

OPEN ALL HOURS

Every primary care trust in England was told to set up an open access health centre to make seeing a GP easier, but has it worked, asks **Nigel Hawkes**

England's general practitioners took a risk in opposing the government's call in 2007 for longer opening hours. It was a battle they were destined to lose, and one that might easily have threatened the long established pattern of primary care in the National Health Service.

Gordon Brown had set his heart on making access to GPs easier. To achieve this (and despite assurances that a "top-down" solution was not envisaged) an England-wide programme of new health centres was imposed.

All 152 primary care trusts (PCTs) were instructed to create such a centre. Confusingly, they were initially known as polyclinics, after the model devised for London by Lord Darzi. And the fact that any patient, registered or not, could walk into them for treatment caused further confusion with the existing nurse led walk-in centres.

What emerged was different from either. Now referred to generically as GP led health centres, their distinguishing characteristic is their opening hours, 8 am to 8 pm, seven days a week, 365 days a year. They provide access to GPs or nurses to anyone who turns up and also register patients like a conventional general practice.

This cuckoo in the cosy nest of primary care has predictably drawn criticism from those who fear they may go hungry, or even get displaced. Running a general practice has been seen as a franchise for life, with all the advantages of private enterprise for those so inclined, crowned with a public sector pension on retirement. What's not to like?

Demands of 24/7 culture

Plenty, in the government's view. The 2004 general practice contract had enriched the doctors while allowing them to opt out of 24 hour responsibility for their patients. Accident and emergency departments were filling up with people who would better have been treated by GPs. Modern standards of customer service are not compat-

ible with 8 am to 6 pm opening hours, awkward appointment systems, and no availability at week-ends. People are more mobile and expect public services to adapt to them, not the other way round. Times have changed but primary care has not.

Alan Johnson, then health secretary, opened the first GP led health centre in Bradford in November 2008. There are now 78 of them, with three more opening shortly, according to Department of Health figures in February. A further 67 PCTs have yet to announce their plans. (It is true that this adds up to 148, not 152, but NHS Choices website, where all the centres are listed, says "around 152" will be opening.)

Not all the centres promise quite what it said on the tin, with opening hours that fall short of 8 am to 8 pm every day. But a few open longer, 8 am to 10 pm. They trade under many different names: health centre, healthcare centre, medical centre, walk-in centre, GP access centre, open access centre, health access centre, centre for health, primary care centre, and even polyclinic. Some sound like conventional general practices: the Hurley Group Practice in Peckham, south London, for example, or the Phoenix Medical Practice in Doncaster. The NHS may have imposed the model,

but it didn't impose the name, losing an opportunity for clear branding.

BMA concerns

The British Medical Association opposed the new centres from the beginning, launching a Save our

Surgeries petition in 2008 signed by 1.3 million people and broadening the attack in a campaign called Look after our NHS, which recently went public. This muddies the water by treating polyclinics and GP led health centres as if they are the same, enabling critical comments by the King's Fund about polyclinics to be cited in evidence against GP led health centres.

The BMA's fears are that PCTs have too little money to fund the new centres, that they could destabilise local services, and that they may be run by private commercial companies "accountable

to their shareholders." This commercialisation of primary care would, it says, damage continuity of care and transfer public resources from general practices to commercial companies.

Hamish Meldrum, chairman of the BMA Council, elaborated on this in a letter to the *Times*. Market led reforms were fundamentally flawed, he argued, because the object of a market is to drive up demand in order to increase profits, something the country can ill afford. For patients they meant a fragmented experience of care, for taxpayers "eye-watering examples of poor value for money." Leave decisions about patient care to healthcare professionals, he said.

This letter won Dr Meldrum the coveted "Reactionary of the Week" award from the market oriented think tank Reform. But Dr Meldrum's views are moderate compared with those of the Scottish parliament, which recently passed legislation banning commercial companies from providing NHS general practice services, a decision welcomed by BMA Scotland.

Despite the BMA's protestations, the impetus behind the centres came less from the market and more from Department of Health frustration at the inequitable distribution of primary care and poor access to it. In the run-up to the tendering process, private companies with a likely interest were kept informed, and their advice sought, in regular meetings. The department was worried that the cancellation of the second wave of independent sector treatment centres had alienated potential bidders for GP led health centres and for the 100 APMS (alternative provider medical services) contracts also promised for under-doctored areas.

So it is tempting to see GP led health centres as the primary care version of independent sector treatment centres: a means of shaking up the sector and focusing minds, rather than transforming care. Primary care is often praised (usually by GPs) but remains the least examined part of the NHS. Is it genuinely good, or merely lacking a comparator? Apart from the Quality and Outcomes Framework, quality measures are few and far between. It would be understandable if the department had decided to put some grit in the oyster to see if it could produce a pearl.

The BMA's attitude was most neatly summed up by Kailash Chand, a member of the GP committee, who said last year of the health centres: "They

will poach patients from neighbouring practices or else they'll become white elephants. Either way the taxpayer will be short-changed."

Do the new centres work?

But there is a middle way between these extremes, in which the centres supplement existing services by providing care at times and to people that regular general practices cannot reach. At a branch of Boots in Yeovil, Somerset, the waiting room of a GP led health centre established by a group of local GPs was buzzing on a Friday morning in late January.

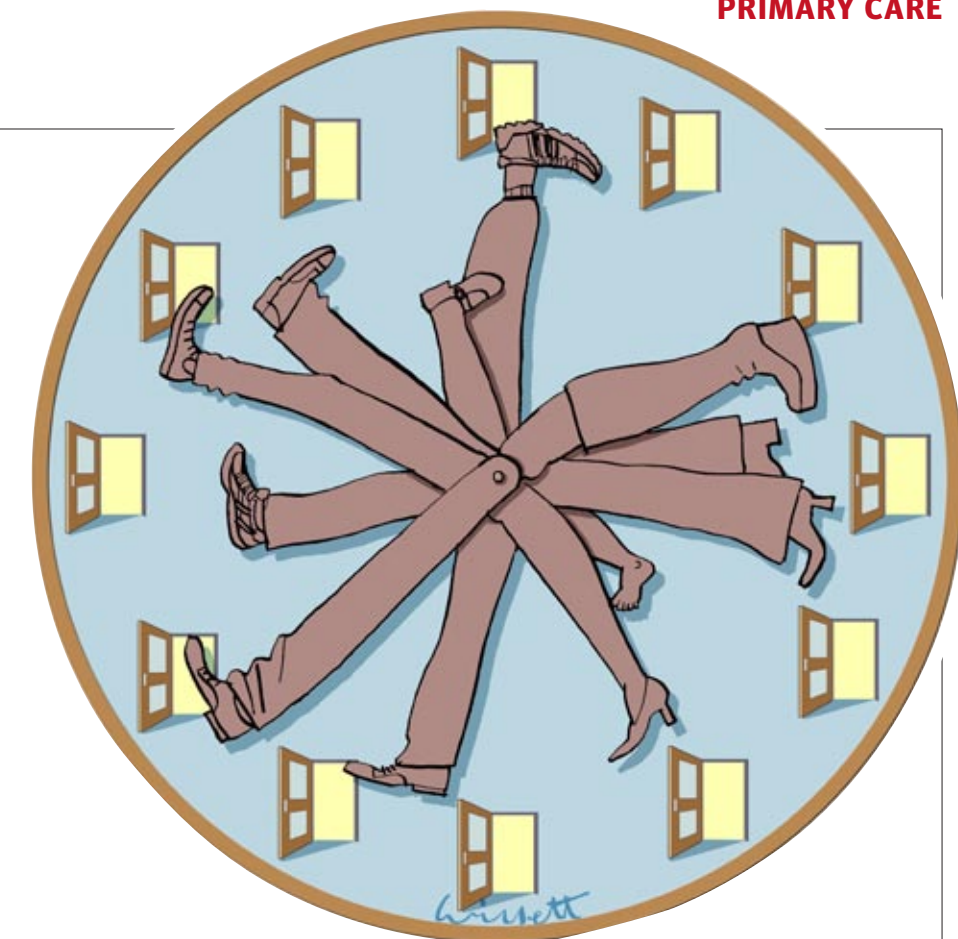
The centre has seven consulting rooms, five salaried GPs, two practice nurses, and five care coordinators. It is run by Pathways Health and Social Care Alliance, a company set up by four local general practices. Paul Scott, a GP from one of these practices, is a director of the company and medical director of the centre. Boots, which gave up some of its retail area to provide space for the centre, is the landlord.

Pathways won the contract after a tendering process in which several national and local companies competed. Ian Brown, healthcare development manager for Boots UK, says: "Pathways led the tender, we are just the premises provider." Boots benefits by providing pharmacy services on the floor below, which have shown good growth since the centre opened. "Patients could walk out of the door and go wherever they want to get their prescriptions dispensed, but convenience is the key," says Adam Carbis, the store manager. "They get great service in the health centre and that leads them down to the pharmacy."

Since opening on 12 August, the centre has seen 20 000 patients, against a forecast by NHS Somerset of 11 000 by the second year. Over Christmas, when local general practices were closed, the centre saw 400 patients, 164 of them on the bank holiday Monday.

"There's definitely a demand" says Daniel Vincent, the practice manager. "The majority are walk-in patients. Some are registered elsewhere but work in Yeovil. Some are migrants or transients, people temporarily in the town, who aren't registered anywhere or who can't access a normal GP because they can't get time off. We expected to see some elderly patients and we have, but 45% are under 30, and there are a lot of children."

On arrival, walk-in patients report to reception and are then seen by a care coordinator who takes basic information—height, weight, age, sex, blood pressure, smoking status, and so on—before referring the patient to a nurse or GP. "They could have



a stubbed toe or they could be a 50 year old man who is having a heart attack—anything and everything," says Mr Vincent.

The centre has also registered 300 patients, against an aspiration set by NHS Somerset of 1000 a year—5000 over the five year contract. In general, registrations are proving a hard target for the health centres to hit, enabling the BMA to claim that the costs per patient are much higher than they are in standard general practices. But given the volume of patients who have been through the door since Yeovil opened, this criticism seems misplaced: health centres can be accused of "poaching" patients or of failing to meet registration targets, but not of both at once.

Mr Vincent sums up his experience: "I didn't know if we were creating a white elephant. But it's been a huge success. Everybody says thank you when they leave—I've never worked anywhere like that before. We get some fantastic comments."

Tottenham in north London is a very different environment, an inner city area in which 80% of the population are from minority ethnic groups, 67 languages are spoken, and health status is poor; it is also suffering the stigma of having failed to protect baby Peter from death at the hands of his mother and her partner. Just a few streets from where he died, the Laurels Healthy Living Centre opened its doors on 1 October last year.

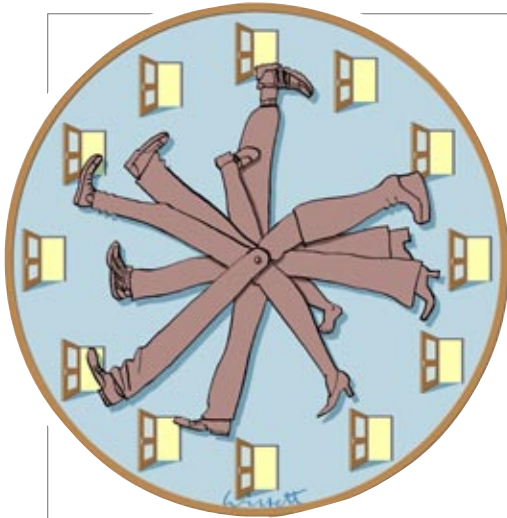
The contract to run the centre was awarded to a partnership comprising local GP Jatinder Pandya, the out of hours cooperative Camidoc, and a general

practice already operating out of the same building. It will be one of two GP led health centres in the area, says Mayur Gor, chairman of the professional executive committee of Haringey PCT.

"Having two is good," he says. "We want to see what the outcomes are. If they are not delivering, it will be pointless. For both centres, we want to divert patients from local emergency departments, and we're keen to see them as the focus of a lot of primary and community care. Seven out of eight people who go to accident and emergency don't need to be there, and once we have both centres running we will be encouraging patients to use them." He expects the shift from accident and emergency to gather speed when a walk-in centre at North Middlesex Hospital closes.

Dr Pandya, a GP for 25 years and medical director of the centre, is enthusiastic about the possibilities. Since opening, the centre has registered 600 patients, most of whom were unregistered before, and is serving a growing number of walk-in patients. These are running at about 80-100 a month, Dr Pandya says; 118 came in for swine flu vaccinations in December. There are plans to convert part of the large ground floor into a pharmacy, licence permitting. "We aim to improve access, meet people's health needs, and improve the whole experience," he says. "But it will take 18 months to get it really going."

But one GP who has worked there found the experience frustrating. Patients registered with the general practice already operating in the building



came in out of hours and were disappointed not to be able to get the results of tests. The lack of medical records makes treating walk-in patients less rewarding than normal primary care, though the summary care record, when it is available electronically, may help.

Neither Yeovil nor the Laurels can yet show they have had any effect on attendance at accident and emergency departments, which (in a switch of tack) health minister Mike O'Brien has suggested will be the primary role of the GP led health centres. This change of emphasis may be designed to head off criticism that in areas where there were already sufficient GPs, the centres may struggle to meet registration targets.

Laurence Buckman, chairman of the BMA's GP committee, says this is a consequence of applying a "one size fits all" policy everywhere in England. "If they had put GP led health centres where they were needed, it would have been OK," he says. "Maybe six in the north east would have made sense. But in many areas, ordinary GPs could have done it. Many health centres were badly positioned, which means they are competing with other GPs for patients."

Walk-in patients, however, have exceeded expectations in many centres. In Suffolk, one provider has agreed to a two thirds reduction in its payment for walk-in patients after demand far exceeded expectations. The Practice, which runs the centre at Haverhill, said it had three times more walk-in patients than NHS Suffolk had expected, and it had agreed to scale down the price per case.

Distribution of contracts

But the threat that most of the contracts would be gobbled up by private companies seems to have been exaggerated. In many cases, local GPs have formed their own companies or cooperatives to bid successfully for contracts— most notably in the case of Dr Meldrum, whose practice joined with others in Bridlington to win the contract for

a GP led health centre. Dr Meldrum defended himself from charges of hypocrisy by saying he would not be directly involved and that his practice had taken the step in self defence, fearing that a private company might win the contract.

The Department of Health declined to respond to a question about how the contracts have been divided so far, and the NHS Confederation said that the data were not collected centrally. Mike Parish, chief executive of Care UK, a company that has so far won 11 contracts, estimates that half the contracts have been won by GPs, a third by private companies, and the rest by consortiums that include GPs and private backers.

This is roughly in line with the only existing published figures, which came out last May and indicated that 42% of contracts had gone to partnerships of GPs, 21% to private companies, and 19% to consortiums. The rest went to third sector organisations or to PCTs' own provider arms.¹

Mr Parish is happy with his company's business model and says that "by some distance," Care UK is the market leader. Others agree; on 3 March the company announced that it was being taken over by the private equity group Bridgepoint in a deal worth about £280m. "We take a very strategic view, looking a decade ahead," he says. "If you look at the UK generally, there is an unusually wide gap between hospital and primary care. Over many decades a very fragmented model has developed in primary care, not equipped or motivated to develop upstream.

"This needs fundamentally addressing. When I look at the traditional GP partner model, it's got merits. But to say that it's got the whole future of primary care in its hands is wrong. Half of GPs are already employees—partner GPs are not the only model. The current situation often gets misrepresented, whether deliberately or by accident I wouldn't say.

"But we get offended when our clinical standards get impugned—and corporately we're playing a long game. If we're deficient, we'll get found out. We've got to get it right or we won't have a future."

Like other GP led health centres, those run by Care UK have taken time to build up numbers of registered patients. "The first appeal is to the walk-in patients," Mr Parish says. "They get much better access. Quite a lot are not registered with any GP, especially in cities. They tend to go to accident and emergency when they're ill. Then there are people for whom it's much more convenient, and then there are 'try before you buy' patients who come in, try it out, and may later register. They are either first time registrants or

they're switching. We don't promote switching from another practice, but some patients choose to do it."

Competition

He has seen the impact of competition on traditional GPs. "Our first practice was in Barking, open in the evenings and at weekends. Within six months, a third of existing general practices in the area were open on Saturday mornings. Competition stimulates. Would it have happened without competition? I doubt it. Choice is good, but to make it possible you have to liberate supply, otherwise there is a choice of one."

Other companies are less happy, and one (Assura) has agreed to sell a majority share in its general practice arm to Virgin. Critics say that private companies take as profit cash that might otherwise have gone to patient care, but details are lacking. Partner GPs take profits too, which is why they earn so much more than salaried GPs.

James Gubb of the think tank Civitas, a market enthusiast, is critical of the BMA's attitude. Of its campaign he says: "Is it ethically right to distribute campaign material in places where patients wait? And the BMA cherry picks its evidence on independent sector treatment centres—they don't mention evidence gathered by the Healthcare Commission.

"The model of health care in the UK is not particularly productive. There are much better and more efficient ways to do it. But as soon as you try to change existing models you get a lot of backlash. And PCTs face such tremendous barriers—the local media, local GPs, local politicians—that they are reluctant to put forward the evidence base."

However, England's GPs are not about to give up. Many have followed Dr Meldrum's lead

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and won contracts, effectively competing against themselves. They will staff the centres with salaried GPs, essentially no differently from the situation if the centres were run by a private company.

The profits may be recycled (as in Dr Meldrum's case) or not. Patients are unlikely to notice or to care who is running the centre but may nevertheless be grateful to be treated at a time of their own convenience. A revolution, or just a shake-up? Time will tell, but the wise money in the NHS is always best placed on the status quo. Radical change is often promised, seldom delivered.

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Competing interests: None declared.

¹ Timmins N. Private companies beef up UK GP presence. *Financial Times* 2009 May 11.

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An old battle: England's libel laws versus scientific debate

Several high profile cases have brought to the fore how England's libel laws can stifle scientific debate, but as **Richard Smith**, former editor of the *BMJ*, explains, it is not a new problem

The question of whether England's libel laws are restricting scientific debate is currently high on the agenda because of prominent cases. Peter Wilmshurst, a Shrewsbury cardiologist, is being sued by a Boston company over his comments on a trial in which he participated. Simon Singh, the science writer, has a case against him brought by chiropractors, and Ben Goldacre, a doctor and author of the best selling *Bad Science*, is being repeatedly threatened.

An old problem

Those unfamiliar with England's libel laws might thus think that this is a new phenomenon. In fact libel obstructing scientific debate is a longstanding problem, and the *BMJ* was involved in one of the longest running libel cases in legal history.¹

The *BMJ* published a study in May 1969 that showed that patients given the intravenous drug methohexitone had various abnormal physiological responses.² These responses may have explained why some patients had died while being anaesthetised for dental surgery. The *BMJ* had peer reviewed the study and decided to accompany it with an editorial, which in those days were anonymous, underlining that the technique was dangerous and should not be used.³

The Drummond-Jackson case

You cannot libel a technique, but unfortunately for the *BMJ* one man—a Harley Street dentist called Stanley Drummond-Jackson—was particularly associated with the technique. He managed to convince the courts that the articles were defamatory of him.

Five days after the two articles were published the journal received a letter from Drummond-Jackson's lawyers alleging grave defamation and that his professional reputation was severely damaged. The lawyers wanted the *BMJ* to unreservedly withdraw all imputations, make an

agreed statement in open court, and undertake not to publish any similar statements in future.

The *BMJ* tried to persuade Drummond-Jackson that the way to sort out a complex scientific issue was not through the courts but through debate in the journal. The editors offered to consider a letter for publication. He declined and issued a writ.

In October 1969 the *BMJ* applied to have the case struck out because Drummond-Jackson had disclosed no cause of action.⁴ It lost and appealed. The Court of Appeal heard the appeal in February 1970 and dismissed it.⁴ As defendants go through these legal processes they run up substantial bills, not least because to have any chance of winning you need to engage a specialist libel barrister.

Lord Denning, a famous judge involved in the appeal (who said he would have struck out the case) made points that might prove useful to those campaigning today for libel reform. He predicted that the time to prepare for the trial and the length of the trial could be enormous. Then he drew a distinction between libel and lawful criticism: “lawful criticism was impersonal and objective: it was criticism of goods, of a design, a system or a technique. It pointed out defects and deficiencies without attacks on the man himself. . . . It would be a sorry day if scientists were to be deterred from publishing their findings for fear of libel

actions. So long as they refrain from personal attacks, they should be free to criticise the systems and techniques of others. It is in the interest of truth itself. Were it otherwise no scientific journal would be safe.”⁴

The case began in the High Court in June 1972, more than three years after the articles were published.⁵ The case was against the BMA (the owners of the *BMJ*) and the four authors of the study.

Defences against libel

There are three main defences to a charge of libel: privilege, justification, and fair comment. Privilege defines circumstances where for the greater public good people should be able to communicate without fear of libel. This applies in parliament and to the reporting of parliament, the courts, and lesser tribunals



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like the General Medical Council so long as the reports are fair and accurate.

The *BMJ* argued that qualified privilege applied in the Drummond-Jackson case.⁶ A 19th century judge explained the reasoning for qualified privilege: “It is better for the general good that individuals should occasionally suffer than that freedom of communication between persons in certain relations should be in any way impeded.” The *BMJ* never got to advance its argument because the case was

settled after 35 days in court before Drummond-Jackson had finished making his case.

The second defence against libel is justification—that what is written is “true.” But the crucial point is that what matters is not whether a statement is true but whether it can be *proved* to be true; and the onus is on the defendants to prove truth.

What this means in practical terms is that if somebody sends a journal an article that is defamatory but, the editors judge, in the public interest, then before the journal can publish it has to assemble enough evidence to convince a court of its truth. This is a time consuming and expensive business, which puts it beyond most scientific journals. Plus it is impossible to eradicate all risk.

In the Drummond-Jackson case the *BMJ* would have had to prove everything to be true to establish a defence of justification. The *BMJ* published a weekly account of the trial,⁷⁻¹⁶ and there is a strong sense of the case becoming so complex that it might never end.

The third defence to a charge of libel is fair comment, but the comment must be made on the basis of facts. You cannot simply say that X has behaved scandalously. You must give true facts to prove that he has behaved scandalously. As a report on the Drummond-Jackson case written by the *BMJ*'s legal correspondent says:

“The law of defamation gives considerable latitude to the authors of defamatory comment so long as at the same time they do not make defamatory and untrue statements of fact. The test . . . is to ask, Would any fair man, however prejudiced he may be, however exaggerated or obstinate his views, have said what had been published?”⁶

A defence of fair comment is, however, undermined if the plaintiff can demonstrate malice, which in libel means “not simply spite but also the existence of an ulterior motive.” Drummond-Jackson alleged this not against the *BMJ* but against the authors of the study. Then he discovered the identity of the author of the leading article and alleged that he was malicious too.

Justification—correctly—is not undermined by malice. As the *BMJ* legal correspondent put it: “The truth may always be published no matter by what disgraceful motives the defendant is actuated.”⁶

The cost of libel

The Drummond-Jackson case took a heavy toll on both parties. The cost to the *BMJ* was around a quarter of a million pounds (equal to several million pounds now), plus the editorial time spent preparing the case and in court.

One of the biggest defects of libel law is that the side with the deepest pockets can almost always see off the other side.

The *BMJ* has not had another Drummond-Jackson case, but has received plenty of threats and lawyers' letters. The one case that cost us a lot of money—£107 000 (€120 000; \$163 000)—we won.¹⁷ We were sued by Dr James Sharp, a doctor, and Jabar Sultan, a vet. They were peddling a bogus treatment for AIDS, and were exposed by Duncan Campbell, an investigative journalist.

I wrote an article for the *BMJ* off the back of Campbell's investigation in which I concentrated on the point that many doctors knew about this bogus treatment but did nothing.¹⁸ It cost us around £10 000 in legal fees just to reassure ourselves that we had enough evidence to defend a libel action.

Ironically we were sued not over this article but over the subsequent news story reporting that Sharp had been struck off for serious professional misconduct.¹⁹ Sharp sued us not for libel but for “malicious falsehood,” a more serious offence where the claimant has to have experienced financial loss and has to prove malice. A great advantage of suing for malicious falsehood in those days was that you could be given legal aid. Sharp was given legal aid, but then it was withdrawn on his barrister's advice. Sultan meanwhile sued for libel and represented himself. The case dragged on for several years until it settled. We had to meet our own costs.

Just before I left the *BMJ* we apologised and paid out around £8000 over an article by the

same Peter Wilmshurst who is now being sued by the Boston company.²⁰ The article told the story of the surgeon, Anjan Banerjee, who produced falsified research that was not retracted for 10 years.²¹ Banerjee's registration with the General Medical Council was eventually suspended. The point of the article was not to criticise individuals but institutions.

We judged that the article made important points and thought it important to publish. We spent thousands on legal fees in preparing the article for publication. After publication we spent some £28 000 defending accusations of libel from various people referred to in the article including the payment of around £8000.

Libel laws and specialist journals

The *BMJ* was much more at risk of libel than the *BMJ* Publishing Group's specialist journals, but a throwaway remark could kill a journal with few resources. This nearly happened, ironically, to the *Journal of Medical Ethics*.

Another of the group's journals—*Tobacco Control*—was almost put out of business by libel laws without an action being taken against it. The journal inevitably contains material critical of tobacco companies. Our insurers at the time decided that the risk of being sued by them was too large and declined to insure the journal. This presented a great problem to the treasurer of the BMA. He was being asked to pick up the risk of what could be a two million pound action on a journal that, although now

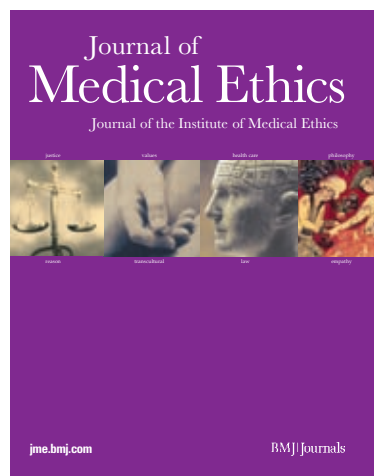
flourishing, was then losing money and might never have made much.

We tried to persuade the insurers that there was no case, as far as we knew, of a tobacco company taking an action against an academic journal, and it probably wouldn't do so because the adverse publicity would be huge and the gain minimal. And, we argued (a risky argument), that if the companies were to take an action it was more likely to be against the *BMJ* than against *Tobacco Control*.

Eventually the insurers agreed to insure the journal on the condition (which was later relaxed) that every issue was read before publication by a libel lawyer. This led to some bizarre conversations with the editor, an American, who found himself perplexed by the concerns of the lawyer—particularly as he was often not



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allowed to print material that had appeared widely in the American media. The fact that material has been published elsewhere is no defence, and it is almost impossibly hard to sue successfully for libel in the United States—which is why England is so attractive to those who want to shut off debate.

Libel tourism

Indeed, the one thing that is new is “libel tourism,” whereby foreigners can bring a libel action in England against other foreigners if they can simply prove that the potentially libellous material can be accessed through the web in England. But the problem of libel obstructing scientific debate is old—and surely now is the time for reform.

Richard Smith director, United Health Chronic Disease Initiative

Competing interest: As the article describes, RS experienced many libel actions while editor of the *BMJ*—and some cases, including one that continued after he left the *BMJ*, have been directed against him as an individual. He continues to write provocative articles and might be sued again—so is more likely to lose than gain from current libel laws. Reform would be in his interest.

This article overlaps substantially with a chapter from RS's book *The Trouble with Medical Journals* published by RSM Press.²²

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LOBBY WATCH Tamasin Cave

Nurses for Reform

When David Cameron held an hour long meeting with the campaign group Nurses for Reform (NFR) before Christmas to discuss “NFR’s ideas on the future of health policy,”¹ few could have predicted the ensuing furor.

The Tory leader woke on New Year’s Day to a press report of the meeting headlined “Cam’s plan to pan NHS,”² forcing him to restate his “wholehearted commitment” to free health care and to reassure the public that the NHS will be safe in Conservative hands.^{3,4}

NFR is a “growing pan-European network of nurses” that campaigns for “consumer-led reform” of the healthcare system in Britain and abroad that is based on “competition” rather than “bland egalitarianism.”⁵ It has labelled the NHS “a Stalinist, nationalised abhorrence” and given its seal of approval to a theory that the history behind the NHS and the eugenics movement have common elements.^{6,7}

NFR’s director, Helen Evans, wrote that the “really heartening thing” about the controversy over the Cameron meeting was that “dozens” of nurses have since signed up to support NFR,⁸ bringing the total number of members who are UK nurses to “a couple of hundred,” she said.

The campaign group was established as a company in 2006 by Dr Evans, a “senior nurse with nearly 20 years’ experience in the National Health Service” and a PhD in health economics from Brunel University.⁹

NFR’s company secretary is her husband, Tim Evans. He is also a member of NFR’s eight strong advisory board. Tim Evans is “a public affairs professional” who has worked for the Independent Healthcare Association, the former trade association representing private hospitals and independent social care providers.^{10,11}

The couple also together run a lobbying consultancy, Farsight Strategic Political Intelligence. This claims to “predict the health policy output and thinking” of policy makers, opposition politicians, and other opinion formers and markets these insights to, among others, “private hospitals and pharmaceutical companies.”¹²

Another member of NFR’s advisory board is Robert McIndoe, a nurse¹³ and actor¹⁴ who also runs his own marketing company, The Marketing House.¹⁵

Clients of The Marketing House have included the CSC Alliance, which is responsible for the delivery of the NHS national IT programme for large parts of England. McIndoe’s firm was employed “to develop, lead, and direct the . . . team in its

communication strategy to reach 275 000 NHS staff . . . with the central objective of winning them over to the largest civil IT project in the world.”¹⁶ McIndoe has also worked for two firms vying to get into the health market, Capita (March 2006 to October 2007) and Logica (from December 2007).¹⁷

NFR also has links to a network of think tanks that favour privatisation. For example, it is a member of the Stockholm Network, a group of more than 130 free market think tanks, where Tim Evans was formerly development director.¹⁸ The Stockholm Network says it pushes for “more consumer-driven health care” through reform of European health systems and markets.¹⁹

Another advisory board member with links to this network is Eamonn Butler, cofounder of the Adam Smith Institute,²⁰ a Westminster based think tank and member of the Stockholm Network.²¹ Tim Evans is a senior fellow and Helen Evans a fellow of the institute,²² which argues for the transformation of today’s “state monopoly providers into independent, competitive ones.”²³

Another adviser is the economist Ruth Lea, director of the Eurosceptic campaign group Global Vision.²⁴ Lea formerly headed the Centre for Policy Studies, a free market think tank and Stockholm Network member that also promotes “the opening up [of] state monopolies” in health.²⁵ And another is Shane Frith; former managing director of the Stockholm Network,²⁶ Frith now runs the free market think tank Progressive Vision. This states that the NHS is envied by few outside Britain “apart from a number of socialist ideologues” and advocates “change to a more effective” health system.²⁷ Frith is also behind the Doctors Alliance, “a pan-European movement of reform minded doctors” that was also involved in “influencing the debate on the need for market-oriented health system reform across Europe.”²⁶

References are on bmj.com

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