

The Case for Hospital Reconfiguration –

**NOT
PROVEN**

A Response to the IPPR's The Future Hospital

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Executive Summary

(1) The Institute for Public Policy Research (IPPR) published a report in January which purported to present the evidence for hospital reconfiguration – including controversial closures of A&E departments (J Farrington-Douglas and R Brooks *The Future Hospital: The Progressive Case for Change*, IPPR, 2007). However, the authors have not engaged in a proper systematic review of the evidence and their conclusions and argument are open to challenge. The evidence for hospital reconfiguration is at best inconclusive.

(2) On December 5th, Tony Blair, in a widely reported speech, quoted figures released simultaneously in an IPPR press release and a Department of Health report both published that day which claimed that hundreds of lives could be saved through service specialization in the NHS. However, the IPPR report containing the evidence behind the figures was not released until January 7th. Close scrutiny of this report against major relevant studies reveals that the evidence base for reconfiguration is not as convincing as might have been thought at the time of Mr Blair's speech.

(3) The IPPR claim that the interdependency of services creates pressures to concentrate in order to improve safety. However, the evidence does not indicate reconfiguration for routine and chronic cases (which form the majority of cases) and rapid triage for the minority requiring tertiary referral should instead be considered.

(4) Major systematic reviews have been omitted in the IPPR's analysis. These reviews conclude that whilst there is some evidence for a relationship between volumes of procedures and outcomes, no general relationship exists and the policy significance of the evidence is confounded by the fact that much of the existing research is of poor methodological quality. Moreover, bigger hospitals rarely result in cost savings.

(5) A&E services are highly valued by the public and contribute both to patient empowerment and to reducing inequities of access, particularly for socially excluded groups.

(6) *The Future Hospital* provides no evidence to substantiate the assertion that hospital configurations must be made more flexible in response to changing patient expectations, except a pie chart showing patients favour more local provision. In fact, closer examination of the views underpinning this pie chart summary reveals that they were multi-faceted and more complex than the IPPR admit and that participants strongly favoured retention of A&E units.

(7) *The Future Hospital* argues that bed numbers can be reduced through shorter lengths of stay. However, evidence in this area suggests that more information may be needed to interpret the data.

(8) The IPPR has a record of close collaboration with organizations which stand to benefit from privatization and the IPPR's report has been sponsored in part by a commercial organization with a potential vested interest in hospital reconfiguration. This fact, along with a selective approach to evidence, weakens rather than strengthens the case for reconfiguration since it stands to undermine

further the trust placed in decision-makers by local campaigners seeking to defend services.

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Introduction

The Institute for Public Policy Research (IPPR) published a report in January which purported to present the evidence for hospital reconfiguration (J Farrington-Douglas and R Brooks *The Future Hospital: The Progressive Case for Change*, IPPR, 2007). However, the report made selective use of evidence and its conclusions and argument must, as a result, be challenged. This response focuses chiefly upon the IPPR's case in relation to the concentration of services/outcomes debate and the matter of patient choice.

The authors themselves admit they are trying to influence the political debate surrounding hospital reconfiguration and this is a perfectly reasonable objective. However, if a think-tank wishes to enter the political debate by putting forward a case based at least in part on evidence, then it must present the evidence fairly. Like many think-tanks, the IPPR operates in the hazy borderland between academic research – where criteria of careful, systematic and disinterested evaluation of evidence is supposed to be the standard which should inform publications, and political action - where publications reflect the interests of those who fund and run the think-tanks themselves and where evidence may become modified by political spin. In the case of *The Future Hospital*, the handling of evidence appears to have been compromised by the political objective.

Background

The timing of the report is significant since one of the biggest problems for Tony Blair (as well as Labour MPs with fragile parliamentary majorities) is the opposition of local communities to the closure of local services in the interests of 'rationalization'. Whilst people may accept the re-organization of services when that will result in better services, they are deeply suspicious, and rightly so, of re-organization in a context of NHS budgetary crisis. This crisis is itself in part a product of Department of Health financial miscalculations in relation to the new medical contracts as well as the cost of meeting waiting time and other targets; the introduction of an expensive competitive market and Payment by Results; reorganization; the National Programme for IT (currently estimated to be costing £2 billion per year for ten years with no guarantee that it will work); and privatization through PFI and Independent Sector Treatment Centres and other public private partnerships. The public have to be persuaded that re-organization will make things better and that requires evidence. *The Future Hospital* claims to have that evidence.

Rather surprisingly, a summary of the main arguments was released in September (*Hospital Reconfiguration: An IPPR Briefing*) in which claims were made without the details of the substantiating evidence being made available at the same time for public scrutiny. The release of the briefing coincided with Mr David Nicholson's first public interview as the new Chief Executive of the NHS with *The Guardian's* John Carvel. This interview focused upon the 'reconfiguration' agenda which demands:

... up to 60 "reconfigurations" of NHS services, affecting every strategic health authority in the land. Some changes will try to

squeeze out overcapacity that contributed to the NHS's £512m deficit in the last financial year. But most will be aimed at redesigning the NHS to improve care by concentrating key services in fewer hospitals. Mr. Nicholson identified A&E departments, paediatrics and maternity services as areas where provision would have to be overhauled. (John Carvel 'Plan for wave of closures of NHS services', *The Guardian* 13th September 2006)

The release of the 5th December claimed that hundreds of lives could be saved with service specialisation. Two other reports advocating reconfiguration were 'launched' on the same day (although, despite claiming to provide clinical justification, these contain no referenced sources) (Alberti, G. *Emergency Access: Clinical Case for Change*, Department of Health; Boyle, R. *Mending Hearts and Brains: Clinical Case for Change*, Department of health). Also on the 5th, Tony Blair made a widely reported speech quoting figures supplied in both the Boyle report and the IPPR's press release of that day. The IPPR's focus is upon A & E: it claims that if a minimum catchment area of 300,000 is established for A & E units, about 58 such units will have to close or be downgraded.

Well now we have the full report itself and can assess the 'evidence base' for the re-organization it demands. This response focuses on two of the principles invoked to justify the claimed need for re-organization. The first is that this will result in better health care through concentrating resources so that units handle large volumes of patients and achieve better outcomes. The second is to enhance patient choice. To quote:

"Preserving current configurations of hospitals will not allow the NHS to meet the personal needs of individuals. Creating a more demand-led health system, using choice and some competition, will require providers of healthcare – including hospitals – to respond to changes in needs and preferences more rapidly" (page 5).

However, in relation to both principles we find a selective and indeed often misleading use of evidence. We will deal with each in turn.

Concentration and Outcomes

Here, *The Future Hospital* interweaves generalisation and more limited claims. Overall, the message that comes across is summarised thus in the executive summary:

"The public often assume that the local hospital provides a full range of services that are clinically safe. However, this is often not the case.... In order to provide complex health care safely, professional teams need to see sufficient volumes of patients with a particular condition. The potential benefits for specialisation are greater for some life threatening conditions like heart attacks and major injuries, but the safest treatment cannot be provided at every district general hospital because there are not enough patients for teams to maintain their skills" (p4).

And in the more detailed discussion:

"This section summarises the case for concentrating a *small amount* of hospital care. We have selected treatment for heart attack, major injury and vascular surgery as *examples* of life-

saving services that people are concerned they will not be able to access if their local accident and emergency department is closed. As the evidence shows, these are *particular examples* where better outcomes are achievable from more centralised services. *However, the arguments also apply to other hospital services where there is a need to provide more specialist services to improve patient safety*" (p14; italics added to emphasise shift from limited claim to broader, indeterminate claim).

There is evidence that concentration of resources for treatment leads to better outcomes in relation to some areas of treatment. This is well established for cancer, paediatric surgery, neuro-surgery and a set of relatively rare but life threatening conditions. In practice the NHS has already concentrated many such services, especially oncology for cancer patients, in regional centres, and this makes excellent sense. However, *The Future Hospital* wants to take this concentration further. The particular target is Accident and Emergency – A & E – which is a core local service for many general hospitals. The IPPR's Briefing asserts "the interdependency of services creates pressures to concentrate in order to improve safety" but the more detailed *Future Hospital* provides evidence for essentially three sets of emergency procedures, relating to heart attacks, major accident trauma, and vascular surgery for aortic aneurysm. It is important to emphasize that all these are discussed in relation to emergency procedures and there is some evidence that, for emergencies of these kinds, concentration of expertise is beneficial.

However, this is not the case for non-emergency care. So, for example, the major recent US systematic review looking at: 'Is Volume Related to Outcome in Health Care?' (which is NOT referenced by the IPPR) notes that for coronary care, whilst there is some evidence for better performance for larger units with bigger throughputs in relation to emergency intervention, there is no evidence for this in relation to non-emergency intervention (Halm, E., Lee, C., and Chassin, M. 'Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature' *Annals of Internal Medicine* 2002 137 511-520). This matters because, in the UK, the vast majority of coronary care is given on a non-emergency basis. The IPPR make big play of coronary heart disease being a major source of both all death and of premature death. Actually, the diagram they use to illustrate this (Figure 2.1 page 14) tells us nothing about premature death at all, only about death at all ages. However, it does distinguish between acute and chronic heart disease. Most coronary heart disease is not acute although 7% of all deaths at all ages are from acute myocardial infarctions (heart attacks). However, in 2004, just 14% of such heart attack deaths and less than 1% of all deaths (5461 from 39274) were of people under the age of 65. Most people who die of heart attacks are over 75 ('Deaths by age, sex and underlying cause, 2004 registrations', *Health Statistics Quarterly* 26). The issue in heart disease is as much morbidity as mortality. The British Heart Foundation notes the following:

"Whereas mortality from CHD is falling rapidly, morbidity from CHD and other heart disease appears to be rising, especially in older age groups. In those aged 65 and older, morbidity has risen by around one third since the late 1980's. Around 1.3 million people in the UK have had a heart attack and approximately 2 million people are suffering from angina, the most common form of CHD. Around 670,000 people have definite (and a further 230,000 probable) heart failure."

<http://www.bhf.org.uk/professionals/uploaded/factsheet2005finalaw.pdf>

The best way to reconcile the interests of emergency and non-emergency patients is the rapid triage of the relatively few patients with these kinds of life threatening conditions requiring tertiary care. This could be achieved through training ambulance paramedics to recognize them and take affected patients directly to the appropriate regional centre which will have a clinical network of cardiologists, neurologists, vascular surgeons and other specialists plus the appropriate support resources. This means that the District General Hospital can have the best of both worlds by treating the majority of patients near its catchment area and ensuring that the minority who require the services of more specialised facilities access these in time.

To sum up, regional specialist centres are certainly required for the relatively few people who need very rapid emergency care. District General Hospitals are the best means of dealing with the great majority of cases.

In addition, there are matters of medical training and staffing which emerge. In relation to training, these are easily managed by the rotation of doctors in training through specialist and general units in a planned way. A lot of the staffing problems are asserted to derive from the impact of the European Working Time Directive on the availability of both junior doctors and consultants given the shorter working weeks required under that legislation. However, appropriate rotas for smaller hospitals, increased medical staffing of small to medium sized hospitals or shared rotas among hospitals should address this, along with an examination of roles which can be transferred to other clinical personnel.

The Use of Evidence

Here we must note that *The Future Hospital* does not observe the protocols which should inform the assessment of evidence. In other words, its authors have in no way engaged in a proper systematic review: 'an overview of primary studies which contains an explicit statement of objectives, materials, and methods and has been conducted according to explicit and reproducible methodology.' (Greehalgh, T. 'How to read a paper' *BMJ* 1997; 315: 672-675). In Tables 2.2 which 'summarizes' the evidence on the impact of trauma care on mortality, they explicitly state that they have presented 'a sample' (with no description of sampling procedure) of evidence rather than a systematic review. This procedure is aptly described by Greehalgh thus:

"Remember the essays you used to write as a student? You would browse through the indexes of books and journals until you came across a paragraph that looked relevant, and copied it out. If anything you found did not fit in with the theory you were proposing, you left it out. This, more or less, constitutes the methodology of the journalistic review—an overview of primary studies which have not been identified or analysed in a systematic (standardised and objective) way."

In considering hospital re-organization, it is a serious mistake to consider hospitals merely as assemblages of discrete and completely separate services. They are complete entities with inter-dependent relationships among the units composing them. This point is well made by the Working Party of the Royal College of Physicians on *Isolated Medical Services* (2002) who concluded that what was required for seriously ill medical patients was a facility which could provide:

- Acute general surgery
- A&E departments
- Resident anaesthetic cover
- Intensive care
- Cardiac care

That describes a District General Hospital. What should be the appropriate size of a District General Hospital? Well, this was examined in some detail in NHS Centre for Reviews and Dissemination Report 8 *Concentration and Choice in the Provision of Hospital Services* (Ferguson, B., Posnett, J. and Sheldon, T. 1997). This major systematic review and economic assessment is, again, not cited by authors of *The Future Hospital* although they do reference a useful summary of it. Let us quote from that summary:

“The best research suggests that there is no general relationship between volume and quantity. However, in some specialities there appear to be quality gains associated with increased hospital or clinician volume.

“There is no evidence that cost savings can be secured merely by increasing scale in acute hospitals beyond 200 beds and it is likely that large hospitals (above 600 beds) display diseconomies of scale, although these inefficiencies may be offset in other ways.”

(‘Hospital Volume and health care outcomes, costs and patient access’, *Effective Health Care*, Vol 2 No 8 1996, Nuffield Institute for Health, University of Leeds and NHS Centre for Reviews and Dissemination, University of York)

The most recent major US systematic review and methodological critique of the literature comes to exactly the same conclusion:

“Twenty years of research have established that, for some procedures and conditions, higher volume among hospitals and physicians is associated with better outcomes. However, the magnitude of the relationship varies greatly among individual procedures and conditions. The clinical and policy significance of this finding is complicated by methodological shortcomings of many studies. Even when a significant association exists, volume does not predict outcomes well for individual hospitals and physicians” (Halm, E. et al, 2002).

Precisely the same point about quality of evidence was made in the Leeds and York study cited above. As that study commented:

“Much research examining the relationship between hospitals and clinician volumes is of poor quality and does not make adequate adjustment for differences in patient case-mix.”

The Future Hospital's approach is to summarize an at best arbitrary selection of studies of individual procedures without any discussion of quality of research procedures. But in summarizing systematic reviews dealing with the overall impact of hospital size on health outcomes where these consider the quality of research procedures as well as findings, we must conclude: we JUST DON'T

KNOW. There is no clear evidence and assertions to the contrary are NOT TRUE. What we do know is that to function as a resource to a locality a hospital needs the services specified by the Royal College of Physicians for seriously ill medical patients and that category is the largest category of people likely to need inpatient care, particularly in relation to the inpatient needs of the elderly.

The Future Hospital cites (p19) the work of Professor John Posnett to acknowledge that the evidence on the volume-quality link is 'debated' and the relationship of volume to outcomes 'a matter of some controversy among experts'. This is to put it mildly. Professor Posnett, who co-authored CRD Report 8 (*Concentration and Choice in the Provision of Hospital Services*), has been brutal in his discussions of the claims of the would-be rationalisers. The Health Evidence Network (HEN) of World Health Organisation's Regional Office for Europe uses Professor Posnett's work to address the question: are bigger hospitals better? The summary appears thus:

"The issue

It is tempting to think that larger hospitals are more cost-effective than smaller ones because of the operation of economies of scale. However, the evidence does not back up this belief. While increasing hospital size can cut costs for some specific procedures, such economics are exhausted at a relatively small size.

Many people also believe that patient outcomes improve with hospital size. Unfortunately, most studies of this relationship are poorly controlled for differences in prognosis, if at all. When such differences are taken into account, the correlation between outcomes and size turns out to be relatively minor or even absent.

Findings

The literature on hospital economies of scale suggests that they are fully realized in facilities of 100 to 200 beds. Yet, in many countries, the concentration of hospital services continues to be a major policy aim, especially through mergers. In private health care markets, mergers are undertaken primarily to reduce competition and enhance profits.

In public systems, two other justifications predominate. First, when hospitals operate at less than full capacity, mergers are a way of eliminating excess capacity and cutting costs. Second, a merger can address performance issues for particular units or services.

However, concentrating hospital services often reduces patient access because it increases social and economic costs for many patients. Research suggests that these increases have the greatest impact on the use of diagnostic, outpatient and screening services in primary care. Evidence of the impact on secondary and tertiary services is mixed; some studies suggest that patients who live further from a hospital have lower referral and intervention rates, while other studies show no difference.

Policy considerations

Bigger hospitals are not necessarily better. Research shows that they rarely result in lower costs or better patient outcomes. A good

deal still needs to be understood about how to achieve better clinical results, and common size indicators, like hospital activity volume, are too crude to be useful in planning clinical services.

Optimal hospital size depends on local health care needs and the availability of complementary services. The burden of proof for any proposed merger ought to lie with its proponents, who should be able to quantify the expected benefits and costs and explain how the benefits will be realized.”

(http://www.euro.who.int/HEN/Syntheses/short/20050204_1)

(See also Posnett, J. 1999 'Is bigger better? Concentration in the provision of secondary care', *BMJ*, 319: 1063-5.)

Interestingly *The Future Hospital* focuses only really on A & E in its discussion of rationalization. It avoids the very thorny question of rationalization of paediatric and maternity services which was raised by Nicholson, the NHS chief executive. *The Future Hospital* proposes a far greater use of nurse-led minor injuries units and correctly asserts that the majority of patients presenting in A & E present with primary care needs. This in part arises from the difficulties in accessing GP led primary care for those of marginal or excluded status as well as more generalised difficulties of access consequent upon government policies on GP contracts and out of hours GP provision. Ironically, the result of these has been at least in some places to constrain access whilst simultaneously making it more costly. There is certainly the potential for transferring more functions in a clinical specialist led A & E to nurse practitioners, and this is in fact a sensible method of resolving the issues which arise from proposed concentration of medical training and a consequent reduction of available junior doctor numbers in A & E. However, as the IPPR admits, it is often impossible to discern in advance who will require acute care and who will not. A & E requires clinical specialist availability for those cases which do turn into non-trauma emergencies – in effect the serious illnesses which are not picked up directly by paramedics from a car accident or with an identifiable heart attack. People understand this and this is precisely why they defend full cover local A & E provision. We need to look at A & E in a different way: it is a universal and upon demand service. It makes an enormous contribution to countering the inequities of access that characterise some other parts of the service since it is considered accessible and useful by typically marginalised and excluded groups. Patients generally know where their A & E services are; they know they are available at any time; they know that they will be treated whatever the nature of the ailment. A more effective approach to A & E units is, not to withdraw them from a public which clearly wants and uses them, but to run more primary care provision on site and alongside them so that resources can be used effectively following proper triage. This approach is already adopted in at least some A & E units. Rather than regarding A & E as a problem, we should celebrate its contribution to patient empowerment.

Patient Choice

Let us turn to the issue of patient choice. Repeatedly, *The Future Hospital* asserts that hospital configurations have to be made more flexible in order to be responsive to changing needs and expectations and that patient choice, along with other reforms such as a regulated quasi-market, is a mechanism to achieve this. Despite this construction of patient choice as a means of satisfying what are variously described as patient 'needs', 'expectations', 'desires' and 'control', the IPPR report abstains from exploring the implications of the fact that many real patients are in practice declining to choose choice. The best evidence on this comes from study carried out by researchers at Manchester and Cardiff for the

NHS Service and Delivery Organisation – a study which has proved so contentious that the Department of Health has removed it from its website. This is an important study and its 'key messages' demonstrate the complexity of this issue and are worth reproducing in summary form:

- Patients want to be treated as consumers of health care. They want better information about treatment options and to be more involved in the decision making process as to which option to follow.
- Patients' attitudes depend on the severity of their illness, the nature of the procedure and the individual's circumstances. The severely ill facing complex treatment typically prefer to have decisions made on their behalf by an informed and trusted health professional.
- Patients want to go to a distant hospital for non-urgent treatment only if local appointments require a long wait or there is a local history of poor service.
- Most patients prefer access to one good hospital and GP rather than to several of indeterminate quality.
- *Ceteris paribus*, wealthy and well educated populations will be the main beneficiaries of a policy of extending patient choice.
- There is no evidence that giving patients greater choice will improve the quality of their care. Some studies suggest that increasing choice may result in a deterioration in the quality and cost effectiveness of services.

This by no means indicates the 'choice of provider' is important for patients. What they want is involvement in their own treatment through negotiation with professionals and when they are seriously ill and faced with complex processes they prefer to rely on good and trusted professionals.

The authors of *The Future Hospital* are careful not to say that patients want choice, which is as well since the evidence to date would not support such a stark claim. They persist, however, with claims for patients' 'desires' and 'expectations' which are similarly unsubstantiated. In fact, no empirical evidence whatsoever is offered for patient desires or expectations of flexibility in service location save a pie chart summarising the extent to which participants at the 2005 Citizens' Summit on *Your Health, Your Care, Your Say* supported providing services locally (p11). The authors point out that the majority of participants 'supported providing services more locally in order to improve access and convenience' (p10). Closer examination of views underpinning this pie chart summary, however, reveals that participants' perceptions were many-sided, assessing service relocation against context and consequences. This should not come as a surprise and is consistent with local campaigning to defend A & E services. Indeed, concern to retain local and accessible A & E services was widespread among participants.

The views of participants described in the report were multi-faceted, welcoming the potential advantages of more local care (including less travel, more personalised services, more joined-up care) *but* – and the authors of *The Future Hospital* don't mention this – raising concerns about factors such as quality (perceived by some as superior in hospitals), extra costs arising from the duplication of facilities and equipment and waiting times. Participants were attracted to the possibility of reduced waits for appointments in the community but the vast majority made it clear they were not willing to wait longer for a community appointment (for example, where a particular specialist conducts a clinic only once a month), preferring to travel to hospital instead. These views

reflect a subtle insight into the multi-dimensional character of access: making services more local is not necessarily perceived as improving access. The complex character of these views may contribute to understanding the 'support to some extent' position of 43% of participants, which the IPPR include in their majority-for-more-local-services assertion. In fact, only 16% 'strongly' supported localisation. (Opinion Leader Research (2006) *Your Health, Your Care, Your Say: Research Report*) <http://www.dh.gov.uk/assetRoot/04/12/74/62/04127462.pdf>

This is an important and interesting consultation exercise and it is worth reading through the excellent evaluation of it at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4138622&hk=CUI0La

What is clear is that the participants in this process wanted more involvement in decision making about health service provision. That is very different from individual consumerism – they wanted local civic engagement.

Length of Stay and Bed Usage

The Future Hospital also promotes an efficiency agenda in relation to the actual use made of hospital beds. It argues, correctly, that people should only remain in hospital for the minimum time necessary for their treatment and that more care should be provided on a day basis and through non-hospital units. However, a note of caution should be struck as evidence in this area has advanced a number of paradoxes, indicating that more information may be needed to interpret the data. *The Future Hospital* draws on data generated by the privatized health care information system 'Dr Foster Intelligence' to argue that if all hospitals reduced their 'length of stay' time so that length of stay moved 25% closer to the median level, then 13% of total hospital capacity could be saved. Keeping people in hospital for longer than necessary is both expensive and exposes them to the danger of hospital acquired infections. However, discharging them too rapidly can result at best in their having to be re-admitted which counts as another separate episode of care, and at worst in death. The Dr Foster system has examined the relationship between length of stay and subsequent emergency re-admission (Dr Foster's Case Notes, *BMJ* 331 15th August 2005). The figure included with this article demonstrates that for stays of up to 30 days, the chance of re-admission rises the longer the stay but for stays of more than 30 days there is no relationship between length of stay and re-admission.

This sort of nonlinear pattern is also identified in various other studies. Baker et al (Baker, D., Eisnstadter, D., Husak, S. and Cebul, R. 'Trends in Postdischarge Mortality and Readmissions: Has length of stay declined too far?' *Archives of Internal Medicine* 164 5 2004 538-44) found that in the US where private providers for publicly funded patients under Medicare have sought to minimize stays, there was higher mortality for patients with early Do Not Resuscitate Orders who were discharged early. It is not clear whether this reflects a perfectly reasonable approach by discharging earlier clearly terminally ill patients or whether it indicates inappropriate clinical risk.

A similar need for additional information for the proper interpretation of data arises in the study of Westert and colleagues who found that countries where lengths of stay were longer tended to have lower readmission rates but that those individuals who were readmitted tended to have had higher initial lengths of stay (Westert, G., Lagoe, R., Keskimaki, I., Leyland, A. and Murphy, M. 'An international study of hospital readmissions and related utilization in Europe and the USA' *Health Policy* 61 2002 269-278). In fact a reader's response to the Dr

Foster's Case Notes article came from a surgeon who had identified that in his hospital the coded data records system was not accurate enough for the assessment of emergency general surgery admissions as it allowed inclusion of significant numbers of patients who were not readmitted for the same or a similar condition but for an unrelated reason. These data problems may occur in other hospitals, too.

THE IPPR and the privatization agenda

The Future Hospital is as much as anything an exercise in political persuasion. There are a number of devices the authors use to persuade the reader that concentrating some services and devolving others away from district general hospitals is good for us. Generalisations are interspersed with more cautious and qualified statements; observations are juxtaposed such that the impression is given that they are linked; 'studies' are referred to which are not then identified; assertions are made without evidence to back them up.

The IPPR has history of engagement with the privatization agenda, with strong connections both to the New Labour leadership and the private sector. This was clearly identified by Allyson Pollock and colleagues in the appendix to their Catalyst Working Paper, *Public Services and the Private Sector – A Response to the IPPR*. This followed the publication of the IPPR's major report *Building Better Partnerships* (Commission on Public Private Partnerships, 2001) which purported to provide a philosophical and evidence base for greater commercial involvement in welfare. They noted:

"The commission represents a striking coalition between big business and government. Commission members have direct links into many of the key government departments...A growing share of the sponsors' revenues and profits are built on the billions of pounds of public funds and government contracts" (p41).

<http://editiondesign.com/catalyst/pubs/paper1.html>

Commission members included corporate chairmen, advisers on earlier privatisations and government officials charged with introducing PFIs. The Director of IPPR at the time of that report was Matthew Taylor who had already been director of policy for the Labour Party during the 1997 Election and was subsequently to be seconded back to work in the No.10 Policy Directorate.

The current Secretary to the IPPR Board of Trustees is Dr Chai Patel who is a significant donor to the Labour Party and the Chief Executive of the Priory Group, the UK's largest private mental health and specialist education services group. *The Future Hospital* project has been sponsored by the BMA and the Royal College of Nursing and by the Pharmaceutical company, Wyeth. That is reasonable enough – two professional bodies and a corporate sponsor with no direct interest in privatizing clinical care. However, the fourth sponsor is Prime PLC – a specialist development company investing in the buildings from which the public sector delivers integrated primary and intermediate care services – in other words, part of the public private partnership system for privatizing our health care system. This is how it describes itself:

"The Prime group companies forge and sustain innovative partnerships with both the public and private sector, to plan, design, develop, fund and manage state-of-the-art primary care

facilities. Prime is the UK's largest investor and developer in the primary and social care sector."

<http://www.primeplc.com/business/business.html>

The closure of existing local general hospitals could quite feasibly lead to an array of new 'primary and intermediate care centres' being constructed, many on a PFI basis by the companies such as Prime PLC.

Conclusion

What we have demonstrated in this critique is that the evidence for the re-organization of hospitals within the NHS is at best inconclusive. The New Labour government, concerned by the growing popular unrest in response to threats to local hospital services and fearful for the majorities of numerous Labour MPs, has undertaken, along with NHS Chief Executive, Mr. David Nicholson, to persuade the public that losing local hospital services is in the public interest. The IPPR, an organization intimately connected to commercial health interests, has produced a report saying that the evidence is clear enough to point to hospital re-organization. The danger for the IPPR and government alike is that the combination of sponsorship by an organization with a potential vested interest in a particular outcome along with a selective approach to evidence weakens, rather than strengthens, the case for reconfiguration. Local communities campaigning to defend services could continue to distrust policy makers not only because reconfigurations smack of cost-cutting but also because they conveniently create business opportunities for powerful interests.

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