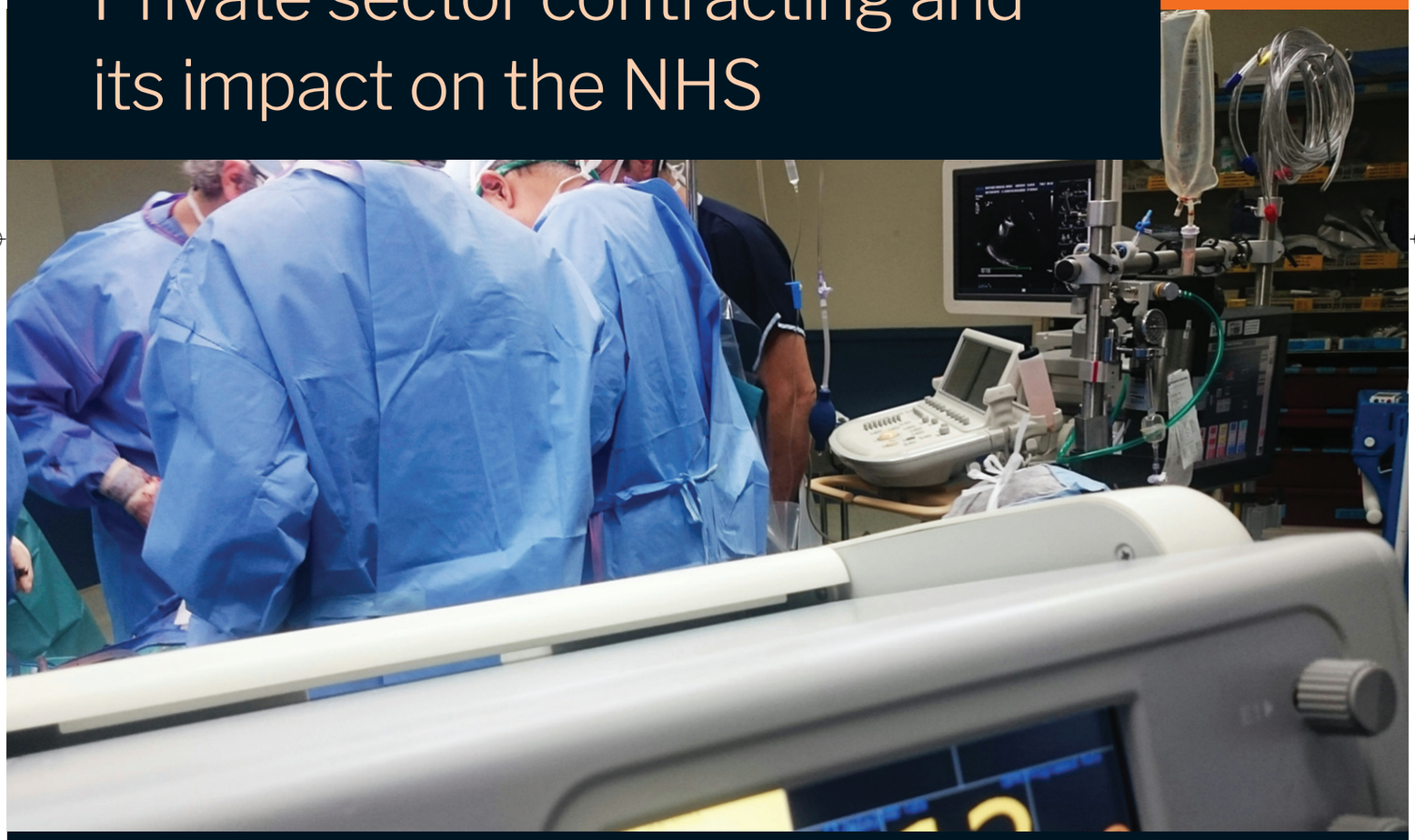
Profiteering, Privatisation and Outsourcing in the NHS

A Guide to Forty years of failure: Private sector contracting and its impact on the NHS



Report Summary February 2025

Public Interest Law Centre

NO LONGER INVISIBLE
UNITED VOICES OF THE WORLD

INDEPENDENT WORKERS UNION

Kanlungan
Empowering Filipino, East and Southeast Asian Migrants in the UK

Summary Report: Forty years of failure – private sector contracting and its impact on the NHS

Introduction

Forty years of failure: Private sector contracting and its impact on the NHS is an in-depth analysis of the history of outsourcing and privatisation in the NHS. Dr John Lister, specialist health journalist and senior lecturer in Health Journalism at Coventry University, has researched and written extensively on the subject since 1984.

The report explores the historical roots, costs and consequences of the 40 years of outsourcing of services by the NHS, which meant that thousands of staff playing key roles in the NHS did not enjoy NHS terms and conditions, but were employed by private companies. Their inferior terms and conditions – most notably sick pay – meant that thousands of staff were unable to afford to take sick leave, even as the Covid-19 pandemic gathered pace.

Outsourcing of clinical work has diverted hundreds of millions into private profits that could otherwise have been use-fully invested in the NHS, improving the pay and conditions of staff, and making the NHS itself more resilient and better equipped to meet the challenge of the Covid-19 pandemic.

1979-1997: The Thatcher Era

The first outsourcing of NHS services came at the outset of the Thatcher government – that is, to say, privatisation and profiteering through the back door. Driven by ideology rather than evidence, ancillary services, such as cleaning, laundry, and catering, began to be put out for competitive tender. Workers in these roles, who previously had NHS pensions, terms and conditions, and a valued role in the NHS system, were now employed by private companies. As a result, they typically got lower pay, with fewer rights, and increasing disregard for the value of their work.

From 1990 onwards, healthcare services also began to be financed in a whole new way. Disguised as "partnerships", with the promise of improved efficiency and savings, the NHS entered into 'Private Finance Initiative' (PFI) contracts with private companies. These were meant to deliver everything from hospital construction to ongoing equipment and maintenance services. However, not only did these schemes fail to deliver the savings promised, they left hospitals owing huge debts to their PFI 'partners' for years after they had finished paying off the original cost of the hospital.

- **1980** – Prescription charges increase 500% over 18 months.

- **1983** – Health and Social Care Act 1983 begins outsourcing services. Ancillary services – cleaning, laundry, and catering – are outsourced to private companies and local health authorities are given deadlines to put these services out to tender.

- **1984** – Healthcare workers go on strike against privatisation at Barking and Hammersmith hospitals. There is already a long list of contract failures by private sector providers, including failing to meet hygiene standards and leaving nursing staff to complete cleaning.

- **1987** – Plunging hygiene standards caused by outsourcing leads to spread of MRSA in hospitals.

- **1988** – Health and Medicines Act 1988 ends free dental check-ups and eye tests.

- **1990** – National Health Service and Community Care Act 1990 established NHS Trusts, and the beginning of the 'internal market'. Trusts would be self-governing bodies and require hospitals to compete for contracts from health authorities. They are responsible for managing their own budgets, staff pay and conditions, and have new freedoms to expand private wings and 'for pay' beds.

- **1992** – The PFI system is launched. Instead of the Treasury borrowing money on behalf of government departments, this created a new form of private sector debt. Breaking existing rules on the use of private capital, each project more than £5m now had to be put out to tender and invite bids from the private sector.

- **1996** – After slow uptake of PFIs and concerns from the private sector about investment risk,

regulations were introduced to allow government to effectively act as a guarantor for any debts to PFI consortiums if Trusts went bankrupt.

1997-2010: The New Labour Years

Having initially opposed PFIs, the incoming Labour government further entrenched the system after their election in 1997. They also expanded outsourcing to even more services, such as social care and mental health services, despite the failures already demonstrated by earlier attempts.

Public health spending increased in this this era, but with strings attached. The NHS was significantly restructured to expand the internal market on the basis that greater competition would improve efficiency. In reality, this only served to pit hospitals against one another to the detriment of local services, and eventually created greater and greater obligations to contract out to private companies.

■ **1997** – NHS (Private Finance) Act 1997 further facilitated the PFI scheme, and a wave of agreements were signed after it passed.

■ **2000** – Labour begins year on year increases in NHS spending to work towards the average spending of comparable European countries. However, there were strings attached. The NHS Plan in 2000 further expanded the internal market into clinical services, such as diagnostics and elective hospital treatment.

Private hospitals were contracted to take on treatment of uncomplicated NHS waiting list patients, but the funding was taken from the NHS trusts under the greatest pressure from waiting lists, creating a cycle of reliance on the private sector.

■ **2002** – Foundation Trusts (FT) are created, which allow the best performing NHS Trusts to opt out of NHS structures. Foundation Trusts have greater freedom to borrow, including from the private sector. However, their borrowing would count against the total cash limits of the NHS, leaving less funding for other non-FT Trusts. They would also be free to set up their own private companies that offered managerial and other services within or outside the NHS.

■ **2003** – 'Independent Sector Treatment Centres', privately-owned clinical units, were set up and were allowed to recruit up to 70% of their staff from the NHS, potentially stripping local hospitals of their staff. NHS Trusts would now not only compete with each other for service contracts, but with the private sector.

■ **2004** – The Agenda for Change brought an improved pay agreement, terms and conditions for NHS staff, jointly conducted with the unions. However, outsourced staff were not included, creating a two-tier workforce.

■ **2005** – Primary Care Trusts are required to offered patients a 'choice' of providers, including at least one private hospital. Patients were not informed that the potential consequences of their decisions could include the closure of their own local NHS hospital.

■ **2008** – A report by the Audit Commission and Healthcare Commission shows that NHS reforms had cost up to £1 billion but appeared to be having little significant effect. Yet this still understated the scale of the failure, as the report did not cover the failing of the PFI or 'payment for results' schemes. It was also criticised for failing to consult with frontline workers or unions.

2010-2020: The Coalition and Conservative Governments

Following the 2008 financial crash, the Conservative/Liberal Democrat coalition government oversaw massive public spending cuts and austerity policies. Huge sums were spent on management consultants that delivered little to no benefit. New legislation introduced Clinical Commissioning Groups (CCG) with broad requirements to put contracts out to competitive tender.

In addition, the introduction of the Hostile Environment policies with the 2014 and 2016 Immigration Acts introduced additional healthcare charges for overseas visitors and migrant workers. In practice, this resulted in the disproportionate targeting of people of colour in enforcement of healthcare charging.

The cracks in the PFI system continued to show as hospitals overwhelmed by debt had to be bailed out to satisfy the private creditors. Meanwhile, several private companies ended their contracts years early after serious criticisms from the Care Quality Commission (CQC).

■ **2011** – The Treasury Select Committee concluded that the use of PFI had the effect of increasing the cost of finance for public investments. The Health Service Journal also reported that 60 hospitals faced collapse over PFI deals. A new wave of outsourcing took place including musculoskeletal services, adult mental health services, ulcer and wound care and wheelchair services.

■ **2012** – The Health and Social Care Act 2012 introduced another round of reorganisation to introduce Clinical Commissioning Groups (CCGs).

The Act included far-reaching requirements for CCGs to put services out to competitive tender. Treasury figures revealed that 17 NHS Trusts had paid the full cost of their new hospitals, but still faced years of PFI payments. Wycombe and Amersham Hospitals Trust owed almost 14 times the original cost of the £45m hospital built through a PFI.

In February 2012 the Department of Health announced that it would make £1.5 billion available - in grants not loans - to seven hospital trusts in England with the heaviest PFI debt, to enable them to make PFI payments.

■ **2013-2015** – Both Serco and Circle withdraw from NHS contracts years early due to performance failures, possible fines, allegations of bullying and falsified performance data, high staff turnover and excessive spending.

■ **2014** – Hostile Environment policies are announced, including increased healthcare charging for migrant workers and overseas visitors, and immigration data sharing agreements between the NHS and Home Office.

■ **2018** – Carillion collapses, disrupting services like cleaning and catering at multiple NHS trusts.

■ **2019** – Listeria outbreak traced to outsourced catering prompts calls for bringing services back in-house.

2020 - Present: COVID-19 and reversals.

When the Covid-19 pandemic hit, the NHS was seriously underprepared. There was a serious deficit of hospital beds and healthcare resources, and the government turned to the private sector to plug the gap. However, following previous patterns, this spending didn't deliver. Many private sector beds went unused. The outsourced Test and Trace system cost billions, but ultimately failed to be effective. Private companies were fast tracked to personal protective equipment (PPE) contracts, but the government frequently overpaid for equipment and stock was often faulty or expired.

As the pandemic worsened, the health systems, health workers and the general public all paid the price of previous decisions. The impact of previous outsourcing had created a two-tier workforce where outsourced workers received little to no PPE, inadequate training on Covid-19 procedures, low wages and a lack of sick pay. All of these factors exposed them to greater risk of exposure to the virus, and put both their lives and wider public health on the line.

Unions and community organisations supporting frontline workers, such as United Voices of the World (UVW), Independent Workers' Union of Great Britain (IWGB) and Kanlungan sourced PPE for their members where employers and government failed to do so. Their organising also brought about massive wins for bringing outsourced staff back in-house.

■ **2020** – Instead of using local structures, such as public health laboratories and GPs, Test and Trace contract was outsourced to private companies with no relevant healthcare experience. By October 2020, the system had cost £4 billion but failed to be effective.

Following major strikes of outsourced workers, cleaners and catering staff at Imperial College Healthcare NHS Trust and Great Ormond Street Hospital are brought back in-house.

■ **2021** – As the pandemic progressed, NHS hospitals transferred whole departments to nearby private hospitals, such as cancer treatment, cardiology, stroke rehabilitation and neurosurgery.

■ **2022** – In February 2022, £8.7 billion of government spending on PPE was written off because it was faulty or expired.

NHS England's Delivery Plan was intended to enable the recovery of acute services from the effects of the pandemic, but it was focused above all on the need for long-term reliance on the capacity of the private sector. However, thousands of the beds commissioned from the private sector had gone unused, and there was no capital to enable trusts to reopen beds that had remained empty since pandemic first struck.

By the end of 2022, the new 'Elective Recovery Task Force' attempted a fresh increase in NHS use of private hospitals. The NHS Confederations – representing commissioners and providers – raised the longstanding limitations of this approach. Once again, the private sector would not be willing or equipped to deal with the more complex and costly cases on the waiting lists, and would only accept routine procedures that gleaned the best profit. The NHS would retain these complex cases and shoulder the higher cost. In turn, those patients left on waiting lists would need more complex care as their conditions worsen.

Conclusion

The history of outsourcing in the NHS has demonstrated time and time again that private sector contracts deliver worse outcomes at higher cost. If the NHS spends the same amount of money but brings in private providers, the net result is less money for services, or fewer staff and fewer hours worked – because profit must take its share.

Some NHS Trusts are beginning to make the transition towards bringing staff and services back in house, but outsourcing remains a live issue. The PFI system has extracted huge sums from the public sector for benefit of the private sector, and some hospitals still pay more in PFI payments than clinical services.

The Covid-19 pandemic drew out the stark reality of these decisions. When Britain needed decisive leadership, all it had was a disparate network of private companies acting independently and with ineffective oversight. From outsourced, migrant workers on low wages working without protection, to disabled and ethnic minority patients with complex health needs, the most vulnerable paid the highest price, with their health and their lives.

NO LONGER INVISIBLE
UNITED VOICES OF THE WORLD

INDEPENDENT WORKERS UNION

Kanlungan
Empowering Filipino, East and Southeast Asian Migrants in the UK