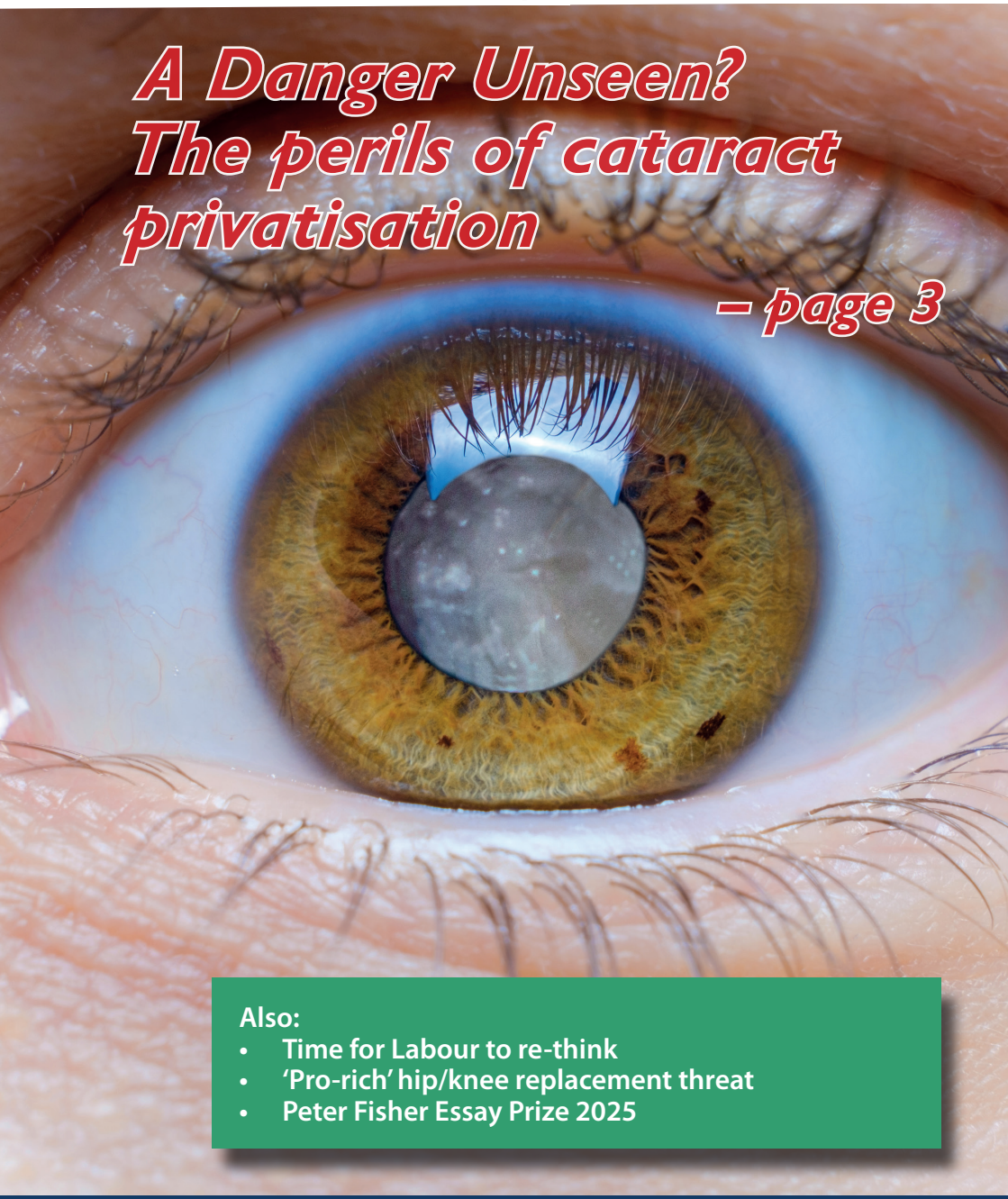
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

A Danger Unseen? The perils of cataract privatisation

– page 3



Also:

- Time for Labour to re-think
- 'Pro-rich' hip/knee replacement threat
- Peter Fisher Essay Prize 2025

APRIL – JUNE 2025

CONTENTS

Copies of the newsletter may also be downloaded from the website (https://www.doctorsforthenhs.org.uk/newsletters). If you wish to stop receiving printed copies please let Alan Taman know.

Managing Editor – Alan Taman
healthjournos@gmail.com

Published quarterly. Contributions welcome. Next issue: July – September 2025

A View From the Chair

As most members probably know, Doctors for the NHS (DFNHS) began as the NHS Consultants Association in 1976, to show support for the government's policy to remove pay-beds from NHS hospitals, in contrast with the BMA which wanted them retained and was calling for strike action.

From that time onwards, we have aimed to attract doctors who recognise the power and benefits of a national health service that is publicly provided, publicly accountable and publicly funded from general taxation.

It is therefore with sadness that we note the passing of one of our longstanding Scottish members, Matthew Dunnigan. I am very grateful to Dr Frank Dunn and Professor Allyson Pollock for their fascinating obituary describing Matthew's resolute fight against the excessive cuts to hospital bed numbers and the waste from the use of Private Finance Initiatives to fund the building of hospitals.

Old arguments – fresh evidence

It is disappointing that the argument in favour of the founding principles of the NHS still needs to be made, as much to many of our professional colleagues as to our political masters, but maybe it isn't necessarily surprising when the opportunity arises to tap some of the massive flows of public money that are ear-marked for the nation's health. It is important to remember that, even though the British Social Attitudes Survey for 2024 showed that only one person in five is satisfied with the NHS, compared with seven people out of ten in 2010, the level of public support for the NHS to be free at the point of use, funded from general taxation and available to all, remains overwhelming.

As England waits with bated breath the outcome of the Government Spending Review and the eventual emergence of their Ten Year Plan for the NHS, there is a heightened sense of concern that statements about increasing partnership with the private healthcare sector, inadequate levels of public funds for capital to repair the damage caused by 15 years of austerity, and the placement of individuals with strong links to private healthcare industries into positions of influence at the heart of the NHS could indicate moves to an even greater level of privatisation and commercialisation in the years to come.

There is a sense that we need to hone our arguments against such moves, and to back them up with as much evidence as possible. A number of the articles in this Newsletter explore this area of concern. John Puntis refers to a recently published paper by Graham Kirkwood and Allyson Pollock on the impact of increasing outsourcing of NHS hip and knee replacement surgery to the private sector (1) (*page 7*) and Graham Kirkwood has the opportunity to explore their findings in greater detail in an interview with Alan Taman (*page 13*). The increase in outsourcing was accompanied by a sharp fall in NHS capacity for these operations, leading to longer waiting times for all patients, but particularly for patients with greater levels of deprivation, increasing inequity in accessing treatment.

John Puntis puts increased private involvement into the context of wider government policy, including the possible re-emergence of Accountable Care Organisations and the encouragement to NHS trusts to set up yet more wholly-owned subsidiaries to manage their hospital estates. John also refers to detailed and illuminating research carried out by the Centre for Health and the Public Interest (CHPI) on the implications of the outsourcing of a large

proportion of this country's cataract surgery to the private sector and Alan Taman reviews some of the associated publications (*page 28*). I want to consider their findings a bit further.

Whose need is being met?

A private company has a legal duty to its shareholders to maximise its value. In the provision of healthcare, it can do this by reducing the cost of providing treatment as much as possible, through keeping staff numbers as low as possible; keeping their salaries as low as possible (typically by reducing the level of experience within the staff); using the cheapest possible equipment, disposables and pharmaceuticals; and minimising variation, to allow as many patients as possible to be treated in a given operating session, akin to the production line model. Within the NHS we have a responsibility not to be profligate with public resources, but the quality of care and patient safety usually take priority, in my experience. We also have to be prepared to deal with a much greater variety of clinical problems concurrently, and to provide emergency care at all hours: this flexibility has a considerable financial implication. There is evidence that increasing the amount of healthcare that is outsourced to the private sector is associated with a proportionate increase in mortality from treatable causes (2), and this study suggests some of the possible contributory factors, both from the perspective of the quality of the service offered, but also from the impact of redirecting resources away from the public provider.

The model on which most private healthcare is based in this country means that, although it might be able to make a modest contribution to elective treatments in straightforward cases, the private sector has little to offer towards those essential elements of the NHS – managing emergency care and disease prevention.

A private healthcare provider has 'a product' which they will have designed to be delivered as cost-effectively as possible and to maximise their profit, they will want to sell as much of their product as possible. There is a risk that the drive to market their product might skew clinical decisions, such as the threshold at which surgery is offered to a patient – the discussion of the unavoidable risks of treatment, in relation to the amount of benefit that can be anticipated.

Regarding cataracts, almost anybody over the age of 60 will have a degree of opacity of the lens of their eye, but that does not necessarily mean that they need a cataract operation, unless it is interfering significantly with their daily activities. There is no benefit, and some risk, in pre-emptive surgery. And yet the study by CHPI has revealed a huge increase in the number of cataract operations that have been performed in England since large-scale outsourcing of this surgery to private providers has taken place, with a doubling of the NHS spend on cataract surgery between 2018/19 and 2022/23, and an increase of the proportion of NHS-funded cataract surgery taking place in the private sector from 24% to 55%. The majority of NHS cataract surgery now takes place in private facilities (3).

Income from cataract surgery accounts for 20% of the budget of an average NHS ophthalmology department. On average, there has been a 21% reduction in cataract surgery in NHS units over those 5 years. In some units the impact has been much more severe (4). This has reduced the budget available to NHS units to treat potentially blinding conditions such as glaucoma, macular degeneration and diabetic retinopathy. There continue to be long waiting lists for out-patient appointments for many such patients, while operations for often trivial degrees of cataract take place within a few weeks. There are also associated issues of reduced training opportunities for Specialist Registrars to develop the skills required for cataract surgery for Specialist Registrars, as it is only recently that some Independent Sector Providers (ISPs) have begun to offer a degree of training.

A bigger scandal than PFI?

Five major ISPs have set up more than 150 clinics to deliver NHS-funded cataract care, mainly in the past 6 years, but very few of these have arisen at the request of NHS commissioning bodies. The regulations governing the market in England make it possible for ISPs to establish a clinic without any requirement for an ICB to assess whether there is a need for additional services. The set-up costs of such a clinic are relatively low, about £1.8 million. The patient choice regulations are such that a new clinic can demand a contract from the local ICB and, if a patient is referred to that clinic by a GP or an optometrist, the ICB is obliged to pay for their care, even if there is no budget. Even if they don't have a contract with the local ICB, that ICB must pay up, as long as the ISP has a contract with another ICB elsewhere (5). The risk to ICB budgets of this lack of control of their financial liabilities is obvious.

In the case of cataract surgery, there isn't even the opportunity to exercise control through the GP, because the great majority of referrals for cataract surgery come via high-street optometrists. CHPI's report describes the commercial pressures and incentives that could encourage optometrists to refer patients for surgery for relatively mild degrees of cataract, and potentially incentives to refer patients to particular private providers, such as fees for carrying out post-operative follow-up checks, which can then be augmented by NHS Sight Test payments and the opportunity to sell new glasses of contact lenses.

Interestingly, out of the five large ISPs, Newmedica has been wholly owned by Specsavers since 2021. Another ISP chain, Optegra, is owned by EssilorLuxottica, which also owns Vision Express. SpaMedica and CHEC are owned by private equity companies.

Potential conflicts of interest also arise for significant numbers of NHS ophthalmology consultants who own shares in private companies

in which they work, or ownership of equipment in those businesses, giving them a potential conflict of interest if their activities in the private hospital undermine the level of service provided by their NHS trust.

The latest publication from CHPI resulting from their research may be the most damning indictment of the way that the market in healthcare has been set up, and the potential to destabilise the NHS as a whole, unless action is taken promptly (6). This analysis shows that for 2023/24 the five private companies providing cataract surgery to the 42 NHS Integrated Care Boards made £169 million in profit, with an average profit margin of 32%. If you thought that Private Finance Initiatives (PFI) were poor value for money, the profit leaking out of the NHS to these five private companies for NHS eyecare each year is almost the same as the annual profit of the companies providing all the 100 NHS PFI schemes! And the average profit margin for a PFI contract is only a miserable 10%.

In addition, many of these companies have taken on large amounts of debt, mainly in the form of loans, often at high rates of interest, taken out by Private Equity investors to purchase the company from its previous owners. These interest payments come from income from the NHS and are estimated to cost a further £68 million. With a PFI scheme, once the loans have been paid, the NHS gets a hospital: with these ISPs, there is nothing to show for all those interest payments at the end of the day.

To put this in context, in 2023/24 the budget

deficit of the 42 ICBs in England totalled £109 million. If there was no profit leakage from outsourced NHS eye care, these ICBs could move from being £109 million in deficit to being £60 million in surplus. Just consider how much additional healthcare that could provide! If this isn't a lesson in the perils of a poorly regulated market, I don't know what is. Time to return to the founding principles?

References

1. Kirkwood, G. and Pollock, A.M. (2025) 'Outsourcing National Health Service Surgery to the Private Sector: Waiting Time Inequality and the Making of a Two-Tier System for Hip and Knee Replacement in England', *International Journal of Social Determinants of Health and Health Services*. 2025;0(0). doi:10.1177/27551938251336949
[Available at https://tinyurl.com/mrn5au3s]
2. Goodair, B. and Reeves, A. (2022) 'Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation', *Lancet Public Health*; 7: e638-46
[Available at https://tinyurl.com/5bhdtv5t]
3. Rowland, D. and Ryan, S. (2024) *Out of Sight – understanding the hidden impact of cataract outsourcing on NHS finances*. CHPI
[Available at: https://tinyurl.com/dscx2fnt]
4. Rowland, D. (2024) *Out of Sight – the hidden impact of cataract outsourcing on NHS eye care departments*. CHPI.
[Available at: https://tinyurl.com/2hf3m799]
5. Rowland, D. (2025) *Out of Sight – the hidden profits and conflicts of interest behind the outsourcing of NHS cataract care*. CHPI.
[Available at: https://tinyurl.com/3nu4bwzb]
6. Rowland, D. (2025) *Briefing Note: The local and national impact of profit leakage in the outsourcing of NHS eye care services to the private sector*. CHPI.
[Available at https://tinyurl.com/4mkevzxb]

Colin Hutchinson
Chair
colinh759@gmail.com

- **Save the date**
- **DFNHS AGM and Annual Conference**
- **Thursday 16th October 2025**
- **Bedern Hall, York**

Underfunding, re-disorganisation and privatisation will not save the NHS: Time for Labour to rethink

In its manifesto, the government promised to recover services and 'transform' the NHS to make it 'fit for the future'.

A 10-year plan (to be informed by Lord Darzi's report (1)) is under preparation to tell us how this could be achieved, including shifts in services towards more community-based care, prevention of ill health and use of digital technology. Labour now claims to be making progress with restoring the NHS, yet after almost one year in office, improvements to date suggest much more needs to be done. Furthermore, a far-reaching reorganisation including the abolition of NHS England (2) is being carried out in advance of the 10-year plan even being published. There is little so far to reassure the public that Labour has a grip on the crisis in health care, and some are speculating that the 10-year plan when eventually it does appear will ignore the system failures (3) requiring urgent attention.

Structural reorganisation without assessment of risk and impact

Pre-election, Wes Streeting declared (4) he had 'absolutely no intention of wasting time with a big costly reorganisation of the NHS'. The Darzi report (6) warned that the 2012 Lansley reforms were 'a calamity without international precedent' not least because of the loss of experienced managers that negatively impacted on NHS performance. Darzi also pointed out that organisational change is often distracting, results in the loss of experienced leaders, takes time and attention away from work that directly impacts on patients and the public, and may have unanticipated consequences. Surprising then that the abolition of NHSE England (6) was announced in March 2025 followed by a 50% cut to Integrated Care Board operational costs and advice that trusts must shed jobs.

A failure to assess the impact (7) of so many management posts being axed raises further huge concerns with regard to the government's stewardship of the NHS. Recommendation 286 in the Robert Francis inquiry (8) into Mid Staffordshire actually stipulates that an Impact assessment must be conducted prior to making structural changes. Labour should explain why it has disregarded this together with the clear warnings given by Lord Darzi, while embarking on major reorganisation in advance of presenting its 10-year plan. The staff reductions (9) now being planned by trusts can be expected to have a further negative impact on services, just as NHS England has instructed all Integrated Care Boards to slow down any expansion of elective care services (10).

Positive gains to date are modest and far from transformational

Any progress with NHS performance is being talked up by NHS England (11), with at least one sympathetic commentator claiming nothing less than a 'remarkable turnaround' (12). Writing in the *Lowdown*, John Lister (13) recently put Labour's achievements in context. While it is positive that the waiting list has fallen by almost 148,000 (2%) over a year, if this rate is maintained and not improved upon, it would take almost 34 years to get numbers back down to 2.5 million. Meanwhile, efforts directed at tackling waiting lists run the risk of reducing patient safety (14). Some reported improvements relate to actions taken by the last

government rather than the present one. For example, the number of people waiting more than 18 weeks for treatment has been falling since it peaked in Decemebr 2023.

Improvement in time from referral to diagnosis of cancer (15) is welcome, but this is only up by 2.1% comparing February 2024 and 2025. Urgent referral to first treatment time for cancer shows little change and was achieved within the NHS operational target for only around 67% of patients rather than the desired 85%. A&E waits of over 4 hours in core emergency departments decreased only marginally, while numbers of patients waiting over 12 hours (over 60,000 a month (16)) increased. Data from the Royal College of Emergency Medicine shows that this is likely to have contributed to 16,600 deaths over a year (17), up 20% from 2023. This shocking figure from the acute sector seems to be off the radar for government yet speaks volumes to the enormous pressures in the service both from lack of beds and difficulty discharging patients in the absence of community and social care support.

Social care reform put on hold

Tackling what is perceived as the 'politically difficult' issue of social care reform has been deferred for the duration of Labour's first term in office, with an independent review chaired by cross-bench peer Louise Casey only due to report in 2028 (18). Meanwhile, there is a mounting cost not only to individuals denied care, but also to the economy as a whole – an issue highlighted recently by the health and social care select committee (19). Further damage to a sector struggling to fill staff vacancies can be expected from Labour's immigration reforms. Social care providers will no longer be able to recruit staff (20) from abroad via the health and care worker visa. This situation was described by the Chief Executive of Care England (representing adult social care) as "a crushing blow to an already fragile sector. The Government is kicking us while we're already down" (21).

While the immigration changes are directed mainly at social care, there is also likely to be a negative impact on the NHS. General Secretary of the Royal College of Nursing, Professor Nicola Ranger, said (22) that the proposed immigration measures could 'accelerate an exodus of migrant staff'. Nurses, particularly those from overseas, are increasingly leaving the NHS due to a combination of factors, including immigration policies, low wages, and a hostile work environment (23). A recent survey of 3,000 migrant nursing staff showed that 42% were already planning to leave the UK. On top of the changes to immigration rules, the drastic cuts to disability benefits will also pile pressure on both the NHS and social care, bringing them an estimated £1.2bn additional costs (24).

Labour's obsession with use of the private sector

Alan Milburn's Concordat with the Private and Voluntary Health Care Provider Sector in 2000 (25) established a policy framework committing the NHS and private sector to work together. It was claimed that this would deliver high-quality care for patients and value for money for taxpayers, although this did not turn out to be the case (26). Despite this experience, Labour still insists on seeing the private sector as a valued partner with shared objectives, a view reiterated in the recent elective recovery partnership agreement (27). Mark Thomas of the 99% Organisation (28) (and coming from a business background) points out that there are real problems with this approach. Businesses, unlike the NHS, would never hand over core services to key competitors, just as they would never be frank and open about their strategic aims with regard to being 'partners'. Investing in the NHS offers economies of scale, while required profit margins and sales and marketing costs for the private sector divert resources from patients. Importantly, there is an inevitable and damaging tension between a company's legal duty to maximise shareholder value and the objectives of the NHS to maximise the health of the population.

Hidden costs of outsourcing

Some recent striking examples show how using the private sector to 'help' (based on the deeply flawed 'spare capacity' justifcation (29)), has had a damaging effect on the NHS. The Centre for Health and the Public Interest (CHPI) has continued to put NHS funding of cataract surgery (30) in the private sector under the spotlight. The estimated amount of profit from NHS contracts leaking out to five private eye care companies in 2023/24 was £169 million. The profit margin for these companies was a staggering 32%, and out of the £536 million paid to them by the NHS in 2023/24, £68 million was used to pay interest on the high-cost loans taken out by the private equity investors to purchase these companies.

CHPI has previously demonstrated how cataract surgery contracts have distorted clinical priorities, summed up as 'very mild cataracts getting surgery at the expense of other patients going blind' (28). This has left NHS eye care departments as a 'poor service for poor people' (31) while significantly undermining the training of the ophthalmology workforce. CHPI has also highlighted major conflicts of interest (32) with over 100 NHS ophthalmic consultants owning shares or equipment in the private clinics in which they provide NHS funded cataract care. The Royal College of Ophthalmologists has called for reform of commissioning to ensure that private sector capacity supports rather than damages sustainable NHS ophthalmology services.

A recent paper by Graham Kirkwood and Allyson Pollock (33) also raised major questions about the benefit of NHS contracting out of elective orthopaedic surgery. The authors studied NHS funded hip and knee replacements from 1997-2023. When few patients were treated in the private sector (2003-2008), NHS admissions increased and waiting times halved. Following expansion of private providers, NHS admission rates fell and waiting times rose for all patients. Those from a more affluent background (with both fewer comorbidities and access barriers) were more likely to be admitted to NHS funded private providers and experience a shorter waiting period. The authors concluded that introduction of private providers into the NHS is associated with a contraction of in-house NHS provision, increased waiting times for all patients and a two-tier system operating in favour of the wealthy while leaving the poor behind. This exacerbates health inequalities which the NHS has a statutory obligation to reduce. They recommended much more critical scrutiny of the costs of outsourcing and its impact on NHS services. [See *also page 13.*]

Far from the private sector helping by adding additional capacity, contracting out may reduce overall activity and undermine NHS services. This is entirely plausible given that NHS surgeons and anaesthetists operating in the private sector have less time to work in the NHS. In addition, the private sector with its limited facilities and focus on rapid throughput cherry picks the less complex patients, leaving those needing more time and resources to the public sector. The Nuffield Trust (34) has also warned that Government plans to speed up access to elective surgery will favour the wealthiest people in UK society, who are already over-represented in elective activity.

Further moves towards privatisation

Sir Jim Mackey, interim director of NHS England, has announced two measures that herald a further tilt towards the private sector. Firstly, and contrary to the Labour manifesto commitment (35) to roll back outsourcing, he has called for trusts to outsource their facilities staff through wholly owned subsidiaries (SubCo) in order to reduce costs. In the past, SubCo have reduced costs through driving down staff terms and conditions, and avoiding the payment of VAT. However, Mackey has said he thinks all staff in SubCo should be maintained on NHS pay and pensions arrangements, while the treasury is actively looking to close the VAT loophole. Given this, it looks as if promoting SubCo

may not be related to the prospect of immediate cost savings, but to them being able to dispose of NHS assets and raise capital (36). Wes Streeting has already made it clear that he is sympathetic to private capital (37) being brought into the NHS, raising the possibility of a return to costly Private Finance Initiative deals (38).

Secondly, Mackey has stated that he supports the concept of Accountable Care Organisations (ACO). Long established in the USA and designed to reduce healthcare spending, an ACO is an organisation with responsibility for providing or subcontracting all the care required for a defined group of people, such as those living in a particular area. Although Sir Jim did not define what an ACO would look like in the NHS, a large Foundation Trust might be designated as such, with responsibility for all the healthcare in a city. Subjected to a Judicial Review backed by *Doctors for the NHS, Keep Our NHS Public* and others, moves in 2017 to set up such bodies were stalled (39). However, the recent elective recovery agreement insists that private providers are an important part of NHS systems and 'should be involved in planning local services'. To raise the spectre of ACOs once again at a time of massive financial pressures (£6.6bn deficit) (40), restructuring and merging of ICBs, raises the possibility that a large private health care company might be designated as an ACO (39) to commission care and reduce costs by restricting services; it is already clear that major cuts to services (41) are on the way.

We need our leaders to adopt a different vision for the NHS

The government currently shows some indication of moving towards reversing damaging decisions on winter fuel payments and the two child benefit cap (42). If this does happen, it will be because of intense lobbying from MPs under pressure from constituents. Similar pressure must be applied in relation to the NHS. Underfunding (43) has to be addressed in order to rebuild services and prevent the economy from being further undermined.

Given a cumulative underspend of £423 billion (43) since 2009/10, the £26bn allocated in the last budget (44) over 2 years should be recognised as wholly inadequate rather than signifying Labour's commitment to rebuilding the NHS as a public service. As Darzi pointedly remarked: 'it is not a question of whether we can afford the NHS. Rather, we cannot afford not to have the NHS'.

This will require that the Treasury abandon its arbitrary and absurd 'ironclad' fiscal rules (45) and recognise the need for investment in the future of the country and its public services for meaningful growth to occur. The logic of such an approach is illustrated by the recent report on the outcomes of setting up Sure Start centres (46) which generated £2 financial benefits for every £1 in costs. Myths around health and care services must be dispelled (47); for example that they represent a cost rather than an asset, that they are unaffordable, that privatisation brings efficiency and private providers are there to help the NHS, and that public health is solely about personal choice. There is a long way to go to restore services, but we should not forget that only 10 years ago the NHS was rated as the best healthcare system among advanced countries (44). By no means has all yet been lost – the fightback must continue (48) and be intensified.

References

1. Dropkin, G. (2024) 'Darzi report – a fig leaf for Labour.' KONP
[Available at https://tinyurl.com/6yp3rw2w]

2. Puntis, J. (2025) 'NHS England abolition – diversion or cunning plan?' *Public Sector Focus*, March, 16-17
[Available at https://tinyurl.com/k689en2x]
3. Black, S. (2025) 'The mythbuster – the public doesn't know what's best for the NHS' *Health Service Journal*, 27 May
[Available at https://tinyurl.com/mwmcs984]
4. Sky News (2025) 'Wes Streeting admits he did not anticipate scrapping NHS England - and 9,000 will lose jobs' 13 March
[Available at https://tinyurl.com/2s3z2mbb]
5. Darzi, Lord (2024) Independent investigation of the NHS in England. DHSC
[Available at https://tinyurl.com/jww3srmr]
6. KONP (2025) 'NHS England abolished as Starmer and Streeting take control', 14 March
[Available at https://tinyurl.com/52tf3ppy]
7. Campbell, D. (2025) 'Ministers admit failing to assess impact of thousands of NHS job cuts in England' *Guardian*, 6 May
[Available at https://tinyurl.com/43fs38e2]
8. UK Government (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 6 February
[Available at https://tinyurl.com/3k5jdjj7]
9. Precey, M. (2025) 'Job cuts planned as NHS trust looks to save £73m', BBC News, 30 April
[Available at https://tinyurl.com/mr2dbzy4]
10. Lister, J. (2025) 'NHS told to slow down referrals amid rising waiting lists and job cuts', *The Lowdown*, 23 May [Available at https://tinyurl.com/bdef2efp]
11. NHS England (2025) 'Over three million additional appointments delivered as NHS exceeds faster diagnosis standard for cancer' 10 April [Available at https://tinyurl.com/bddcdrs6]
12. Salek, S. (2025) Threadreader post, 17 April
[Available at https://tinyurl.com/4h8tu6vd]
13. Lister, J. 'What difference has Labour made so far', *The Lowdown*, 28 April
[Available at https://tinyurl.com/3sjz5hwe]
14. Clarke, R. (2025) 'The NHS will be paid to cut waiting lists – at great cost to patient safety', *New Statesman,* 30 April
[Available at https://tinyurl.com/yvkkefhd]
15. NHS England (2025) Monthly operational statistics – April 2025 10 April
[Available at https://tinyurl.com/yhz6zunh]
16. Royal College of Emergency Medicine (2025) RCEM describes record 12-hour 'trolley waits' as 'a catastrophe' 13 February
[Available at https://tinyurl.com/4jhx25rt]
17. Royal College of Emergency Medicine (2025) 'Each a dearly loved family member' – Excess deaths linked to long A&E waits increased to over 16,600 last year, 15 May
[Available at https://tinyurl.com/52er8wph]
18. Gregory, A. (2025) 'Fixing England's social care will be biggest challenge yet for Louise Casey' *Guardian,* 3 January
[Available at https://tinyurl.com/mry7fc2y]
19. Moran, L. (2025) 'We all know the crisis in UK social care damages lives and the economy: it's the Treasury we must convince', *Guardian*, 5 May
[Available at https://tinyurl.com/ewc8zufu]
20. NHS Support Federation (2025) 'Explainer: social care workforce crisis', The Lowdown, 17 May
[Available at https://tinyurl.com/588nh2sn]
21. Care England (2025) Care England Responds: "A crushing blow to an already fragile sector", 11 May [Available at https://tinyurl.com/54msdf7t]
22. RCN Magazine (2025) 'Nicola Ranger's Congress keynote: 'Let's get what nursing needs, together", *RCN Magazine*, 12 May
[Available at https://tinyurl.com/4untz82d]
23. Royal College of Nursing (2025) 'Immigration measures could 'accelerate' staffing crisis', Press release, 14 May
[Available at https://tinyurl.com/bdcuvds7]
24. Lister, J. (2025) 'NHS must brace for hidden costs of disability benefit cuts', *The Lowdown*, 22 May [Available at https://tinyurl.com/mre2c24v]
25. KONP (2025) Alan Milburn and the Labour agenda for the NHS
[Available at https://tinyurl.com/3weunfmv]
26. KONP (2025) Using the private sector to help the NHS – is Labour intent on repeating the mistakes of the past
[Available at https://tinyurl.com/mtww328b]
27. NHS England (2025) Elective recovery: a

partnership agreement between the NHS and the independent sector, 6 January
[Available at https://tinyurl.com/3r4xkve8]
28. Thomas, M. (2025) *The Rational Policymaker's Guide to the NHS*, The 99% Organisation
[Available at https://tinyurl.com/4p3fhvcc]
29. Puntis, J. (2024) Myth of spare capacity in private health care sector straining to help the NHS, 5 June [Available at https://tinyurl.com/359yfx3a]
30. Rowland, D. (2025) Briefing note: The local and national impact of profit leakage in the outsourcing of NHS eye care services to the private sector, CHPI, May
[Available at https://tinyurl.com/2s384csf]
31. Kollewe, J. (2024) 'Eye doctors say private cataract operations have hurt the NHS', *Guardian*, 10 July [Available at https://tinyurl.com/yr7jux37]
32. Rowland, D. (2025) Out of Sight: the hidden profit and conflicts of interest behind the outsourcing of cataract care, CHPI, February
[Available at https://tinyurl.com/yc5pv55z]
33. Kirkwood, G. and Pollock, A.M. (2025) 'Outsourcing National Health Service Surgery to the Private Sector: Waiting Time Inequality and the Making of a Two-Tier System for Hip and Knee Replacement in England', *International Journal of Social Determinants of Health and Health Services*. 2025;0(0). doi:10.1177/27551938251336949
[Available at https://tinyurl.com/mrn5au3s]
34. Feinmann, J. (2025) 'Elective surgery: Plans to cut waiting lists favour rich patients, says NHS analyst', *BMJ*;389:r861
[Available at https://tinyurl.com/3wp4tr63]
35. Lister, J. (2024) 'Rolling back privatisation?', *The Lowdown*, 9 July
[Available at https://tinyurl.com/53dycv9t]
36. KONP (2025) 'Five things to know about NHS SubCos in 2025 and why they should be resisted', 22 May [Available at https://tinyurl.com/mr2zy7ft]
37. Daily Mail Online (2025) 'Health Secretary Wes Streeting signals support for more private cash to fix the NHS', 18 February
[Available at https://tinyurl.com/ypexc8mv]
38. Edwards, N. (2020) 'Lessons from the last hospital building programme, and recommendations for the next', discussion paper, Nuffield trust, July
[Available at https://tinyurl.com/bdza6zz4]
39. KONP (2025) 'ACOs': a taboo term is back on the NHS agenda'
[Available at https://tinyurl.com/3d57dkxh]
40. Jefferies, D. and Wickens, C. (2025) 'Tight budgets and tough choices: the reality of an NHS living within its financial means', King's Fund, 18 May [Available at https://tinyurl.com/mbja2jva]
41. Triggle, N. (2025) 'NHS plans "unthinkable" cuts to balance books', BBC News, 9 May
[Available at https://tinyurl.com/u67sn3e7]
42. Crerar, P. (2025) 'Labour could review other benefit cuts after winter fuel U-turn, sources say', *Guardian*, 21 May
[Available at https://tinyurl.com/4s8h5p78]
43. BMA (2025) 'Health funding data analysis'
[Available at https://tinyurl.com/2c5k5ft5]
44. Davis, K., et al. (2014) 'Mirror, Mirror on the Wall. How the Performance of the U.S. Health Care System Compares Internationally', Commonwealth Fund, June
[Available at https://tinyurl.com/yy9b8ncx]
45. Elgot, J., et al. (2025) 'Reeves in standoff with ministers over proposed cuts to public services', *Guardian*, 27 May
[Available at https://tinyurl.com/yc3zu245]
46. Adams, R. (2025)' Sure Start centres generated £2 of financial benefits for every £1 spent, study finds', *Guardian*, 22 May
[Available at https://tinyurl.com/3fnz48p9]
47. Independent SAGE (2021) 'Building a consensus for health, care and support services fit for the pandemic era', 25 October
[Available at https://tinyurl.com/35esuzsx]
48. KONP (2025) 'NHS in crisis: emergency appeal', crowdfunder page
[Available at https://tinyurl.com/47fz3tk6]

John Puntis
Co-Chair, KONP
john.puntis@yahoo.co.uk

Research Paper

Waiting times for NHS hip and knee replacements worsen as increased privatisation favours the well-off

Graham Kirkwood and DFNHS member Professor Allyson Pollock's paper (*see abstract overleaf*) shows a disturbing trend with NHS hip and knee replacements as privatised services increasingly take over NHS provision. Graham spoke to Alan Taman about the findings. Graham is a former nurse, and is now a guest researcher at the University of Newcastle. His field of interest includes privatisation and inequality of access to services. The current paper is part of a series looking at the effects of privatisation on the NHS.

"One point the paper makes [*in relation to hip and knee surgery*] is that there is a 'pro-rich' trend emerging with treatment over time. I think it's quite likely that you would find the same trends we found, with high-volume cases moving to the private sector. So operations for hernias, or varicose vein surgery, I suspect you will find the same thing. Researchers have found a difference to this with procedures that are more critical and risk averse, like CABG [*coronary artery bypass surgery*], where there isn't a switch to 'pro-rich' treatment, and very little involvement by the private sector. But there is growing evidence that the switch from 'pro-poor' to 'pro-rich' treatment is happening more generally over the NHS. We have also found this to be evident in cataract surgery.

"There is a general perception that work carried out by the private sector somehow helps NHS capacity. But that's not what we found. We found that capacity is shifting from the NHS to the private sector. That money goes out and it doesn't come back again. That's one thing that people have not been told about or given the full picture. People have had a bad experience with privatisation generally, from bus privatisation to utilities, to council services. I think there's a general feeling amongst most people that privatisation doesn't work and doesn't make things better, and a good understanding that money's being siphoned off to shareholders – and that's money that's no longer available for patients or service users. I don't think the link between treatment inequalities and social deprivation is well understood, and it's certainly not given to the public in an easily digestible form. But I think most people understand that privatisation hasn't made services better in general. Why should the NHS be an exception? I think people are starting to understand that.

"Politicians often say that 'quality is much better for the private sector'. We haven't looked at that, but at access to treatment: waiting times and treatment rates, with an objective point of reference, which is then peer reviewed.

"In terms of inequalities, we can't say there is a causal relationship between expanding private provision and inequality in treatment. But if you are poor it's more likely that you would have co-morbidities. Need is higher. You might not have support at home. The private sector can pick and choose who they want to treat. So there are several mechanisms that might be causing the inequalities and the association with private provision – it needs to be investigated further. The increased presence of the private sector does seem to be making things worse. The answer to

Kirkwood, G. and Pollock, A.M. (2025) 'Outsourcing National Health Service Surgery to the Private Sector: Waiting Time Inequality and the Making of a Two-Tier System for Hip and Knee Replacement in England', *International Journal of Social Determinants of Health and Health Services*. **2025;0(0). doi:10.1177/27551938251336949**
[Available at https://tinyurl.com/mrn5au3s]

Abstract

This study analyses National Health Service (NHS)-funded elective primary hip and knee replacement admissions and waiting times in England by provider (the NHS and private), socioeconomic deprivation and comorbidity, both prior to the introduction of Independent Sector Treatment Centers from 1997 to 2003 and following the rapid expansion in NHS contracts with the private sector from 2008 to 2019.

Between 1997 and 2019, NHS-funded admission rates more than doubled. Between 2003 and 2008, when the proportion of patients treated in the private sector was negligible, admissions to the NHS increased and waiting times more than halved. After 2008, following the expansion in use of private providers by the NHS, NHS admission rates fell and waiting times rose for all patients. Waiting times for private providers were half those for the NHS, and the poorest 20 percent waited longer than the richest 20 percent. Between 2003 and 2019, inequalities in waiting time rose for the poorest 20 percent.

The introduction of private providers into the NHS is associated with a contraction in in-house NHS provision, increasing waiting times for all patients and a two-tier system operating in favour of the rich.

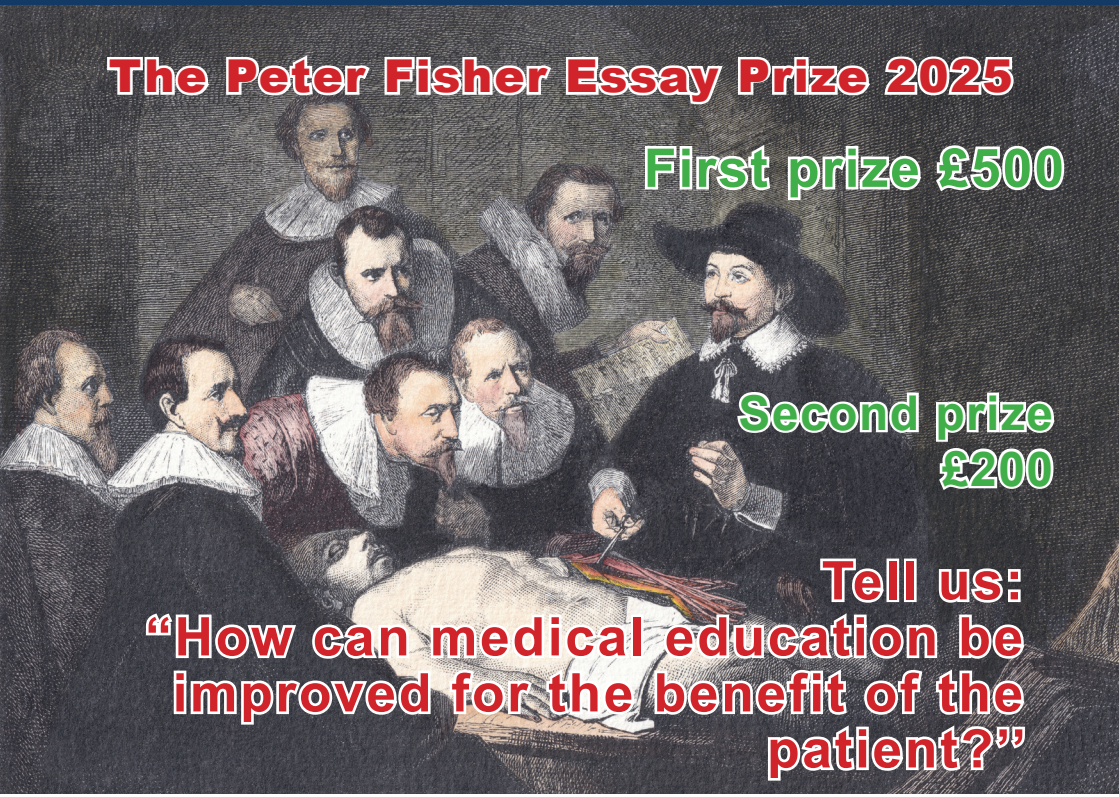
reversing the trend of increasing inequalities of care is to invest in more NHS provision.

"There is also a difference between what is happening in England compared with what is happening in Scotland. Scotland hasn't gone down this road anywhere near as much, with very limited privatisation. There are inequalities in provision in Scotland but nowhere near as much as there has been in England – in another paper yet to be published we found inequalities in England have been increasing at a rate two and a half times faster than in Scotland for hip and knee replacement. So what's the explanation for that?

"We have also looked at the effects of cataract surgery privatisation on the NHS, and one of the things we highlight is that private cataract surgery is having a destabilising effect on all the other NHS eye surgeries.'

[*A summary of these papers will be included in the newsletter once they are published.*]

Graham can be contacted at:
Graham.Kirkwood@newcastle.ac.uk



- An essay competition open to all doctors in training/ Resident doctors.
- The essay should be under **2000** words (excluding references) and use the title shown above.
- Essays will be judged on originality and flair, clarity of writing and relevance to the topic.
- Shortlisted candidates may be asked to attend a short viva via Zoom to discuss their essay with the judges.
- Closing date for submission **31st July 2025**.
- Winning and runners-up essays will be published in this newsletter and on the website, and submitted for consideration for publication by the *Journal of the Royal Society of Medicine*.
- Any questions about the competition can be sent to **doctors4thenhs@gmail.com**

Conference Report

The Jenny Vaughan Memorial Conference
Saturday 17 May, The Wellcome Collection, London.

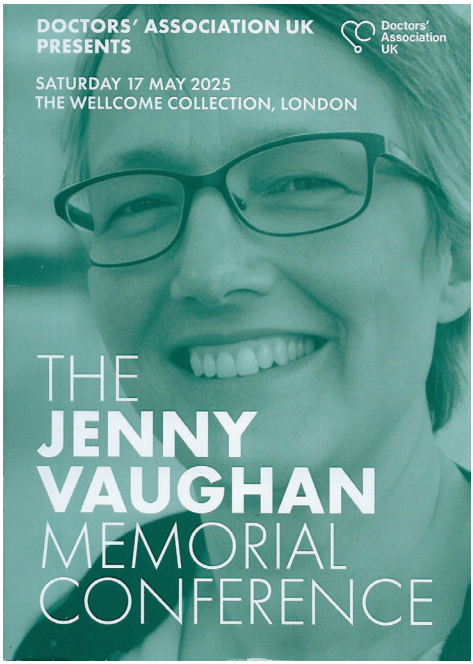
Doctors' Association UK held this conference in memory of Jenny Vaughan, who chaired DAUK and campaigned fearlessly for many years both in DAUK and DFNHS. EC member Helen Fernandes is also currently DAUK Co-chair and spoke to Alan Taman about the conference. Helen works as a Consultant Neurosurgeon.

'The conference went down very well. I'm pleased with the feedback we've got. We're already thinking about how we build on that, and what we do next year. Although everyone needs a rest for a few weeks! There were around 70 online and 80 attended in person. Most have said they would be willing to pay to attend another conference.

'There were some really good and powerful sentiments and emotions apparent during the day. Rachel Clarke's talk at the end about "kindwashing" in medicine really resonated. Imran's talk on injustice [see *programme summary opposite*] was good. But it would be difficult to highlight any one particular speech over and above the general content of the day, which was thought provoking and inspiring. There was also a lot of resonance in the room in terms of feeling an absolute joint purpose and struggle.

'I see DFNHS and DAUK as complementary. DAUK reaches out to a younger audience, it has quite a big medical student membership. DFNHS offers some experience and longevity, with people who have been in the medical profession for decades who have seen a number of changes and can speak to those changes positively or negatively over the years, which is about a wiseness of experience, which a lot of the younger members in DAUK necessarily don't have.

'The two groups do different things: DAUK lobby quite a bit more, and it does quite a lot of work behind the scenes for members who contact us who are in some sort of workplace difficulty. That's a big part of what DAUK do, and something we'd like to do more of.



'We like to call out bad practices and bad policy, so we've done a lot of work with Anaesthetists United on putting together their legal case, which could do better than the BMA's legal case!'

You can see more details about the conference on DAUK's website:
https://tinyurl.com/4ftpr24x
Helen can be contacted on
haatchy1966@gmail.com

Summary of Programme

- Did he save lives? Jenny's role in this story – *David Sellu*
- Physician associates in the NHS: panel discussion
- Plant-based eating for health and the planet
- Media panel (chaired by Helen Fernandes)
- How to save the NHS – *Scarlett Mc Nally*
- You don't have to be mad to work here – *Benji Waterhouse [reflecting on his career and the book with that title]*
- Experience of injustice – *Imran Khan*
- Fitness to practise and freedom of speech
- GMC fitness to practise myth busting and compassionate regulation – *Andrew Hoyle, GMC*
- General practice in 2025: panel discussion with GP team
- Threads of survival – *Christine Hyde and the Threads team*
- Covid impact and maintaining meaning and reward in medicine – *Rachel Clarke*

Book Reviews

The Age of Diagnosis: Sickness, Health and Why Medicine Has Gone Too Far
(£17.45, Hodder Press, available via Amazon, hardback; also via Kindle)
Suzanne O'Sullivan, 2025, 320pp.

Conventional wisdom often assumes that a diagnosis brings clarity, truth and agency to our suffering and distress. This book uncovers and explores when and how this is often a myth, and the price we then pay.

Dr Suzanne O'Sullivan's recently published book has been, rightly, well-received and much publicised. Its subtitle *Sickness, health and why medicine has gone too far* captures its essence; that theme is pursued in a style that is pleasurably readable.

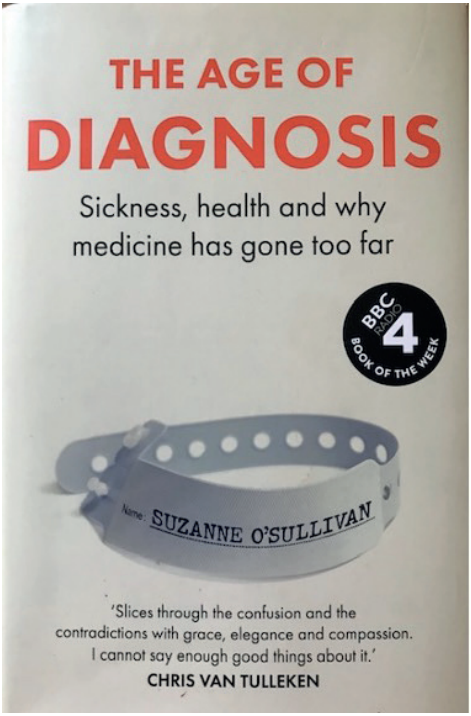
Written with warmth and clarity, the reader is guided through wide-ranging topics of often great complexity, yet in a way that will be undaunting and engaging to the non-specialist.

O'Sullivan's central thesis is that medical diagnosis, thinking and language have become increasingly indiscriminately employed and – like promiscuity – such excessive uses then rarely yield what is desired. She cogently explains that, by contrast, the more correct and disciplined use of diagnosis yields a guided precision of description (a tight cluster of what something is), prediction (what will probably happen with, or without, intervention), and – hopefully – prescription (helpful things we might do). Increasingly, though, our currently expanded use of diagnoses often manages to do none of these effectively.

What is happening? And why?

In many ways it is about the very characteristic human folly of not knowing when and how to stop doing 'good' things (other species are more limited to their functional teleology; they rarely stymie themselves by fictions or excess).

But *Homo sapiens* is all too easily allured by the wishful rather than the actual. Clearly our



biodeterministic medical model – with its *lingua franca* of diagnoses – has been powerfully and massively successful in countering or eliminating many organic physical illnesses and infirmities. Cataracts, hip fractures, coronary artery occlusions, poliomyelitis … this is just a small, random sample of the kind of problem either eradicated or effectively countered by our realistically anchored medical model. Yes, of course, there remain many (often new) refractory conditions, but nevertheless biomedicine's power and success over the last century has been formidable and charismatic. Diagnostic terms have been both emblematic of, and fundamental to, that power.

But that charisma then lures us to our wishfully generated indiscriminate use and then overuse. If something is 'good' let's have more of it! So we have recurrently lowered the threshold for diagnostic inclusion and so expanded its territory.

What does that mean? Well, traditionally, the medical model and diagnoses were applied to people who had an evident and active current complaint or infirmity, usually of a physical kind. Psychiatry was, perennially, a kind of problematic, struggling foster-sibling. Such erstwhile entry requirements and territorial reach were never completely uncontentious, but they were certainly more realistically achievable and useful than what is evolving now.

O'Sullivan provides many examples of how the professional and public appetite for extending medically modelled diagnoses then loses precision and usefulness. Lyme disease and long covid receive thorough scrutiny – she shows how the frequent lack of solid evidence has in no way impeded the rapid proliferation of diagnoses. She plausibly infers that this overuse derives more from cultural and psychological need than biological reality. The result is many more people with certain-sounding, but specious diagnoses requesting treatments that cannot then be assured or effective. In addition, the consequent diagnosis-labelling can itself induce illness experience and behaviour by the unconscious power of suggestion and attribution: the nocebo effect – the belief that we are ill. Clearly the costs to the (often self-diagnosed) patients, the health services and the sustaining economy become cumulative.

"The result is many more people with certain-sounding, but specious diagnoses requesting treatments that cannot then be assured or effective."

This pyrrhic-victory-practice trap ensnares, particularly, any condition whose existence and definition depends on a person's inner experience rather than externally observable, thus (relatively) objectifiable or measurable, enduring organ pathology. Hence the whole of mental health – disorders of behaviour, appetite, mood and impulse (BAMI) – is particularly likely to be so compromised. O'Sullivan readily acknowledges, however, that competent diagnoses of severe mental illnesses – say bipolar, major depressive and schizophrenic disorders – may have very similar natural histories and treatment-responses to undisputed physical illness.

But these serious problems now constitute only a small minority of psychiatric diagnoses. The book casts its gaze instead to the now profligately diagnosed cases of mild, 'masked' or 'atypical' claims of autism/spectrum disorders, depression, ADHD and neurodivergence. How can we distinguish these from 'normal' variations of human struggle, angst and distress? Unlike bodily damage or organ pathology, objectification is almost impossible and so highly contentious – but this has not impeded the appetite to seek and confer such diagnoses.

Why is this? A major root of this imbroglio is that we humans struggle to cope with the complexity and discordance of our consciousness, our experience and imagination. Our approach-avoidance patterns are myriad and everywhere. We struggle to understand or accept issues of fate, responsibility, limitation and suffering. We wish both to be relieved of such burdens yet somehow be part of a recognised community of fellow-sufferers – to know we are not alone. The medical model – diagnoses – can do all this in a way that is both socially sanctioned and, now, conventioned: our industrialised and corporatised lives are increasingly made up of the packaged and the generically coded. These now certify validity and legitimacy.

So such quasi- or pseudo-diagnoses can bring certain kinds of relief, if rarely cure. But what of the problems they bring? O'Sullivan

provides us with many and alarming statistics to show us the economic and professional drain of such unboundaried mission-creep. And, quite as importantly, she explores how such diagnostic misattribution can eclipse and obstruct opportunities for the growth of personal agency, responsibility and autonomy. The nocebo effect is not just limiting, it can be disabling. We become what we believe, what we have been told. Specious diagnosis can make us sick.

All of this was foreshadowed more than half a century ago. The radical social critic, Ivan Illich, wrote in his polemical *Limits to Medicine* (1975) how hazardous – both to health and economies – was the unbridled growth of medical practice, especially when fuelled by corporate and commercial interests. In that same era the psychoanalyst and investigator Michael Balint published *The Doctor, his Patient, and the Illness* (1964). He explored the vast hinterland of human meanings and experiences that were often pushed aside and then discounted by insistent medical protocols, procedures and diagnoses. Many GPs reported how much more efficient and gratifying their work became through such insights.

So what addition does Dr O'Sullivan bring to this book, so many years later? Well, it is instructive to see how accurately instructive and prophetic those pioneer-luminaries were: what they said then is even more problematically true now. Even though longevity and general health has improved, more and more of us receive medical diagnoses and sickness disability benefits. Market forces, Big Pharma, and assumed wisdoms of ever-increasing specialisations provide perverse incentives for more and more diagnosis-definitions and their necessarily recruited patients – professional careers and financial investments depend on continually expanding the medical lexicon and its operating territory.

Our later current era has massively increased the problem in another way. In Illich and Balint's time there was little predictive testing or diagnosis, no genetic testing or treatments. We dealt with what is, not what could or will be. That is now very different, and The Age of Diagnosis considers how the benefits of such knowledge and power are often undertowed by complex ethical problems and the painful foreknowledge of destiny. For example, the clear and future knowledge of the inheritance of Huntington's Disease can deprive an individual of a prior carefree life, shadowing it instead with a dread-future with its many nocebo-effects. If such a predictive diagnosis cannot change the disease, who benefits from such knowledge?

Another difference between Illich, Balint and Suzanne O'Sullivan is that she is a senior practising doctor with many years' experience. They were neither of these. Although a very specialised doctor – an Epileptologist – O'Sullivan's view of healthcare is wide, long, deep and multifaceted. Her notions are conveyed with compassion, clarity and a comprehending tolerance of what she disagrees with. Her very human and credible case histories add poignant resonance to her well-researched arguments.

Yes, much of this may have been said long ago, but it needs to be updated, said again, by this generation, and with such humanity.

David Zigmond
davidzigmond@icloud.com

Scars and Stains: Vital Lessons from Intensive Care
(£14.79, Hawksmoor Publishing, available via Amazon, paperback)
Mark Z.Y.Tan, 2024, 264pp.

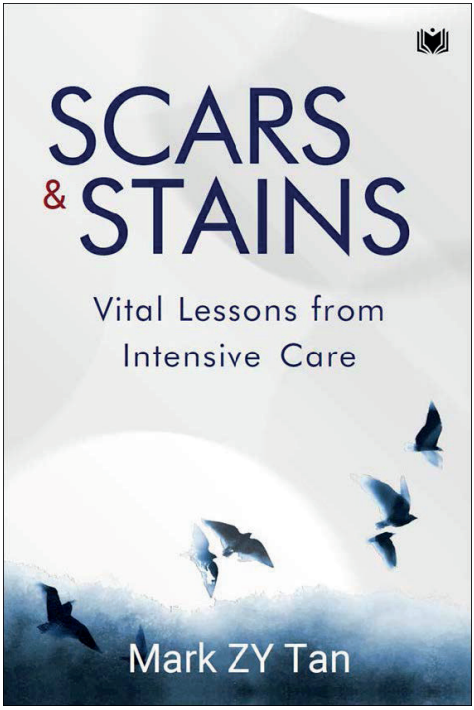
Mark Tan is an anaesthetist and intensive care doctor who clearly enjoys speaking and writing about his specialty, the variety of patients and their conditions and the clinical and ethical dilemmas involved in their care.

He was brought up in Singapore and came to the UK as a medical student. His experiences during Covid inspired a short broadcast piece on Radio 4, followed by a Lent Talk in 2021 as well as a prize in the DFNHS essay competition the same year. The book is aimed at the general reader who would like to know more about what happens in the intensive care unit, a part of the hospital which most people do not see, and it would also be of interest to anyone considering a career in this field.

Intensive care and anaesthesia depend on a solid foundation of knowledge from medical school, particularly anatomy, physiology and pharmacology. The long postgraduate training builds on this to develop the ability to manipulate bodily functions such as heart rate and blood pressure and also to build a detailed understanding of the many machines used in intensive care.

It sometimes seems that only a minority of patients survive a stay in the ITU, but we are told that up to 75% are successfully discharged, so many lives are saved. Almost all of the 26 short chapters contain a vignette which illustrates a specific aspect of a patient's care and many also make reference to aspects of music, literature or art. The need for oxygen, for instance, is likened to the necessity for a clean water supply described in a historical novel about Pompeii – a supply which in the book was restored even though the city was later destroyed by volcanic eruption.

The book begins with cardiac arrest, the need to know each patient, and the trauma to both staff and patient if resuscitation is attempted inappropriately instead of what should have been a peaceful death. We read about the differing significance of oxygen saturation in different patients and about dealing with various problems involving the airway, including an emergency tracheostomy, pneumothorax, a collapsed lung and drug-resistant TB.



Most doctors need to learn to perform various procedures, some much more difficult (and potentially dangerous) than others. Dr Tan writes about the way he became proficient in inserting central venous lines and his anxiety during his first attempt as a junior trainee, but his deep sense of achievement when it was completed successfully. A few central lines later, however, he accidentally caused a pneumothorax. Although this is a recognised complication of the procedure, he felt really mortified, as though 'incompetent'

should be branded on his forehead. It was only the calmness and kind encouragement of his senior registrar that gave him the courage to continue, a lesson he made use of himself later on, when teaching procedures to junior colleagues. He likens this learning process to the mastery of a musical instrument, with inevitable difficulties at first which are helped by a supportive teacher.

Every patient is an individual, and management must take account of their wishes if these are know – though of course this is often not the case. Many patients with aortic aneurysms are identified by screening and have planned surgery, but three are described in which the aneurysm ruptured. One was successfully repaired and one sadly died during surgery, but the third, an 84 year old, knew of his diagnosis and had decided against repair. As his family knew this, he was able to die peacefully.

ITU work is often stressful, and can be emotionally draining for the entire team. We read of the tragic case of a pregnant 25 year old with completely uncontrollable bleeding which caused the death of both mother and infant, completely unexpected by the husband or the staff. Another young patient, a previously fit and active 35 year old, developed respiratory failure, renal failure and cardiac failure following a viral infection, then a cerebral bleed and fits. To everyone's astonishment, and possibly helped by songs from her favourite musical, *Les Miserables*, she gradually recovered, illustrating how impossible it can be to predict the outcome of severe illness. Another young patient, a 20 year old admitted from prison in an unrouseable state as a result of an inadvertent drug overdose, was left with permanent brain damage, a dreadful consequence of what had been a relatively minor offence.

The International charter of the Red Cross has reviewed psychological torture. As Dr Tan points out, many of the torture methods are alarmingly similar to the environment and experiences of patients in ITU. They may be sedated, sometimes ventilated, constantly disturbed, with no clear distinction between day and night and with little or no contact with family or friends. It is not surprising that some patients become delirious and confused, and this is usually worse at night. Several such patients are mentioned here. One patient, an elderly woman, decided that the nurses were trying to kill her and started to attack them, while another, following bowel surgery, thought he was being imprisoned in a sewer. A particularly memorable picture concerns a six foot tall bodybuilder who had been admitted after a heroin overdose. His breathing had improved but he became delirious and escaped from ITU during the night, then appeared stark naked (but with a urinary catheter) in the nurses' coffee room where he terrified everyone by turning off all the lights.

"The International charter of the Red Cross has reviewed psychological torture... many of the torture methods are alarmingly similar to the environment and experiences of patients in ITU."

Significant numbers of patients develop psychiatric problems or cognitive impairment after an episode of delirium so ITU units are trying to create a more normal environment whenever possible. Lights are turned down at night and relatives encouraged to help with care, although seeing a loved one in this situation is traumatic for them too. Some of the misconceptions which arise during delirium may persist as alarming and unpleasant memories, and some units have set up special psychological follow-up clinics to reduce any persisting problems.

Intensive care medicine has developed from the specialty of anaesthesia, and Dr Tan is a trained anaesthetist. While patients often need

conventional management with regional or local anaesthesia or systemic analgesics, he writes in one of the later chapters about about the role of music in reducing pain and anxiety – and of course it has no side effects at all. He tells us that ancient Egyptian frescoes from about 4000 BCE show the use of music in healing, and that this was also well known in ancient Greece and China. In his unit, a regular volunteer guitarist playing calming music such as Satie's 'Gymnopedie' has been of noticeable benefit to both staff and patients.

Dr Tan has worked in Papua New Guinea, where modern health care is often unavailable, and in Uganda, where it is available but only for those able to pay. He is a strong supporter of the NHS as a free and universal service available to all, even the really undeserving. He describes a violent and racially offensive ex-prisoner who boasted of assaulting his girlfriend by dragging her out of the house while naked, by her hair. In spite of this, the staff overcome any feelings of dislike to give the same careful and compassionate care as for other patients as do A+E staff when faced, as they often are, with aggressive drugged or drunken individuals who attend their service. Throughout history, a deep religious faith has often motivated the care of social outcasts and the needy, such as St Basil who founded a hospital outside Caesarea in the 4th century for those ostracised by Roman society as well as monastic and Islamic hospitals in the Middle Ages. Clearly Dr Tan feels this too.

For some patients on the ITU, death becomes inevitable and two of the later chapters explore the ways they and their families are helped to deal with this situation, and the importance of frank communication. Advanced care plans can help the family and the hospital team to know what matters most to the patient – such as a cuddle with a favourite pet – even when they are no longer able to communicate.

The final section describes some of the author's experiences during the Covid pandemic, the constant worry of staff for themselves and their families, and the difficulty of trying to explain the patient's situation by phone to their family at a time when visits were impossible and the outlook often hard to predict.

Patients who need intensive care come in with a huge variety of conditions. They are the sickest in the hospital but the diagnosis may be very uncertain at first, so quick and difficult decisions may be needed. The training for intensive care medicine is long and demanding, but readers of this book will be left in no doubt about its necessity.

DFNHS members will all be aware of political pressure to use lesser-trained staff such as physician associates instead of doctors, and there are anecdotal reports of this occurring even in intensive care. Perhaps those responsible should read this book and examine their consciences.

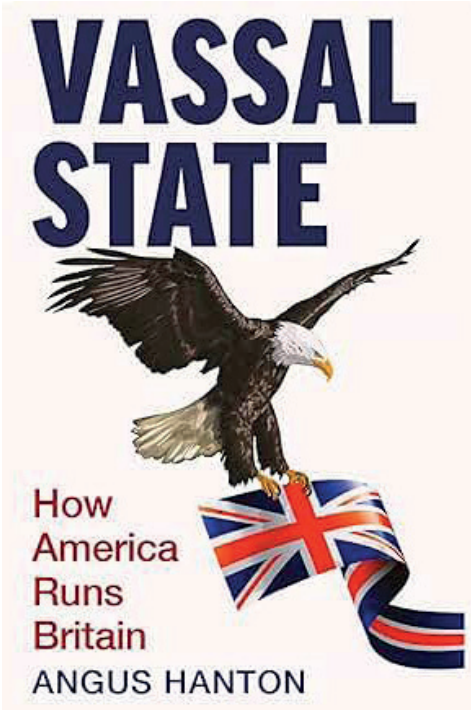
Andrea Franks
roger.franks@btinternet.com

Vassal State. How America Runs Britain
(£10.17, Swift Publishing, available via Amazon, paperback and other formats)
Angus Hanton, 2024, 298pp.

Angus Hanton admits to being a business economist by both training and instinct, having started two businesses in his teens, well before studying economics at Oxford University. He's engaged in public policy debate having jointly set up the Intergenerational Foundation, a think tank focused on the interests of younger generations.

"Painstakingly researched and elegantly written, ***Vassal State*** is an eye-opening revelation of US-based corporations' near-complete control of the UK economy. Tracing the reasons behind the takeover, why it matters, and what needs to be done to reverse it, this is a must-read for anyone who cares about the UK's future".

– Joel Bakan, author of The New Corporation.



American Companies Using British Brand Names

Supermarket brands

Weetabix, Ready Brek and *Alpen* are owned by Post Holdings of Missouri. Kelloggs, *Special K, Cheerios* and *Honey Monster Puffs* by General Mills of Minnesota. Cadbury of Bournville and *Toblerone* are fully owned by Mondelez of Chicago. Incorporated of Virginia owns Mars, Wrigley, Galaxy, *Maltesers, Uncle Ben's rice*, and pet food *Pedigree* and *Whiskas*. *Pepsi, Coca-Cola, Fanta, Sprite, Dr Pepper, Innocent*, Haagen Daz ad Green Giant are American owned. As are *Colgate* toothpaste, *Fairy Liquid, Kleenex, Andrex, Huggers* and *Pampers* nappies, *Tampax, Compax* and *Pearl* brands of sanitary towels.

At the supermarket check-out: Visa, Mastercard, Amex, Google Pay and Apple Pay are American entities.

Boots UK has its headquarters in Deerfield, Illinois – it is now subject to a $10 billion takeover bid by the US private equity firm Sycamore Partners. The concern is of the firm making a quick profit with closure of branches, reduction of staff and maintenance, and disregard of the consequences.

In the high street *Starbucks, Café Nero, Costa, Pizza Hut, McDonalds, KFC, Gail's Bakery, Majestic Wine, Nike, Gap, TKMax, Timberland, Levi's Costco, Waterstones, Ralph Lauren* and a few other less known brands are American based. Online shopping Amazon, based in Seattle, has sales making up more than 30% of all UK online commerce. eBay is based in the San Francisco Bay area. Online delivery: FedEx, UPS and XPO

have more than 15,000 lorries and vans in the UK. These three have bought up their UK rivals TNT, Lynx Express and ANC. Hermes which delivered more than a tenth of UK parcels was snapped up by Avent, a Massachusetts private equity company, and renamed Evri.

Entertainment

Netflix has 17 million UK subscribers who are invoiced from the Netherlands which has low tax rates. *Disney, Amazon Prime* and *Apple TV* and the majority of suppliers of online games are American: Microsoft, Apple, Amazon and Epic Games. They pay minimal tax. Eventbrite. Arsenal, Liverpool and Everton football clubs have American owners.

Ninety per cent of business software comes from the US West Coast and to use it, UK companies pay more than £20 billion annually which equates to £700 pa for every British household.

The City of London

As well as owning property BlackRock, Vanguard and State Street manage worldwide funds of more than $20 trillion. US banks Include Goldman Sachs, JP Morgan, Morgan Stanley, Wells Fargo, Citigroup and Bank of America. American insurance groups such as Aeon and Berkshire Hathaway have taken large chunks of the London insurance and reinsurance markets. There are 16 US legal firms in the UK with annual revenues of more than $100 million.

Between 2000 and 2018 US companies spent $56 billion more on buying UK firms than UK firms spent across the Atlantic. In recent years this has been by far the biggest route of US cross-border takeovers in the world.

London's West End

Management consultancy firms include Bain, McKinsey and Boston Consulting Group. The three private equity houses of Blackstone, KKR and Apollo are the leading companies buying up the British industry and for each of these New York firms the West End of London is just the place for the regional offices. It is becoming clear that the true financial capital of the UK is located on Manhattan Island.

"Data is the new oil" and the five big US corporations at the UK well-heads are Meta/Face book, Apple, Microsoft, Amazon and Alphabet/ Google collectively known as MAMAA. Ancestry. com sells access to its vast database of family trees.

Outside of London and into the countryside

The commercial agencies Jones Lang LaSalle (JLL) of Illinois and Coldwell Banker Richard Ellis (CBRE) of Texas generate £2.5 billion in fees each year from recurring income from revaluations, property management and rent reviews and have the lion's share on the commercial property market.

Fifty per cent of British farm machinery including 10,000 tractors comes from the US companies Massey Ferguson, John Deere, Caterpillar and Case IH. There is no record nationally of how much farm land is owned by "Copella" which is owned by Pepsico and other companies. Four US companies buy about $2 billion worth of British farming output to sell on. CF Industries (Illinois) has a dominant position in UK fertiliser production.

Blackstone spent more than £1 billion buying up St Modwen Properties, the brownfield land development company and KKR bought up more than £4 billion for Viridor which has local council

Table 1 US penetration of the UK compared with other countries

Country	*Sales of US multinationals as a percentage of GDP*	*Percentage of workforce employed by US multinationals*
UK	25	6
Italy	5	0.8
Spain	6	0.9
France	7	1.2
Germany	9	1.2

properties across the UK.

Aviation fuel supplied by Fawley, the UK's biggest refinery, is owned by ExxonMobil.

BP, Shell, GSK, Aviva and HSBC are about a quarter owned by the U.S.

Royalties are paid to the US for Airbnb, eBay, Tinder, Bumble and Amazon.

Other outsourcing eg to G4S which has won 50 UK government contracts running into £ billions.

Comparison With Europe

See Table 1 for US penetration of the UK compared with other countries.

Of all the assets held by US corporations in Europe, over half of them are held in the UK. Measured by sales, the largest US companies sell more than $700 billion of goods and services to the UK which amounts to a quarter of the UK's total GDP.That is 36% greater than since 2020.The figures are in fact greater because US companies with less than $850 million of annual sales are not included in the Inland Revenue Service figures. In terms of profit, US corporations made $88 billion in 2019, equivalent to £2,500 for every British household.That doesn't include billions of US sales to the UK that exit via tax havens.

What has been the response to the US corporations rapid and deep penetration of the UK's market? They have been welcomed with open arms. The UK's rules of corporate governance amount to a system of self-regulation by the financial sector. In contrast, Germany has statutory anti-takeover provisions and the public and politicians are strongly opposed to hostile takeover bids. German firms must by law have a large contingent of employees on their management boards.

The NHS Cash Cow

Tony Blair's Labour government kickstarted growing US involvement in private provision in 2002 when many elective procedures were outsourced. In 2004 Simon Stevens was at the forefront of advocating for adoption of aspects of the US healthcare model. He argued for freestanding surgical centres run by international private operations as the first step. In 2006 Blair outlined the aim of increasing private provision up to 40% of operations and this was actively supported by successive Conservative governments.

Of the 25 private hospitals in the UK and dozens of private clinics, three of the biggest operators are Aspen Healthcare of Texas, HCA healthcare of Tennessee and BHI Healthcare of Missouri. These private hospitals have large contracts for government-financed work and every year carry out 500,000 elective procedures meaning that the NHS pays the private rate. Almost half of NHS consultants work part-time in the health service and supplement their earnings by private work which makes up a third of their income.

In 2021 Centene of Missouri quietly took over 58 GP surgeries. Portman Dental Care, a spin-

off of Bain Capital of Boston, engulfed 350 dental clinics and 1.5 million patients. One in seven mental health in-patient beds in the UK are now provided by American suppliers. The NHS has cut its own mental health beds by 6000 while the private sector has increased its beds by 9000. This out-sourcing costs the NHS about £2 billion a year, with private margins that are typically 15 to 20%.

Hanton describes the scandals associated with the government response to the Covid pandemic.

The US drug companies Pfizer, Eli Lilley, Merk, Amgen, Bristol Myers Squib, Gilead, AbbVie and Johnson and Johnson seriously outgun the UK's GSK and AstraZeneca. Big Pharma, made up mostly of US companies, has annual worldwide sales of half a trillion dollars.

The Solutions

Thus far the UK government has wilfully refused to ask questions about who owns assets and who runs parts of the economy. No voice in UK politics questions the growing American dominance. There is a perverse unwillingness to identify suppliers and buyers by their nationality, as if doing so would somehow be offensive or politically insensitive.

1. Stop the sell-offs

The idea that foreign direct investment is good in all its forms is a policy that should be reversed at speed. The capital sum received is followed by years of loss of revenue. France has policies covering buyouts of quoted companies and requires the buyer to guarantee jobs and investment. Unions and works councils have to be consulted. It has a list of protected sectors (which includes yoghurt as a strategic business) and bars foreign companies with raw profit-maximising objectives. Both France and Germany have laws preventing takeovers in the sectors of defence, energy and telecoms.

There should be a policy of retaining British ownership of companies which operate principally in the UK. Europe and the US have just such policies

2. Government should actively support innovation

The UK spends less on R&D than either the US or the E27 average. SpaceX has received 15 billion dollars in US government contracts since 2003 and through Starlink has enabled worldwide internet access.

3. Invest in people

Before Trump the US invested heavily in its citizens including new arrivals. US immigrants were more likely to gain degrees than those in other OECD countries and the US was the world leader in adult education.

A Vassal State

Hanton paints a bleak picture of a country that has willingly relinquished control of its profitable enterprises to foreign powers, principally the US. The UK government has failed to act in the interests of its citizens in relation to sovereignty, accountability, and the public interest. Without a shift in policy, the UK risks becoming little more than an economic vassal in all but name.

Acknowledgement

I thank Angus Hanton for his comment.

Morris Bernadt
mbernadt@hotmail.com

Out of Sight. The hidden profits and conflicts of interest behind the outsourcing of NHS cataract care

(Free PDF, CHPI, available at: https://tinyurl.com/3nu4bwzb)
David Rowland, 2025, 32pp.

This short (32 pages) report from the CHPI will not disappoint but may well enrage you. The systematic syphoning of NHS money into private hands for cataract surgery is now so blatant and widespread that the CHPI rightly considered it merited a third report, following on from *Out of Sight – understanding the hidden impact of cataract outsourcing on NHS finances* (March 2024) (1), and *Out of Sight – the hidden impact of cataract outsourcing on NHS eye care departments* (July 2024) (2).

This last member of the trilogy turns to describing 'how private sector provision of NHS funded eye care has grown so rapidly over the past 6 years, looking in particular at how the NHS market regulations have permitted very large numbers of private providers to set up and win contracts with the NHS in England','**even if no need for them to provide services to patients has been clearly identified**' (emphasis mine). As if that were not enough to generate warranted concern, the report 'also shows how the relationship between private providers and high street optometrists is critical to generating referrals to private providers and sets out concerns about how these relationships may lead to NHS patients being referred for treatment in private clinics rather than NHS hospitals'.

Could there be a clearer example of how the perverse incentives caused by 'competition' mirrored in the many purchaser-provider splits now operating in the NHS (largely but not exclusively in England) in fact undermine our health service, benefiting the private providers both by allowing the setting up of eyecare services even where none is strictly needed, then allowing private referrals to bypass NHS provision completely? Yet this goes largely unnoticed, and unchallenged. It goes from bad to worse. The report notes how:

> **'significant numbers of NHS consultants are found to have shares in, or own equipment in, private clinics or hospitals which deliver care to NHS-funded patients. These arrangements can be financially very beneficial to the doctors involved. Despite doctors being required to declare conflicts of interest, the conflicts often remain hidden and undisclosed to patients and NHS staff.'**

The authors are very careful to point out that this systematised and faciliated profiteering is not down to individuals doing anything the current system does not allow them to. The crucial point is that it is the system itself that is now engineered to undermine and weaken this part of NHS care, to the point where it may soon prove impossible to do without the very private provision that is

causing the weakening.

A further perspective is gained from the report's listing how much NHS money is currently going to the profits, dividends and interest payments of the private companies. Money which could better be spent on NHS care. Last year alone, £75 million was paid out in the form of interest payments (12-38% of then income received by the companies themselves). CHPI estimate that:

> **'... out of the £536 million paid to these 5 companies by the NHS in the financial year 2023/24, £169 million went to profits (EBITDA) and £68 million went on interest payments on high-cost loans. In total, over the last 4 years, these 5 companies have paid £205.3 million to investors in the form of interest payments and dividends, with the NHS providing the great majority of the income received by these companies over this period.'**

The setting up of eyecare services by private providers even when they are not needed should be a 'never event' if there is any kind of social justice and value for money for public funds – but that is precisely what has been allowed to happen, to the point where 'around one in 7 (14%) of all NHS-funded cataract operations in the private sector were provided on a non-contract basis. In total, around 84,000 cataract operations over a 3 year period were provided on a non-contract basis with private providers', which also poses a potential risk to patient safety as it'limits the ability of the ICB to have control and oversight of the care that is being delivered'.

Not needed, taking public money for private gain, and unsafe. Add to that the perverse incentives and glaring conflicts of interest for high-street optometrists to refer people to the private suppliers and bypass the NHS completely and we have what should be regarded as a dystopian if not Kafkaesque misuse and abuse of public money. Instead it is becoming increasingly the norm, out of sight while in plain sight. Accepted under the twisted mantra of 'private must be better' and appearing to offer a faster treatment. But at what cost? This report spells that out.

CHPI make five recommendations to stop this nightmare parody of healthcare:

1. Limit the leakage of public funding from NHS-funded eye care services to shareholders and investors.
2. Review the price paid for NHS-funded cataract surgery by private companies.
3. Provide Integrated Care Boards with the powers to determine how the private healthcare sector is used to support NHS services.
4. Make it illegal for high-street optometrists to receive financial benefits for referring NHS funded patients to particular private companies.
5. NHS consultants should be prohibited from owning equipment or shares in private hospitals, particularly where these hospitals are in competition with NHS hospitals.

'Eyesight is precious' is perhaps the most common phrase used to describe our ability to see. This should mean the best value for money is the governing principle for eyecare services. CHPI have shown this to be far from true, and that the public are at increasing risk. The only fitting fate for the current system must be to see it gone.

References

1. Rowland, D. and Ryan, S. (2024) *Out of Sight – understanding the hidden impact of cataract outsourcing on NHS finances.* CHPI
[Available at: https://tinyurl.com/dscx2fnt]
2. Rowland, D. (2024) *Out of Sight – the hidden impact of cataract outsourcing on NHS eye care departments.* CHPI.
[Available at: https://tinyurl.com/2hf3m799]

Alan Taman
healthjournos@gmail.com

Obituary

Doctor Matthew G. Dunnigan

Fearless medical academic and scourge of Health Boards and the Private Finance Initiative

Dr Matthew Dunnigan, who was a consultant physician at Stobhill hospital for 27 years and a member of DFNHS for many years, has died at the age of 93. He made many important contributions to medicine and improved the lives of many patients in Glasgow, leaving a continuing legacy to this day.

When he suspected that patients with severe mental and learning difficulties admitted to Stobhill Hospital from the now infamous Lennox Castle Hospital were not being fed adequately he undertook a study of the patients there. He showed they were being severely malnourished, especially those who were unable to feed themselves. He confronted Glasgow Health Board with his findings, shaming the Board into agreeing to provide more staff and better nutrition for patients. Lennox Castle was later closed.

Dr Dunnigan also noticed that recently arrived Asian children to Glasgow in the 1960s were suffering from rickets. In their homeland, the sun provided all the Vitamin D they required. This was not the case in Glasgow's tenement blocks. Having identified the problem, Matthew arranged to have Vitamin D added to the flour that families used to make chapattis, and the rickets all but disappeared. He continued to conduct studies and write about on Vitamin D deficiency in South Asians for more than two decades.

When he retired from his consultant post in 1996 he turned his attention to Glasgow Health Board's disastrous plans to close hospitals and beds replacing them with one huge hospital, the Queen Elizabeth University Hospital (or 'QE2'). Instead of just grumbling about these closures, he undertook a forensic analysis of Glasgow's bed planning models and showed that the new QE2 Hospital would not cope with the needs of an increasingly frail and elderly population. He was fearless in challenging the Health Board. It ignored his predictions and the consequences of insufficient beds are with us today.

The late 1990s was a period of major hospital closures and the building of new hospitals under the exorbitant Private Finance Initiative (PFI) throughout the whole of the UK. All of these PFI hospital schemes entailed selling off NHS land and hospitals and enormous reductions in beds and services.

He met Allyson Pollock at an AGM of the then NHSCA (now Doctors for the NHS) and together they extended his forensic analysis of bed planning to Lothian Health Board's plans for the New Edinburgh Royal and many of the new PFI hospital plans in England. In every case working with Allyson Pollock's team at UCL, the flawed assumptions regarding bed provisions were exposed by Matthew and in every case the evidence was ignored by the policy makers. His meticulous work on bed numbers culminated in UCL's devastating report 'Deficits before Patients' written for the famous 'Save Kidderminster hospital campaign'. Public opposition to the PFI driven hospital closures saw the sitting MP David Lock lose his seat in Wyre Forest to the campaign candidate Dr Richard Taylor. Matthew's analysis, unlike those of the NHS bed planners, has stood the test of time. Meanwhile 'Pernicous Financial Idiocy' as the editor of the *BMJ* described it, has left the UK NHS with an albatross around its neck. It is continuing to pay exorbitant annual charges to bankers and equity investors for the use of its

hospitals and now has among the lowest hospital bed numbers of all the countries in Europe.

Matthew was born in 1931 in a 'steel house' in Clydebank. He described his parents as 'poor and honest' and as being 'both keen on self improvement, evening classes and "getting on"'. His mother taught primary school classes of 50-60 children as a 19 year old until marriage prevented her from continuing. His father, who left school at 15, was self-educated and became a cost accountant. As a very young child Matthew suffered from scarlet fever, which was a life-threatening illness. He spent several months in hospital and his parents were not allowed to visit him and could only send messages to him through the chief nurse. Cruelly, this experience was to be repeated in the last years of his life during Covid, when his daughter could only wave through the window for a while.

The family moved to Troon during the Second World War and Matthew attended Marr College where he was Dux. He studied Medicine at the University of Glasgow, graduating (with many certificates of merit along the way) in 1955. He then embarked on a medical career, choosing endocrinology as his specialty. This was after completing an outstanding MD in the area of atherosclerosis under the guidance of the renowned cardiologist Dr J.H. Wright. He was appointed Consultant Physician at Stobhill Hospital in 1969 until his retirement in 1996.

Thereafter, he was a Senior Research Fellow at the University of Glasgow.

Matthew's strengths included being a gifted orator, having a wonderful way with words and with the ability to back up his arguments with evidence and thoroughly analysed data. His concern and care and curiosity was always to the considerable benefit of his patients. Within all of these activities, his family were front and centre in his life. He cared lovingly for his wife Anna in her final illness. He is survived by his son Matthew and daughter Sarah, both of whom are distinguished academics in Edinburgh.

Dr Frank Dunn and Professor Allyson M. Pollock

EXECUTIVE COMMITTEE : Elected at AGM 2024

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

Dr Arun Baksi
General Medicine/Diabetes,
Isle of Wight
01983 883 853
07786 374886
baksi@baksi.demon.co.uk

Dr Morris Bernadt
General Adult Psychiatry,
London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr Chris Birt
Public Health
07768 267863
christopher.birt75@gmail.com

Miss Helen Fernandes
Neurosurgery, Cambridge
haatchy1966@gmail.com

Dr Andrea Franks
Dermatology, Chester
0151 728 7303 (H)
Roger.Franks@btinternet.com

Dr Mike Galvin
Haematology, Wakefield
01784616649
drmcgalvin@hotmail.com

Dr Alison Hallett
Trainee, Leeds
alisonelizabeth@live.co.uk

Mr Colin Hutchinson (Chair)
Ophthalmology, Halifax
07963 323082.
colinh759@gmail.com

Dr Malila Noone (Secretary)
Microbiology, Darlington
01325 483453
malilanoone@gmail.com

Dr Maureen O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr Peter Trewby (Treasurer)
General Medicine/
Gastroenterology
Richmond, North Yorkshire
01748 824468
trewbyp@gmail.com

Dr Eric Watts
Haematology,
Brentwood, Essex
01277 211128
eric.watts4@btinternet.com

Dr David Zigmond
General Practice/Psychiatry
London
0208 340 8952
davidzigmond@icloud.com

Dr Pam Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager (Hon. member, non-voting)
Mr Alan Taman
07870 757309
healthjournos@gmail.com

Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

Address for correspondence:
19 Northolt Grove
Great Barr
Birmingham B42 2JH