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Safe in Their Hands? Health and the Market

The public provision of health care constitutes a large percentage of the public spending budget of any major Western country. The establishment of the National Health Service in 1946 was rooted in the core principle of a comprehensive health service free at point of use, a principle that, broadly, still remains intact, despite growing colonization by the private sector. The cost of health provision is inevitably a pressure point in government expenditure, as resources are finite and the needs of health care are extensive. The growth of medical technology, expanded range of drug-based treatment, and rising life expectancy all push costs upwards. The National Health Service still constitutes, compared to other systems in the world, a remarkably efficient means of fulfilling health services delivery, with a high level of quality.

In the United States, the enormous sums spent on health by the state and by individuals paying for insurance, combined with the lack of a proper publicly owned health system, has generated a large and profitable private sector. As part of the extension of neo-liberal economic policies, pressure has fallen on governments around the world to reduce the scope of public spending by involving the private sector. Major American health and medical companies have been prominent lobbyists seeking new opportunities for profit around the world. Potential profits are tempting in the social democratic countries of Western Europe (and also in the new middle income countries, such as Brazil, China and India), if only health services could be prised from the grip of the public sector.

At first appearance, the politics of health in the United Kingdom appear complex, with the structure of the NHS subject to constant reorganization. Yet, examined over 40 years, from 1979 onwards, one trend is clear – there has been a gradual advance towards privatization, with the sector being progressively opened up to private providers. Politicians are well aware that the NHS (like the BBC) enjoys a high level of popular support and that

there is great suspicion of those who would meddle with it. Consequently, politicians and civil servants appear to have gone to great lengths to mask what is happening, to cloak it in mystifying rationale, all the while uttering the ritualistic assurances that the NHS is 'safe in our hands'.¹ This chapter will examine the growing importance of sponsorship of health-care activities, the gradual marketization of the NHS and the increasing role of private companies in public health provision. The first section examines the expansion of sponsorship; the second looks at the problems associated with regulating relations with the pharmaceutical industry; and the third section traces the last 30 years of development of British health policy, by which a road to privatization has been constructed.

The NHS employs large numbers – according to some estimates, it is the largest single employer in Western Europe. It also spends large sums on pharmaceuticals, medical supplies and other equipment and consumable items. Not surprisingly, suppliers have been keen to establish their brands in the minds of those – consultants, doctors, GPs, nurses and managers – who make purchasing decisions. Such companies have been prominent in the growth of commercial sponsorship in medical centres and hospitals. Commercial sponsorship of health products and services grew throughout the 1990s and, in 1993, the perceived need within the profession to establish general principles to manage the relation between sponsors and health professionals had prompted the Royal Society of Medicine to stage a conference to open a dialogue on the subject.² At that conference, the following exchange took place:

Professor Paul Turner (Vice President, The Royal Society of Medicine):

"Is there a role for the middle man here ? The honest broker who understands the problems of both sides linking people together ?"

Mr D. W. G. Barrett (Wyeth Laboratories): "It is difficult to know who would be that honest broker".

(Turner 1993, p. 1)

This exchange is symptomatic of two features of the growth of commercial sponsorship. First, the perceived need for a system, and second, the uncertainty about how that system might work. The sponsorship of health services and related products began discreetly at the margins and has steadily etched its way towards the heartlands of provision. The conference featured speakers from the health profession, representatives from Hospital Trusts and from Health Authorities and from pharmaceutical companies. The vice president of the Royal Society,

Paul Turner, is clear in his introduction to the published proceedings that the nature of changes to funding in health had made commercial sponsorship essential to the running of the Health Service:

The development of hospital Trusts and the concept of the 'provider-purchaser axis' with all the financial restraints that have been associated with that has forced Trusts and others concerned with the provision of healthcare into looking for other sources of financial help. Commercial sponsorship through industry, in various forms, is now being seriously considered and has been adopted in many places . . . (Turner 1993, p. 1)

In other words, the restructuring of the National Health Service around cost centres in which providers would sell services to purchasers heightened the pressure to pursue sponsorship. Don Barrett, a representative from Wyeth Laboratories, made the same point, that underfunding and changes in the health sector required health professionals to seek sponsorship. He identified a four-fold increase in requests for funds in the last 2 years, 'as a result of changes in the NHS and restrictions on money availability'.³ The Society president, Sir George Pinker, set the tone in his introduction that

changing patterns of healthcare funding have brought into sharp and prominent focus the issue of sponsorship. This has become a well organised feature of modern business life. Increasingly there is an apparent need for potential providers of sponsorship to sit down with the recipients of that sponsorship to discuss quite frankly their mutual needs and limitations. (Turner 1993, p. 2)

The NHS has a huge expenditure on pharmaceutical products, medical products and equipment, and commercial suppliers are anxious to establish themselves in that market. Susan Scott, a representative of the Royal College of Nursing, warned that companies would not sponsor a nursing post unless 'there is a product to be purchased and a commercial advantage to be gained' (Turner 1993, p. 30). Scott declared that nurses felt they were often the unwilling subjects of a sponsorship deal, and that there was 'an implied threat that their post would be at risk if they did not comply'. Nurses had to complete sales figures for the sponsoring company and there was 'covert pressure to use the company's products because of the fear that sponsorship would be withdrawn and the post lost if insufficient products were used' (Turner 1993, p. 31). Carol Jones, from Osteoporosis Dorset, gave an account of how she had to 'develop entrepreneurial skills' because she was given funding for her salary, but no budget for her work (Turner 1993, p. 3). The commercial logic of sponsorship was clearly put by Don Barrett, who outlined

the way that constraints on direct advertising were a factor in leading medical companies to consider sponsorship. Such sponsorships though, had to 'benefit the business', otherwise, 'fund for future investment in sponsorship will decline' (Turner 1993, p. 11).

As financial pressures grew, and more and more people in the NHS were forced to look for sponsorship support, understandably, companies would choose the high-profile activity over one with a lower profile and would opt for those activities that give them the greatest returns in terms of promotion and sales boosting. It is clear that companies were interested in sponsoring educational events for health-care professionals – conferences and symposia – but these were often a means to promote products to health-care professionals. The free provision of sponsored pens and notepads all served to further reinforce brand names of medical products in GPs, surgeries, clinics and in the minds of those who wrote prescriptions. The new entrepreneurialism meant senior and highly paid staff had to devote a lot of time, energy and resources in pursuing sponsorship – one speaker referred to being 'a fundraiser as well as an Operational Manager for the hospital. I am also a Business Manager for Gynaecology, so I have many hats' (Turner 1993, p. 16). Evidence for the ways in which sponsorship had moved from peripheral to core can be found in Turner's remarks that:

Ten years ago, if you had said to a pharmaceutical company. 'will you buy our district a densitometer?', or 'would you buy some flow machines for our practice?', the answer would have been 'no, this is something that should be provided from the NHS budget'. It is interesting that now pharmaceutical companies and charities are having to provide MRIs and CAT scans. (Turner 1993, p. 24)

The tenor of discussions at such conferences constituted a consistent retraining of public sector staff in the ethos, values and ways of thinking of entrepreneurialism. One floor speaker, from Shire Hall Communications, argued that health professionals should 'adopt a realistic approach to the company's need to get a return on its investment' and suggested that the NHS should be more accepting of industry's needs to ensure a return for its shareholders' (Turner 1993, p. 25).

The 1995 Annual Report of the Association of the British Pharmaceutical Industry (ABPI) devoted two pages to a list of deals between hospitals and health-care organizations and many of the industry's major players. The short section on sponsorship in the ABPI's code of practice commented that while traditionally the industry had concentrated its sponsorship in the NHS on clinical research, it now 'spreads its net much wider, and puts money into bricks and mortar, specialist interest groups, medical and nursing posts, health service

symposia and awards, and patient and other literature' (*Health Service Journal*, 19.10.95). Since the 1980s, a wide range of medical activities, such as equipment and supplies, information provision, research, training and professional associations, have become routinely supported by sponsors.

Equipment and Supplies: The large sums that the NHS spends on medicine inevitably attracts attention from the major pharmaceutical companies. A sponsorship given to a special interest group for a disease or syndrome appears as a benevolent act and may well help to raise awareness of the disease area and the need for better management and improved quality of life for patients. However, sponsoring the group is also likely to increase prescriptions of the sponsors' products (*Health Service Journal*, 19.10.95). The competitive pressure from companies wishing to be involved can place undue pressure on staff. In the case of the sponsorship of specialist cancer-care nurses by manufacturers of stoma care products, the RCN received numerous reports during the 1990s from sponsored nurses who felt they were being pressured into prescribing their sponsors' products. In an article in the *Health Service Journal*, Sue Scott, assistant adviser in nursing practice at the RCN, said,

About 30% of stoma care nurses are sponsored and most companies are involved. Because of the nature of the industry, there is enormous competition for a very lucrative business and problems arise when nurses are appointed who don't have the maturity or experience to hold their own against the demands of their sponsor. (*Health Service Journal*, 19.10.95)

By the mid 1990s, NHS bodies were routinely seeking a wide range of sponsorships. For example, Leicester Royal Infirmary NHS Trust sought companies to sponsor beds. In return for a one-off payment of £4,000, a donor company got its name on a commemorative plaque above a bed, plus a free health check for the boss or a nominated employee (*The Observer*, 01.09.95).

Information: Health information leaflets became sponsored as a matter of routine and were widely available in clinics, surgeries and hospitals. Ashtons, makers of towelling nappies, produced one that proclaimed that your baby would be more comfortable in towelling nappies than in disposables, while an Ultra Pampers leaflet suggested exactly the opposite (*The Guardian*, 22.04.92). This of course makes 'educative' information almost useless, and such commercially motivated advice also tends to contaminate the more neutral informational material around it. New mothers, *The Guardian* argued, are 'particularly vulnerable to advertising dressed up as health education'. A survey in one district health authority found 90 leaflets related to nutrition and health, of which nearly

two-thirds were produced by food companies of food industry bodies (*The Guardian*, 22.04.92).

Sponsored Research: For many years much medical research has benefited from the support of sponsors, and every so often, there are disturbing reports as to what can happen if research is not in the best interests of sponsors. In 1996, *The Observer* (28.04.96) reported that Boots (a long established retailer of pharmaceuticals) suppressed research results that demonstrated that its most lucrative drug could be replaced by products three times as cheap and just as effective. *The Observer* commented that this 'reinforced fears that corporate sponsorship compromises medical research when it threatens profits'. In the early 1990s, the *International Consensus Conference on Food and Nutrition* was held under the patronage of the IOC Medical Commission. A video report of the conference uses clips from doctors and scientists and ordinary people. The cumulative effect was to suggest the following argument – carbohydrates are an important element in diet, both simple and complex carbohydrates have a role; sweets are one useful source of simple carbohydrates. There is a perfectly valid case that simple carbohydrates are a useful source of quick energy, particularly for athletes in training who may not always want the bulkier complex carbohydrates (see Brewer et al. 1988). The fact is, though, that the conference was sponsored by confectioners Mars.⁴

Sponsored Training: Among forms of medical training sponsored by drug companies during the 1990s were: asthma instruction training for nurses, courses for registrars seeking posts as consultants, epilepsy educational packs, diabetes treatment, medicine for managers seminars, rheumatoid arthritis videos, management protocols for cancer care and clinical training for GPs in contraception advice (*Health Service Journal*, 19.10.95). Glaxo Wellcome sponsored asthma nurse training, with an explicit intent: 'The main benefit for Glaxo is that if asthma is diagnosed earlier and managed correctly so that patient compliance is improved we will gain commercially' (Veronica Prentice, senior customer planning manager at Glaxo Wellcome UK, quoted in *Health Service Journal*, 19.10.95). A range of evidence from America suggested that drug companies constituted a significant influence on the prescribing practices of doctors.⁵

Professional Associations: In 1994, *The Observer* (19.06.94) reported that the professional body of Britain's child health doctors was in disarray over secret payments from a multinational food company, whose vigorous marketing of baby-milk substitutes in developing countries has prompted an international boycott. Senior officials of the British Paediatric Association faced resignation

calls after confirmation of the secret £140,000 donation from Nestlé. The 4-year deal involved £35,000 contribution to a BPA research unit. Under the World Health Organisation (WHO) guidelines, all such donations should have been fully disclosed by the recipient.

Guidelines, ethics and product promotion

The activities of private companies, particularly but not solely from the pharmaceutical sector, wishing to promote goods and services, poses ethical issues that require attention, but effective measures have proved difficult to implement. During the 1990s, concern at ethical issues was sufficient to prompt the development of a whole series of guidelines. The NHS executive included guidelines on certain forms of sponsorship in its 1993 Standards of Business Conduct for NHS staff (*Health Service Journal*, 19.10.95).⁶ These guidelines were struggling to get to grips with a new form of income and were symptomatic both of the rapid spread of sponsorship into new areas and of a widespread concern that the health service did not have a clear or unified ethical position. The guidelines served to confirm the relation between health professionals and sponsors rather than to restrict the continued expansion of sponsorship.

As a major investor in a range of medical activities, the role of the pharmaceutical industry has for a long time been a cause of ethical concern, despite the Association of the British Pharmaceutical Industry (ABPI) claim that 30 per cent of UK pharmaceutical industry's sales income is ploughed back into the research and development of new and better medications.⁷ In the United States, where the pharmaceutical industry has greater freedom to promote medicines directly to the public, the industry is constantly developing new forms of promotion.⁸ The use of sponsored patient groups in medical research can mean that NGOs become unwitting collaborators in advancing a drug company's own agenda (see Hogg 2009). The WHO has found it necessary to develop ethical guidance in this area.⁹

In 1999, a report by the Royal College of Paediatrics and Child Health proposed to differentiate between acceptable and unacceptable sources of sponsorship, based on how products are used and marketed, rather than on the products themselves. Lisa Bero (1999, pp. 653–4) suggested that this strategy was unworkable, and that adopting restrictions on sponsorship, regardless of source, would be more viable, arguing that this would set a strong example for other organizations that had to deal with the reality of accepting increasing corporate

sponsorship, as public funding contracted, while maintaining ethical standards. This suggestion has not been adopted. Elizabeth Wagner (2003, pp. 1196–8) drew a distinction between four types of non-governmental guidelines. However, such guidelines are in the end only as strong as the authority that enforces them and the ability and willingness of those authorities to enforce them. Only governmental regulation can have the force of law and then only when the policing of infringements is rigorous. Effective government-led regulation of this type has not been decisively imposed by either Labour, Conservative or coalition governments.

It is clear that, in this period, public finance conventions and policy guidelines have been systematically restructured in order to maximize incentives for the NHS both in selling services and in contracting them out.¹⁰ Consequently, ethical concerns became more widely articulated among a range of health organizations.¹¹ As a result of these ethical concerns, a range of bodies has felt it necessary to devise codes of practice.¹² In 2004, the World Medical Association published its first guidelines on how doctors should handle their relationship with commercial enterprises. The guidelines were seen as necessary because the ‘inappropriate influence of commercial enterprise on the autonomy of physicians’ was beginning to cause concern. The guidelines, which cover medical conferences, gifts, research and affiliations, are a bid to satisfy the public’s demand for greater transparency in doctors’ relationship with the pharmaceutical industry, but are rather anodyne in character (Kmietowicz 2004, pp. 329–76). In 2005, the NHS responded to concerns within the profession by issuing ‘Sponsorship - Frequently asked Questions’, which summarized current policies.¹³ Also in 2005, the European Medical Writers Association (EMWA) produced guidelines on the role of medical writers in developing peer-reviewed publications.¹⁴ The Medical Research Council (MRC) offered advice on good research practice, which includes conflicts of interest, confidentiality and consent, authorship, sponsorship and the free dissemination of findings.¹⁵ The Wellcome Trust research guidelines, which use MRC guidelines as a template, similarly cover issues of integrity, conflict of interest, openness, intellectual property rights and ethical and publication practices.¹⁶

The major development, however, was the Health Committee’s 2005 *Report on the Pharmaceutical Industry*.¹⁷ This report, examining the interface between the public and private interests of health care and the pharmaceutical industry, was the first major committee inquiry into this area for almost a century, a fact that the Committee felt pointed to the unchecked free reign that the pharmaceutical industry had been enjoying.¹⁸ The report argued that the

influence of the pharmaceutical industry was huge, and affected every level of health-care provision, from the initial development of drugs, through clinical trials, promotion to prescribers and patient groups to the development of clinical guidelines. The report found that there was no effective regulatory system and said that the Department of Health faced a conflict of interest between the pharmaceutical industry and the health of the nation. The pharmaceutical industry in the United Kingdom had been left to its own devices; the influence of the industry had expanded and several practices had developed that were against the public interest. Sponsored research and development findings were given a positive spin, and selective publication practices and ghost writing by pharmaceutical company employees had become common practice. The report stated that National Institute of Clinical Excellence (NICE) guidance was not always unbiased or complete.¹⁹

However, the trajectory towards private involvement had continued, unrestrained by this wave of ethical concern. The first Labour Government White Paper, *The New NHS: Modern and Dependable* (1997), placed an obligation on Primary Care Groups, Health Authorities, NHS Trusts and Primary Care Trusts to work together and in collaboration with other agencies.²⁰ The White Paper defined sponsorship very simply but broadly as defined by external funding:

For the purposes of this guidance commercial sponsorship is defined as including - NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises.²¹

This description is in itself evidence of the expanded range of activities now supported by external funding. The private sector became adept at circumventing guidelines. A *Consumers' International* report discovered a growth in marketing techniques designed to negotiate EU legislation, which does not allow direct to consumer marketing. These techniques included the sponsorship of patient groups, internet chat groups and drug or disease websites. In the pharmaceutical industry, the report stated, self-regulation is weak and generally inadequate in terms of protecting consumers from potentially misleading claims. The report asserted that there was a need to deal with veiled relationships between pharmaceutical companies and health researchers.²²

Despite all these guidelines, disquiet within the profession persisted and had grown throughout the 2000s. Edwin Gayle, Professor of Diabetes and

Metabolism, at the University of Bristol, argued that 'formal guidelines and declarations of interest are inadequate as a means of policing an interface where undisclosed amounts of money change hands so freely'.²³ Gayle cited the going rate for a doctor to speak at a drug symposium organized by pharmaceutical companies as between £1000 and £6000. He argued that 'evidence-based medicine is the first casualty of drug development . . . because the pivotal studies are designed, analysed and presented in such a way as to favour the positive aspects of new drugs'. Gayle stated that we are 'locked into an unsustainable pattern of growth, the legal department is increasingly crucial to the survival of the pharmaceutical giants and the battle for market share is set to become more ruthless', and commented that 'Some doctors exhibit a naïve and bare-faced venality that is almost beyond belief'.²⁴

Similarly, Sir Iain Chalmers argued, in the *Journal of the Royal Society of Medicine* (June 2006), that Britain's pharmaceutical industry could not be trusted to run clinical trials safely without outside regulation and that the untrustworthiness of clinical health trials had reached endemic proportions in the United Kingdom. Sir Iain Chalmers criticized doctors who, he claimed, collude with the drugs industry by 'collaborating with scientific misbehaviour driven by the marketing departments of pharmaceutical companies'. Sir Iain wrote, 'Their systematic under-reporting of negative results and lack of transparency is blatant scientific misconduct and unethical. Without radical change this will continue . . . stricter government regulation is likely to be needed'.²⁵ Ray Moynihan cites evidence that interactions with industry influence the prescribing behaviour of doctors, even those who deny their susceptibility to such things. The evidence strongly suggests that sponsored research tends to produce results favourable to the sponsor. This, Moynihan argues, is not because sponsored science is necessarily bad science, but rather that the scientific questions being asked reflect the self-interest of the sponsor.²⁶

Doctors are often paid substantial sums by pharmaceutical companies to use patients as drug guinea pigs. One doctor earned more than £100,000 in 5 years from companies including AstraZeneca, GlaxoSmithKline and Bayer to test drugs. Some patients without symptoms were given drugs, while others needing treatment were given placebos. The doctor involved was found guilty of serious professional misconduct by the General Medical Council. According to one investigation, around 3000 UK doctors are paid by pharmaceutical firms to test drugs. They are given £1000 for each patient signed up, and the drug companies spend around £345 million a year on this

(*The Observer*, 09.02.03). Doctors are given all expenses to attend conferences sponsored by companies, with senior doctors able to earn between £1000 and 2000 to speak. Pharmaceutical companies actively seek opinion leaders to nurture; one example is the annual European conference for cardiologists, attended by 18,000 delegates (*The Guardian*, 05.10.04). Some doctors have been found to be prescribing unsuitable or unnecessary drugs, and studies suggest links to interactions with drug company representatives and attendance at sponsored medical conferences and educational seminars.²⁷ Nurses, in particular nurse prescribers, are also now being targeted by the industry and are influenced in the same way as doctors.²⁸

Jacobs and Wagner (2005) describe the common practice for many papers in biomedical journals to be drafted by professional medical writers, or ghostwriters, under close supervision of those who become the 'named' authors of the piece. They argue that since the pharmaceutical companies funding the named author usually employ the medical writers, concerns have been raised about the objectivity of the final paper. In response to concerns expressed by medical journal editors regarding the role of commercial sponsors in publishing research relating to their own products, the EMWA has had to develop guidelines to address the issue.²⁹ There has been growing concern during the last decade over doctors and medical researchers putting their names to papers written for them, for financial reward (*The Guardian*, 12.02.02). *British Medical Journal* (BMJ) editor Richard Smith has highlighted this as a major problem for the medical profession (Smith 2005). An inquiry (*The Observer*, 07.12.03) revealed hundreds of articles that were written by ghostwriters paid by pharmaceutical companies. Gayle claimed that 'Editors of medical journals seem to be losing the battle for open disclosure', suggesting editors cannot be confident that reviewers of papers are declaring their links with companies, and argued that 'there is a widespread assumption that you are not under oath when it comes to conflict of interest statements and creative ways of navigating this obstacle have emerged' (Gayle 2003, p. 540).³⁰

The long history of peddling remedies for diseases, real or imagined, illustrates that once consumers are persuaded that they have an ailment, they will wish to purchase a cure. Drug companies will set up apparently independent campaign groups as a drug-promotional strategy. A 2006 *Consumers International* report suggested that drug companies were promoting their products through patient support groups, students and internet chat rooms to bypass restrictions on advertising. Companies sponsor patient groups and disease awareness campaigns and pay specialized medical communication

agencies to recruit and train leading doctors, specialists and academics to become opinion leaders.³¹

One impact of the intense competition between pharmaceutical companies has been the tendency to develop and promote new syndromes, new diseases for which there is a supposed pharmacological cure. The vaguely defined GAD – general anxiety disorder – is one example. In the *British Medical Journal*, Ray Moynihan (2003) examines the supposed ‘disease’ Female Sexual Dysfunction (FSD) and suggests that the majority of conferences and forums held to investigate female sexual dysfunction have been sponsored by drug companies. Drug companies have sought a definition of the ‘disease’ which highlights only physical problems and does not take into account any social, economic, emotional or psychological factors. This lack of a holistic approach could in turn persuade doctors to prescribe medication in order to change sexual functioning, rather than recognizing the influence of external factors in dysfunction. Misleading statistics, identified in the paper, imply that almost half of the female population are sexually dysfunctional, whereas leading psychologists say that true dysfunction of this type is not prevalent. The danger is that a definition of ‘normal’ is becoming ever more narrow, and so the complaints and dissatisfactions of the healthy can be turned into the conditions of the sick (Moynihan 2003).

Proctor and Gamble hoped to be one of the front runners in selling a testosterone patch for the treatment of this controversial ‘disease’. They invested heavily in the sponsorship of key scientific meetings in sexual medicine, the hiring of leading sex researchers as consultants, funding of continuing medical education activities and informed press and public about the possible uses of testosterone. Despite dissensus in the scientific community, a selective use of facts and figures de-emphasized the possible risks of the drug, while overemphasizing the benefits (Moynihan 2005). The BMJ describes FSD as the clearest example yet of the ‘corporate sponsored creation of a disease’. Other syndromes about which questions have been asked include attention deficit disorder, attention deficit hyperactivity disorder and the male menopause (*The Observer*, 05.01.03, p. 11). In 2006, the journal *Public Library of Science Medicine* published 11 papers linking the definition of new diseases to medical specialists funded by drug companies. The implication was that the pharmaceutical industry was guilty of ‘disease mongering’.

Commercial sponsors are constantly attempting to intervene in medical practice in ways that bend health provision and education towards their commercial interests. Drug companies frequently fund health charities – a

mental health charity, Depression Alliance, gets almost 80 per cent of its funding from drug companies. Arthritis Care receives money from Merck Sharp and Dohme (*The Observer*, 03.04.05). Much 'health advice' available on leaflets in GP's surgery waiting rooms and hospital waiting rooms is unauthorized, unvetted and funded by corporations with an interest in the relevant products (e.g. advice on caffeine from Nestlé). This is a lucrative business – WIS (Waiting Room Information Services) had a turnover of £1.6 million in 2005 and claimed that it could reach 38 million patients in 6000 surgeries in the United Kingdom. It distributes on behalf of the Department of Health, but also on behalf of companies such as Nestlé and Kraft (*The Guardian*, 14.12.07). These practices have damaged and undermined the very concept of public health information. Information can no longer be trusted when it is a disguised form of advertising.

Basic services to patients are being commodified. The company Patient Line provides television and telephone services for patients in hospitals across the United Kingdom. Patients must pay to use the system, which also constitutes a constant running commercial for the company's services, which patients are subjected to, even if they choose not to use those services. There is clear and accumulating evidence that the impact of commercial sponsorship of health products, services and research is neither benevolent nor neutral. Despite numerous guidelines and codes of practice, senior practitioners continue to voice concerns about the impact. Yet state policy has continued to progress towards an ever-greater utilization of private sector providers of public health care.

Marketization of the health service and the road to privatization

The final section of this chapter places the concerns outlined above in the context of a gradual expansion of private provision within the framework of an increasingly hollowed out public health service. The NHS has provided a persistent problem for the neo-liberal version of British conservatism that began its advance to hegemony during the 1970s. For much of the first term of her premiership, Mrs Thatcher had to struggle against the patricians, traditionalists and one-nation Tories who constituted a significant element both in the party and in her cabinet. After the victories against the Argentinians and the Miners, she was able to sail into a second term with greater confidence and greater support. The privatization of the utilities (gas, water, electricity and telephones) was carried out in the context of the ideological figures of 'popular capitalism'

and 'enterprise culture'. The NHS, however, was more problematic. It had always enjoyed a high level of popular support and any political attempt to meddle with it, particularly from the Conservatives, was typically regarded with great suspicion. Despite her Friedmanite views about the need to allow market forces to rule untrammelled, Mrs Thatcher was astute enough to move cautiously and slowly in health reform. Nonetheless, it was her own frustration with this slow pace of change that led her to insist that something must be done to introduce market principles (Young 1990, pp. 548–9).³²

From this period to the present day, there has been a hidden agenda within government and civil service circles. This agenda has been pushing the NHS, inch by inch, towards an imagined future in which it will become an insurer and a brand, rather than a provider of health services. The agenda has been heavily influenced by powerful lobbying, behind the scenes, by private medical services companies, many of them American, and by the big pharmaceutical companies. The agenda has remained hidden because those politicians, political advisors and civil servants sympathetic to it understand the massive public hostility that would be unleashed if the trajectory of change was clearly understood by the public. Between 1997 and 2008, New Labour were, for the most part, every bit as complicit as the previous and subsequent Conservative governments, in this slow privatization by stealth.

During the period from 1948 to 1963, the political landscape was characterized by a Butskellist consensus. By the 1960s though, disagreement between the parties about health policies grew, particularly around issues such as pay beds in NHS hospitals and the percentage of time consultants could spend on private patients. Health services in any society are subject to rising costs, rising demand and expectations and face the problem of cost control. In 1973, the Conservative government attempted to tackle this by allowing Regional Health Authorities to use profits from land sales, encouraging the consolidation of hospital facilities on a few large sites, freeing up land, often in inner cities, for lucrative sales. But only post-1979 did the new agenda begin to unfold. By 1980, according to Allyson Pollock, privatization began to be official policy (Pollock 2004, p. 36). The phasing out of pay beds was reversed, the contracting out of support services was introduced and there was a gradual elimination of some services from NHS (routine optical services, dental care and long-term in-patient care).

In 1982, a system of 'option appraisal' was introduced in the NHS to encourage contracting out. In 1983, the Griffiths Report led to the introduction in the NHS, at senior level, of managers rather than consultants. In 1987, the concept of an

internal market, separating providers and purchasers, was developed. Plans were made to break up the structure of the NHS, establishing hospitals and community health services as semi-independent trusts.

In 1991, the internal market was first introduced (Pollock 2004, p. 20). Hospitals were converted into financially independent trusts that had to balance their books. GPs were able to become fund-holders, commissioning services from providers. In 1995, the GATT Agreement enforced, globally, a significant opening up of public services to private provision. With considerable irony, while it was possible to exempt public services if they did not charge for services, under its new internal market system, the NHS did not qualify for exemption. In a new regulation for the NHS in 1993, there would be no government funding for hospital building works until the option of private providers had been considered. This laid the basis for the incursion of private contractors into significant areas of health service provision; George Monbiot explains the Conservative government's argument:

The private sector, the government maintained, would run hospitals more efficiently, and therefore more cheaply, than the public sector. Private companies would build new hospitals and let them to the National Health Service. They would also take care of all the 'non-clinical' services, such as catering, cleaning and portering, leaving the NHS to concentrate on looking after patients. By mobilizing private capital, the government would be able to open more hospitals than the Exchequer alone could afford. By cutting the costs of peripheral services, it could plough more money into caring for patients. (Monbiot 2000, pp. 62–6)

This laid the groundwork for the Private Finance Initiative (PFI), which shaped, and continues to shape, the provision of public services and infrastructure in health care. By the mid-1990s, private companies were playing a significant role in the NHS, providing cleaning, catering and laundry services. The establishment of an internal market, separating purchaser and provider, and the establishment of trusts helped set the ground for the next phase of developments during the era of New Labour.

The welfare state that had introduced a more civilized and healthier existence for the inhabitants of the British Isles was being eroded. A caring nurturing society, with its free orange juice, malt and milk for growing children, was now being represented as thoroughly old-fashioned and unnecessary. Labour Prime Minister Harold Wilson had removed free milk provision from secondary schools in 1968 and, more notoriously, Margaret Thatcher had, as Education Secretary

in 1971, removed it from primary schools (leading to the popular chant ‘Maggie Thatcher, Milk Snatcher’). So it is interesting that almost 40 years on, research by Dr Mark Vanderpump, associated with the British Thyroid Association, has discovered significant iodine deficiency levels, particularly serious in pregnant women. Children of women with underactive thyroids can suffer from mental impairment (*BBC News*, 12.04.11, *Camden New Journal*, 14.04.11). So, as well as contributing calcium and vitamins, free milk may have had another unsuspected social value in combating low iodine levels.

During the 1980s and 1990s, the image of a public health service was systematically restructured in discursive terms. It moved from a public good, a socially desirable institution, to being perceived as a problem of rising costs and supposed inefficiency, in need of reform. Underpinning this shift, of course, was the triumph of a neo-liberal philosophy that did not believe in the value of public provision and sought to return such activity to the market and to the individual. It was just that, in the case of the health service, this was a view that had to be partially masked.³³ Colin Leys asked the pertinent question:

What explains Labour’s drive to destroy the institution it is most admired for creating? A key part of the explanation has been the desperate desire of Blair and Brown and their allies to be seen as ‘pro-business’ (Leys 2009)

From 1997, commercial sponsorship of health-related activities continued to grow, given greater impetus by the business-friendly policy environment of New Labour. The involvement of the private sector in the provision of public health care would subsequently be given much greater scope by the Conservative-led coalition government in the restructuring of the NHS established by the Health and Social Care Act 2012.

Financial investment from medical and non-medical sponsors increased in scope and scale. The Labour government steadily increased NHS spending, aided by a reckless reliance on PFI schemes, enabling improvements in both staffing and infrastructure and producing growing public satisfaction levels. However, it also continued the trajectory of expanding the role of the private sector in public health, which had begun in the early 1980s. The controversial Health and Social Services Act 2012 was, in large part, one more step (albeit a dramatic one) down the road already well mapped out by previous governments.

From 1997, the Labour government’s strategy was to maintain Conservative spending plans in its first term, to avoid tax rises and to improve the credibility of the Labour Party as a safe manager of the economy. However, this gave the new government a dilemma – it was necessary to secure funding for visible

improvements in health and education, while remaining within its self-imposed constraints. So the PFI concept, which raises private funding for public projects while keeping such sums out of the government accounts, had a particular appeal. Labour had derided PFI in the health service while in opposition: Harriet Harman, then shadow health secretary warned that 'the future of services will be driven by the short-term priorities' of the companies involved, but once in office, they embraced PFI with enthusiasm. Health Minister Alan Milburn declared in 1997 that 'When there is a limited amount of public-sector capital available, as there is, it's PFI or bust' (both quoted in Monbiot 2000, p. 63). In committing to PFI, the Labour government was stacking up public debts and risk exposure for the future. By 2011, it had become clear that many hospitals, saddled with PFI-related debt commitments, would be unable to balance their books and hence meet the financial requirements necessary to become Foundation Trust hospitals.

The architects of New Labour, as keen on enterprise as Mrs Thatcher had been, nurtured suspicions of the unions and the public sector workforce. The popularity of the NHS, however, is such that all British governments (up to and including the coalition established in 2010) have felt impelled to claim that the NHS is 'safe in their hands' and to deny that any policies might be designed to usher in privatization. In the first 3 years of office, Labour's health policies were slow to coalesce. Several changes in shadow health secretaries (Cook/Beckett/Smith) during the 1990s impeded systematic planning. Blair's surprise appointment of Frank Dobson as Health Minister meant internal resistance to New Labour's marketization agenda (see Wood 2000, p. 195), and so the early developments in health policy were cautious. The 1997 Primary Care Act allowed for some deregulation and experimentation in the area of primary care. When Labour came to power in 1997, they decided not to reverse the purchaser/provider split, but to establish PCGs (Primary Care Groups) which would take over commissioning from local Health Authorities. In December, Labour published the 1997 White Paper *The New National Health Service: Modern, Dependable* and in 1998 the White Paper *Working for Patients*, which made clinical auditing of needs a requirement on hospitals, and thus made the role of hospital managers more powerful. The internal market required such managers to make decisions on economic grounds, rather than on the grounds of long-term health-care strategy.

Between 1997 and 1999, the staunch defender of the NHS, Frank Dobson, as Minister of Health, fought a rearguard action, calling for an end to the internal market. However, as he was prevented from abolishing the distinction

between purchasers and providers, this proclamation had rhetorical force but no real impact. One assessment of Dobson's short reign as Minister of Health has argued that he:

produced proposals for wide ranging reforms to the organisation and culture of the NHS through ending the competitiveness and short-termism of the internal market. He had also put the medical profession on the defensive, pursued a range of populist policies, fielded the daily crisis issues pretty capably, and presided over the announcement of a substantial funding increase. (Wood 2000, p. 205)

Dobson also called for the end of GP fund-holding, but all GPs had become, in effect, fund-holders through the establishment of Primary Care Groups, which had been proposed by the previous government and which subsequently became Primary Care Trusts. In 1998, the Government announced that PCGs were expected to progress to being freestanding Primary Care Trusts, at which point they become responsible for providing community services as well as the purchase of hospital services. The establishment of PCGs did not appear to make cost control any easier and gave GPs effective control over a large proportion of the health service budget (see Paton 1999, p. 64). According to Paton, health inequalities could not be reduced without a redistribution of people's incomes (Paton 1999, p. 68). In 1999, Dobson was pressurized into leaving the Ministry to run as Labour candidate for London Mayor, against the popular left-winger, Ken Livingstone. Dobson, whose heart was never in the contest, lost, remained on the backbenches and never really forgave Tony Blair for taking away a job he loved.

Dobson's major achievement may have been the introduction of National Service Frameworks. These for the first time identified the key service areas based on evidence-based (i.e., epidemiologically informed) needs such as mental health, cancers, diabetes and provided targets for provision, showing service users what they were entitled to expect. In the most recent moves towards commercialization, epidemiologically informed targets highlighting health status outcomes are being shelved to be replaced by financial targets (as is clear from recent debates about the role of Monitor, the independent regulator of NHS Foundation Trusts).

In New Labour's first 18 months in office, a series of major public/private partnership deals were announced, particularly in the transport and health sectors and in local government (see Coates 2000, p. 129). From the second half of 1997, measures were taken to encourage and develop local government Private Finance Initiative (PFI) projects and by February 1998, 40 of these had

been approved (Burch and Holliday 2000, p. 74). The development of PFI meant new hospitals could be financed and managed by the private sector and leased by the state (Paton 1999, p. 55).

Labour's major policy initiative, the *NHS Plan: a modernization strategy*, was issued in 2000. It was impressively expansive in ambition, calling for 100 new hospitals by 2010, 7000 more beds, 500 new one-stop primary care centres and 7,500 more consultants. There is no doubt that from 2000, the Labour government, benefiting from economic growth and utilizing PFI, was able to improve the staffing and infrastructure of the NHS. This increased spend was matched by growing public approval. Public satisfaction with the NHS had declined from 55 per cent in 1983 to 35 per cent in 1997, when Labour took office. But a continuous upwards trend from 2002 saw this figure reach 64 per cent by 2010.³⁴ According to Leys and Player, the NHS Plan also marked a further step down the road to privatization. Since 2000, the year of the NHS Plan, they argue, a central feature of government policy for the NHS has been the concealment of its real trajectory (Leys and Player 2008). At the acute health-care conferences organized annually by private health-care analysts Laing and Buisson, for example, ministers and top civil servants had for several years given detailed policy briefings to companies on new private sector health-care opportunities, while Patricia Hewitt, then Minister for Health, was constantly assuring journalists that NHS privatization was 'out of the question' (Leys and Player 2008). In 2000, the Independent Healthcare Association, which represents the private health-care industry in the United Kingdom, negotiated a concordat with the new Minister of Health, Alan Milburn (Leys and Player 2011, p. 1). This made private companies permanent providers of treatment to NHS patients and meant that 'NHS' was to become a brand, a kitemark, that could also be displayed by private providers, blurring the distinction between the NHS and the private sector in the public mind.

A number of key figures moved between public and private sectors, evidence of the close links being forged between government, the civil service and private companies. Simon Stevens, Tony Blair's key advisor on health and the main architect of Britain's health reforms, moved in 2004 to UnitedHealth, America's biggest insurer. Mark Britnell, former Department of Health head of commissioning, now leads KPMG's European Health Division. Lord Carter, chairman of the NHS's competition panel, is also McKesson's UK chairman. Penny Dash, the Department of Health's former head of strategy, co-authored the NHS Plan of 2000, which initiated the marketization process and now works for McKinsey. Mark Hunt, once in the Strategy Unit at the Department of Health, is

now managing director of Health Care at Care UK. Professor Chris Ham, ex-head of the Department of Health's strategy unit, has close links with Kaiser. Former health secretary Patricia Hewitt is an advisor to the private equity company Cinven, which has acquired BUPA's hospitals. Tom Mann, formerly head of the Department of Health's 'national implementation team' which awarded the first Independent Sector Treatment Centre (ISTC) contracts, subsequently became chief executive of Capio, which won a large number of these contracts. Danny Murphy, a former special adviser to both the prime minister and the health secretary, became director of corporate lobbyists APCO UK. Matthew Swindells was chief information officer of the Department of Health and a special adviser to Patricia Hewitt, and then became director of Tribal's health-care division. Former health minister Lord Warner is now working in private health sector for AXA. Former health minister Alan Milburn went to work for private equity firm Bridgepoint Capital, which obtained several NHS contracts.³⁵ The health policies of the Blair government were shaped by people who had or were to have vested interests in the private sector. Safe in their hands?³⁶

Person	Role	Moved to
Simon Stevens	Blair's key advisor on health	UnitedHealth
Mark Britnell	DOH head of commissioning	Leads KPMG's European Health Division
Lord Carter	Chairman of the NHS's competition panel	McKesson's UK chairman
Penny Dash	DOH head of strategy	McKinsey
Mark Hunt	Strategy Unit at the DoH	Managing director of Health Care at Care UK
Chris Ham	Ex-head of the DOH strategy unit	Links with Kaiser
Patricia Hewitt	Health secretary	Advisor to Cinven
Tom Mann	Head of DoH 'national implementation team'	Chief executive of Capio
Danny Murphy	Special adviser to prime minister and health secretary	Director of corporate lobbyists APCO UK
Matthew Swindells	Chief information officer, DOH	Director of Tribal's health-care division
Lord Warner	Govt. health advisor	AXA
Alan Milburn	Health minister	Bridgepoint Capital

Leys and Player have argued that the covert strategy for privatization of health provision required three crucial steps. First, openings had to be created for private firms to provide clinical treatment to NHS patients. Second, NHS organizations had to be reorganized into competitive businesses. Third, a growing percentage of the NHS workforce had to be made ready to transfer to the private sector (Leys and Player 2011, p. 13). In this context, it becomes easy to see the line of continuity between Thatcher's internal market, Blair's NHS Plan and Cameron and Lansley's Health and Social Care Bill.

Private providers were moving into the heartland of clinical provision. During 2002, the old District Health Authorities were replaced by 28 Strategic Health Authorities, reducing local community input into decisions, and new ISTCs (Independent Sector Treatment Centres) were established to provide 'low-risk' elective surgery. The government was warned (not for the last time) that private companies would cherry-pick the easiest and cheapest work. Over 5 years, £5.6 billion was transferred from the NHS to private companies. However, crucial data on costs and performance remained hidden (*The Guardian*, 17.05.11). The National Institute for Clinical Excellence (NICE), intended to assess the effectiveness of drugs and other technologies, in order to limit growth in the NHS drugs bill, was established in 2002. However, health policy expert Allyson Pollock has argued that it was soon 'captured' by the pharmaceutical industry (Pollock 2004, p. 81). The leading historian of the NHS, Charles Webster, commented that Labour was moving towards privatization faster than had the Conservatives and argued that any increased spending on the NHS would tend to be absorbed by the higher costs of privatized services (Webster 2002).

In 2003, Foundation Trusts were introduced, converting hospitals into semi-independent organizations, required to manage their own business plans and to balance their books. Colin Leys argued that hospital trusts would face great financial uncertainties and risks. First, he suggested, payment by results coupled with 'patient choice' prevented hospitals from knowing in advance what their income would be. Second, a significant part of the hospital budget would be transferred to the primary-care budget, much of it destined for for-profit providers. Third, by 2008, up to 40 per cent of the NHS hospital budget could be transferred to pay for work carried out by private hospitals and treatment centres.³⁷ These predictions have proved perceptive as by 2012 many Foundation Trust hospitals were already facing severe financial difficulties.

The *Health and Social Care Act 2003* allowed PCTs to contract out almost all forms of primary care. The new GP contracts made after-hours care optional,

allowing for contracting out to private providers. New Labour rhetoric had adopted the free-market mantra of 'choice', although there was no clear evidence that choice was the main thing that people wanted from a health service, nor that giving choice produced greater efficiencies, cheaper costs or better quality.³⁸

During 2005, the Department of Health (DoH) commissioned a study of NHS administrative costs. According to the 2003 statistics, administration had cost 14 per cent of the budget. This was devastating information, as, in the 1970s, before the marketization process began, administration had only cost 5 per cent. The argument that competition would reduce costs was now demolished. The Department kept the report private and the results only emerged in 2010 (Player and Leys 2010). However, such was the ideological commitment to enterprise among key New Labour figures that no change of direction could be contemplated. In 2005, The Adam Smith Institute, a right-wing think-tank, held a conference in the Commons for senior NHS and private health-care executives. One senior NHS official proclaimed 'we have created a market. It's up to you now' (Allyson Pollock, *The Guardian*, 24.05.05).

The Department of Health set aside £3 billion to buy 1.7 million operations from the private sector over the next 5 years. This money was earmarked for ISTCs which did not require the same level of training for doctors. The government also introduced LIFTS: local improvement finance trusts, the counterpart to PFI in primary care. Doctors were now typically being tempted by commencement payments of several thousand pounds to leave the NHS, to become salaried employees of transnational health-care corporations (*The Guardian*, 24.05.05). The private medical sector has benefited massively over the years from the publicly funded training of doctors and nurses.

In 2006, the DoH introduced semi-privatization to the NHS supply system, centralizing ordering in NHS Logistics and establishing a joint venture with global corporation DHL, called NHS Supply Chain.³⁹ The Department kept up its pressure on NHS managers to pursue private income with revised guidance on income generation.⁴⁰ In 2007, the Department of Health signed up to an exclusive joint venture with the Dr Foster organization without going to open tender. The scheme, involving working with official data and selling it on to inform patient choice, cost £12 million. The National Audit Office condemned the deal as poor value for money and said that it broke almost every rule designed to protect the tax payer (*The Guardian*, 06.02.07). In the same year, Polyclinics, an experiment in grouping facilities on one site, were introduced.⁴¹ Almost entirely privately built and run, and renamed neighbourhood health centres, they took over, from hospitals, a whole range of chronic outpatient services, facilitating the ability of

the private sector to cherry-pick routine low risk work, while leaving the public sector with high-risk, high-cost surgery (see Leys 2009).

The systematic official rhetoric, which had begun in the 1980s, to try and replace words such as 'passenger' and 'patient' with the enterprise-oriented term 'customer', has restructured thinking, sometimes to a bizarre degree: hospitals could now advertise to attract patients. By 2010, over 200 GP surgeries and Health Centres in England were being run by private companies. Nine firms, including Care UK and Assura Medical, each held 10 or more contracts. Discreetly, without adequate scrutiny, the private sector had already established strong bases at the heart of the public NHS. Despite the rhetoric of community involvement in Cameron's 'Big Society', many of the economic forces restructuring the health service have been working in the opposite direction. The Women's Royal Voluntary Service (WRVS) has 28,000 volunteers in more than 40 hospitals, many providing catering for visitors. But hospital cafés are being replaced with chain store cafés and fast food providers, such as Burger King and Costa Coffee. The WRVS cannot compete with the commercial rents that hospitals can charge (*The Guardian*, 28.05.06, p. 13). Volunteers have been squeezed out by big corporations.

Private sector involvement has also undermined public health strategies. Since the coalition government was formed in 2010, they have launched the Government Public Health Responsibility Deal, which involves alcohol and food company representatives, who, in return for funding, hoped for non-regulatory approaches to their industries. The deal gave companies such as Diageo, SABMiller, McDonalds, Pepsico and Mars privileged access to policy formation. They were also invited to contribute to government health campaigns that could carry their logo, which *The Guardian* (22.02.11) described as 'the sort of brand stretching and credibility enhancing opportunity of which companies dream'. Six health bodies (The Royal College of Physicians, the British Liver Trust, the British Association for the Study of the Liver, the Institute of Alcohol Studies, the British Medical Association and Alcohol Concern) rejected the 'responsibility' deal on alcohol, saying that the industry had been allowed to drive through insignificant pledges that would do nothing to cut drink-related illness (*The Guardian*, 14.03.11). Public health advice is being financed by those very manufacturers whose products give rise to concern.

The advocates of contracting-out claim that due to better resource management, efficiency savings will result. According to the Business Services Association, which represents support service companies, NHS Information Centre statistics show that contracting out services is cheaper and saves around 13 per cent. But as Unison point out, these savings are obtaining by utilizing low

wage rates and smaller work forces.⁴² So, almost inevitably, the quality of service drops. An efficiency saving on paper can mean a delayed or cancelled operation. An open letter from the Federation of Surgical Specialty Associations (15,000 members) claimed operations were being delayed or downgraded as being of 'limited value' in order to save cash.⁴³ An Age Concern report found 8 out of 10 nurses said they did not have time to ensure that patients could eat the food provided or even reach the trays. From the late 1980s and the introduction of CCT, hospitals, required to offer catering services out for tender, managed to save around 25 per cent on their food budgets and this money has never been restored. Some PFI-funded hospitals no longer even have kitchens, requiring them to use externally prepared and delivered catering.

Private companies have already acquired significant parts of health service work, without much publicity or public debate. Serco took over the pathology services at Kings Hospital, London, making Serco the largest UK provider of pathology services (*The Guardian*, 18.03.11). Serco is also a leading independent provider of health services in prisons, where the users are, of course, not in a position to exercise choice.⁴⁴ Meanwhile, Serco's chief executive, Chris Hyman recently gained an 18 per cent pay rise, taking his annual pay to £1.86 million. The finance director, Andrew Jennings, got a 7 per cent increase to £948,295 (*The Observer*, 03.04.11).

The Southern Cross affair offers a salutary lesson in what can happen when private companies hit financial problems and illustrates that while private companies take the profits, the public are burdened with the risk. Ninety per cent of the elderly residential care in the United Kingdom is now provided by private companies. A House of Lords ruling in 2007 confirmed that private sector firms, unlike publicly owned homes, had the right to evict residents (*The Observer*, 04.11.07). Southern Cross, United Kingdom's biggest provider of residential care homes, with 750 homes and 31,000 residents, had a financial crisis in 2011 and began struggling to meet its annual rental payments of £200 million. This inevitably raised disturbing questions as to what happens when a private provider goes bust. Opposition MP Michael Meacher said that if the company failed 'it would expose the brutal logic of profit driven private services' (*The Guardian*, 15.05.11). The 750 care homes of Southern Cross were in trouble because of their rental debts on the homes, largely owned by a range of investment companies and private equity companies, including the Qatari Investment Authority (QIA) (*The Guardian*, 25.05.11). There is no question of these companies having to forego their rent: the public authorities, local or

national, are required to intervene to ensure continuity of care. As is typical, despite claims to the contrary, the profits go to the private corporations, while the burden of risk is shouldered by the taxpayers.

The battle over the 2012 Health and Social Care Act

In January 2011, Health Secretary Andrew Lansley introduced the Health and Social Care Bill to the House of Commons. The Bill, a long and complicated document, longer indeed than the original Act establishing the NHS in 1946, proposed a series of changes that would transfer a high percentage of the NHS budget to GPs and groups of GPs, who would purchase health services from whichever providers, public or private, offered the best deal. One of the most contentious phrases, later modified, referred to potential providers of health services as ‘any willing provider’, seen by its critics as implying that only willingness, and not experience, might be the key criteria. Coming after the financial meltdown of 2008, and proposing radical changes, it could be regarded as an example of what Naomi Klein dubbed the ‘Shock Doctrine’ – exploitation of a crisis to advance the neo-liberal agenda of privatization (see Klein 2007). *The Observer* (03.04.11) described Lansley’s plans as ‘so far reaching and detailed that it left fellow ministers disorientated’.

It took a while for the full radical implications of the Bill to be appreciated by the opposition parties, the public and the medical profession, but when they did, the hostile reactions grew rapidly. Labour opposition was muted because, despite the radicalism of the Bill, it also represented a continuation of a march towards privatization commenced under Major in the 1990s and continued by Blair.⁴⁵ Player and Leys (2010) commented that ‘The reality is that successive Labour health secretaries, working closely with the private sector, had already constructed almost the entire edifice of a healthcare market. The Tory plan merely speeds up the final stage and makes it more clearly visible’. By early 2011, KPMG and McKinsey were already being paid millions to teach business skills to GPs in anticipation of the impact of the Act.

It was clear that job losses in the health sector could be significant: 24,000 NHS managers could lose their jobs (*The Guardian*, 31.01.11). The Royal College of Nursing predicted that up to 40,000 nursing posts would go by 2015.⁴⁶ According to Sue Slipman of the Foundation Trust Network, some hospitals and A and E facilities would not survive, and the power of GPs to commission would

destabilize Foundation Trust hospitals (*The Guardian*, 17.03.11). The incentive for GPs to attract more patients and compete with each other to do so would encourage overspending and make GP Groups vulnerable to foreign takeover, according to Dr Laurence Buckman, chair of the BMA GP committee (*The Guardian*, 25.01.11).

The coalition government became increasingly desperate to rally support. Downing Street talks were held with supporters of the Bill, but opponents of the NHS reforms, such as the BMA, the Royal College of GPs and other leading medical organizations were not invited. By March, the progress of the Health Bill was reportedly perceived among some senior Tories as such a shambles that the proposed White Paper on Care was delayed for revision (*The Observer*, 04.03.12).

The opposition to the bill was substantial: the people didn't like it; one poll said two-thirds of Britons did not trust the Tories with the NHS.⁴⁷ The doctors didn't like it, and the BMA called for the bill to be withdrawn.⁴⁸ Nine out of ten doctors opposed the NHS Bill, and a Royal College of Physicians Poll showed that 70 per cent of doctors wanted the NHS changes scrapped (*The Guardian*, 17.03.12). The nurses didn't like it; The Royal College of Nursing passed a vote of no confidence in the Health Secretary Andrew Lansley.⁴⁹ The GPs, despite being the most obvious beneficiaries, were suspicious. The Royal College of General Practitioners called on the PM to make major changes (*The Guardian*, 09.05.11). For the most part, NHS managers didn't like it: NHS Chief Executive David Nicholson was strongly against NHS care being opened up to 'any willing provider' (*The Guardian*, 05.04.11). The medical organizations opposing the bill included: The Royal College of Nursing, The Royal College of Midwives, the BMA, The Royal College of GPs, The Royal College of Radiologists, The Royal College of Psychiatrists and the Chartered Society for Physiotherapy (*The Guardian*, 17.03.12).

Many of the Lib Dem coalition partners didn't like it: The Liberal Democrats conference in spring 2011 voted against the proposed NHS changes by around 90 per cent, and Shirley Williams called the bill 'stealth privatisation', although after amendments to the details in the House of Lords, she eventually agreed to support it (*The Observer*, 13.03.11). Even veteran right-wing ex-MP Norman Tebbit was opposed to the bill – he pointed out that the difficulties involved in organizing 'fair' competition between state-owned hospitals and private ones. State teaching hospitals, he said, have to provide training, an obligation not imposed on the private providers (*Daily Mirror*, 04.04.11).

The privatization agenda was clear: according to a study by McCabe and Kirkpatrick, 31 per cent of HCHS (Hospital and Community Health Services) were likely to be privatized by 2016.⁵⁰ As Peter Fisher of the NHS Consultants Association pointed out, the real reason for the bill was to 'allow unfettered access for the private sector, turning an integrated service into one where competition on a commercial basis is the driving force. There is no evidence that this is what the people of this country want . . .'.⁵¹

According to Jacky Davis, the endgame was 'to transform the NHS into a system that finances but does not provide healthcare – an national insurance system which pays the bills while care is provided by competing private, publicly owned and voluntary organisations'. Davis suggested that GP commissioning was the bait to win the support of GPs, but that most had seen the danger that they would be held responsible for cuts and rationing.⁵² The Government tried to suggest that GPs were enthusiastic, citing the number of pathfinder groups that had been established, in order to prepare GPs for the task of establishing consortia (GP's practices who would collectively purchase health services). A government reception for GPs path-finding consortia was peopled by GPs favourable to the changes, who had been identified by the outsourcing company Tribal (*The Guardian*, 31.01.11). But Dr Laurence Buckman, chair of the BMA's GP committee, said 'Having large numbers of GPs signed up to consortiums doesn't prove they are in favour of reforms. Just because someone gets into a lifeboat doesn't mean they support the sinking of the ship' (*The Guardian*, 14.04.11).

Despite the length of the Bill, many aspects had not been thought through: in April 2011, the Public Accounts Committee said the NHS proposals did not include details of what would happen if providers failed (*The Guardian*, 27.04.11). The recent scandal over faulty breast implants provided by private medical companies, many of whom were no longer trading or were avoiding responsibility for remedial surgery or compensation, provided a dramatic example of how the public sector has to intervene, at considerable cost, to cope with private failure. Accountability of private providers had already been identified as a problem: Kieran Walshe (professor of Health Policy and Management at Manchester Business School) said 'Once NHS money flows out of public bodies such as PCTs, and the new GP commissioning consortiums, into the private sector, it's very hard to work out how it's being used and who is profiting from it' (*The Guardian*, 16.03.11). The claims that major savings could be made by cutting back on bureaucracy are highly questionable: Frank Dobson called on

the coalition government to abandon its 'wholesale marketisation' of the NHS, and stated that before the internal market was introduced (in the 1990s), the cost of administration had been 4 per cent and but had now risen to 12 per cent. A full-scale market would, he said, raise this percentage even more (*Camden New Journal*, 10.05.11).

By March 2011, the Government was showing signs of panic. It suspended the progress of the bill to allow time for a 'listening' exercise. However, while the government continued to lobby to build support, there was little sign that critical voices were being listened to. Cynics suggested that the 'listening exercise' had been established, not so the Government could listen more closely to the opposing voices, but rather because the public hadn't been listening carefully enough the first time. By the end of April, the Government was rethinking and, in May, was reported to be scaling back privatization plans after the extent of adverse reactions (*The Guardian*, 04.05.11). By 9 May, Clegg and Cameron had apparently agreed on changes to the bill, allowing Clegg to attack the original bill, which antagonized an increasingly beleaguered Lansley (*The Guardian*, 09.05.11).

A further blow to Lansley's Bill came when the inflammatory comments of a government advisor were publicized: Mark Britnell (a former head of commissioning for the NHS, and now head of health at KPMG), who had been appointed in May 2011 to a kitchen cabinet advising the prime minister on NHS reform had, in October 2010, told a conference of executives from the private sector that future reforms would show 'no mercy' to the NHS and offer a 'big opportunity' to the for-profit sector. Britnell said at the event, in New York, that the NHS would become an insurer rather than a provider and would be better served by breaking with the mantra that all services should be free at the point of delivery.⁵³

Meanwhile, a MORI poll said 66 per cent of British people believed the NHS was the best health service in the world and that 37 per cent expect deterioration following the reforms. Lansley threatened to cease funding opinion polls on the NHS (*The Observer*, 15.05.11). The NHS Information Centre was told by the Department of Health to scrap its contribution to several statistical publications on public health and usage of health services.⁵⁴ This funding cut was the subject of an Early Day Motion, in the House of Commons.⁵⁵

In July 2011, The British Medical Association (BMA) voted for the Bill to be withdrawn; it rejected the idea that the Government's proposed changes to the bill would significantly reduce the risk of further marketization and privatization, agreed that the Government was misleading the public by repeatedly stating that

there would be 'no privatisation of the NHS' and proposed that the BMA start a public campaign to call for the withdrawal of the Bill.⁵⁶ During Autumn 2011, the Bill entered the Committee stage in the House of Lords. Despite growing opposition both within and outside the Palace of Westminster, the government remained determined to push the Bill through, even though the medical professional bodies were almost entirely in opposition and some had called for the Bill to be withdrawn.

Although the revised Bill has made some cosmetic concessions, including the removal of the significant phrase 'any willing provider' and the reinstatement of the clear responsibility of the Minister of Health for health service provision, it did not address the fundamental concerns of the many opponents within and outside the medical profession. Despite the muscle-flexing of Nick Clegg, those who had hoped that the Liberal Democrats would defend the core values of the NHS were disappointed. In *The Orange Book*, a reassertion of the centrality of economic liberalism to the Liberal Democrats, it was clear that the Liberal Democrats would be happy with the opening up of the NHS to private providers. Vince Cable had called for 'a plurality of providers' in the Health Service (2004, pp. 132–73). David Laws made clear his commitment to the role of private providers:

This means more competition within the NHS, and more provision from the private and not-for-profit sectors, where this delivers quality treatment and is good value for money. The state must fund health services on behalf of its citizens, but it need not provide them itself. (Laws quoted in Marshall and Laws 2004).

The distinction between the 'private' and 'not-for-profit' sectors is not developed in Laws' argument. The Bill marked both a continuation of and an acceleration of the hollowing out of the welfare state and its colonization by the private sector. Having won some concessions, the Liberal Democrats supported the bill, which became the Health and Social Care Act 2012 on 27.03.12.

Even before the Bill had passed, Whitehall had had to defend the dual health role of the NHS Watchdog. Lord Carter, who has been appointed chair of the NHS Co-operation and Competition Panel, was also UK chair of US-owned health company McKesson (*The Guardian*, 05.03.12). The substantial sum of £799,000, earned by Lord Carter as chairman of McKesson UK, is dwarfed by the \$120 million earned by McKesson's US boss last year, earning more in a month than most will earn in an entire career.⁵⁷

The problems that stem from large-scale contracting-out of services are already apparent: evidence of inexperience, lack of accountability, erosion

of workers' conditions, conflicts of interest, tax avoidance and profiteering is not hard to find. Power cuts at one PFI hospital left surgeons operating by torchlight. The company who run the hospital, Consort, failed in January to tell the NHS that fire alarms in 10 operating theatres were not working (*The Guardian*, 21.04.12). Companies such as Serco and Virgin Care have been able to bid for running children's services despite their lack of previous experience of running specialist children's services for the NHS (*The Guardian*, 16.03.12). Allegations have been made that the Serco-provided out-of-hours GP services in Cornwall have been inadequate and unsafe (*The Guardian*, 26.05.12). Medical staff can be transferred from local councils to private companies like Virgin, with little or no say in the matter, less protection of terms and conditions and job security and weaker union support. It was clear that competition undermines the co-operation essential to quality delivery of health care.

It is already clear that there will be a substantial growth in the casualization of the workforce. James Cusick (*The Independent*, 03.09.12) reported that NHS trusts are increasingly employing key clinical staff on 'zero-hours' contracts which bind employees to on-call working but do not guarantee any specified number of hours or income or employment rights. Contracts of this type require an employee to be available on-call but only provide payment for the number of hours worked. The TUC say those on zero-hours contracts have fewer workplace rights and can struggle with the uncertainty of not being able to calculate week-to-week earnings.

A consortium of 20 health trusts in South-West England, which is threatening to abandon the NHS's nationally negotiated pay and conditions framework and install its own pay structure, has also discussed extending the use of zero-hours contracts to help cut its wage bill (*The Independent*, 03.09.12). The reality behind promises of greater efficiency is heightened exploitation of workers, who will have less rights, lower incomes, less job security and not even predictable or regular levels of income.

It has been reported that in 22 of the new Clinical Commissioning Groups CCGs, at least half, and sometimes all the GPs on the boards, have personal financial interests in private or non-NHS providers (*The Guardian* 28.03.12). Many private health companies have elaborate arrangements to avoid tax. Spire Healthcare made an operating profit in 2010 of £123 million but declared a loss of £53 million, utilizing complicated corporate structures in Luxembourg. They paid just over £3 million tax in the last 3 years despite an operating profit of £123 million in 2011 alone.⁵⁸ Care UK reduced its tax bill by taking out loans through

the Channel Islands Stock Exchange. Circle Health is owned by companies and investment funds in the British Virgin Islands, Jersey and the Cayman Islands. Ramsay Health Care uses a subsidiary in the Cayman Islands. General Healthcare owns 37 hospitals through 37 different companies, each of which is owned by firms in the British Virgin Islands.⁵⁹ These companies are not accountable to the public, but rather to their shareholders. The profits stay with them, while the risk remains with the public.

The constant assurances from all governments since 1979 that the NHS is safe in their hands have proved hollow. This fine national institution, possibly the single most impressive British government achievement of the twentieth century, now stands in danger of fatal damage. The hope must be that continued opposition from health workers and the public can bring about a change of policy.⁶⁰

Notes

- 1 First said by Margaret Thatcher, at the 1983 Conservative Party Conference and repeatedly reiterated by David Cameron in the 2010 General Election campaign – see website of The Margaret Thatcher Foundation, www.margaretthatcher.org.
- 2 The 1993 Conference on Commercial Sponsorship in the Provision of Healthcare.
- 3 Don Barrett 'Dealing with donations and requests', in Turner 1993, pp. 10–17).
- 4 The conference referred to here was an event Whannel discovered in the course of his own investigations into the Olympic Games and commercialization, some of which, including this paragraph on the nutrition conference, was originally published as 'Profiting by the presence of ideals: sponsorship and Olympism', in *International Olympic Academy: 32nd Session, Greece International Olympic Academy*, pp. 89–93, 1994. This paper was subsequently reprinted in *Culture Politics and Sport: Blowing The Whistle Revisited*, Routledge, 2008.
- 5 'Physicians' behaviour and their interactions with drug companies – a controlled study of physicians who requested additions to a hospital drug formulary', in *The Journal of the American Medical Association (JAMA)*, 271(9), 02.03.94.
- 6 Other examples included:
 1993: *Standards of Business Conduct for NHS Staff* (HSG(93)5) regarding the general standards which should be maintained by staff working in the NHS.
 1994: Medicines (Advertising) Regulations 1994 (regulation 21 'Inducements and hospitality'), HMSO.

1994: Guidelines for Company sponsored Safety Assessments of Marketed Medicines. (joint statement of practice, signed by the ABPI, the BMA the Committee on Safety of Medicines, the Medicines Control Agency and the Royal College of General Practitioners).

1995: The European Public Health Alliance offered guidelines related to drug company sponsorship.

- 7 'Partners in Healthcare', *ABPI Annual Review*, 1998.
- 8 *Blurring the Boundaries: New Trends in Drug Promotion*, by Barbara Mintez, HAI – Europe, 1998.
- 9 *Ethical Criteria for Medicinal Drug Promotion Guidelines* (see 'Taming the Drug Lords: The Ties that Bind: Industry Sponsorship of Patient Groups' Lisa Hayes, in *Multinational Monitor*, September 1999, v20, n9.
- 10 See for example, *Selling into Wider Markets: A Policy Note for Public Bodies*, Enterprise & Growth Unit, HM Treasury: December 2002.
- 11 One example, from the breast cancer charity Breakthrough, is *Financial Support from the Pharmaceutical Industry* (2002).
- 12 1993 *Standards of Business Conduct for NHS Staff*.
1994 *Commercial Approaches to the NHS Regarding Disease Management Packages*, (Royal College of Nursing).
1994 *Medicines (Advertising) Regulations* 1994.
1998 *Good Medical Practice*, General Medical Council.
1999 Royal College of Paediatrics and Child Health policies on industry sponsorship
1999 WHO (1999) *Ethical Criteria for Medicinal Drug Promotion Guidelines*.
2000 *Commercial Sponsorship: Ethical Standards for the NHS*
2002 *Research Governance Framework for Health and Social Care*
2002 *The Missenden Code of Practice for Ethics and Accountability: The Commercialization of Research in Universities: An Ethical Intervention* (2002)
2002 *Selling into Wider Markets: A Policy Note for Public Bodies* (HM Treasury, Enterprise and Growth Unit)
2004 *Medicines for Human Use (Clinical Trials)*
2004 World Medical Association first guidelines on how doctors should handle their relationship with commercial enterprises.
2005 European Medical Writers Association (EMWA) *Guidelines on the Role of Medical Writers in Developing Peer-Reviewed Publications*
2005 *NHS Research and Development forum: Sponsorship - FAQs*

- 2005 *Research Governance Framework* (Department of Health)
- 2005 *The Influence of the Pharmaceutical Industry*, House of Commons Health Committee
- 2005 *Government response to the Health Committee's Report on the Influence for the Pharmaceutical Industry*
- 2005 *Financial support from the pharmaceutical industry* (Breakthrough Breast Cancer Research and Development Policy)
- 2005 *Good Research Practice*, Medical Research Council (MRC)
- 2005 *Guidelines on Good Research Practice*, by the Wellcome Trust.
- 2006 *Branding the Cure: A Consumer Perspective on Corporate Social Responsibility, Drug Promotion and the Pharmaceutical Industry in Europe*, Consumers International, June 2006
- 2006 *ABPI Code of Practice*, 2006 Edition, Prescription Medicines Code of Practice Authority (PMCPA)
- 13 *Sponsorship - Frequently Asked Questions*, a summary of issues from the Research Governance Framework (DH 2005) and the *Medicines for Human Use (Clinical Trials) Regulations* 2004 (SI 1031).
 - 14 *Current Medical Research*, V21, n2, 2005, pp. 317–21.
 - 15 *Good Research Practice* by the Medical Research Council (MRC) Updated September 2005.
 - 16 *Guidelines on Good Research Practice*, by the Wellcome Trust. Updated November 2005.
 - 17 Health Committee Report on *The Influence for the Pharmaceutical Industry*, September 2005 Cm6655 and the Government response to it. (*Government Response to the Health Committee's Report on the Influence for the Pharmaceutical Industry* September 2005 Cm6655).
 - 18 *The Influence of the Pharmaceutical Industry*, House of Commons Health Committee, Fourth Report of Session 2004–05, Vol 1, Published 22.03.05).
 - 19 Ibid.
 - 20 p. 3, White Paper *The New National Health Service: Modern, Dependable* (DoH 1997).
 - 21 Ibid.
 - 22 See *Branding the Cure: A Consumer Perspective on Corporate Social Responsibility, Drug Promotion and the Pharmaceutical Industry in Europe*, Consumers International, June 2006.
 - 23 *Clinical Medicine* (2003: 3, pp. 538–41, this quote p. 538).
 - 24 Ibid.
 - 25 Chalmers, Sir Iain (2006), *Journal of the Royal Society of Medicine*, July 2006, 99, pp. 337–41.

- 26 Moynihan, Ray (2003), 'Who pays for the pizza? Redefining the relationships between doctors and drug companies.1. Entanglement', in the *British Medical Journal*, 31.05.03, 326, pp. 1189–92) (see also Chren, M. M. and Landefeld, C. S. (1994), 'Physicians ' behaviour and their interactions with drug companies. A controlled study of physicians who requested additions to a hospital drug formulary', *Journal of the American Medical Association*, V271, n9, 02.03.94.
- 27 *British Medical Journal* (30.05.03, see also BBC News – www.news.bbc.co.uk/go/pr/fr/-/1/hi/health/2946276.stm, 30.05.03.
- 28 Davies, Jill and Hemingway, Steve (2004) *Nurse Prescriber*, 1(12), Page 1 of 4, e42, January 2004.
- 29 see Jacobs, Adam and Wagner, Elizabeth, 'European Medical Writers Association (EMWA) guidelines on the role of medical writers in developing peer-reviewed publications' *Current Medical Research and Opinions*, 21(2): 317–21, (Copyright 2005, Librapharm ltd).
- 30 See also Smith, R. (PLoS Med 2005), 'Medical Journals are an Extension of the Marketing Arm of Pharmaceutical Companies'(medicine.plosjournals.org). Richard Smith subsequently left the editorship of the *British Medical Journal* to become chief executive of UnitedHealth Europe, one of the companies most active in seeking public health contracts.
- 31 *Branding the Cure: A Consumer Perspective on Corporate Social Responsibility, Drug Promotion and the Pharmaceutical Industry in Europe*, Consumers International, June 2006, see also *The Guardian*, 26.06.06.
- 32 During the 2000s, the policy analysts behind the Cameron-led Conservative Party concluded that Mrs Thatcher had been too cautious. They appear to have planned in advance to launch the Health And Social Services Bill (and other legislation attacking the public sector) very early on in their first Parliament.
- 33 This section can only provide a brief snapshot of these issues. Concerned readers might want to look at some of the following accounts:
- 34 Ham 1992, Kuttner 2002, Lister 2005, Mandelstam 2007.
- 35 *Transparency International report, Cabs For Hire? Fixing the Revolving Door Between Government and Business*, May 2011.
- 36 We are greatly indebted to the work of Colin Leys and Allyson Pollock, who have offered incisive critical commentary on health policy for many years, and much of this information is derived from their writing.
- 37 Leys, Colin (2006), 'Not safe in their hands', in *Red Pepper*, March 2006; see also 'The great NHS "deficits" con' in *Red Pepper*, May 2006; and Colin Leys, *The Guardian*, 26.04.06.
- 38 See Barry Schwartz (2005), *The Paradox of choice, Why More is Less*, published by Harper Perennial, and the piece by Schwartz in *The Guardian*, 23.06.04.
- 39 See www.supplychain.nhs.uk/portal/page/portal/Public/About%20us, accessed 28.04.11.

- 40 *National Health Service Income Generation – Best Practice: Revised Guidance on Income Generation in the NHS*, February 2006.
- 41 *Healthcare for London: A Framework for Action* (2007).
- 42 *Health Services Journal*, 21.04.11.
- 43 Michael White, *Health Services Journal*, 21.04.11.
- 44 SERCO website, (www.serco.com/markets/health/index.asp, accessed 26.05.11).
- 45 The GP commissioning idea has two roots: in the GP fund-holding scheme introduced by the Tories in early 1990s, and in practice-based commissioning, introduced by Blair in 2005 (*The Guardian*, 16.03.11).
- 46 see *Health Services Journal*, 21.04.11.
- 47 YouGov Poll, reported in *The Observer*, 12.02.12.
- 48 Jacky Davis, *The Guardian*, 06.04.11.
- 49 see *Health Services Journal*, 21.04.11.
- 50 *The Guardian*, 13.04.11.
- 51 Peter Fisher, NHS Consultants Association, letter to *The Guardian*, 03.05.11.
- 52 Jacky Davis, in *The Guardian*, 06.04.11.
- 53 *The Observer*, 15.05.11. Note that these remarks were made in October 2010, but only reported in May 2011.
- 54 Wellards (www.wellards.co.uk/v4/?pgid=20&artid=14145, accessed 26.05.11. Wellards is an information and training website for the medical and pharmaceutical industries.
- 55 EDM number 1839 in 2010–11, proposed by Valerie Vaz on 23.05.11. See www.edms.org.uk/2010-11/1839.htm, accessed 26.05.11.
- 56 KONP Campaign newsletter, (www.keepournhspublic.com) 01.08.11, accessed 01.08.11.
- 57 EHealth Insider, www.jhoeksma.wordpress.com/tag/mckesson/, accessed 20.07.12.
- 58 *An Unhealthy Business, major healthcare companies use tax havens to avoid millions in UK tax*, compiled by Corporate Watch, www.corporate.watch.com
- 59 Ibid.
- 60 In Autumn 2012, The Socialist Health Association was publicizing a European Manifesto opposing the commercialization of health systems. See www.sohealth.co.uk/2012.08.21/european-manifesto-opposing-the-commercialization-of-the-health-system/.
The Socialist Health Association can be contacted at www.sohealth.co.uk.
www.facebook.com/Socialist.Health.