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TRANSCRIPT OF "FILE ON 4"- 'PRIVATE CORPORATIONS IN THE NHS'

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"FILE ON 4"

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NORTHAM: At today's news conference, the Prime Minister stressed the need for radical reform of the health service.

BLAIR: The key driving force behind the changes that are happening in the NHS today is the need to deliver healthcare in a different way in a changing world. And we have got to hold our nerve and see these changes through, particularly over the next few months. It's the next few months that are going to be absolutely critical as to whether this happens or it doesn't happen.

NORTHAM: The most contentious of the changes the Government has introduced is the extension of the private sector in the provision of healthcare. It's a highly politicised and emotionally-charged development. The Government believes corporations will help create a health service fit for the 21st century, while critics fear the beginning of the end of the NHS, Labour's proudest creation wilfully sold off by a Labour Government. Whitehall has already introduced competition in the field of surgery and claims the results are a resounding success and good value for money. But are they? File On 4 has tried to find where the evidence points. We have uncovered complaints of waiting lists being manipulated and there are allegations of doctors being bribed in an attempt to favour the private sector.

SIGNATURE TUNE

ACTUALITY AT SURGICAL CENTRE

WOMAN ON PHONE: Greater Manchester Surgical Centre, good afternoon.

NORTHAM: This is the bright, tastefully-furnished reception area at the Greater Manchester Surgical Centre, which opened last year to carry out a variety of relatively routine operations, from orthopaedics to ear, nose and throat.

WOMAN ON PHONE: Your appointment's at 4.30.

NORTHAM: It's raining fairly constantly outside, but from the pictures here around the wall of giraffes, leopards and wildebeest, you might think you're in southern Africa - and in a way you are, because the centre is run by a huge international corporation, Netcare, which is based in Johannesburg. It's one of 29 privately-run treatment centres the Government has created, funded by the NHS in an attempt to cut waiting times.

ACTUALITY OF DOCTOR AND PATIENT

JUHASZ: Mr Alan Gee, good afternoon sir. How are you today?

GEE: Good afternoon.

JUHASZ: Come in please, take a seat.

GEE: Thank you very much.

NORTHAM: At the end of a short corridor, the ENT consultant, Dr Attila Juhasz, is working through his list of appointments.

JUHASZ: Now you can remember we performed a CT scan of the sinuses last time.

GEE: Yes.

JUHASZ: And we found that the left maxillo sinus seems to be infected still, so I think we're going to have to go for the surgical solution.

NORTHAM: Alan Gee has a painful sinus problem, which is going to need surgery under general anaesthetic. He doesn't seem unduly worried, and volunteers his high opinion of the treatment he's received so far at the Centre.

GEE: This place is absolutely amazing. The before care, the after care and the backup is absolutely incredible. I mean, this is nothing like what I would consider the normal National Health Service as we know it today. You can't compare this place.

NORTHAM: How do you face the prospect of having an operation here?

GEE: I don't mind, I mean obviously I'm not happy to have an operation, but if it's what I need to be well, then fine. And to have it here, well I'm over the moon.

NORTHAM: The idea of a specialist treatment centre for routine surgery isn't new. It means that patients can be given appointments, secure in the knowledge that they won't be cancelled at the last minute as theatres and surgeons are taken over for victims of car crashes. The NHS too runs a number of such dedicated treatment centres, and there's no doubt that waiting times for many operations have been cut dramatically in recent years. The theory behind bringing in the private sector, like Netcare in Greater Manchester, is that it will inject some energising competition. And for Joe Rafferty, one of the Directors of NHS Northwest, the hoped-for results have been amply realised.

RAFFERTY: At one level one could argue that that the Surgical Centre achieved some of those results before it ever opened. During the planning phases of the Greater Manchester Surgical Centre, we did observe that waiting times across the system did begin to drop rather radically. NHS Trusts locally saw the introduction of the centre as a potential competitor for services and provided them with, I think, in many instances actually a welcome opportunity to begin to present the arguments internally in their own organisations for sharpening up the services.

NORTHAM: You're suggesting that it gave the NHS something of a kick up the backside, are you?

RAFFERTY: Well, I think, like every major national organisation, it's difficult sometimes to move at a very fast pace, and I think this is true for the NHS, like a great many of our public services. And while I wouldn't quite describe it in your terms, I think it introduced an interesting frisson into the system, which did allow, I think, NHS organisations to move along at a pace faster than might have happened without the Surgical Centre.

NORTHAM: Leaflets at the Surgical Centre proudly claim a 98% satisfaction rate among patients. But one of the other statistics they give is that 5,500 inpatients were treated in the first year. What this doesn't say is that Netcare has been contracted by the NHS for a much higher number of operations each year than it's managed to date, and that it's paid for that higher number whether it carries out the surgery or not. This was a controversial decision and was fiercely opposed by some in the health service, who saw it as a financial threat to existing NHS departments, which stood to lose patients to the new privately-run centre, without the cushion of a guaranteed income. NHS-run facilities only get paid for the work they actually do. Debbie Abrahams, the former Chair of one northwest Primary Care Trust – Rochdale - regards the Netcare contract as an unnecessary diversion of funds from the NHS, which will prove poor value for money for one simple reason.

ABRAHAMS: Lack of demand, which was what was anticipated by PCTs when we were required to enter into these contracts with Netcare UK.

NORTHAM: You said, we won't need as much as has been contracted?

ABRAHAMS: Yes, yes, that was something that all the PCTs were quite cross about. We felt that we would not need that demand, and that it was totally inappropriate to be entering into a five year contract with Netcare for a minimum volume of activity which we didn't know that we would be needing.

NORTHAM: If you, as the Primary Care Trusts, didn't think you would need that volume of surgery done by the private sector, who told you it had to be in the contract?

ABRAHAMS: This was very much driven by the Department of Health. It was a central national procurement of the independent sector treatment centres, so it was driven by the Department of Health. I was disgusted, I have to say, and there is correspondence between myself and the then Chair of Greater Manchester Surgical Centre to that effect.

NORTHAM: Debbie Abrahams was so disillusioned at the way the Netcare contract was introduced that she resigned as Chair of the PCT two months ago, concerned that the implications haven't been properly considered. She wanted a thorough appraisal as a condition of accepting the contract.

ABRAHAMS: The comprehensive evaluation of the surgical centre was going to be undertaken. This was suddenly dropped. And I had done an awful lot of work, I'd really pushed for this and thought we had got it all approved, and then it was pulled, it was dropped, it was said it wasn't going to happen.

NORTHAM: And what was the reason given for dropping the comprehensive evaluation you wanted?

ABRAHAMS: It was said the way that the design for the evaluation had been put together was inappropriate. I, to be honest, felt that this was just another obstacle that was being put up, and I didn't see that there was ever going to be the type of

ABRAHAMS cont: transparent evaluation that was needed, and it was at that point that I thought it was better to try and remove myself from the NHS and make people aware really what's going on.

NORTHAM: In response, the Primary Care Trust leading negotiations over the Surgical Centre says that the impact on the NHS economy will be looked at later in the contract rather than at this early stage, and that substantial monitoring of clinical quality, patient experience and value for money is ongoing. The cost of the privately-run treatment centres to the broader NHS economy is a continuing point of conflict. A survey by Health Service Journal has recently published national figures showing the under-use of these centres compared to the yearly average levels for which they are contracted. It finds that in the first year of the policy, many were working far below capacity. One in Medway did less than a quarter of its contracted rate. The national average was 59%. Greater Manchester Surgical Centre comes out relatively well - it did 68% of its contracted procedures. But that still leaves almost a third that the NHS paid for but hasn't had. So is Joe Rafferty of NHS North West worried?

RAFFERTY: We would always want these sorts of services to be 100% utilised and it's important to note that the Greater Manchester Surgical Centre is, in fact, one of the best utilised of these independent treatment sector centres in the NHS.

NORTHAM: A survey recently suggested that in its first year it had done 68% of its capacity, which means something like a third has been wasted.

RAFFERTY: Well I think you need to also put this in context. Utilisation of the GMSC is continuing to rise on a monthly basis.

NORTHAM: But there's no money to spare in the NHS. If you've got a centre which is not operating to 100% of what you're paying for, that's money which the NHS has got to pay twice - once to the centre that's not doing it and once to the NHS hospital that is doing those operations. That's just money down the drain.

RAFFERTY: Yes, but I mean I think it is an attempt to help the NHS rethink how it deals with its very severe excess issues.

NORTHAM: It's a very expensive attempt in that case.

RAFFERTY: Well one could argue, but also the use of the independent sector in the NHS anywhere, which has been happening for many years, is also a very expensive solution to NHS waiting times problems, so I think (a) first of all we need to think about this in the round and (b) it is an investment in an approach that will deliver very very high quality long term gains for the NHS. And in that sense, one has to accept that there is some sort of investment cost in these types of things.

NORTHAM: File On 4 asked the NHS for the latest statistics of the Netcare centre. They're improving. From its opening in May last year to the end of August this year, the centre carried out 74% of its contract target. At Netcare's UK headquarters, the Chief Executive Mark Adams argues that it was necessary to guarantee a high level of income, regardless of the work actually done, in order to get the private sector to take part.

ADAMS: When the Department of Health started the independent sector treatment centres, it wanted to encourage UK healthcare companies and international healthcare companies to come into the market. I don't think the people would have come in and put the level of capital investment and taken on the levels of staff that they needed to unless there was a minimum guarantee of volume.

NORTHAM: So it's a sweetener?

ADAMS: At the outset, on the first wave contracts it absolutely was. But that is totally now changing, where the second wave of contracts are completely at risk.

NORTHAM: But under the first wave, the 29 centres that were opened operate on block contracts. You get paid whether you do the work or not. And in Manchester, which is one of the better performing centres, to date you've done 74% of what you've been paid for. Does that mean 26% of the NHS's money has gone down the drain?

ADAMS: Absolutely not. I mean, when it was started we had very low awareness. We're working with fourteen Primary Care Trusts across the North West and effectively the Greater Manchester Surgical Centre was a sort of beacon of excellence that was sort of invisible to most people at the outset.

NORTHAM: But if they've paid for 26% of operations that you haven't done, what value has the NHS had for that money?

ADAMS: The point I'm coming on to is that we started little over twelve months ago, and with any new operation you've got to let the General Practitioners know that you're there, the patients know that you're there, and you've got to build very strong referral relationships with the Primary Care Trusts. They're five year contracts and at Netcare we are totally committed to fulfilling the obligations on our contract.

NORTHAM: So over the period of five years, will you actually achieve 100% of the operations for which you've been paid?

ADAMS: Our intention is to do exactly that.

NORTHAM: Can you guarantee that you will?

ADAMS: I believe that if we can maintain the patient clinical outcomes, the patient satisfaction and continue to build our profile and relationship with the important stakeholders in the Manchester community, yes we will.

NORTHAM: The contracts with privately-run treatment centres create a real pressure on Primary Care Trusts to see patients treated in them rather than in NHS departments. But under the Government's doctrine of Patient Choice, this is not something the PCT is supposed to dictate. It's up to doctors and patients to decide together where to refer for treatment. As the financial screw tightens, there are accusations that some Primary Care Trusts have adopted unorthodox methods to try to influence decisions in favour of the private sector.

FOX: I have written to the PCT to ask them to not pay me this money, and a close colleague of mine has received two payments and he has returned the money to them.

NORTHAM: Dr Steven Fox is a GP in Leigh in Lancashire, one of the towns in the Greater Manchester catchment area. He's also the Secretary of the Local Medical Committee. In March this year, he was surprised to receive a circular from his PCT, saying that doctors would get an extra payment of £30 a time for referrals of patients to the private sector. Dr Fox was troubled and looked up the General Medical Council's code of good practice, where he read the rule:

READER IN STUDIO: You must act in your patients' best interests when making referrals, so you must not accept any inducement, gift or hospitality which may affect or be seen to affect your judgment.

NORTHAM: The PCT said the £30 payment was for extra work involved in making referrals to the Surgical Centre, but Dr Fox felt uneasy.
Was it clear to you that this £30 would only be paid if you made a referral to the Greater Manchester Surgical Centre?

FOX: Yes, it was not to any other organisation, such as our local district general hospitals.

NORTHAM: How much extra work is involved in making the referral to the Surgical Centre?

FOX: Under this scheme it was only answering half a dozen extra questions, such as was the patient on warfarin, was the patient pregnant, was the patient under eighteen. If the patient met those criteria, then the referral could go to the Greater Manchester Surgical Centre, and the district general hospital would have to take up anything else if those criteria were not met.

NORTHAM: And how long would it take you to assess those criteria?

FOX: Only a few seconds. In my practice it would be looking at the patient's history and medication on the computer.

NORTHAM: And for that you would get £30?

FOX: For that we were being told we would get £30.

NORTHAM: And what did you think of the offer?

FOX: Well, I thought it was against the advice given in Good Medical Practice, which has been issued by the General Medical Council. If this payment had been for a referral to any district general hospital, including the Greater Manchester Surgical Centre, and the work was documented and properly structured in the form of what we call a local enhanced service, then this would have been perfectly acceptable. But because it was solely to Greater Manchester Surgical Centre and not to other district general hospitals, I felt that this could have been seen to be an inducement payment.

NORTHAM: Dr Fox has taken his concerns to the British Medical Association, which says it considers the £30 payments 'an ill-disguised financial incentive'. The Primary Care Trust concerned has told File On 4 that very few doctors have accepted the money. But the Trust's Chief Executive, Peter Rowe, insists that the offer is genuinely to cover extra work, not any kind of bribe.
When you introduced this payment, did you anticipate it being referred to in the press as a bung?

ROWE: No, we worked with GP colleagues. We thought that they were happy. It was a surprise to us when this accusation was made and in fact we felt it was very wrong. I'm surprised it's controversial and I mean that very genuinely. We recognised early on there are elements of how people are referred to this Centre which are different to the traditional NHS method. In other words you don't really need an outpatient appointment. So we put it to what's called our Professional Executive Committee, which is a committee which is dominated by professionals, including GPs, and they felt on balance this was a good idea. And it was good value for the taxpayer because outpatient appointments cost £65.

NORTHAM: The Secretary of the Local Medical Committee, Dr Fox, has said to me that he thinks that these extra checks would take a matter of seconds for a GP to do.

ROWE: That's interesting, because clearly not all his GP colleagues agree with him and they felt that this required some extra work.

NORTHAM: He thinks that it looks like an inducement and is therefore against the General Medical Council's code.

ROWE: We would never ever offer an inducement to GPs. That would be quite unethical.

NORTHAM: And what do you say then to the British Medical Association, who've said to us that it looks like a thinly disguised financial incentive?

ROWE: Well, I'm unfortunately not aware of what information the BMA have been presented by the Local Medical Committee, because they've never actually shown us what was sent to the BMA. So I can't judge the BMA's response.

NORTHAM: At the British Medical Association, this is just one example of NHS behaviour which has raised concern. The Chair of the Association's GPs Committee, Dr Hamish Meldrum, concludes that the money guaranteed to privately-run treatment centres has led a number of Primary Care Trusts to seek improper influence over patients' decisions about where to go for operations.

MELDRUM: In many areas we are finding that Referral Management Schemes or other sort of schemes are in place to actually try to direct patients to these particular centres. We've even heard of cases where GP referrals to other providers have been intercepted and redirected.

NORTHAM: Intercepted by who?

MELDRUM: By the PCT. The GP is informed that they've made a referral here but it's been decided that it would be more appropriate for the referral to go to provider x rather than provider y. The patient is informed that this change has been made and to help them agree to it they're often told that this will mean they'll get treated more quickly than if they were going to go to the place they were originally referred to.

NORTHAM: So let's just get this quite clear. You're saying that you've got evidence that doctors and patients make a particular choice, which the Government says they're entitled to make as to where they want to go for their hospital referral, and this is then changed by the Primary Care Trust, who then tell the patient, 'We'd like you to shift to somewhere else.'

MELDRUM: Yes. It seems to me not appropriate that somebody who hasn't even seen that patient, and in some cases we're even led to believe these decisions are being made not by doctors but by managers, should then second-guess that decision and send them to a different place. It doesn't seem to be at best a very coherent policy and at worst it seems a rather devious policy.

NORTHAM: File On 4 has learned of another complaint that the NHS is tilting competition to favour a new privately-run treatment centre with which it has a block contract, at the expense of its own hospital. A clinician at the Countess of Chester hospital in Cheshire has contacted File On 4 to reveal that the hospital's orthopaedic department has been placed under a disadvantage by the local Primary Care Trust.
We have agreed not to identify the clinician concerned, and have seen documentary evidence supporting the complaint. This is what we are told:

READER IN STUDIO: The Primary Care Trust, having paid for the block contract, is very keen to get patients to go to the Independent Treatment Centre and not to the hospital. They try to persuade patients to go to the treatment centre in part by telling them they'll have to wait longer if they go to the hospital.

NORTHAM: But the hospital has been handicapped, according to this complaint, by not being allowed to reduce its waiting times for operations. So it's unable to compete fairly.

READER IN STUDIO: The Primary Care Trust has said that it won't pay the hospital for operations if the patients are seen earlier. So even if the hospital could see patients sooner, which I understand they could, they are not being allowed to.

NORTHAM: File On 4 put these allegations to the Primary Care Trust concerned. In reply, it acknowledges that it has requested the hospital not to cut its waiting times, but gives a different explanation for this:

READER IN STUDIO: The financial deficit has worsened and as part of our recovery plan we have asked the hospital not to take on the additional activity necessary to reduce their waiting times, not because of our contract with the treatment centre. We fully appreciate that this current arrangement does not sit well with our colleagues.

NORTHAM: Nobody from the Primary Care Trust was available for interview. The Government's reason for introducing the Independent Treatment Centres was to increase the capacity for operations and thereby reduce waiting times. But a report from the Commons Health Committee published a day before the summer recess raises doubt about whether either aspiration has been much helped by the policy. The Committee Chairman, the Labour MP Kevin Barron, finds the case unproven.
The whole point of these treatment centres was to reduce waiting lists by increasing the capacity of the health service to do operations. You say that not only your conclusion is, but the Government's conclusion is that there is no evidence that they have made a major difference to capacity or waiting lists?

BARRON: I think that's right. We've published in this report what we found and what was said to us by ministers. If that's embarrassing, it's embarrassing, but that's the big question and that's the problem in a sense that the Government have got to answer.

NORTHAM: How is it that the Government can introduce such a fundamentally important policy in the health service and yet not assess its impact?

BARRON: Well, I mean that's a question for them. It's an obvious question that we couldn't find an obvious answer to when we did the inquiry.

NORTHAM: Let's look now at the question of value for money. You say you can't assess this because the Department of Health won't give you the detailed analysis of the figures that's needed.

BARRON: Yes, absolutely right. I would have liked to have seen them, but in real terms we did not get the detail and actually what we did in the report, we said the National Audit Office ought to look at it. They do have a department that will and can go in there and understand the issues around money. But I would have been quite happy to see the figures, quite frankly, and then discuss with Government what we could publish or what we couldn't.

NORTHAM: But the Health Minister, Lord Warner, insists that the policy has been successful and that the Government has not improperly withheld information from the Select Committee.

WARNER: We've given the Select Committee an extensive list of the Independent Sector Treatment Centres that have been established and that are operational and that are in the pipeline. We've given them the evidence on, for example, cataracts, where the waiting lists have melted away. All that evidence has been given to the Select Committee. It seems to me that evidence suggests that extra capacity has been bought in, it's actually enabled people to get their treatment quicker and we've seen drops in the waiting lists for certain procedures as a result.

NORTHAM: The Select Committee say that they're not able to determine whether these treatment centres represent good value for money because you won't give them the detailed figures, why not?

WARNER: Well, some of the figures that were being asked for by the Select Committee were commercially in confidence. There's a long established principle under successive Governments that you don't disadvantage the public purse by revealing data which is commercially confidential.

NORTHAM: And you couldn't reveal that to the Select Committee, even in a private session? These are senior MPs who can be trusted to keep a secret.

WARNER: What I would say is that there were established rules of commercial confidentiality, which were operated on this particular occasion. We have given as much as we can that's available to the MPs to help them make their judgments, and we're satisfied that they are value for money.

NORTHAM: And the Select Committee can't make its own judgement?

WARNER: Well we've given the information to the Select Committee …

NORTHAM: But you haven't.

WARNER: We have given the information to the Select Committee, providing we did not give the information that was commercially in confidence.

NORTHAM: The question of value for money is critical at a time when parts of the NHS are facing financial crisis. And within the health service, the biggest cause of resentment at the Independent Treatment Centres is their cost. The first wave of them set the NHS back £1.7bn, and with the second wave that will rise to more than £5bn… at a time when jobs are being cut and wards closed for lack of cash. There's particular irritation at the premium rates the private sector is paid. The government says the average private operation costs 11.2% more than under the NHS. The leading health economist, Prof Alan Maynard of York University, is at a loss to justify this.

MAYNARD: Well I think the premium is very high and it's very frustrating for people in the NHS to see private sector facilities getting this rather outrageous price premium and then not actually filling their beds because they're getting contracts, they're getting paid and sometimes there's no patients going into those beds. That diverts resources from other hospitals in the area and it makes life more difficult for them.

NORTHAM: Now why do you call the premium outrageous?

MAYNARD: The NHS is struggling financially, and the high level of funding going into the ISTCs with a failure to actually deliver the volumes they're contracted for means that they're taking money away from Primary and Secondary Care in the ordinary NHS. And those people are very strapped for cash at the moment and having to not fill posts, make people redundant and generally change their configurations in a rather radical fashion.

ACTUALITY AT HORTON CAPIO CENTRE

NORTHAM: One of the hospitals which has felt the impact of a privately-run surgical centre is here in Banbury. These are the spacious wooded grounds of Horton Hospital, one of the Oxfordshire sites that is struggling to cope with a substantial deficit. So it's a surprise to find just opposite the entrance to A&E, a gleaming new yellow and red brick building with a sign saying NHS Treatment Centre. What the sign doesn't say is that it's run by a Nordic multinational corporation, Capio.
Once the centre opened, the NHS orthopaedic department stopped doing elective surgery for adults. All that work, and the money for it, has transferred to Capio. The cost to the NHS is almost £7million a year. This has added to protests over the current downgrading of the hospital, protests led by a local retired consultant, Dr Peter Fisher, who's the President of the NHS Consultants Association. He argues that the money going to Capio could more than pay to keep other services at the hospital open.

FISHER: They have now put forward a number of proposals for the services that they offer, which in summary will be downgrading paediatrics to a daytime only service, removing the Special Care Baby Unit, changing the maternity unit to a midwife-led instead of consultant-led service, reducing the hours of emergency surgery, so it's quite a large package. The cost of staffing all these specialties in order to meet the European Working Time Directive and the current training regulations, and enable all services to continue, that will be £1.85 million a year, top whack. I did do some figures on the back of an envelope when I heard the cost of the Capio contract and it works out about thirteen weeks of that contract would pay for a year's full staffing.

NORTHAM: So thirteen weeks of the contract that Capio currently have at the Horton Hospital would pay for all these other services to be staffed up and not have to be downgraded?

FISHER: The actual cost would be met by that, yes. It's something that's very difficult for local people to accept, and one does have to wonder whether it is right to put so much money into one part specialty.

NORTHAM: Nobody was available for interview from the local Primary Care Trust. In a statement, the PCT has told File On 4 that it is too simplistic to assume that if it didn't pay Capio for operations, that money would automatically be spent on preserving services in the hospital. Horton Hospital says that it is increasingly difficult to recruit enough skilled doctors to run obstetric and paediatric services at night, and that even if the funding was available to pay for them, experience shows that this would not be sustainable in the medium to long term. When it reported in late July, the Commons Health Committee was concerned at the impact the money going to the private sector would have on the NHS generally. It spoke darkly of major NHS hospitals being closed in future and their elective services switched to Independent Sector Treatment Centres. The Department of Health has carried out an analysis of the possible effects on NHS facilities, but refused to disclose it. Once again, the Health Committee Chairman, the Labour MP Kevin Barron, is angered that the Government has deliberately kept important evidence from the Committee.

BARRON: I just think this is a failure, you know, and why? I actually think that our report, whilst quite damming about the introduction of ISTCs, but I just think that not giving us the evidence for us to have a look at, and if there was anything commercially sensitive there, then clearly we wouldn't have published it in our report.

NORTHAM: But the position is this: the Department of Health has carried out precisely the analysis you wanted of the impact on the NHS, but it won't give it even to the Select Committee?

BARRON: It's had time now since July to think about this, we'll see what it says when it comes up in a few weeks' time, their response. But of course the other side of the coin is we can have debates about these matters in Parliament as well, and it would be up to the Committee whether or not we will be applying for a debate when we see the response to this particular report.

NORTHAM: You mean you'll try and force the information out of the Government?

BARRON: Well, if we have a debate we have a minister and you know you can hear it on the radio. We will do what our job is as an oversight of the health service and this is a very, and always has been a very sensitive area, particularly for people who work inside the National Health Service. And I just keep thinking politically and not to have these assessments done or to have them done and not published is a bit naff. Politically they should have done it. And quite frankly, if evidence is there then why the hell didn't they give it to us?

WARNER: I think there's some confusion over what is involved here. We are going to respond to the Health Select Committee's Report and I think you'll just have to wait patiently until we've made our response. What I would say is that all the cases for Independent Sector Treatment Centres were done in full consultation with the Strategic Health Authorities and the local Primary Care Trusts. We've given good evidence to the Health Select Committee on the patient benefits that have actually arisen from Independent Sector Treatment Centres.

NORTHAM: The Select Committee say this: the Department of Health has carried out an analysis of the possible effects of the treatment centre program on NHS facilities, but it has refused to disclose the analysis to us. Why was that?

WARNER: What I've said already is that we have actually given the information about many of the decisions and we will respond to the Health Select Committee Report when we respond in the near future.

NORTHAM: But on this particular point can you tell me why you didn't give them this analysis, which apparently has been done in the Department?

WARNER: I've given you an answer to your question.

NORTHAM: But you haven't answered why you didn't give it to the Select Committee?

WARNER: I have no other answer to give to your question, which I've exhaustively answered as far as I can at this point in time.

NORTHAM: The Health Minister, Lord Warner, says there will be a full response by the Government and it's expected by the end of this month. It will be eagerly awaited. Nobody can doubt the momentous nature of the decision to bring private corporations in to run some surgical services. But what surprises the health economist, Professor Alan Maynard, is how little rigorous evaluation there has been of the effect of this change in policy. The Health Committee calls it 'a leap in the dark', and Professor Maynard agrees.

MAYNARD: This is a matter of faith for the Government. You could say it's ideological belief that putting the private sector in will engender greater efficiency in the NHS, but if you go back to an academic perspective and look at the evidence, the evidence is not there to support this policy. Therefore, it's rather like having a drug. If you brought a drug to the market and gave it to your patients immediately and killed them off, this would be regarded as outrageous. What we do is we evaluate the drug to make sure it's safe and improves the patient's health, and we should do exactly the same things with ISTCs. It's an experiment on people, on patients, and we should evaluate those experiments because, like dangerous drugs, they may damage the economy of the National Health Service and use resources which could be better used elsewhere in the system.

NORTHAM: And this evaluation, you're telling me, simply isn't happening

MAYNARD: The evaluation is not there sadly. It's what I call evidence-free policy making.

NORTHAM: For the Government, Lord Warner insists that the effect of the private sector is benign and that the facts speak for themselves.

WARNER: What you have to understand and Professor Maynard has to understand is that day surgery was not advancing as quickly as it might in this country until we injected the innovations from Independent Sector Treatment Centres. And that failure to advance is a failure of patient care. These are bringing new ways of treating patients, many of whom are in the working populations who do not wish to wait in pain and suffering for their operations longer than they need to.

NORTHAM: But when Professor Maynard, who is one of the country's leading experts in health economics, says what you're doing is based on faith, because there is simply not the evidence anywhere to show that the private sector does these things better than the NHS, you're saying he's wrong, are you?

WARNER: I'm saying that we are putting as fast as we can the evidence from these Independent Sector Treatment Centres in the public arena. The evidence is high levels of patient satisfaction, large numbers of NHS patients getting free treatment, getting that treatment faster, improved procedures for elective surgery from which the NHS is learning. All this is well documented, it's in the public arena for Professor Maynard and anybody else who wishes to read it to find.

NORTHAM: As arguments over evidence continue, further advances of private provision are already underway. The second wave of Independent Treatment Centres will be more than twice as expensive as the first, and there are now multi-national health corporations taking over GPs' practices. By the end of this year, one-third of Primary Care Trusts expect to put some GPs' surgeries out to tender. Local protest movements have begun to make themselves heard. The Government will need all its powers of persuasion when it publishes a defence of private sector involvement in response to the damning report from the Health Select Committee. Its response is due in a couple of weeks' time.

SIGNATURE TUNE