BODY POLITIC **Nigel Hawkes**

Is the union tail wagging the health secretary dog?

Andy Burnham's hasty capitulation to the unions has backfired badly on the NHS

When Unite, Britain's biggest trade union, delivered a petition to the Department of Health last August urging England's health secretary, Andy Burnham, to "roll back the privatisation of the NHS" its 3000 signatories can hardly have expected quite such a prompt and rewarding response.

The next month Mr Burnham gave a speech to the healthcare think tank the King's Fund reversing a decade of health policy in a few sentences. Instead of allowing "any willing provider" to bid for NHS services, he said that in future the NHS itself would be the "preferred provider" (*BMJ* 2009;339:b4085). This loaded the scales heavily against any private or voluntary sector organisation winning a contract to provide NHS care.

Apologists for Mr Burnham have since suggested that this was a mere rebalancing of policy or, alternatively, that he had failed to understand fully what he was saying. As the policy subsequently unravelled Mr Burnham is reported to have had a rough ride in Cabinet and to have been told to find a diplomatic means of retreat.

This narrative—to use a New Labour word—strikes me as implausible. Heaven knows, plenty of health policies in the past decade have been delivered on the hoof or off the back of an envelope. But in this case it must have been an envelope of generous dimensions. Soon after the speech was delivered the chief executive of the NHS, David Nicholson, was providing chapter and verse in a letter to Brendan Barber, general secretary of the Trades Union Congress (TUC). Both the contents of the letter and its recipient tell us something about the policy.

It's hardly normal for the head of the NHS to elucidate policy by means of a letter to the TUC. It implies that the staff of the NHS matter more to its bosses than do the patients. For a moment, memories of the 1970s flashed before my eyes. In that benighted decade prime ministers couldn't cough without checking first with Jack Jones or Hugh Scanlon, the union giants of the day.

Under Tony Blair the Labour Party rid itself of overdependence on union support. Mr Blair was a skilled money raiser and appealed sufficiently to wealthy entrepreneurs for them to open their purses. But since around 2005 this flow has dwindled. Labour is once again heavily dependent on union contributions. Unite helped it escape financial collapse in 2008 by guaranteeing future contributions, and in 2009 the union's payments of £3.6m (€4m; $5.4m) represented almost a quarter of the party's total income.

With an election looming and financial support even more urgently needed, it defies credibility to suggest that a policy appealing so strongly to a major source of cash came about either by accident or by inadvertence. Mr Burnham may have been dog whistling, hoping that code words clearly audible to trade unionists would be beyond the hearing range of anybody else. If so, he miscalculated badly.

The shift was indeed applauded by Unite, by Unison (which gave £1.65m to the Labour Party in 2009), and by the BMA, which makes no political contributions. But it was condemned by the Blairite wing of the party, by voluntary organisations that have been encouraged to become service providers by this government, and naturally enough by the private sector.

It was then wrecked by a test case in Norfolk, where NHS Great Yarmouth and Waveney had asked for tenders to run its community services from any willing provider but changed the rules after Mr Burnham's speech (*BMJ* 2010;340:c132). The private and voluntary sectors appealed to the NHS Cooperation and Competition Panel, which looked set to rule in their favour until the department intervened, ordering primary care trusts (PCTs) in the East of England region to stop all procurements for community services.

This is the same department that had ordered PCTs to have plans in place to hive off community services by 10 March and to implement them by mid-April 2011. The new instruction is that PCTs must get "approval in principle" for their plans by the end of this month and that those plans must follow guidance issued in February that the NHS is the preferred provider to take them over.

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The implications for community services—district nurses, health visitors, physiotherapists, chiropodists, and others—are alarming. If these services really are going to be shaken loose from PCTs but cannot set themselves up as independent organisations (an idea described as "nonsense" by David Nicholson) or as social enterprises, there is only one place left to go: to acute or mental health trusts.

The paradox is that the idea of separating providers from purchasers is essentially market driven. It assumes that the providers (community services) will operate more efficiently under contract to the purchasers (PCTs) than they do as an integral part of PCTs. Yet while the market drives this part of the policy, its role in the actual divestment process has been removed. To call this a muddle would be unfair to ordinary, run of the mill muddles. It is a complete policy whiteout in which nobody can see where they are going or why.

The upshot is likely to be vertical integration in which most community services are taken over by hospital trusts, the only suitors that fit the preferred provider rule. Are hospitals the best organisations to run community care? A case could be made, perhaps. But I'm not sure it would be a persuasive one.

A new guidance document is said to be brewing, with input from departments other than health. Guidance is certainly needed, but will the document include the words "NHS" and "preferred provider"? If it doesn't, Mr Burnham will look silly, and the unions will be cross. If it does, confusion will be worse confounded.

Nigel Hawkes is a freelance journalist
nigel.hawkes1@btinternet.com

Cite this as: *BMJ* 2010;340:c1604

MEDICINE AND THE MEDIA

The hard sell in cosmetic surgery advertising

Unlike for prescription drugs, only weak and often voluntary codes protect patients from advertisements for cosmetic surgery. **Neil Graham** wonders why

Advertising practices used by UK providers of cosmetic surgery during the recession, from "buy one get one free" offers to time limited deals and surgical holidays, are attracting unwanted attention as well as patients. Nigel Mercer, cosmetic surgeon and president of the British Association of Aesthetic and Plastic Surgeons, has been leading diverse calls for tighter rules, warning of a perfect storm of hype, public expectation, and professional greed in the sector.[1]

The changes made by the Health and Social Care Act 2008 to consolidate the work of several regulatory bodies tasked with patient safety are limited. The Care Quality Commission regulates the premises in which surgery takes place.[2] Any General Medical Council registered doctor can practise as a "cosmetic surgeon" in the United Kingdom. Rules about advertising are absent from the reforms.

In contrast, the direct advertising of prescription drugs to consumers is illegal in the UK. However, UK and European law, professional rules, and government monitors such as the Medicines and Healthcare Products Regulation Agency (MHRA), which oversee the advertising of prescription drugs, make few specific references to cosmetic surgery. They focus on drugs and devices, "substances which treat or prevent disease," in the agency's definition, whose justification is the potential for harm. "Medicines cannot be treated as an ordinary general commodity. They have the potential for harmful as well as beneficial effects and can cause serious problems if not used safely."[3]

Because cosmetic surgery clinics are not aimed at treating disease, their advertising is exempt, and regulation falls almost entirely with the advertising industry itself. Codes are set by industry committees and enforced by the Advertising Standards Authority (ASA), a body funded voluntarily by advertisers, which works with the broadcasting regulator, Ofcom, in television and radio.[4 5] Sanctions range from naming and shaming offenders to referral to the Office of Fair Trading or Ofcom for legal action.

According to an ASA spokesperson the absence of specific clauses about cosmetic surgery is not a problem. "The codes are deliberately broad and applied in spirit and in letter, in order to prevent advertisers from trying to find ways of circumventing the rules and to allow the ASA council to reflect the general public's perception of what is decent, honest, and truthful."

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Largely, complaints have surrounded claims of superiority ("Britain's number one cosmetic surgery group"[6]), and are often brought by competing clinics rather than the general public, whose objections on broad grounds of "social responsibility" have generally not been upheld.[7]

The promotional activities of cosmetic surgery clinics raise dilemmas for the medical profession. Is it ethical to seek to persuade the public to undergo procedures that are associated with serious complications, without providing all the relevant information on the advert? Will the doctors involved come to be regarded as financially motivated, undermining trust in the profession? And can the NHS, the care provider of last resort, afford to underwrite all of the failed procedures produced by the trade in its current form?

"If it's ethical to advertise breast augmentation, it's also ethical to advertise hip replacements and coronary artery bypass grafting"

Big industry players, including the Transform Cosmetic Surgery Group and the Harley Medical Group, have worked to produce more stringent rules through the Independent Healthcare Advisory Services (IHAS), a trade body that represents independent health care. These state that materials must not produce unrealistic expectations, use photographs of models, or include offers with deadlines, but many clinics choose not to subscribe to these voluntary codes.[8]

The rules set by the General Medical Council, which governs doctors' activities, are far from optional. According to their spokesperson, "Being honest and trustworthy and acting with integrity, lie at the heart of medical professionalism."

"The GMC provides ethical guidance for doctors on providing and publishing information about their services . . . and is clear that doctors must not put pressure on people to use a service, for example, by arousing ill founded fears for their future health." To date, however, there have been no cases brought at the GMC against doctors for advertising cosmetic surgery directly to the public.

Mercer favours the establishment of an independent regulator of cosmetic surgery to govern clinical and marketing activities. "We need a code of conduct that is decent, honest, transparent, and enforceable by law . . . it should be the same as for prescription medicines. If it's ethical to advertise breast augmentation, it's also ethical to advertise hip replacements and coronary artery bypass grafting." He stopped short of calling for an outright advertising ban as in France, where the measure was implemented in response to a public inquiry after concerns about the lack of traditional safeguards for patients.[9] He says this would be "almost impossible to police." In Spain, fears that advertising practices were contributing to eating disorders in young people have been tackled by restrictions on television adverts for some cosmetic surgery procedures before 10 pm.[10]

Mel Braham, chairman of the Harley Medical Group, dismisses talk of a complete ban as "ridiculous" but is happy to formalise the IHAS rules on discounts and time limited offers through the ASA codes. "Why would you want to restrict advertising of something that is in demand and does a lot of good? The advertisements only affect those who have an interest in the first place."

Stricter regulation of this sector might be seen as illiberal and paternalistic, but a sufficiently strong ethical and professional case would justify this concession to patient safety. Whether these grounds are fulfilled is a debate long overdue: is it really one to leave to the advertising industry?

Neil Graham is a fifth year medical student at University College London, London WC1E 6BT
n.graham@ucl.ac.uk

References are on bmj.com

Cite this as: *BMJ* 2010;340:c1223