This situation will worsen with the implementation of the *Health Reform* document. The Chief Medical Officer Sir Liam Donaldson noted in his 2005 Annual Report that public health budgets were critical in reducing health inequalities, but that public health budgets were particularly vulnerable to being cut or 'raided'. Spending funds on public health often does not have a tangible monetary benefit through financial savings or generating a profit, placing public health budgets at even greater vulnerability than they experience now under the reforms within the *Health Reform* document.

16.2. A reduction in local services available free at the point of need, either through the discontinuation of a service or the introduction of a 'top-up' charge combined with cuts in public health budgets will clearly worsen health inequalities.

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¹⁴ Statement from the Royal College of Midwives, 19th January 2006.

¹⁵ *HSJ*, citing a letter from Minister for Public Health Caroline Flint to Primary Care Trust Chief Executives, 21st September 2006.

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