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A private function?

Have reports of the death of the NHS been greatly exaggerated? **Philip Carter** reports on the ambitions—and reservations—of the private companies poised for greater involvement in healthcare delivery

The Health and Social Care Bill sets out a landscape that has few boundaries for private sector involvement. In a speech this September, the English health minister Earl Howe said there are "huge opportunities" for the private sector within the current health service reforms.[1] To critics this was the articulation of their long held fears: that the reforms are little more than privatisation by the back door. But what is mere rhetoric and what is fact? What is the current extent of the role of the private sector and is this set to expand rapidly and irreversibly as critics maintain?

"People have simply not appreciated the magnitude of the changes the bill proposes," says Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine. "There is nothing in the bill to stop the entirety of NHS services being provided by private sector firms in a few years' time. There is no brake and no restraint to the role of the private sector within the reforms."

But Jill Watts, chair of NHS Partners Network, a body that represents private sector NHS providers, points to a different reality. "I'm afraid there has been a ridiculous amount of scaremongering in the debate over the NHS reforms and specifically about what the role of the private sector might be as a result of this," she says.

Private sector reach

Underpinning the debate has been the belief that the vast bulk of NHS services are currently provided directly by NHS bodies. According to NHS Partners Network, about 5% of NHS services are provided by independent organisations—both commercial and not for profit organisations. Yet, an Office of Fair Trading report this summer suggests a starkly different position.[2] Its breakdown of healthcare finance and supply provided by public and private sources during 2008-10 suggests there is a far greater private sector provision than has been generally recognised: 2% private finance, public supply; 11% private finance, private supply; 42% public finance, private supply; and, 45% public finance, public supply. Nevertheless the question remains, will the private sector's role, whatever its current extent, increase as a result of the reforms. Here, the outlook is far from clear.

Uncertainty ahead

One thing is sure; companies hate uncertainty—and that is perhaps the biggest obstacle to them taking a greater role in NHS provision. "The picture is so confusing," says Kieran Walshe, professor of health policy and management at Manchester University. "There is very little certainty on the extent to which the reforms will lead to greater private sector provision of NHS services. People with long memories will say we have been here before and not much actually happened." He is talking here about independent sector treatment centres and patient choice. Here, the government had to effectively promise guaranteed levels of activity to get the treatment centre programme under way. "Without that, the commercial risk would have been too great," says Professor Walshe.

Monitoring Monitor

Over the summer, the government's listening exercise on the reforms resulted in an important shift in the role of Monitor, the organisation that oversees foundation trusts. No longer will it be tasked solely with promoting competition. And that is a development that has caused frustration among some private sector firms, according to Viggo Birch, vice president of Novo Nordisk.

"While we believe that the government's stated desire for greater competition, patient choice, and an increased role for the private sector provides an ideal opportunity for third sector/patient organisations, social enterprise, and commercial companies such as Novo Nordisk to share respective expertise and insights, we note that Monitor's mandate to 'promote' competition has been drastically reduced in the revised NHS bill," he says.

"The revised brief for Monitor to promote and protect patients' interests and integration would appear incompatible, or at the very least inappropriate, for the economic regulator of the NHS."

Mr Birch adds that the cost cutting agenda underlying the reforms is arguably incompatible with the aspirations of the bill. "We welcome the emphasis on greater patient involvement and improved patient outcomes, patient choice, and patient education contained in the bill . . . but are concerned that these may be diminished by local commissioning decisions and budgetary pressures," he says.

Mr Birch points here to the uncertainty that many people think will severely limit the role of the commercial sector. It's a view shared by Nigel Edwards of the King's Fund, a health think tank. "It's very difficult to predict the extent to which

the private sector will become further involved in the provision of NHS services," says Mr Edwards. "There is an increasingly uncertain financial environment, and this, combined with a cultural resistance within the NHS, suggests that its role will be more of a slow take off."

According to Mr Edwards, the reforms only marginally increase the likelihood of significantly greater private sector involvement. Any change in the current balance will be gradual and at the margins. Where we are likely to see the most activity is in community and elective care and in provider management. Some may take the form of back office support and behind the scenes organisational and strategic support.

"Companies are targeting consortia [clinical commissioning groups] with specific tools and strategic assistance," says Stephen Lawrence, a general practitioner with a specialist interest in diabetes from Kent. "For example, offering to help consortia to identify patients at risk of complications or unscheduled hospital admissions as a result of their diabetes. Data around patient care are being collated and analysed to see what works and what doesn't."

Beyond clinical and care analysis, one of the peripheral areas where private firms are likely to step in is organisational support for clinical commissioning groups (CCGs). Last month a sense of things to come emerged with the news that a reported £7m (€8m; $11m) agreement was struck by a group of London based CCGs with a range of private sector firms including PwC, Capita, KPMG, and a partnership with the Royal College of General Practitioners' Centre For Commissioning, McKinsey, and Ashridge Consulting.

People with long memories will say we have been here before and not much actually happened

Other firms listed within the framework of providers to deliver support services for London CCGs include Capsticks, Entrusted Health Partnership, BDO, and Ernst and Young. The firms will offer advice on matters such as strategy, organisational structuring, and finance.

In truth, many such firms have already provided advisory and other services to the NHS.[3] The question now is how reliant commissioning groups will become on private firms to deliver their mandated functions and whether this will put these businesses in a stronger position to scale up their offerings to the NHS.

On the clinical side, the Department of Health announced in July a range of other services, beyond non-urgent care, where patients will be able to choose their providers. Patients will be offered a choice of pre-approved or qualified providers in eight care areas: services for back and neck pain; adult hearing services in the community; continence services; direct access diagnostic tests; wheelchair services (children); leg ulcer and wound healing; psychological therapies (adults); and podiatry services.

Drug companies have viewed the reforms as an opportunity to extend their businesses by providing services such as diagnostics and testing and beyond. "There is a potential for them to extend their range of services by tying patients to a set of products," says Professor Walshe. "But it has been slow to happen, and I am sceptical about whether the reforms will do much to increase this."

One firm that has been considering its approach under the reforms is Novo Nordisk. "By bringing diverse groups of clinicians together, in several locations, Novo Nordisk is helping the NHS to develop better quality and better integrated care across the whole diabetes pathway," says Mr Birch. The company has begun working with a big healthcare trust to modernise and optimise management of glucose levels among diabetic patients in primary care. "This will be one of the NHS's pioneering population based integrated care services in diabetes," he says.

Another company that is developing services to meet the new landscape of the NHS is Pfizer Health Solutions. The company creates and delivers health system solutions, including consultancy work, redesign of services and patient pathways, and telephone based self care programmes for people with long term conditions.

"Pfizer Health Solutions recognises that the NHS is experiencing a time of unprecedented change," says a spokesperson for the company. "We work in partnership with the NHS and aim to help improve patient care and clinical outcomes and, by doing this, help the NHS release resources for other healthcare priorities. We will continue to work with the NHS over the coming months and years to identify areas where we can provide this partnership and support."

Care pathways

One of the most controversial areas for greater private sector involvement is that of integrated care pathways.

Already, several primary care trusts are looking to follow the lead set by NHS East of England in tendering out entire care pathways. NHS East of England called for bids earlier this year for an estimated £300m of care, including for respiratory and musculoskeletal services.

But it is an approach that concerns Clare Gerada, chair of the Royal College of General Practitioners. "The college has a real worry about the concept of outsourced care pathways," says Dr Gerada. "Turning patients into individual diseases is the wrong approach. We know, for example, that patients with diabetes may well have many other conditions that require integrated care. Except in very specific and easily defined areas such as maternity, the risk is that care pathways create a linear relationship to a disease rather than providing integrated care to meet a patient's overlapping and complex requirements."

A model that works

Will private companies be happy to take on board all of a care pathway for patients? For this to happen private sector firms will need a consistent and workable model. And whether that will emerge satisfactorily is a question that remains. "In what will still be a nationally run NHS, the private sector will be at the whim of government policy," says Professor Walshe. "There is huge uncertainty, and the policy picture is so confused as well. We know very little about how clinical commissioning groups will eventually turn out. So I think private sector organisations will be very wary about getting too committed too soon."

So if the outlook for companies to provide much greater services to the NHS is mired by uncertainty, what are the prospects for the so called third sector? The government has been keen to promote the idea of NHS services being delivered by voluntary organisations. But again, the outlook is gloomy according to Professor McKee. "The government is being totally disingenuous in the way it is describing the role for the third sector and NGOs [non-governmental organisations]," he says. "Our concern is that while the government talks endlessly about the involvement of the third sector, the reality is that costs of tendering are very high and simply exclude most NGOs and charities. You might see some such organisations fronting for companies, but to expect much participation from the third sector bodies on their own is unrealistic."

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New image for the drug industry

The drug industry is often given a bad press, but Stephen Whitehead, the new head of the ABPI, thinks that it is largely undeserved. **Deborah Cohen** finds out more about his plans to change our perceptions

If there's something that Stephen Whitehead, chief executive officer of the Association of the British Pharmaceutical Industry (ABPI), doesn't like being called it's a "public relations man"—even though that's precisely the work experience that has made him eligible to be the figurehead of the British drug industry.

"Reputation is about what you do, not what you say, rather than just sort of PR-ing stuff," he says.

And he should know. Coming from the financial and alcohol industries, he has a comprehensive understanding of what it means to ward off negative publicity and to try to rebuild a damaged reputation. Most recently he had to defend Prudential's botched takeover of Asian insurance giant AIA. He and the Pru parted company shortly after, in November 2010.

Not far away from the ABPI's headquarters in central London protesters camp outside St Paul's cathedral, aggrieved at the perceived excesses in the City. Though he tentatively agrees that some of the vitriol directed at the financial services industry may be warranted, he's not so sure that the notoriety of the drug industry is similarly deserved. Reeling off a list of drug discoveries in the past 40 years that include β blockers, H2 receptor antagonists, and antiretrovirals, he maintains that drug companies should be seen in a better light–overlooking, perhaps, some recent high profile industry misdemeanours.

ABPI and clinical trials

The ABPI is working with the royal colleges and has agreed to sign up to a new set of principles that will be coming out of the Royal College of Physicians' medicines forum.

This will include registering trials on a publicly accessible register early in the process and making the methods and results of the trials available. The trial should be reported fully and transparently, ensuring that the interpretation of the trial in the published report accurately reflects what actually went on with no bias.

No aspect of the study or the results should be left out of reports, and any discrepancies should be reported fully. The trial should be reported in enough detail to allow other researchers to extract the methods.

"There's an issue around timing because we've obviously got the whole competition side of that, but we can come to a mutually appropriate understanding," Amanda Callaghan, director of corporate communications at the ABPI, says.

ABPI and medical education

Stephen Whitehead believes that the industry sales model has fundamentally changed but that its reputation is lagging. "We used to have our armies of sales reps, and I'm not going to pretend that wasn't the case because we did. And did we always do everything right? No, of course not. Nobody does," he says.

He maintains that industry has a fundamental role in medical education. The ABPI is about to launch a report on funding medical education and is amending its code of practice.

"I think given that most of what we do is new technology, you have to educate around it," he says, giving examples of new drugs for hepatitis C and to replace warfarin.

"But that education has to be absolutely appropriately pitched and absolutely not driven by sales targets and marketing approaches, and not glib. It has to be really about the science, and ideally has to be led by senior healthcare professionals themselves, which is mostly what we do. This is not something that can be dispensed within three minutes in a GP's surgery or a piece of plastic," he says.

He uses antiretrovirals as an example of industry's role. "Unless you could educate when the medicines came along, how would the prescriber and the clinician know what to do? Who was going to tell them what to do? Who was going to tell them how the medicines fitted together? Who was going to tell them about the side effect profile? Who was going to tell them to report on the pharmacovigilance? Who was going to manage that process if it wasn't the industry but the regulator?"

The role of medical education is to keep healthcare professionals abreast of their particular therapeutic area. "They have their specialist publications that we seek to get published in as well. But the reality is that one to one contact, the attendance at congress, and all those sort of things are a fundamental part of, I think, pretty high valued medical education," he adds.

"If you end up looking at all the things the industry has done, you would think people would love it. But they don't," he says.

Collaboration is the way forward

Mr Whitehead thinks that the industry is at a turning point. Gone are the days of the blockbuster where "you discover a drug 'big' and you sell it 'big'"—now the move is towards collaboration and partnership with the NHS.

"Partnership is not a new word for [drug] marketing. Partnership is quite distinct," he says. And the medical profession seems to want it, he adds, mentioning collaborations that industry has set up with organisations such as the royal colleges, universities, and NHS bodies to look at provision of medical education, clinical trials registers, research partnerships on chronic obstructive pulmonary disease (COPD), and healthcare services.

The current NHS reforms have presented the pharmaceutical industry with an even greater opportunity to move from a "sales based relationship" to a relationship based on "pathways of care," he says, by providing services to the NHS—something they have started for diabetes and COPD. The ABPI has started working on pilot schemes with the NHS Confederation in several disease areas.

One example of this type of collaboration is AstraZeneca's partnership with a general practice consortium in East Surrey. For the project, called ESyDoc, AstraZeneca has redesigned the COPD pathway using its project management skills and brought together people who have typically worked separately in silos. The company has also flexed its auditing and data mining skills and has provided nursing staff. Patients are given personalised care plans—and outcomes surveys have reported high satisfaction with the scheme, the company says.

Mr Whitehead is at pains to stress that this type of service provision is purely non-promotional. Yet there is an inherent risk, says the BMA. Earlier this year, the association warned that stringent firewalls and protocols need to be in place to ensure there is no pressure on health professionals to prescribe a particular drug or treatment. To that end, the ABPI has been working with the Department of Health to draw up guidance about joint working.

And history should provide ample warning about the risks. In 2004, the global drug company Sanofi Aventis was slapped on the wrist by the UK's Medicines and Healthcare Products Regulatory Authority (MHRA) for its "Insulin for Life" diabetes scheme. The MHRA said that "relating the remuneration given to individual nurses to the number of insulin starts made in the practices they support and for changes in dose was very ill-advised."[1]

Where are the benefits?

Despite Mr Whitehead's insistence that there's no money in it for the companies, even the most strident champion of the drug industry would struggle to believe this in the long term. And given that the "profit incentive," as Mr Whitehead puts it, is essential for drug discovery, the shareholders who fund company research and development must wonder what's in it for them.

Despite collaborations being "strictly non-promotional," Andrew Roberts, head of partnership at AstraZeneca, admits they do see a return on investment from EsyDoc. Use of drugs increases, although he adds these are prescribed appropriately and according to guidelines from the National Institute for Health and Clinical Excellence (NICE). They also get valuable "real world data" showing how their drug works in the clinical setting—it is essential, industry believes, to prove their drug works.

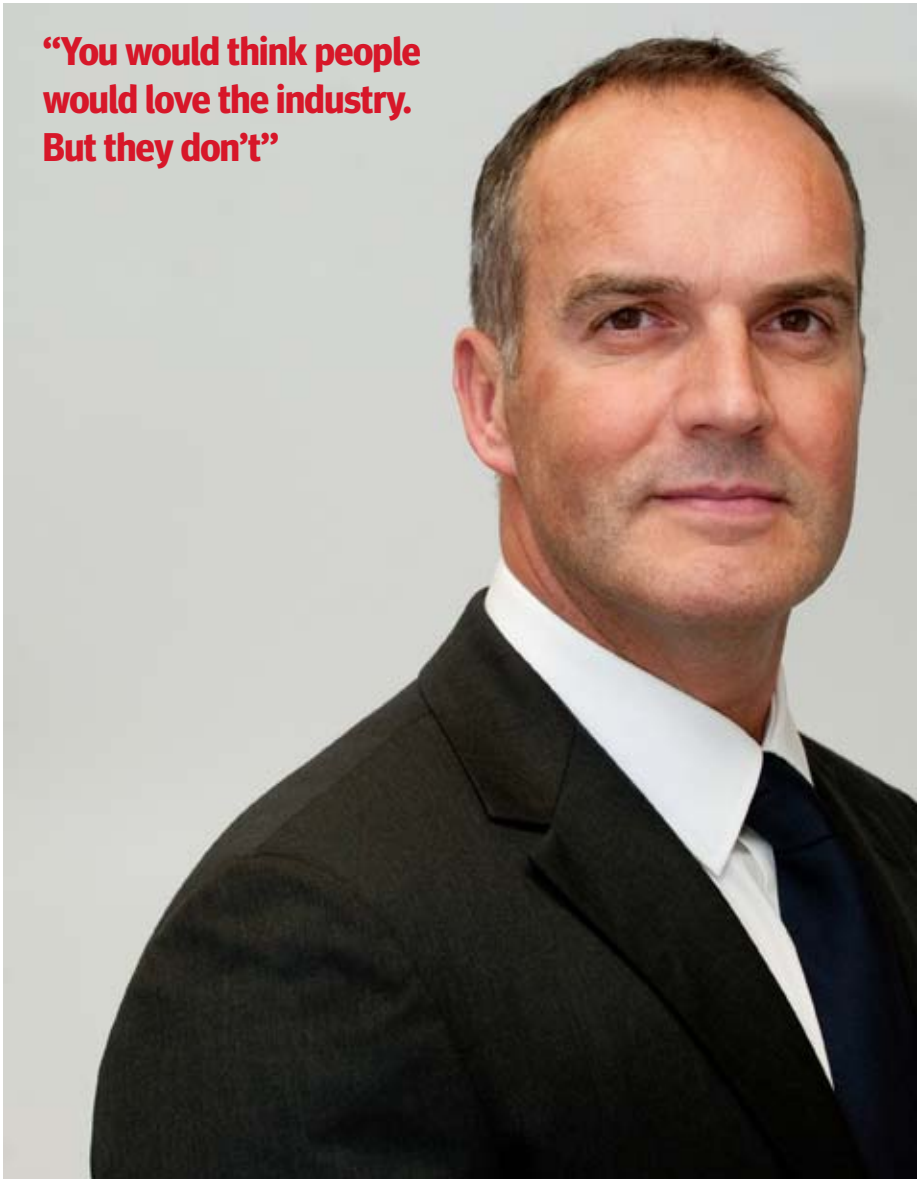
Ramona Sequeira, managing director of Lilly UK, an ABPI member, also counters that industry has a role in helping adherence to treatment. Currently, the World Health Organization estimates that 30-50% of patients do not adhere to their treatment, and rectifying this can save money on drugs bills. If drugs for hypertension were used correctly, she says, each trust would save £0.5m (€0.6m; $0.8m) a year. Patients also need better access to NICE approved drugs, she concludes.

There is an industry view that UK doctors are conservative in their prescribing patterns and drugs are not prescribed after NICE has given them the green light. Commissioners tend to go for generics. As Ms Sequeira puts it, the UK spends only 0.9% of gross domestic product on drugs compared with 2% in the rest of the EU.

"The NHS is very good at the uptake of old and very cheap technology. The uptake of innovation is a problem in the UK," Paul Catchpole, value and access director, of the ABPI said.

The current collaboration mantra extends beyond working directly with doctors. It also includes universities and research charities sharing their expertise—best exemplified by a collaboration between the Medical Research Council, the ABPI, and multiple academic institutions and companies to research drugs for COPD. Another example of an effective partnership is that between Alzheimer's Research UK and Elan Pharmaceuticals, an Irish drug company.

Back in 2000, Elan Pharmaceuticals stopped their phase II clinical trial of an amyloid β peptide vaccine (called AN1792) in people with Alzheimer's disease in the UK when 6% of people on the trial developed meningoencephalitis. Alzheimer's Research UK subsequently funded a long term study to allow scientists at the University of Southampton to follow-up the results of the initial Elan trial in the UK. They were given access to the details of the trial by Elan and made contact with and followed-up the people who had been enrolled in the study.



Clinical follow-up of cognitive function showed no evidence of benefit in immunised participants compared with those in the placebo group. Even the small number of participants who showed almost complete clearance of plaques still continued to progress to end stage dementia, raising questions about the understanding of Alzheimer's disease.

"In terms of the medical community and the research community I think most of us start with the fundamental position that the more transparency the better, and the more that is available in the public domain the better," Mr Whitehead says.

This applies to payments to doctors too. He thinks a nationwide equivalent of the US Sunshine Act—whereby companies have to list payments to individual doctors—is inevitable. The ABPI are currently working on this with the Academy of Royal Medical Colleges.

"If we were to come out every year and simply say this is what we pay the medical profession, what does that mean? And who else pays the medical profession?" he says. "You want granularity so that you can say this is what we do, this is how do it, and we are not ashamed of it. It's a legitimate part of the healthcare delivery process."

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Hinchingbrooke comes full Circle

A private healthcare company is to run an NHS hospital. What does the deal involve, asks **Peter Davies**, and will others follow under the government's "any willing provider" policy?

What's unique about the deal?

Circle is to take over Hinchingbrooke Health Care NHS Trust in Huntingdonshire and provide a full range of NHS district general hospital services. Private healthcare companies have for some time run units within NHS hospitals, such as treatment centres, but Circle will be the first to operate an entire hospital. The previous Labour government passed legislation making this possible in exceptional circumstances. Hinchingbrooke is £39m (€45.5m; $60.3m) in the red—the largest legacy debt as a proportion of turnover in the NHS—and the Care Quality Commission is concerned about the trust's stroke and cancer services. All Hinchingbrooke's assets will remain NHS owned, with Circle holding a franchise. "It's not privatisation," says Stephen Dunn, NHS Midlands and East's director of policy and strategy. "Without this, we might have had to cut services or close the hospital."

Catherine Hubbard, joint medical director at Hinchingbrooke, says: "It's difficult to get across the concept of an operational franchise. The only way we will get that message out is by doing it."

Length of the contract

The contract is for 10 years from February 2012. It is worth £1000m, based on Hinchingbrooke's annual revenue of £100m. Circle has pledged to meet the hospital's £250m productivity improvement target as well as pay back the £39m debt. Unlike some previous NHS private sector partnerships, Circle will have no guaranteed revenue. "We've sought to learn that lesson. Circle only gets paid if a surplus is delivered," says Dunn, and then it will be split with the NHS.

The Appointments Commission has selected a chair and two non-executive directors to form a new Hinchingbrooke trust board from February, which will appoint a franchise manager to monitor daily contract performance.

Will the accident and emergency department be closed to save money?

"Circle submitted plans to provide a full range of services over 10 years and was appointed on that basis," says Dunn. Hubbard fully expects Hinchingbrooke will still be providing accident and emergency and maternity services at the end of the contract. Ali Parsa, Circle chief executive, says: "We don't pay our taxes so that people can shut down our A&Es. It's only people sitting in central London in front of spreadsheets who come up with solutions like that."

"Some NHS turnarounds don't work because they're imposed on people rather than created, believed in, and delivered by them. I'm absolutely confident changes like this can turn around the finances"

So how will Circle turn around the hospital's finances? Circle submitted 3500 pages of plans that were scrutinised by 54 evaluators, half of whom were clinicians. The plans include shortening length of stay, rationalising theatre usage, and improving back office functions. Control will be devolved to clinical units.

"Rather than keeping leadership at the top, we devolve and disperse it," says Massoud Fouladi, chief medical officer at Circle. "Leaders are not appointed but go through a process of being mandated by their clinical team. Therefore they have the authority to take through changes."

Parsa says: "Some NHS turnarounds don't work because they're imposed on people rather than created, believed in, and delivered by them. I'm absolutely confident changes like this can turn around the finances."

Consequences of failure

If the trust makes a deficit, Circle must fund the first £5m. Either party can terminate the contract if the trust incurs more than £5m in aggregate deficits, when Circle would have to pay a further £2m termination fee. The company's liability is therefore capped at £7m. The contract can also be terminated at any time on a "no cause" basis, in which case Circle would be compensated.

Doesn't Circle claim to be a social enterprise?

Circle is 49.9% owned by Circle Partnership Ltd, a partnership of its employees, though it is registered in the British Virgin Islands. Circle Holdings plc owns the other 50.1%, and is itself owned by six hedge fund and venture capital companies. It was registered in Jersey until earlier this year, and was floated on the London Stock Exchange in June.

Will staff become Circle employees?

Existing and new staff will remain NHS employees. Hinchingbrooke is not expecting redundancies because of the deal, though Circle says it may redeploy and retrain some staff within the hospital. Circle would like to allocate shares to Hinchingbrooke staff, as it does to its own employees under its partnership arrangement to encourage commitment and enthusiasm. Dunn says it will have to "work through the legality around that," and ensure staff and unions are comfortable with it.

Hinchingbrooke and the future for other trusts

Twenty other hospitals have major problems, but health minister Simon Burns has insisted: "This is not a blueprint or model to be used by other hospitals."

Paul Corrigan, former adviser to previous Labour ministers, believes the government is desperate to avoid accusations of privatising the NHS. "Because of this I think it's unlikely we'll see another private sector takeover of an NHS hospital this side of the election."

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Circle's medical director lays out his plans for Hinchingbrooke

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Unsafe surgery: make it zero

The *BMJ* has chosen Lifebox as its 2011 Christmas charity. Lifebox is working to ensure every operating theatre worldwide has a £160 pulse oximeter, the most important monitoring device in anaesthesia. **Atul Gawande** explains how you can help

How much does it cost to reduce mortality and morbidity in the world's most poorly equipped operating theatres—while at the same time bringing the surgical teams into a community of excellence devoted to patient safety?

"The answer is smaller than most people realise," says Atul Gawande, best selling author of *The Checklist Manifesto* and the lead adviser and authoritative face of WHO's Safe Surgery Saves Lives campaign.

Just £160 (€186, $250) is the cost of a Lifebox pulse oximeter, a virtually unbreakable, operating room quality version of the small non-invasive device that is commonplace in hospitals throughout the West. But until now, it has been an impossible extravagance in poor and middle income countries, available, if at all, at an extortionate price with little back up or spare parts. That's what the *BMJ* Christmas appeal this year aims to change.

"Lifebox is the extra factor that makes safe surgery a global reality," says Dr Gawande, the Boston surgeon, academic, and *New Yorker* staff writer. Along with world leaders in anaesthesia, he is also the driving force behind the newly formed

evidence based charity that has made it possible to deliver a robust pulse oximeter to a hospital in a poor or middle income country for £160.

The pulse oximeter is taken for granted in the West, where every hospital has dozens of these small non-invasive devices that measure the level of oxygen in a patient's blood during and after anaesthesia—and by sounding an early warning alarm offer the opportunity to prevent brain damage, heart failure, and in some cases death.

"We now know that more than 230 million operations are performed annually around the world and an unconscionable proportion of these are carried out in the 77 000 operating theatres that manage without a pulse oximeter," says Dr Gawande. "It's not difficult to find the reason why this is happening. Hospitals in poor and middle-income countries are faced with prices of $2000 or more for an operating theatre quality oximeter—literally unaffordable. It's estimated that around six million patients every year are forced to receive surgery without a pulse oximeter, substantially increasing their risk."

Recognition of this dilemma during the creation of the WHO Surgical Safety Checklist triggered a unique collaboration between the founding partners of Lifebox: the World Federation of Societies of Anesthesiologists, the Association of Anaesthetists of Great Britain and Northern Ireland, the Harvard School of Public Health, and Brigham and Women's Hospital, Boston, under the leadership of Dr Gawande.

Putting the oximeter design out to tender resulted in a robust, reusable, and cheap device.

In under a year, Lifebox has already distributed nearly 1500 oximeters to hospitals in poor and middle income countries.

Methods of distribution vary according to local requirements. The pulse oximeter is delivered to parts of the world where skilled clinicians simply lack the resources. However, Lifebox and the AAGBI are also organising training in both the use of oximeters and in safe surgery in parts of the world that need greater support, notably in sub-Saharan Africa.

With each pulse oximeter being used for an average of 3000 operations every year, a preponderance being emergency caesareans, "the impact of this project on mortality and morbidity will be substantial," says Dr Gawande.

"'I am grateful for the *BMJ*'s Christmas Appeal. It is the first time we have been able to go outside the operating theatre and ask the larger medical world to donate to Lifebox. By donating the whole or part cost of a pulse oximeter, *BMJ* readers can help Lifebox save lives with safer surgery in poorer nations."

Over the next few weeks, *BMJ* readers will have the chance to learn more about Lifebox, through articles, podcasts, and films. Donating is simple; either online (www.lifebox.org/donations) or by posting the coupon below, you can help Lifebox in its aim to reduce to zero the number of operating theatres worldwide without a pulse oximeter. Please do give generously.

Dr Gawande was speaking to Jane Feinmann

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