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In the Interests of Patients?

The impact of the creation of a commercial market in the provision of NHS Care

Revised edition – January 2007

UNISON

In the interests of patients?

Examining the impact of the creation of a competitive, commercial market in the provision of NHS care

Executive Summary

> "The foundations have been laid for the complete transformation of healthcare delivery. We are shifting away from an integrated system in which the NHS provided virtually all of the care to a much more mixed one in which the private sector will play an increasingly major part - first of all in hospital care and diagnostics and probably, in time, other kinds of care from chronic conditions to what has traditionally been seen as family doctor services. The government has started down a road that will see the NHS becoming increasingly a health insurer that provides the funds but where there will be a range of different models of provision in which the private sector will become a big provider."
>
> *Chris Ham, former head of strategy at Department of Health, April 2005*

This paper gives an account of the changes introduced since 2002 which are creating a competitive, commercial market within the English NHS. It explains why UNISON believes that this undermines the key principles which underpin the NHS, why it will be inefficient and costly and why it risks undermining the quality of care. This is an updated version of the original paper produced in September 2005.

More than 85% of the NHS budget has now been devolved to Primary Care Trusts to commission, or buy in, care. Foundation hospital trusts have been established with new powers and freedoms to behave like commercial companies. The private sector has been encouraged to become a long-term provider, to increase diversity and contestability. Patient choice has been introduced that allows patients to choose their provider at the point of referral. This is all underpinned by a new payment system where money follows the patient.

Independent Sector Treatment Centres have been established to carry out many routine procedures, but this has been at higher costs than in the NHS and has involved the transfer of significant numbers of operations and staff from NHS hospitals. The Government now plans to transfer community health services in primary care to external providers, and has begun the process of inviting companies to prepare for Primary Care Trust services being put out to tender. Effectively, in both primary and secondary care, a competitive market is being established.

Some parts of the NHS are already facing financial problems as a result of these changes, despite the large overall increase in investment, with service cuts, ward closures and redundancies taking place in many areas. This is against a backdrop of preparations for a slow-down in NHS funding from 2008.

UNISON believes that there are fundamental problems with introducing a market-based system. Providers will inevitably choose the most financially attractive services, and will avoid those where they risk making losses, thereby compromising the principle of equal access for all in need.

Competition between providers undermines collaborative working and the sharing of good practice. Evidence from other countries shows that the transaction costs of administering the system will be high. Healthcare provision requires substantial capital investment and long-term workforce planning – this means that healthcare markets work inefficiently and are not good at responding quickly to gaps in provision. Patient choice requires good information, the confidence and knowledge to make sound choices and the resources and ability to travel. The risk is that such a system will serve merely to further entrench existing health inequalities.

Finally, the regulatory system overseeing the new system is weak. There is a lack of public accountability; the system is fragmented; there is concern about the monitoring of clinical standards in the independent sector; and Government is losing the ability to enforce workforce related standards and agreements. Furthermore, the Government continues to tinker with systems of patient and public involvement with no discernible improvements in accountability.

1. Introduction

The NHS is undergoing radical reform. NHS care continues to be free at the point of use, and services are improving as a result of the historic levels of investment going into them. Yet at the same time the Government is fundamentally altering the way in which NHS services are delivered, moving towards the creation of a competitive, commercial market in the provision of NHS healthcare.

From November 2006, following the publication of a Department of Health marketing code, the NHS will witness the development of a new phenomenon, unimaginable in years gone by, as hospitals begin spending a portion of their budget on advertising to attract patients. To date this is the clearest indicator of a growing English healthcare market.

NHS staff and patients are extremely concerned that these changes risk undermining NHS service quality and compromising the principle of equity on which the NHS is based. UNISON is therefore calling on the Government to halt further expansion of the role of the private sector in the NHS, until there has been the opportunity for the Government and the Labour Party to discuss the consequences of the Government's reforms, and to review the role, limits and regulation of markets in the NHS.

This briefing:

- sets out the way in which the Government's policies add up to the creation of a new market in NHS healthcare provision
- examines the initiatives through which the role of the private sector is being expanded
- explains why the effects of the new NHS market threaten to be harmful
- discusses the weaknesses of the current framework for the regulation of the new market

2. The new NHS market

In 1997, the Labour Government came to power pledged to end the NHS internal market and to restore the health service as a public service working co-operatively for patients, as opposed to a commercial business driven by competition. Once in office, it set about delivering on these commitments, abolishing many of the structures of the internal market and replacing it with a new emphasis on collaborative working and the collective planning of service provision. The 2000 NHS Plan built on these reforms, setting out an ambitious ten year vision for the future of the NHS, developed in partnership with patients, staff, and other stakeholders.

Since 2002, however, the Government has been putting in place a series of reforms that represent a fundamental change in policy direction. Increasingly, NHS healthcare is being provided by a diversity of competing providers from across the public, private and voluntary sectors. In addition, NHS hospitals are being given independence from Government, and are being turned into organisations that operate according to commercial principles.

The key elements of the market are:

- Retention of the *purchaser/provider split*, with devolution of more than 85% of the NHS budget to Primary Care Trusts (PCTs), and responsibility given to them for commissioning , or buying in, care on behalf of their patient populations.

- *Foundation trust status*, through which NHS hospital trusts, and now also mental health and ambulance trusts, can become independent of Government control and acquire new powers and freedoms allowing them to behave more like commercial companies (for instance the power to borrow from the private sector, the ability to retain surpluses, and greater autonomy to set pay and conditions packages.) By 2008, the Government wants all hospital trusts to be in a position to apply for foundation status.

- The *increasing use of the private sector* to provide NHS healthcare, not as a temporary measure to meet short term surges in demand, but on a long term basis as part of the deliberate cultivation of a diversity of providers. In 2004, then Health Secretary John Reid suggested that the independent sector would carry out up to 15% of NHS operations in the future. More recently, however, his successor Patricia Hewitt has said that no "arbitrary targets" should be set for or limits on one provider or another.[1]

- The introduction of *patient choice of provider*. Since January 2006, all patients requiring planned hospital care have been able to choose, at the point of GP referral, from a range of four or more providers. Since May 2006 this choice has been widened to include a national "menu" of NHS foundation trusts and will shortly include Independent Sector Treatment Centres (ISTCs) as well. From 2008, patients will be able to choose any healthcare provider that meets NHS standards and can deliver to NHS prices.

Underpinning these policies is the introduction of a new NHS financial system, Payment by Results (PbR), which has been rolled out across parts of the NHS in 2005 and 2006. Under this, rather than PCTs allocating hospitals pre-determined blocks of funding, providers will for the first time be paid on a per procedure basis, using a centrally fixed system of national prices or tariffs. This will facilitate competition, as money will follow the patient between providers, with hospital income and PCT expenditure both varying according to the volumes of patients treated. Furthermore, where a hospital loses patients, the drop in income that it experiences will generally be greater than its drop in expenditure, as the national tariff prices reflect average rather than marginal costs.

Together, these reforms are creating a system in which:

- Service providers will be independent of Government and will be left to survive financially or go under – there will be no redistribution of resources between those services that are doing well financially and those that are not.
- Rather than working together collaboratively to share information and plan integrated services, providers will compete against each other to attract the most profitable patients.

[1] Department of Health, Speech by Patricia Hewitt MP, to the Institute for Public Policy Research, 19 September 2006

- Those services that run at a loss because their costs are too high, or because they don't attract enough patients, will close.
- In place of public accountability, decisions about the nature and pattern of service provision will increasingly be driven by profitability and the logic of the market.
- Every aspect of service requirement will need to be contractually defined.
- Providers will seek to cut costs by cutting staff terms and conditions and collective approaches to workforce planning and development will be undermined.

Dramatic evidence of these reforms is already apparent in the hospitals with deficits that are facing the closure of services, and in some cases, possible closure of the hospital itself.

3. Creating the new market

At the forefront of the Government's drive to increase the role of the private sector in the provision of NHS healthcare is its programme of independent sector treatment centres (ISTCs). These new centres are owned and run by private companies, and are contracted by the NHS to carry out routine day case or short stay procedures, such as diagnostic tests, hip replacements and hernia removals. There are currently 21 ISTCs in operation, with more on the way. The total investment in Wave One ISTCs is expected to be more than £1.6 billion over five years, with a subsequent Phase Two of ISTCs coming in at £3.75 billion.

However, this provision by the private sector has come at a cost. In order to attract sufficient interest in the Treatment Centre market from private providers, the Government has been obliged to bend the rules of its own market. While NHS hospitals are already having to switch to payment by results, ISTC providers are being offered the following incentives:

- Exemption from national tariff rates until 2008, in order to attract new entrants and to reflect start-up costs. In 2006, the Department of Health acknowledged that procedures purchased under the ISTC programme cost on average 11.2% more than the NHS equivalent cost.[2]
- Fixed volume contracts, in which revenues are guaranteed regardless of actual levels of patient usage.

At the same time, substantial volumes of work and resources are being outsourced from NHS Trusts to the ISTC sector:

- When the ISTC programme was originally announced it was justified on the basis that it would bring in additional capacity to the NHS. In fact, a substantial proportion of ISTC activity has come from work that was previously being undertaken within the NHS, leaving a number of NHS Trusts with spare capacity.
- NHS staff have been seconded across from the NHS Trusts in order to undertake the work transferred to ISTCs. In addition, for Phase Two ISTCs, the Government intends to relax the restriction on the poaching of NHS staff that applied under Wave One, retaining no-poaching clauses only for shortage specialities.

[2] House of Commons written answer, 20 September 2006, Ivan Lewis MP

- As part of the ongoing expansion of ISTCs, attempts have been made to contract out the management of a number of recently developed and highly successful NHS-run Treatment Centres – for example, the South West London Elective Orthopaedic Centre.

The result of these policies is an uneven playing field between NHS providers and the private sector. ISTCs providers are being allowed to undermine NHS provided services by taking work and staff away from them, but are themselves being insulated from the effects of competition, and allowed to transfer the commercial costs and risks of provision back onto the public sector.

The Government's policy of introducing ISTCs to the health service received a series of criticisms from the House of Commons Health Select Committee report into ISTCs in July 2006:

- ISTCs are not necessarily more efficient or better value for money than NHS treatment centres.
- ISTCs have not made a major contribution to increasing capacity.
- The expansion of the ISTC programme could destabilise local NHS trusts, especially those with financial deficits.
- With Phase Two ISTCs to be used as part of reconfiguration plans, this could mean major hospitals being closed and the elective services they provide being undertaken by ISTCs.

> "The ISTC programme is intended eventually to provide about half a million procedures per year at a cost of over £5 billion in total. This could clearly affect the viability of many existing NHS providers over the next five years and possibly beyond."
>
> *House of Commons Health Committee, Independent Sector Treatment Centres. Fourth Report of Session 2005-6, Volume 1.*

As well as opening up the provision of NHS hospital care to the private sector, the

Government is seeking to do the same for primary care services. Since 2004, commercial and voluntary sector organisations have been able to provide GP services through contractual arrangements known as the Alternative Provider Medical Services Model. In addition, in March 2005, the Government announced a new pilot scheme to procure additional GP practices and walk-in-centres, with bidding open to a range of providers including Foundation Trusts.

Such developments have led to local upsurges of patient rebellion against contracts for running GP practices ending up in the private sector. For example, following North-Eastern Derbyshire PCT's choice of UnitedHealth Europe as its "preferred bidder" to run the Creswell Primary Care Centre in December 2005, the consequent uproar among the local community eventually led to an Appeal Court decision in August 2006 that quashed the selection of UnitedHealth and ordered the tender to be reopened, with the PCT required to involve and consult the local community properly on its plans.

In July 2005, the Government issued *Commissioning a Patient Led NHS*, announcing a reconfiguration of Primary Care Trusts (PCT) and Strategic Health Authorities (SHA) structures

and functions, including community services currently provided by PCTs, such as district nursing, health visiting, and occupational therapy. In terms of structures, the NHS has been reduced to ten SHAs from 28 since July 2006 and to 152 PCTs from 303 since October 2006. Functional changes mean that PCTs and SHAs have to review their services with the objective of bringing in alternative providers to increase contestability. This means the fragmentation of community health services and transfer of tens of thousands of NHS staff to new employers. Potential alternative providers include:

- Foundation Trusts, which have been lobbying for the opportunity to expand into Primary Care.
- Local Improvement Finance Trusts (LIFT), joint venture companies with a majority private sector stake. These were originally set up to provide new primary care premises, and have been granted exclusive rights to provide specified services for periods of up to 20 years. However, there are signs that the Government is seeking to expand the scope of LIFT into clinical services.
- Other private sector companies.
- Voluntary sector organisations.
- New forms of not for profit provider, known as Community Interest Companies or Social Enterprises. An example is East Elmbridge and Mid Surrey PCT which has sought to divest itself of direct provision to a new social enterprise, Central Surrey Health, despite the opposition of 80% of staff to having their employment transferred.

Following the publication of Commissioning a Patient-led NHS, the Health Secretary promised that PCTs would not have to divest themselves of their provider function. However, the Government's January 2006 primary care White Paper, Our Health Our Care Our Say, included plans for a major programme of generating competition among providers and transferring NHS primary care services to the independent sector. The Department of Health's Commissioning Framework reaffirms the split between the commissioning and providing roles of PCTs to better facilitate the arrival of alternative providers, with competition seen as the driver of improvements. Furthermore, the publication of adverts in July 2006 in the Official Journal of the European Union explicitly invited companies to prepare for PCT services being put out to tender.

4. The effects of the new market

The effects of the new market are already being felt. There is growing evidence that it is leading to:

- Widespread financial problems. Department of Health figures for 2005-06 show that the NHS ran up debts of £547 million and approximately a third of NHS institutions were in debt. The Audit Commission has warned that levels of financial volatility and risk experienced by NHS Trusts will continue to grow, as the volume of private sector provision increases and payment by results is applied more widely.[3]
- Service cuts and bed closures as NHS managers seek to reduce costs and balance budgets. A survey of medical directors carried out by the BMA before the worst effects of deficits

[3] Early Lessons from Payment By Results, Audit Commission, October 2005

began to be felt, revealed that 37% were planning to reduce services due to financial difficulties.[4]

- Recruitment freezes and staff redundancies across all categories of NHS staff. Government attempts to play down the impact of job cuts by insisting that the number of compulsory redundancies is minimal does not take proper account of the impact of fewer staff on patient care, whether due to compulsory redundancies, voluntary redundancies, vacancies not being filled or temporary staff being laid off.

The Government claims that the solution to these problems is better financial management, and that a level of instability in the system will lead to positive incentives. It hopes that introducing competition into the system by giving patients choice of provider will result in:

- Greater equity, with patients able to switch from poorly performing to better performing providers
- Higher standards, as providers improve in order to retain patients, or are forced out of business
- More diverse and responsive services, as the number of providers increases, and providers are forced to adapt more quickly to changing patient needs
- Greater efficiency, as providers seek to drive down costs, and resources are channelled to the most popular providers

Much of this sounds attractive in theory. However, there are real reasons and evidence for doubting that the new market will work this way in practice. Far from leading to the benefits described – these reforms could have the opposite effects. The main problems are:

Equity

> "For markets to work effectively, individuals need to be primarily motivated by the furtherance of their own interests, narrowly defined… They should seize all profit generating opportunities regardless of the impact on the service provided or the people using that service…"
>
> *Julian le Grand, former No. 10 Policy Adviser*

It is a fundamental principle that the NHS should provide equal access to services for those in equal need. But under the new centrally fixed pricing system that the Government is introducing, some services and treatments will become more profitable than others for providers, whilst at the same time providers will have to break even financially in order to survive. As a result, providers will be incentivised to take service provision decisions based on profitability rather than patient and/or population need, competing for those services and patients that are most financially attractive (cream-skimming), whilst seeking to avoid those on which they would make a loss (patient dumping). This was the experience when a system of centrally fixed prices was introduced for Medicare in the US[5].

[4] Funding Difficulties in the NHS: a survey of medical directors of trusts in England, BMA, 5 October 2005
[5] "Will More Choice Improve Outcomes in Education and Health Care? The Evidence from Economic Research", The Centre for Market and Public Organisation, p. 33.

> "Some patients who, because of their speedier treatment, will enjoy better health for longer. Others who, because of their unwillingness or inability to travel, or because of the choices of the first group, will have to settle for slower or possibly declining services … the reasons why people may not take up on offers of faster treatment with alternative providers … may be intimately related to the inequitable distribution of other resources across society – income, power, education."
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> *John Appleby, Anthony Harrison, Steve Dewar, 'Patients choosing their hospital – may not be fair and equitable', British Medical Journal, February 2003*

A second threat to equity is that some individuals will find it more difficult to exercise choice of provider than others. Some patients may not feel capable of investigating and assessing the different options open to them in order to arrive at an informed decision, whilst others, particularly the less affluent, may be prevented by travelling difficulties from using more distant providers. In the Government's patient choice pilots, these problems were addressed by the provision of dedicated Patient Care Advisors, and by the offer of free transport for all participants[6]. By contrast, under the national roll out of choice at the point of referral, free transport will be restricted to those who qualify for Patient Travel Services or under the Hospital Travel Costs Scheme, and Patient Care Advisers will be provided on only a limited, localised basis.

A study commissioned by the Department of Health found that people did not want to have to select a hospital while they were seriously ill, preferring such decisions to be made by a trusted GP. It said there was no evidence that greater choice would improve quality of care, and good reason to fear it would benefit only the wealthy and articulate. According to the BMA, the report, which discredited government policy on choice, mysteriously disappeared from the DOH website.[7]

Quality

The new NHS market risks undermining the quality of services in three ways:

- Where the cost of treating a patient is higher than the national tariff price but the provider is unable to avoid doing the work, there is a danger that they may be tempted to drive down costs at the expense of quality (skimping). There is evidence of this happening with US Medicare patients[8].
- High quality clinical care depends heavily on collaboration and joint working between staff – for example through the formation of cancer networks, which have played a critical role in improving the quality of cancer services. There is a danger that, by increasing service

[6] See for instance "Patient's experience of choosing where to undergo surgical treatment: evaluation of London Patient Choice Scheme", Picker Institute, July 2005.
[7] "Doctors claim study on patient choice suppressed", Guardian, Monday January 1, 2007
[8] "Competition, payers and hospital quality", Gowrisankaran G and Town R, 2003, *Health Services Research*, 38: 1403-1421.

fragmentation and introducing competition, the Government's reforms could put such models of collaborative working at risk and undermine continuity of patient care.

- Competition could also erode the more general emphasis on the sharing and spreading of best practice that has characterised the NHS since 1997.

Supply problems

Economic theory states that markets work best when there are a large number of competing providers that are able to enter or exit the market quickly and without costs – conditions not generally matched by the nature of healthcare provision. Hospital services involve substantial capital investment and tend to be characterised by significant economies of scale and scope (the volume and range of services provided). Furthermore, the supply of healthcare services does not respond quickly to demand: there are often significant time lags involved, for instance due to the need for workforce planning. These factors mean that the potential for meaningful competition between different locally based NHS providers may be limited in many areas, with the result that if people want to exercise choice of hospital they have to travel long distances to do so. In addition, if services in an area do close, the market cannot be depended upon to fill the gap: the Government will still need to be prepared to step in to ensure the continued provision of local services.

> "The case for public provision of health care … rests on the presence of extensive market failures on both the demand and supply side that could not be effectively or efficiently resolved by government regulation alone" including "potential abuse of monopoly power – economies of scale resulting from the clusters of specialisms required to deliver emergency care can create local monopolies" and "it is hard to write and enforce contracts – the non-standardised, patient-specific nature of medicine makes it hard to judge or contract for specific outcomes"
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> *HM Treasury, Public Services: Meeting the Public Productivity Challenge, April 2003*

Efficiency

One of the biggest risks to the efficiency of the new NHS market is that of transaction costs – the costs of administering and managing the market, such as providing information, operating the pricing system, and monitoring and enforcing contracts. Experience throughout the world - from the US to the NHS internal market - has shown that these are significantly higher in market-based systems of healthcare provision. The Department of Health has estimated that the additional infrastructure and transactional costs of introducing patient choice at the point of GP referral are likely to be around £122 million[9]. Many Trusts have reported having to invest considerable resources into implementing Payment by Results, which led to a partial Government climb-down on extending its implementation in July 2006, with a number of children's hospitals also bailed out of financial difficulties created by the tariff. There has, however, been no overall assessment of the additional transaction costs that will arise as a result

[9] Patient Choice at the Point of GP referral, National Audit Office Report, January 2005, p.1.

of the Government's marketisation reforms – indeed this was another area of criticism by the Health Select Committee where ISTCs are concerned.[10]

In addition, the new market carries with it a range of other threats to efficiency:

- If hospitals are allowed to close and services are dismantled then publicly trained professionals are left looking for jobs, with considerable wastage of valuable public resources and investment. For example, in evidence to the Health Committee in November 2006, the Council of Deans reported that only 56% of nurses who qualified in 2006 are employed and 58% of midwives – both figures that would normally be 100%. In physiotherapy 15-20% of those graduating in summer 2006 are employed.[11]
- With the switch to a fee per procedure payment system, there is a real risk that hospital providers may seek to artificially inflate the amount of work they do in those categories of treatment that are the most financially profitable for them (known as supplier-induced demand.)
- Because healthcare supply takes time to respond to demand, if real choice of providers is to be offered to patients, this will involve paying for a degree of unused capacity within the NHS system. Already PCTs that have been pressured into signing up to ISTC contracts are doing so in areas where there is spare NHS capacity going to waste.

There is also a growing realisation that it is actually a phoney market being created within the NHS, which is deliberately bringing instability. Indeed the Government acknowledges that "financial volatility" will be brought about by new incentives.[12] The market is artificially skewed in favour of independent providers, with the much-lauded principle of contestability apparently not applying to companies setting up ISTCs that are paid regardless of contract delivery.

Similar problems exist with LIFT schemes where LIFT companies are granted exclusive long-term contracts and with the Private Finance Initiative where a handful of construction and facilities management companies control the market. However misguided the concept of a market in healthcare is in the first instance, traditional pro-market arguments based around competition and efficiency are rendered spurious by a lack of genuine contestability.

5. Regulating the market

The current regulatory system in the NHS consists of the following components:

- The Healthcare Commission is responsible for assessing the quality and provision of NHS services in England, for publishing information about the state of health care, and for carrying out investigations into serious failures. In addition, it has a duty to regulate the independent healthcare sector through registration, annual inspection, monitoring complaints and enforcement.

[10] House of Commons Health Committee, Independent Sector Treatment Centres. Fourth Report of Session 2005-6, Volume 1.
[11] House of Commons Health Committee, Uncorrected Oral Evidence on NHS Deficits, 2 November 2006
[12] Department of Health, The NHS in England: the Operating Framework for 2006/7

- The Independent Regulator for Foundation Trusts, Monitor, has the job of authorising, monitoring and regulating Foundation Trusts. The Independent Regulator is responsible for approving Foundation Trust applications, determining the services that Foundation Trusts are required to provide, regulating Foundation Trust borrowing, and monitoring compliance with the terms and conditions of Foundation Trusts' licenses. If a Foundation Trust breaches one of the conditions of their licence, the Independent Regulator may take steps to intervene, but in other circumstances it may not.
- The Department of Health is responsible for setting national tariff prices under the new payment by results system.
- Primary Care Trusts still have the job of placing and managing contracts with NHS providers in order to secure services that are in line with NHS standards and to facilitate patient choice, although this role may be lessened by proposals to contract out commissioning functions of PCTs.

However, there are serious questions about whether this framework is adequate to regulate the emerging competitive commercial market. The main areas of concern are as follows:

- A *lack of political and public accountability* at all levels. The Healthcare Commission and the Independent Regulator for Foundation Trusts have only limited duties and neither is subject to the direction of the Secretary of State. At local level, many of the structures introduced to increase patient and public say over NHS services have failed to operate effectively. It is not yet clear whether new proposals for Local Involvement Networks (LINks) will boost meaningful public and patient involvement (PPI) in health decisions.
- The *fragmentation of regulatory functions*, which is hindering the development of a coherent and joined up approach and makes it difficult to discern where responsibilities lie.
- It is unclear what mechanisms are being put in place to *prevent cream-skimming of patients and services by providers*, and to ensure that a holistic approach is taken to planning service provision to meet the needs of the whole population.
- There are also questions about the adequacy of the current framework for *monitoring and enforcing clinical standards* where NHS services are being provided by the independent sector. Although the Healthcare Commission inspects independent sector providers of NHS care such as ISTCs against national minimum standards, it is currently moving towards a more risk based approach to inspection that relies more heavily on self-disclosure. At the same time, there is little transparency about the quality requirements and monitoring procedures that are in operation as part of the ISTC contracts. Too often "commercial confidentiality" is cited as the reason for evasive responses on the exact details of contracts involving private sector providers.
- As the Government gives up control over more and more of the organisations providing NHS care and as market pressures begin to bite, so it is losing its ability to *enforce workforce related practices and agreements*, for instance the improving working lives HR standard and the Department of Health's code for international recruitment. Health Minister Lord Warner had to write to all SHA chiefs in August 2006 requesting they urge local trusts to implement Agenda for Change pay increases that deficit-hit hospitals were reneging on.[13] In the longer-term, failures to improve working conditions can have a

[13] Department of Health, Agenda for Change and NHS contractors' staff – implementation of the joint statement for soft facilities management staff, letter from Lord Warner to SHA Chairs and Chief Executives, 14 August 2006

critical impact on the health service, affecting the quality of patient care and the way in which NHS staff are treated. This is a substantial regulatory gap that needs to be closed.

> "Conventionally, regulation copes best in situations where we are insisting on minimum standards. But when there is an explicit undertaking that medical treatment must be given at the highest level to every patient based on health need and not ability to pay, then one is led to the conclusion that, even if that task of market regulation could be practically accomplished, public provision is likely to achieve more at less cost to efficiency and without putting at risk the gains from the ethic of public service where, at its best, dedicated public servants put duty, obligation and service before profit or personal reward."
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> *Gordon Brown MP, Speech to the Social Market Foundation, February 2003*

Resources

UNISON has a number of publications on related issues as well as resources available on the UNISON website www.unison.org.uk

Building Schools for the Future A Branch handbook (Feb 2006) Stock no:2484
It describes key stages in the BSF process and highlights UNISON's concerns.

In the Interests of Profit – At the Expense of Patients Stock no: 2481
An examination of the NHS Local improvement Finance Trust (LIFT) model, analysing six key disadvantages (Jan 2006)

The Private Finance initiative: A Policy Built on Sand Stock no: 2449
Report shows that private finance initiative schemes do not out-perform public sector projects. (Oct 2005)

Operating for Profits
An examination of the UK government's policy of promoting "Independent Sector Treatment Centres". (October 2005). Available on the web : http://www.unison.org.uk/acrobat/B2061.pdf

School Meals, markets and quality Stock no:2442
The effects of deregulation, markets and privatisation on the quality of the school meals service and on the staff. (September 2005)

PFI: Against the Public Interest Stock no:2353
The report analyses the failings of the government's private finance initiative and public private partnerships, highlighting high profile contracts which have failed and PFI companies, such as Ballast which went into receivership. (July 2004)

Cleaners' voices: interviews with hospital cleaning staff Stock no:2398
Lifts the veil on the day to day reality of working life for hospital cleaners and their solution for cleaner hospitals.

Positively Public Briefing
Monthly update on campaigns and developments. Available on the website:
http://www.unison.org.uk/positivelypublic/ppbriefing.asp

Labour Link News
Labour Conference 2006, Special No 1 October 2006 of Labour Link
Dave Prentis explains why marketisation of the NHS is the wrong path for Labour
http://www.unison.org.uk/acrobat/B2747.pdf

Labour Conference Special No 2 October 2006
Dave Prentis explains why the Third Sector will lose its unique strengths and independence if government uses it as a direct service provider in a new market-based system for public services.
http://www.unison.org.uk/acrobat/B2748.pdf

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