NHSCA

EDITORIAL June 2014

What next for the NHS and NHSCA?

The NHS

This is a time of great challenge – the NHS is the subject of increasingly polarised and divisive politics. The 2102 Health & Social Care Act has led to private operators taking over services previously provided by the NHS with concern for both quality standards and the loss of the ethos from the all inclusive comprehensive NHS to a badge indicating 'Funded by the NHS' only.

The NHSCA

Our organisation is facing up to the challenge of influencing health policy and must consider how to increase our influence in the future .To have influence we must grow or form allegiances; In this issue I begin discussion of a possible change of name to broaden our membership to include other doctors and I include articles from members of the Socialist Health Association, which has very similar aims.

The NHS Now

At a time when the mild and moderate President of the RCP has publicly stated that the NHS is 'Under-doctored, under-nursed, under-bedded and under-funded' we have attacks from the government to add to the usual problems. The evidence is clear that to improve the health service we will need to increase funding –the government's sustained attacks have been an effective distraction from this simple truth.

The NHS Federation (which receives grants from the NHSCA) has recently published a review showing the value of NHS contracts awarded to the private sector last year to be £13.5Bn – three times more than the previous year.

To improve the health service we need the next government to have the right policies and I include a piece on the procedure to formulate Labour's policies. To have the greatest effect on improving the nation's health we must look beyond the traditional role of the doctor. I am most grateful to Matilda Allen from UCL Institute of Health Equity for her excellent article on the importance of the social determinants of health and the role of health professionals in preventing ill health and reducing health inequalities.

In this edition I have included articles by Martin Rathfelder of the Socialist Health Association (SHA) and Colin Leys of the Centre for Health and the Public Interest. Following the political spat about the NHS in Wales I include 2 items in reply, one from Open Democracy and one from the SHA website which is also the source of the 'Letter from America'. Our Co-chairs Jacky and Clive have written much in the national press on threats to the service. Clive's is reproduced here and Jacky's bold response to the NHS charges suggestion can be found on the Guardian website.

The Abrahams report, a recommendation on policy to the Labour party has just been published on line and I have included some brief extracts. The EU-US trade agreement, known as TTIP is another threat and I include an article from the STOP TTIP working group. Dr Morris Bernadt will be submitting a response on behalf of the NHSCA through the EU website.

ERIC WATTS
Guest Editor

The Role of Health Professionals

A new agenda in preventing ill health and reducing inequalities

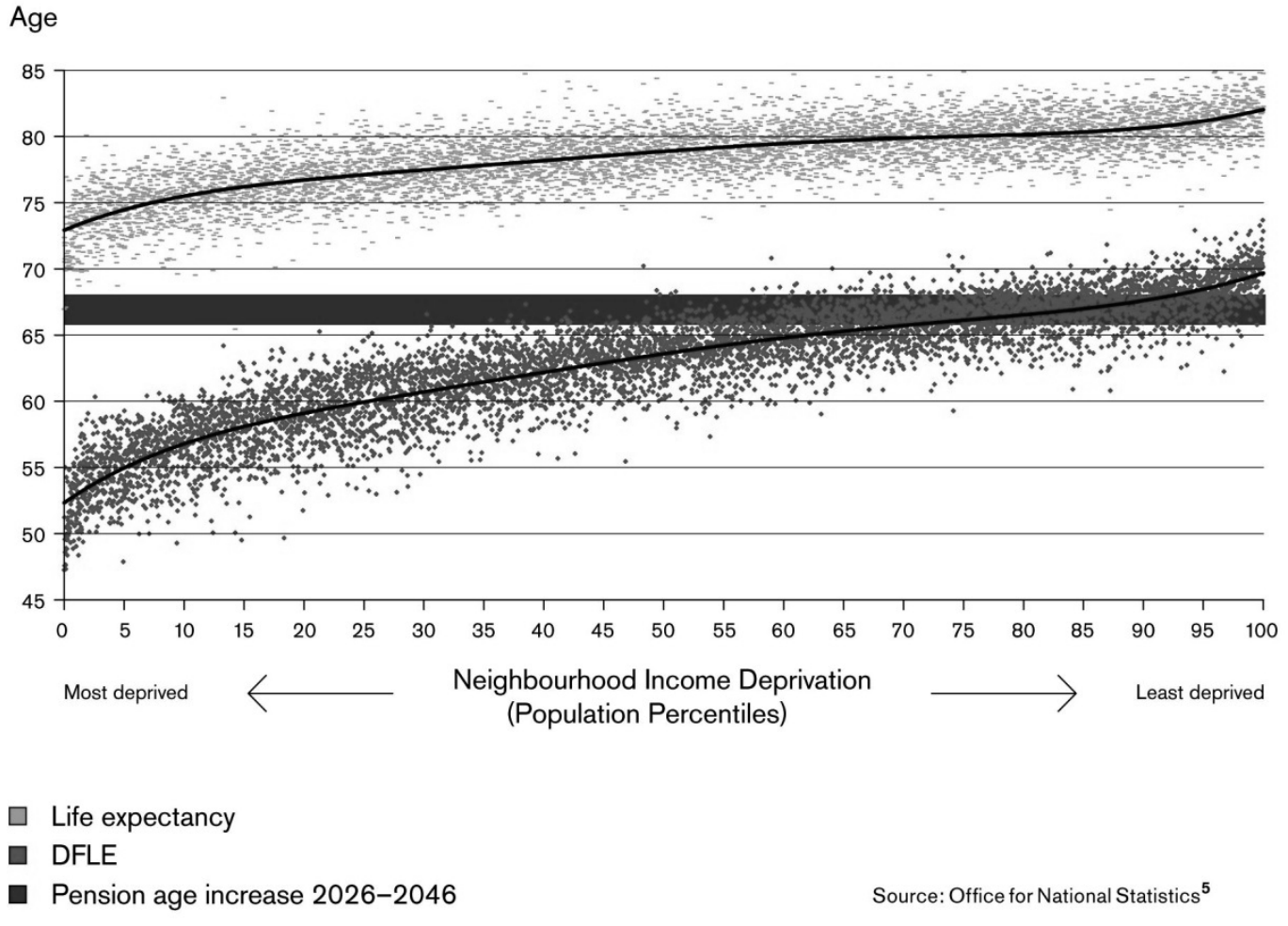
Health Inequalities and the Social Determinants of Health

In England, those living in wealthier neighbourhoods can expect to live an average of seven years longer than those living in poorer neighbourhoods. Furthermore, those who are likely to die younger are also likely to spend 17 more years with a limiting long standing illness or disability[1]. These and other systematic differences in health outcomes– health inequalities – occur within as well as between local areas, regions and countries. The Marmot Review, published in 2010, described the extent of these inequalities and the social and economic drivers that give rise to them. The report makes a series of proposals for action to reduce health inequalities at national and local level, and for a variety of sectors[1]

The evidence shows that health outcomes run along a clear social class gradient. It is not just the very poor or disadvantaged who experience more illness and early death, but everyone falls behind the wealthiest to some degree. Figure 1, below, shows this social gradient in England, for life expectancy and disability free life expectancy (the number of years someone can expect to live in good health), related to neighbourhood deprivation.

Figure 1: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999-2003

Source: The Marmot Review[1]



Similar gradients exist when looking at health related to education qualifications, income, early year's experiences, or quality of work. The reason for this is that health is largely shaped by the conditions in which people are born, grow, live, work, and age. Inequities in the distribution of power, money and resources shape our lives, the opportunities open to us, the conditions in which we live, and the experiences we have – and ultimately our health. These are called the 'Social Determinants of Health'.

The Marmot Review recommended action take place to improve the social determinants of health and achieve 6 broad policy recommendations:

1. Ensure every child has the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

Working for Health Equity

The greatest improvements in health and reducing health inequalities come in areas outside health care. However, the health care sector does have a significant contribution to make and health professionals have an important and often under-utilised opportunity to take action on the Social Determinants of Health and, by doing so, reduce inequalities in health and prevent illness. This was the subject of the 'Working for Health Equity' report, which was published by the Institute of Health Equity in 2013 [(2)], building on the Marmot Review and work with local areas across England. The report included submissions from BMA and over 19 Royal Colleges and other professional organisations.

The report recognised that those working in the health sector regularly bear witness to, and must respond to the effects of the social determinants of health. By effectively adopting preventive measures that improve the conditions in which people live, professionals can help improve life expectancy, increase the number of years spent in good health, and potentially save money.

The opportunity for action is significant – on average the NHS sees one million patients every 36 hours [(3)] and sees patients at key stages during their life course, enabling them to effectively take preventive action appropriate to important life stages. Health professionals are highly trusted and have established and well-recognised positions in local areas [(4)].

Health professionals of all specialties also demonstrate an understanding and awareness of the factors that affect the lives of patients, their families, and the wider community, and many have done, and are continuing to do, important work on the Social Determinants of Health. However, not all health professionals are given the opportunities, are willing, or feel they are able to take action on social, economic, environmental and other inequalities, in order to improve the lives and health of their patients.

The report proposed that lack of action could be improved through initiatives in the following areas:

Workforce Education and Training

Future health professionals will be more able to take action on the Social Determinants of Health, and advance a preventive agenda, if they are successfully trained and taught in these areas. Undergraduate and postgraduate medical education should include teaching on knowledge about health inequalities and the Social Determinants of Health, how to tackle them, communication, partnership and advocacy skills to improve practice in these areas, as well as specific skills such as taking a social history. These should be mandatory, assessed components of courses.

In addition, a wider range of placements, particularly with other sectors, such as social care, and in deprived areas, would be beneficial in exposing students to the effects of poverty and disadvantage on health, while they are training. A commitment to equity would also involve a greater representation of students of all socio-economic statuses, particularly in medical education, which is still dominated by those from wealthier backgrounds.

Furthermore, qualified professionals can enhance their understanding and skills through Continued Professional Development, which should continue to teach knowledge and skills as described above.
Working with individuals and communities

Health professionals can play an important role in gathering and providing information, in order to tackle the causes of ill health. Gathering information from patients can help enable professionals to understand the ways in which social and economic factors are impacting on their health.

Professionals can also provide the patient with information – including through social prescribing and referral to non-medical services. Referral should be to services such as Legal Aid, Relate, CAB, employment programmes or housing advice services which can help patients to improve areas of their lives which relate to ill health. Location of these services in surgeries has been shown to improve the success of this type of referral.

NHS Organisations

The NHS is the largest employer in the country – currently employing approximately 1.4 million staff [5]. Research shows that quality of work, as well as level of income, has a clear effect on health and wellbeing, and NHS organisations have great opportunity to reduce health inequalities through management, providing improved employment conditions, and commissioning.

It is important to ensure that work at all levels increases control, respects and rewards effort, and provides services such as occupational health. A recent audit found that many NHS trusts don't know how many contracted staff they have, and that these staff are less likely to have access to the services, benefits and supports that other staff receive [6]. This highlights the importance of making sure that all staff are treated well and experience good quality work, particularly those towards the bottom of the social gradient, who are likely to be in greater need and benefit most.

In addition, the purchasing power of NHS trusts, CCGs and other organisations can be used to the advantage of the local population. In many local communities, 15-20% of the local employment and income is accounted for by the health sector, giving a clear opportunity for action [7].

Working in Partnership

Health professionals often have experience and expertise of partnership working within their organisation, or within the health sector. This is valuable and important. However, greater collaboration is needed in order to recognise and tackle the causes of inequalities in health. Collaborative, co-operative work that crosses sector boundaries can be strengthened, where appropriate, by joint commissioning, data-sharing and joint delivery.

Partnerships and joint working should include work with public health and local government, other public sector partners, the police and fire service, charities and other third sector organisations, private employers and places of work, and schools. Partnership working with these sectors can not only enable health professionals to better understand and tackle social and economic inequalities, but also to ensure that local action is not unnecessarily replicated or duplicated.

Workforce as Advocates

Health professionals have great potential to act as powerful advocates. Advocacy can take place for individuals and their families, for changes to local policies, for changes to the health profession (as outlined in the Working for Health Equity report and summarised here,) and for national policy change. Advocacy should be focussed on changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions, for instance GPs advocating for better quality parks and leisure facilities, maintenance of early years services and healthy schools.

The Health System – Challenge and Opportunity

There is good reason to believe that opportunities for health professionals to act on the Social Determinants of Health will be both extended and challenged.

While the move of public health from the NHS to Local Authorities has some clear benefits, it may move action on health inequalities further away from practicing health professionals. Some CCGs are treating health inequalities as a core part of their business, but equally there are some who do not want, or feel able, to take on this agenda. CCGs

have opportunities through their assessment and commissioning functions and purchasing power to foster healthy local areas.

In a broader sense, tackling health inequalities is likely to save the NHS, and the rest of society, considerable amounts of money [1] and is necessary to ensure both fairer health outcomes and a more sustainable health care system.

Additionally, a greater emphasis on integration may provide opportunities for collaborative action – for example, there is a legal duty on CCGs and the NHS commissioning board to integrate services where this would reduce inequalities. Both these bodies also must now legally pay 'due regard' to the need to reduce inequalities, in terms of access and health outcomes of patients [8]. There are positive signs that the NHS can work to the benefit of the local community, using mechanisms such as the Social Value Act to ensure that local commissioning is in the interests and for the benefit of the local community. Health and Wellbeing Boards have good opportunities to co-ordinate action both with the health sector, (for example, CCGs) and colleagues in Local Authorities who work on a range of areas that can affect health (for example, education, housing, and benefits support).

Next Steps

There is both the need and good opportunity to extend the role of health professionals, ensuring successful work with patients, communities and other professionals in order to tackle the causes of health inequalities, through action on the Social Determinants of Health.

Existing successful action must be extended, and systematically embedded across NHS organisations. The enthusiasm of health professionals for the types of approaches outlined here was demonstrated by the involvement of over 19 professional organisations in the 'Working for Health Equity' report. The commitments to action that these organisations made are now forming the basis of a programme of work, co-ordinated by the Institute of Health Equity, in order to bring together relevant stakeholders and influence policy and practice across the professions. Through this, and other initiatives, we have a real chance of decreasing inequalities, improving the health of the population, and preventing future illness.

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2. Allen M, Allen J, Hogarth S, Marmot M. Working for Health Equity: The Role of Health Professionals. London: UCL Institute of Health Equity; 2013.

3. N. H. S. Choices. About the NHS 2011. Available from: www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx.

4. Ipsos Mori. Trust in Doctors 2009: Annual Survey of Public Trust in Professions. Royal College of Physicians; 2009.

5. The NHS Information Centre Workforce Facilities Team. NHS Workforce: Summary of staff in the NHS: Results from September 2010 Census 2011.

6. Sloan D, Jones S, Evans H, Chant L, Williams S, Peel P. Implementing NICE public health guidance for the workplace: a national organisational audit of NHS trusts in England. Round 2. London: 2014.

7. Doeksen GA, Johnson T, Willoughby C. Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts 1997. Available from: http://srdc.msstate.edu/publications/archive/202.pdf.

8. Health and Social Care Act 2012 2012. Available from: http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf.

Matilda Allen

The government's attacks on the NHS

These are easily seen in the 2012 Act, the determination to close hospitals and the orchestrated presentation of the Keogh Report in the House of Commons where Tory MPs made political capital out of the failings of hospitals selected for special measures.

The NHS has long been seen as a rare example of political consensus. It was created by Labour and yet Thatcher, the ace privateer, famously stated the NHS was 'safe in our hands' during her time. In April this year Stephen Dorrell (Secretary of State for Health, 95-97) said the NHS "is efficient in financial terms with daily examples of excellence". Our current Secretary of State for Health ignores this and has used the Francis and Keogh reports as evidence of a weakness in the Service as a whole although the reports do not bear this out. Francis reported unsafe staffing levels as a result of cutting the numbers of nurses on the ward to make financial savings and Keogh also found hospitals with high mortality figures often had financial problems and had focused on savings at the expense of clinical quality.

The problems identified come from the new management style in the service of running hospitals as businesses where the ultimate goal has been to finish the financial year in the black – otherwise known as the internal market.

Even by market standards the NHS is a success – still underfunded by comparison with similar countries but delivering comparable or better outcomes. The OECD figures for 2011 showed UK expenditure at 9.4% of GDP compared with 9.9% for Europe. A major review - How the NHS measures up to other health systems a.k.a. Commonwealth Fund study(BMJ 2012; 344 doi (Published 22 February 2012) Cite this as: BMJ 2012;344:e1079) showed this in more detail .

Key conclusions from Commonwealth Fund data

- The NHS outperforms other high income countries on many measures despite spending much less than most of them
- It enjoys the highest levels of public confidence and satisfaction of all the countries studied
- The effects of increased investment and policy improvements over the past decade are clearly visible

Productivity continues to increase - best estimates of NHS productivity suggest that there was an annual increase of 0.9% between 2006 and 2010.
In spite of well publicised shortcomings the detailed in depth reports do not reveal a fundamental flaw but show a system under stress and Keogh often commented on the dedication of staff within the service. The sensible action is to support and encourage such dedication through a reaffirmation of the strengths and values of the NHS and now to restore it as a comprehensive service to move forward through co-operation and to end destructive competition.

The NHS is facing the biggest threat in its history - change it from the service that provided cradle to grave care and freedom from the fear of disease to an insurance system to fund a variety of companies providing care on their terms – i.e. the market.

E. W.

NHS Scotland v England
"It's the economy, stupid!"

Regular readers of the newsletter may remember that I contributed accounts of the relative performance of NHS England and post-devolution NHS Scotland in June 2011, June 2012 and September 2013. These contrasted the return to a public sector healthcare model in Scotland with an increasingly neoliberal model in England. Both health systems rapidly improved their performances between 1998-99 and 2010-11. Substantial differences in clinical trends were more apparent than real and mainly attributable to the perverse financial incentives introduced by Payment by Results (PBR) to NHS England following the creation of financially independent Foundation Hospital Trusts.

The publication by the Nuffield Trust of a further review of the performances of the four UK health systems in April 2014 supports these conclusions (www.nuffieldtrust.org.uk/compare-uk-health). Previous criticism in a 2010 review of NHS Scotland's alleged poor productivity relative to NHS England with respect to trends in inpatient, day case and outpatient activity has been removed in favour of comparisons of a wide range of performance indicators which improved similarly in the Scottish and English health economies. Improving performance in Wales and Northern Ireland is also noted in somewhat less enthusiastic terms.

Despite these conclusions, the report at no point discusses what has been gained by the neoliberal "reforms" inflicted on the NHS in England under New Labour, given that the authors concede that the public sector model of healthcare it replaced improved its performance equally well in Scotland. There is also no discussion of the wisdom of rapidly extending competition and privatisation via the Coalition Government's 2012 Health & Social Care Act which will transform NHS England into a franchise open to "any willing provider".

Given a consensus that in the twelve years after devolution, the performance of the English and Scottish NHS broadly improved equally, attention may now be focused on the most significant factor responsible for this success, namely the unprecedentedly large increases in capital and revenue expenditure initiated by New Labour in 2000 during an economic boom (i.e. "It's the economy, stupid!"). Between 1998-99 and 2010-11 per capita expenditure in NHS England and Scotland increased by 98% and 78% respectively in real terms. As a result, over this period medical staffing levels in England and Scotland increased respectively by 45% and 39% per 1000 population, nurse staffing levels increased respectively by 23% and 13% per 1000 population and GP staffing levels increased by 26% and 22% respectively per 1000 population. Capital expenditure on new hospital building accelerated, albeit mainly through the Private Finance Initiative (PFI), and money was lavished on initiatives to reduce waiting times and waiting lists. Much money was also dispersed on above inflation salary increases for medical staff and managers, expensive PFI schemes, and management consultancy fees, but enough remained to transform the performance of a previously under-resourced NHS which in the preceding decade had been characterised by lengthening waiting lists, recurring winter bed crises and rising numbers of emergency admissions.

This golden era came to a halt with the recession induced by the 2008 banking crisis, but only fully impacted on the NHS with the election of the Coalition Government in 2010 and the instigation of swingeing cuts in public expenditure. The Chancellor's promise to protect NHS spending from the effects of inflation implied a zero increase in real terms. This constitutes an unprecedented reduction in historical terms; since NHS inflation is invariably higher than general inflation. In a detailed review of government funding of the NHS since its inception published in 1999, John Appleby of the King's Fund notes that between 1949-50 and 1996-97, the only period when NHS funding did not increase in real terms was during the Churchill-Eden Conservative administration (1951-52 to 1954-55). Even between 1990-91 and 1998-99, per capita NHS expenditure in England and Scotland increased respectively by 30% and 24% per 1000 population in real terms from a lower baseline than in the following decade. Since

the election of the Coalition Government in 2010, the NHS has had four years of zero increases in funding in real terms.

At the 2012 AGM of the NHSCA in York, John Connaghan, Director for Workforce and Performance for NHS Scotland outlined the Scottish government's provisional budget for all public expenditure between 2009-10 and 2025-26. This projects a 15% reduction in total spending in real terms between 2009-10 and 2015-16, with a return to 2009-10 levels only in 2025-26. While there is a degree of uncertainty about these projections, they indicate the probable scale of the huge reductions facing NHS and public sector expenditure in the UK. Current apocalyptic projections of the results of unsustainable spending reductions in NHS England by the King's Fund and the Nuffield Trust echo the Scottish projections. Most recently, the impact and costs of the further massive reorganisation of NHS England imposed by the Health & Social Care Act has been followed by the rapid collapse of plans for the implementation of a "Better Care" fund which envisaged a further massive switch of two billion pounds from hospital care to local authorities in order to "transform" community care. The ineptitude of this ill-thought-out proposal from the DOH suggests a strong whiff of panic and rearranging the deck chairs on the Titanic.

How well are NHS England and Scotland currently responding to these severe reductions in expenditure? In both countries, rising A&E and emergency admissions continue to impose increasing pressures on staff and bed capacity. Waiting times in A&E departments and numbers of delayed hospital discharges are rising and elective inpatient and day case waiting times increasing.

On the other hand, the Scottish NHS has been distinguished by remarkable organisational stability since the abolition of the internal market and of the privatisation of clinical services. Scotland (and the UK's) largest acute hospital with over 2,000 acute beds, will open next year in Glasgow, funded by the public sector and no Scottish NHS hospital closures are in prospect. Scotland has no "failing" hospitals since it has no financially independent Foundation Hospital Trusts. The bizarre spectacle of failing Hospital Trusts being broken up on purely financial grounds, as in Lewisham in South London, has no counterpart north of the border. The model of financially independent Foundation Hospital Trusts which are dependent for up to 60% of their income on Payment by Results from a complex tariff is proving increasingly fragile and unstable at a time of increasing austerity and as noted in the 2013 newsletter, there have also been no Scottish counterparts to the scandals of the Mid-Staffordshire and Morecambe Bay Foundation Trusts where the attainment of Independent Foundation Trust status led to the suppression of evidence of unsafe patient care by management intimidation of medical and nursing staff.

Scotland's superior level of NHS funding compared with England has been progressively falling in the last 20 years. In 2010-11 the Treasury's Public Expenditure Statistical Analysis (PESA) identifiable health spend for Scotland (£2089) was only 8% per capita more than for England (£1932). This ranked behind spending on London, North East and North West England but ahead of the remaining six English regions. Despite this relatively small spending difference, in 2010-11 NHS Scotland employed 19% more doctors than NHS England (3.2 v 2.7 per 1,000 population), 27% more GP's (0.95 v 0.75 per 1,000 population) and 31% more qualified nurses (8.1 v 6.2 per 1,000 population). In 2010-11 Scotland had 48% more staffed acute beds (3.1 v 2.1 per 1,000 population) than England and 85% more staffed beds in all specialties (4.9 v 2.7 per 1,000 population). This data suggests that NHS Scotland, with relative organisational stability and an absence of radical reform, may have disbursed its NHS revenue more judiciously than NHS England. These large differences in NHS resources in manpower and staffed hospital beds merit further investigation.

By the time of the NHSCA's next AGM, the UK may have lost one third of its land mass and a tenth of its population if Scotland votes "Yes" to independence. With these political and fiscal uncertainties, not least the uncertain future of the NHS, it may be appropriate to conclude on a Scottish note, with the last two lines of Robert Burns' poem "To a Mouse", learned by Scottish school children in primary school!

"An' forward, tho' I canna see

I guess an' fear"

Matthew Dunnigan

Reconfiguration

Labour established a process in 2006 which would be overseen by the SHA and would require 12 weeks consultation with due regard to external experts and due process through a reconfiguration panel.

The Trust Special Administrator (TSA) has new powers to cut through this process and the new procedures are more akin to handling a business through the insolvency process, allowing a hospital to be closed if it was an unsustainable provider.

In the first use of the "unsustainable provider" process, a TSA was appointed by the Secretary of State for Health. After a few weeks, he produced a wide-ranging report that threatened to wreck a neighbouring thriving and financially sustainable hospital – Lewisham.

A legal challenge brought by the local authority and the Save Lewisham hospital campaign showed conclusively that the Secretary of State did not have the power to include Lewisham in a solution to the problems of SLHT.

The government wanted to ensure that in any repeat of the process, a TSA can swiftly reconfigure whole health economies. There are many financially failing trusts in the NHS at the moment. Many have thriving hospitals close by threatened with downsizing or closure. After the legal triumph over Lewisham the government introduced Clause 118 of the 2012 Act which would give greater power to close hospitals. This was passed in the House of Commons despite widespread protests but there has been victory in the House of Lords - thanks to the amendment by Baroness Finlay, palliative care specialist and NHSCA member.

Under the Finlay amendment, where a TSA is appointed, the TSA would treat all commissioners of NHS services equally. The present clause penalises important co-operation between commissioners and providers, and gives a veto to the struggling or indebted commissioners. This inequality is indefensible. Why should successful commissioners, who have worked well with their local NHS Trusts and NHS Foundation Trusts to produce a sustainable set of NHS services, be prejudiced by struggling commissioners and providers in a neighbouring area?

There is now a Clause 119 going through parliament which would extend the remit of an administrator brought in to manage a failing trust, so that he or she can make recommendations about other trusts in the local area. TSAs would be able to consider the wider healthcare system in their investigations, not just the trust in administration.

How this will work in practice may now depend on further legal challenges but the aims are clear – to speed up hospital closures and to prioritise finance above clinical need.

What has been presented by many in the media and campaigners as the big battleground to keep hospitals safe from closure may turn our to be skirmishes in a prolonged campaign.

E. W.

The Centre for Health and the Public Interest

a different point of view on the future of the NHS: an appeal

The debate about the future of the NHS in England has reached a critical juncture. NHS care is now being contracted out to be delivered by private providers in one of the largest outsourcing operations of the past decade. In addition, due to the limits placed on the budget of the NHS at a time of rising demand, questions are being raised about the affordability of the service and whether it should continue to be funded through central taxation.

Yet the NHS, as a direct provider of care services that are free at the point of need, has huge public support. Despite this, the health policy community which is relied upon to find solutions to the challenges facing the NHS is increasingly promoting user charges and further outsourcing of services. [1]

This policy community is an extremely tight network, consisting of a few big think tanks and management consultancies (McKinsey, KPMG, PriceWaterhouseCoopers), with close links to the Department of Health and the bodies responsible for regulating the health service.[2] It is also financially very well endowed. As a result, it is able to frame the debate in the media as well as providing staff and resources to shape the policy proposals of all the major parties. [3]

The Centre for Health and the Public Interest (chpi.org.uk) was established last year, with endorsement from 20 eminent figures in the fields of medicine and health and social policy [4], to be a think tank dedicated to providing an alternative to this market-based orthodoxy. While markets in other areas of the economy and public services may have significant benefits, the academic evidence shows that markets in health care have deleterious consequences for patients and lead to excessive costs for government and the taxpayer. The CHPI seeks to ensure that this evidence is attended to by policy-makers and that the debate is more open and accessible to citizens.

At the moment the CHPI has less than 1% of the resources available to any of the established think tanks and relies mainly on the pro bono commitment of a small network of people in demanding jobs. Despite this we have started to have an impact on the policy debate. In the past year we have published three major reports and seven analyses covering issues which have been high on the policy agenda: healthcare fraud; who has power in the new NHS; competition vs. collaboration; the NHS's capacity to respond to pandemic flu; choice in healthcare; the lessons for the NHS from the introduction of markets in social care; personalisation and mental health. These reports and papers have been commented on in the Guardian, the Independent, the Health Service Journal and elsewhere, as well as in Parliament. An overview of our work and its impact, with details of the people involved, can be seen at...

To make the CHPI sustainable we need a minimum of professional staff (a director and a media expert), and for this we need generous financial support from everyone who is concerned to see the NHS's founding principles sustained. Some of the major charitable trusts which are committed to social change and to ensuring that democratic debate in the UK is open, varied and informed, do not fund organisations which look at healthcare, because (we assume) they consider that the larger think tanks and foundations already cover this issue. This has significantly limited our ability to raise funds to place the Centre on a sustainable footing.

The resulting preponderance of resources available to those who promote only one point of view is detrimental to the debate about the future of the NHS. The core aim of the CHPI is to provide an evidence-based alternative voice in this debate. We are therefore appealing to every member of the NHSCA to help us. We would be grateful for help in any form, including suggestions of individuals or organisations we might possibly approach for major donations, but also, of course, for individual donations or, ideally, commitments to give money on an ongoing basis.

To give some idea of the relative resources involved, the think tanks that dominate the policy community spend between £1m and £14m a year each. The CHPI could be sustainable and effective

on £100,000. If 500 people each gave £200 a year, or 200 gave £500, we could do it.

You can make a donation:

1. By credit/debit card or paypal - visit www.chpi.org.uk and click on the "Donate" button on the right hand side. To make a recurring monthly donation, please tick the relevant box.

2. Via your bank to CHPI, Sort Code 08-60-01, Account 20285326.

3. By writing a cheque payable to CHPI, and sending it to our Finance Officer, Keir Wright-Whyte, at 59 Graces Road, London, SE5 8PF.

And to suggest other possible sources of funds, please write to us at info@chpi.org.uk.

All forms of support will be very gratefully received and acknowledged.

We wish to thank the NHSCA Executive very warmly for the opportunity to make this appeal.

1: For example the Kings Fund has recently (April 2014) published the interim report of the Barker Commission which advocated increased user charges in health. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/commission-interim-new-settlement-health-social-care-apr2014.pdf. This was preceded by a report by Lord Warner for Reform which also advocated user charges for NHS care (March 2014): http://reform.co.uk/resources/0000/1247/Solving_the_NHS_care_and_cash_crisis.pdf.

2: During the passage of the Health and Social Care Act 2012 the Nuffield Trust actively promoted greater marketisation of NHS services: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/the-health-and-social-care-bill-where-next-may11_0.pdf

3: As a CHPI report by Scott Greer and Holly Jarman from the University of Michigan shows, the board of the NHS regulator Monitor is made up of staff from management consultants: http://chpi.org.uk/wp-content/uploads/2014/01/The-architecture-of-power-in-the-NHS-Scott-Greer-Jan-2014.pdf

4: For McKinsey's influence on the future of the NHS see this report to the Department of Health http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/

There's no financial, ethical or clinical justification for NHS charges

Jacky Davis wrote a piece with this heading for the Guardian, published on April 4th and easily found online by Googling her name or the title.

She gives the background to the suggestion which clearly challenges the basic principles of the NHS and describes how it would hit the neediest the hardest and that the proponents avoided stating the obvious – that it would require means testing and would cost more than it would save.

The proposals seem to be the brainchild of Reform – a cleverly named organisation which presents itself as acting in the public interest but is essentially a third party speaking for those whose voice is not trusted; it is a front for the health industrial complex, which for years has worked to get its hands on the NHS budget.

Abrahams Report

The review by the Parliamentary Labour Party health committee, chaired by Debbie Abrahams, parliamentary private secretary to shadow health secretary Andy Burnham, has concluded that markets in healthcare increase inequalities and that the Health Act 2012 should be repealed.

The full version is at http://www.debbieabrahams.org.uk/2014/inquiry-on-effectiveness-of-international-health-systems

The Inquiry was conceived and designed by the PLP Health Committee Chair, Debbie Abrahams MP, who also authored the Inquiry report. The panel included experienced politicians Rt Hon Sir Kevin Barron MP, Rosie Cooper MP, John Cryer MP, Barbara Keeley MP, Ian Mearns MP, Grahame Morris MP, Lord Nic Rea; with support from heavyweight academics. Professor Clare Bambra, Dr Katharine Footman, Professor David Hunter, Professor Martin McKee, Professor Gabriel Scally, Dr Alex Scott-Samuel, ,Dr David Stuckler,.

This was a thorough review in academic paper style, 56 pages and 37 references from the literature as well as reports from practitioners in the field. One significant finding was that there was little good evidence to support wholesale change and a clear need for more research.

The final report, called An Inquiry Into The Effectiveness Of International Health Systems, concluded that competition can "impede quality, including increasing hospitalisation rates and mortality".

It says Labour must redefine "the terms for private healthcare providers' involvement in the NHS".

Quoting from the report

The Labour Party has a proud and historic link with the NHS; it reflects and represents our collective spirit, and the values we hold dear. It is fair to say that in most people's eyes the NHS remains a national treasure. But we know it is not perfect and although the Labour Party has committed to no further top-down structural reorganisation should we be elected into Government in 2015, service change will be needed.

To this end, and to inform the Party's internal policy review process, members of the Parliamentary Labour Party undertook an inquiry into the effectiveness of international health systems in improving health care quality and equity.

There is no conclusive evidence that the UK's internal market, including the establishment of Foundation Trusts, has resulted in improvements in the quality of healthcare;

 There is evidence that additional transaction costs in internal markets outweigh any cost savings in other parts of the system;

 There is no evidence that competition, marketisation or privatisation of a health system improves quality; there is some evidence that quality deteriorates in the for-profit sector;

 There is evidence that more integrated health systems can improve quality, but this varied with the form of integration.

Recommendations

Labour Should

a. Restore the key principle of NHS resources allocated based on health need (and health inequalities)

b. Develop a 'Healthcare For All' funding model: Undertake a review of NHS resource allocation formulae and budgets in order to simplify and develop a new resource allocation model reflecting NHS principles and values

c. Analyse and develop alternative healthcare provider payment models based on quality, equity and capitation rather than activity/utilisation and 'choice'

d. Review the evolution needed by Health & Well Being Boards (HWBs) and Clinical Commissioning Groups (CCGs) to enable them to integrate budgets and jointly direct spending plans for the NHS and social care, including constitution and governance.

E. W.

More of the Perils of Competitive Tendering

A race to the bottom in price with little regard for quality and safety

In the last issue I described how the competitive tendering process carried out by the East of England Strategic Projects Team wasted huge amounts of the time of many doctors, managers and scientists in meetings which were billed as consultations but with no notice being taken of comments. The objective was to reduce the cost of Pathology to GPs and that could have been achieved through local co-operation. Instead the Projects Team came up with plans that would involve a 90 mile journey to a lab working with Serco for routine samples and inadequate provision for contacting GPs with seriously abnormal results requiring urgent action.

The plans were so poor there was an immediate outcry. One CCG invited the preferred providers to attend a meeting to discuss logistics and were amazed to find the logistics team got lost and were over an hour late before trying to present themselves as capable of running a collection and delivery service.

Local GPs were quick to highlight the problem in the local paper – Southend and Basildon Echo made it a cause célèbre and the CCGs – in the best spirit of the NHS -negotiated a deal with the Hospitals. Although the East of England Strategic Projects Team have gone quiet, lessons must be learnt from such poor planning and the local Area Team manager made the following comments - the lessons are clear ;

- There needs to be a clear rationale for the change
- Clinical views should be heard and influence well before the tender
- The data and evidence must be as good as possible
- The tender construct should not be too complicated
- All risks should be fully thought through before tender
- There should be patient engagement from the start and a visible and clear consultation process
- Any company/hospital bidder should be fully assessed for their mobilisation competence

These principles apply to any strategic change tender

And, I would add when contracting with the private sector – ensure there are adequate monitoring arrangements with appropriate termination and penalty clauses for poor performance. This will involve solicitors and increased transaction costs and demonstrates the additional costs of marketisation.

In 2013, James Illman, writing in the HSJ commented that three controversial regional pathology reorganisations have incurred £2m in central costs and experts estimate the total bill for NHS trusts and bidders to be about £10m and rising.

Hopefully the public and politicians in the Midlands will be able to make these points to prevent a contract being given to a provider who impresses the team with excellent sales talk but does not deliver. The lessons are clear from the examples – publicly provided means we own it and can change it, privately owned as with PFI means we pay extortionate rates but have no control

This is particularly relevant now because the same team (now Midlands and the East SHA) are handling the bid for cancer and end of life services in the Midlands (see Clive's article).

E. W.

American Healthcare

From a member of Labour International currently living in California

As a Brit in the US, in common with most other Brits here, the US health "care" system (actually, profit-making industry – health is an occasional by-product which is nice, but not essential) is one of the most shocking, awful, unequal and frankly disgraceful aspects of life in the US.

There is the obvious aspect which most Brits are aware of – people that simply cannot afford to get medical assistance. About 50 million people.

But, there are so many other sociological aspects of this system with subtle impacts which you only really understand by living here. I could (and maybe I should !) write a book.

* The insurance companies are king. Their power is immense. So immense that they control prices of everything in the market. Fine, you say. That is private health care and surely that only affects those with insurance? Well, no. It affects EVERYONE. Because, simple remedies that you would find Over The Counter in the UK are made prescription only here – Zovirax cold-sore gel, pain killers stronger than 750mg paracetamol (for example Solpadeine codeine/paracetamol is only available on prescription). So, that forces you to to to a doctor far more than would happen anywhere else. That is money in the bank for the insurance companies, most of which also run large primary care operations.

* Over The Counter medicines are FAR more expensive here. What you can buy is always MUCH more expensive, because the insurance companies lobby hard to keep them controlled. Aspirin (bought some yesterday at Heathrow 39p for a pack of 12) – $6.80 at my local supermarket. I suffer from regular hayfever – I can't buy the same eye-drops as in the UK because the active ingredient is regulated and therefore only on prescription (a Doctors Office visit here costs me between $50 and $80). Here, the next best thing is over $25 for a tiny bottle. There is a LOT of smuggling of drugs from on-line pharmacies or from Canada and Mexico.
*What is even worse about this is that those with health-insurance can usually put the cost of both prescription and OTC medicines onto some kind of tax-exempt savings card. So, the bulk of the pain of both lack-of-insurance and medicine prices driven up by the insurance companies hits the poor and disenfranchised twice over.

* The stories you hear on the news are supposed to be "heartwarming" – charitable efforts with doctors and dentists giving their time free to treat the uninsured. The last time this happened round here was over a holiday weekend in Oakland (one of the most deprived cities in California). The TV news showed people snaking around a very large football stadium in which a number of doctors and dentists treated people – it was reminiscent of a refugee camp. Rather than thanking the medics for giving their time freely, the news should have reported how it is that the richest country on earth can stoop so low. One woman interviewed said that for 5 years she'd lived in pain from needing three fillings, but couldn't afford to have them done until then. It is utterly sickening.

*Or the other news stories of bankruptcies due to visits to the ER. Take the case of Brian Stow, the 49-ers supporter that was badly assaulted and left for dead at the LA Dodgers stadium. He had basic insurance. But this was no-where near enough to pay for the emergency care and rehabilitation he required. His family had to (and keep having to) arrange charity appeals to pay for him and support his family. And what makes this worse ? He was a paramedic working for the public Fire Dept (ambulances are run by the FD in Californias cities).

But surely if you've got medical insurance, then you're fine ? Err, no. The impact of the private health system is far more insidious. It rots the core of society in ways which you would not believe.

1) You and your family's health is tied to your job. As pre-existing conditions cannot be transferred from health-plan to health-plan, then the WORST position to be in is to be using the health system and lose your job. Because, no matter if you walk into a job the very next day with health insurance, tough – those are now pre-existing

conditions and You're Not Covered. There are some protections (the COBRA Continuing Health Care) that allow employees and their families to stay on an employers plan for up to 18 months after being fired, but that is usually at full market rate – i.e. not with the subsidy that your previous employer would have given. So, you've lost your job and your health care payments have just gone up massively.

2) So, losing your job is bad. That has a massive knock-on on workplace attitudes. Confrontation is bad. Disagreeing with your boss is bad. Because work in most states is "at will" – the will of your manager. Say you don't agree with her on something ? Best to shut up if you're on any form of medication (and chances are you are, because, as I said before, the insurance companies lobby hard to keep drugs behind the prescription wall).

3) People stay in their jobs when, frankly, they should have been pensioned off sick years ago. Not only for THEIR benefit, but for their company's benefit as well. I've seen this SO many times. They cannot afford to retire, because their expensive treatments won't be covered until they hit Medicare at 65, and even then, you can bet that it will be no-where near as nice an experience as the private insurance has weened them onto. Dentists, doctors, clinics advertise here based as much on the type of coffee they serve as the medical outcome.

4) You want your son to go on a Scout Camp, your daughter to play tennis ? You need an ANNUAL medical for that. Yes, a full medical. And you HAVE to have insurance. Every time my son goes away on Scout camp, I have to fill-out a medical waiver form with the insurance details including dental. No insurance – doesn't go. Some sports require even more rigorous exams with increased frequency. At any age. The medical is paid for by my insurance plan, but that is a $250/child expense. Every year. No exceptions. Last week, someone was interviewed on NPR asking what she thought of the Affordable Care Act (Obamacare). "Great," she said. My daughter has wanted go to tennis camp for the last three years, but I've had to say no as we don't have medical insurance and can't afford it." Isn't that truly repulsive ?

5) Even with the ACA, we're not out of the woods. A number of companies that have decided to self-insure (pay their own medical costs rather than use an insurance company) have done so in the hope that they can dictate their political or religious views to their staff. The fight is not over – there has been huge opposition to the provision of birth control by the Catholic charities which took several years to resolve.

6) Then there is just the sheer inefficiency of the system. My wife is a TEFL teacher. She was asked to teach at a local school. State regulations require that she had a TB test. To do that, she had to register with a doctor. That was a $50 joining fee. Covered by insurance, but the plan I have only kicks-in after we've spent $4500 per year. I have to budget and save for that….. So, in early January, she registered, and had the test ($42). It came back negative, and we paid the bill from our savings account electronically. In March, we had a final demand to pay the bill. The doctor we used is part of a national chain, and the health savings account had paid the wrong account so it hadn't reconciled. A call to the collection company in Ohio. Three months later, a summons to pay $42 plus $250 late costs. Another phone call – this time a conference call with the doctor's admin and the savings people. Great. All sorted. Until last week. "Your non-payment has been passed to a debt collection agency and this action will be reflected on your credit score." We've PAID ! So I phoned then debt collection agency. "Oh yes, this happens ALL the time – about 50% of medical bills go astray. Don't worry about it." The irony is, my wife wasn't even ILL ! Can you imagine if you were seriously ill having to deal with banks, credit reference agencies, debt collectors ?

If anyone EVER thinks of dismantling the NHS, then they should come and live in the US for two years, ideally needing to go to the doctor once, send their kids to camp twice, and break a tooth (I did within 3 months of moving – a crown cost me over $5000 compared to the £150 I paid at our UK dentist two years earlier).

supplied by Martin Rathfelder

Outsourcing cancer care - the biggest and most reckless NHS privatisation yet?

Outsourcing over a billion pounds of cancer and end-of-life services is reckless and shows just how threadbare government promises of 'no NHS privatisation' have become.

In the biggest outsourcing to date, the NHS has announced it is tendering a huge £700 million contract for providing NHS cancer care in Staffordshire and Stoke-on-Trent, along with another £500million for end of life care in the region.

It's a dramatic indication of the rapidly increasing commercialisation and privatisation of the NHS.

In the messy fight over the Health & Social Care Act, during the 'listening pause' the Coalition promised parliament the changes they had made to the legislation included "ruling out any question of privatisation".

How much more threadbare can that promise get? This tender - the first on this scale - will cover cancer services for a population of over 1 million people. It has been labelled a 'pioneer project' and has major implications for the future of the NHS as a public service.

Hospital based frontline cancer services including surgery, chemotherapy and radiotherapy could be provided by the private sector.

According to trade press magazine, Health Service Journal, "the CCGs are considering a prime provider model. This would involve making a single organisation accountable for delivering the outcomes for an identified group of patients, such as those receiving care for a particular condition. This lead contractor would then subcontract NHS, private or voluntary sector providers to provide seamless care."

This "bundling" of contracts could undermine and fragment existing services within the cancer network.

There are already national shortages of professionals involved in cancer management. Contracts with non-NHS providers will take many of these highly trained staff away from the established NHS services, where the full range of cancer services are delivered to a regional population.

Private sector providers will only be interested in managing the high volume, low complexity work, leaving more complex and uncommon cancer care to the established NHS centres. The NHS will lose both government money and already scarce staff to the private sector.

Cancer services are highly complex and multidisciplinary. In my work as a clinical oncologist I treat patients with prostate and lung cancer. I work alongside surgeons, radiologists, pathologists, nurses, radiographers, medical physicists, palliative care specialists, physicians, and more.

The government has fundamentally misunderstood the complexity of cancer services, which evolve & develop over many years, but always with the flexibility to react to new developments in cancer treatments. This needs careful planning at every level, from departmental to national. Subjecting the organisation of cancer services to a market driven tender is a reckless approach.

It is remarkable that the cancer charity MacMillan has got involved in this process to help guide the commissioning process. What impact could this have on the public reputation of MacMillan if it was seen to be involved in a tendering process that led to increasing privatisation of NHS services?

Polls show that less than one in five people thinks more compeition will improve NHS services. The public wants to keep the NHS as a public service and reject privatisation.

Of course, it may be that all of the contracts go to the established NHS providers in the region. Which would then rather raise the question, why did we waste taxpayers' money on unnecessary transaction costs, which can easily run into the tens of millions?

And worringly, the project is being driven by the Strategic Project Team (SPT) - a shadowy part of NHS England with a history as "arch privatisers". The SPT - consisting mostly of management consultants not permanent NHS employees - have been involved in most of the 'ground-breaking' NHS privatisations to date. It was they who outsourced Hinchingbroke, the first NHS hospital to be handed over to the private sector to run. Quite who they are accountable to is very unclear - like much in Cameron and Clegg's NHS.

Clive Peedell

Don't believe Cameron's hype - the Welsh NHS has much to teach the English

Cameron this week labelled the Welsh NHS 'a scandal'. But this is largely a propaganda war, designed to justify privatisation.

The Welsh created the NHS, modelled on miners' mutual aid schemes. They have so far strongly resisted attempts to return healthcare to market competition. Since devolution a new generation of socialists has been quietly running NHS Wales as a public service - not for private greed.

And for this reason, the Welsh NHS is now under attack from a propaganda Blitzkrieg.

The crescendo of political and media attacks on NHS Wales are light on evidence. So why do we hear hardly a squeak of dissent from the opposition front bench in Parliament, to defend their own Party in Welsh regional Government?

Nine out of 10 patients who used Welsh hospitals and GPs last year were satisfied or very satisfied with their care. In contrast across Britain as a whole only six out of 10 respondents said they were satisfied with the NHS (a sharp decline from peak approval of 71% in 2007).

Why is Labour not pointing this out?

In the English NHS central planning has virtually disappeared. Each hospital is supposed to compete with its neighbours for survival. Every state service must compete with other services for its share of the budget.

Labour's regional government in Wales, on the other hand, still believes that public services should be centrally co-ordinated. That there should be planning towards shared social aims. If a local hospital is performing badly, people in Wales still expect state action to improve it, not personal choice to go to a competing hospital elsewhere.

Welsh central planning has enabled co-ordinated action across separate institutions and budgets. In Cardiff hospital A&Es and local police share anonymised information, leading to fewer violent incidents and hospital admissions.

There is no question that times are hard. The Welsh government has faced disproportionately higher cuts in its centrally allocated funding - 20% across the board, a context many saw as politically motivated to dicredit the Labour-led government. Faced with this, the Welsh Labour Government decided not to ring fence NHS spending within the UK coalition Government's austerity programme. Instead it took advantage of its more planned environment to allow it to better integrate health and social care services. As a result, councils' spending on all services (except education) fell by only 9.3% in Wales last year, compared with 15.6% in England, according to the Institute for Fiscal Studies.

But key indicators for Wales NHS are moving strikingly in the right direction as a result of improved working across primary community and acute healthcare and social services.

In Wales, emergency hospital admissions of people with chronic conditions fell sharply in 2011-12, by almost 15% for diabetes and 17% for lung diseases. Similar falls were not seen in England. In Wales, re-admissions for these diseases (probably the best single measure of clinical failure) dropped even more steeply, by almost 30% and 25% respectively. David Sissling, chief executive of NHS Wales and director general of health and social services, said shared responsibility for both NHS and Social Services, through Local Health Boards, made it far easier to deliver integrated services. "They don't have any allegiance to hospital-bed care", he said, "and you can think about designing a care pathway without having to think about it in terms of transactions that bring two or three different organisations into the equation."

This success was so obvious that in May 2013 NHS England announced its intention to integrate all NHS and social care services by 2018, without of course acknowledging that Welsh Labour was already doing it.

In Wales there is one minister with overall responsibility for both the NHS and Social Services. There are strong democratic Local Health Boards

and the still powerful role of the Chief Medical Officer for Wales.

In England, in contrast, the minister has no responsibility to secure a comprehensive health service, the Chief Medical Officer role has been marginalized to the point of invisibility, the whole public health system is in tatters, and Public Health medical staff are streaming out of the service.

Why the panic about the Welsh NHS?

Last year 'death rates' in six Welsh NHS hospitals were said to be much higher than the English average. NHS England's Medical Director Sir Bruce Keogh felt compelled to ask his opposite number in Wales to set up an enquiry. He did this in confidence; and so, of course, it was immediately printed and broadcast.

Patients enter hospitals because they are sick. Some of them die, either while still in hospital, or after they have returned home. Outcomes depends on age, the type and degree of sickness, differences in provision of home care, and differences in where patients want to end their days. The proportion of all deaths occurring in hospital throughout UK varies from 45% to 60%.

If hospitals are compelled to compete in league tables for mortality, they may find ways to admit more people at lower risk and avoid those at higher risk of dying in hospital, or send patients home sooner, so that they die at home. Similarly the drive to meet A&E wait targets can give rise to unneccessary admissions. Politicians and media commentators should be careful what they wish for.

Of course there is plenty of genuinely bad news about health in Wales, and some (though much less) about health care in Wales.

The Welsh have been poorer and sicker than the English for at least 300 years. They have more of the principal causes of ill-health and premature death: more heavy industry, more unemployment, and lower average earnings.

In any public service, there will be a few exceptional cases of bad practice, which should be looked into. If relatives complaining of bad treatment refuse permission for their NHS medical records to be made public, as in the case of Anne Clwyd MP's unfortunate husband, it is impossible for anyone to judge where, if at all, the NHS failed.

Valid comparisons would compare Wales not with UK, but with the North East of England. But the Blitzers don't care about validity. Any stick will do, to keep Britain on the Right course - to privatisation.

Sticking to the 'Right' course in England?

In England, Simon Stevens takes over this week as Chief Executive of the NHS after a stint as President of UnitedHealth Europe, the European branch of the largest private healthcare corporation in the USA.

Stevens' background is impeccably New Labour. Blair's chief health policy advisor, he then helped Labour Health Secretary Alan Milburn to create the 'market' that encouraged the takeover of NHS provision by private health companies, justified as 'competition' and 'choice'. In his first speech this week he talked up the "innovation value of new providers".

His return to these shores has been enthusastically welcomed by fellow Blair-era survivors, including Blair's former Political Chief John McTernan. Writing in the Spectator McTernan claims Stevens will be the 'perfect partner' for Jeremy Hunt to "save the NHS".

Following up on Twitter McTernan claimed the best argument for more of the Blairite 'market-orientated revolution' in the NHS was "NHS England vs NHS Wales, for a start", he twittered. "I'll be surprised if you can find anyone to defend NHS Wales".

Let's be unreasonable

The Labour Party has always contained two groups: 'reasonable' people who adapt to the world as it is, and 'unreasonable' ones who insist on trying to change the world and make it a little more civilised. Let's call them Collaborators and Resisters.

Promising to rescue the NHS from Conservative privatization, the Collaborators helped Labour win the 1997 general election. They then pursued policies of NHS privatisation more vigorously than any Conservative Government had dared.

What has been the result of this collaboration? For ordinary voters there is no sign of any caring capitalism to reward their trust.

Struggles

The present opposition front bench in Westminster struggles to resist Tory privatisation. They are faced with accusations that the Tories are only pursuing the Blair/Brown government's policies towards their logical conclusion - a private service for those who can afford it, supplemented by a bare-bones service of last resort for those who can't.

But their caution in opposing privatisation only emboldens the NHS's enemies. Another former Blair advisor, Lord Warner, this week offered to save England's NHS by introducing crude direct charges to patients (with the Kings Fund adding similar suggestions later in the week). Warner speaks for the notorious thinktank Reform, which has been trying to shift NHS funding away from general taxation onto sick people ever since it was set up in 2001. Reform and its ilk have never explained why taxing sick people is a better way to fund healthcare than taxing everybody according to their ability to pay. Most people in Wales still understand that very well indeed.

So far, the attack on the Welsh NHS has met little effective resistance from Labour at Westminster. Labour should be proud - not ashamed - of its record in Wales. We should all reject the Blair-era voices calling for more markets, 'choice' and 'private solutions' on both sides of the border.

Julian Tudor Hart

Welsh NHS : Cameron and Hunt – Apologise to the House and to Wales

The Welsh NHS has for weeks been attacked in the Commons by Cameron and Hunt being described as failing and a shambles. Now, on a weekend when the independent Nuffield Trust reported that NHS Wales compares well with the other UK health systems, Cameron compounded the crime by telling the Tory Conference that the Welsh border separated life and death. Both should apologise to the House for misleading it and correct the record. Cameron should apologise to Wales for the "line of death" slur.

Faced with Nuffield Trust's assessment on Radio Wales 11th April, Welsh Tory MP Alun Cairns was reduced to blustering that the massive failure of the Welsh NHS was all due to elective orthopaedic waiting times -supposedly longer in Wales.

He didn't want to hear that cancer care was better in Wales. He didn't want to debate the impact that the 1978 Barnett formula automatically has on reducing total expenditure in NHS Wales. As a result of the austerity agenda NHS Wales now operates on £1,900 per person compared with the North East of England (similar to Wales in terms of "need") which gets £2,100 – 10% more. He couldn't admit that the cause of the problems in Mid Staffs were slashed nurse staffing levels as the Trust went hell- bent for Foundation Trust status – which doesn't operate in Wales.

He won't want to quote the outgoing English NHS boss rating NHS England only 5 out of 10. Perhaps too he doesn't know that the massive re-organisation of the English NHS- never put to the electorate in either the Tory or Lib- Dem manifestos – has wreaked havoc with hospitals forced to compete rather than collaborate and commissioners forced to put NHS services out to tender. Spending on "regulation", lawyers, and redundancies continues to rise. Will the manifestos of the Conservative and Lib Dem parties in 2015 proudly state " Vote for us and let us finish off the NHS"?

He couldn't say if he supported propping up the NHS Barnett 10% shortfall by robbing large chunks of the Welsh education or social care budget to health. Anybody who knows anything about the inadequacies of Joel Barnett's 35 year old "temporary" fix – which clearly doesn't include Cairns and Cameron and the Welsh Lib Dems – knows that those are the unattractive options for plugging this huge gap in the funding of a devolved service taking about 40% of the total Welsh Government block vote. And what of that orthopaedic waiting time figure?

Cairns might be right that the reported figures show an average hip and knee operation waiting time in Wales of 170 days as opposed to 70 days in England. However, reported figures do not necessarily indicate poorer treatment for real patients. First, English figures are not collected and reported on the same basis as Welsh ones. English waiting times rules describe many ways of "stopping the waiting times clock". Some of the difference in waiting times is almost certainly down to England being better at gaming the data than being better at treating patients. Second, it is more important that patients are treated at the best time for them (and average figures are by definition a mix of short and long waits). For some patients, agreeing with their Welsh doctors the optimum time for such surgery and perhaps waiting a while so that future revision surgery some years hence is less likely, makes sense. Third, for as long as Wales gets 10% less than its English equivalent region, waiting times will inevitably suffer.

Welsh Health Minister Mark Drakeford was right to say that "Nuffield has shot Cameron's Fox". For the Prime Minister to lose one Fox in a term of Government is unfortunate. To lose both Reynard and Liam to different means of pest control is careless.

Tony Beddow

What next for The NHSCA ?

What do we do? – we campaign for restoration of a true NHS – How can we best do it? – as an organisation of consultants only or as a new organisation involving all doctors? This question has exercised the committee for the last few meetings.

A major challenge is getting our message across – we are a small organisation with a clear purpose. Our strength is the clarity of our aims but we are too small to effect change on our own.

Why the NHSCA, why not a more inclusive organisation –Doctors4NHS?

The NHSCA was founded in 1976 by consultants with a strong commitment to the NHS and its founding principles (more history on the website)

- The current objectives are - Restore the NHS as a publicly funded, publicly provided and publicly accountable service
- Secure fair access to health services based on needs not wants.
- Promote professional and public involvement in evidence based planning of health care services.
- Highlight current problems and controversies faced by the NHS and suggest solutions to them.
- Help consultants to engage with policy making and management

For many years the membership grew, particularly when there was public concern for the NHS but in spite of the major threat now the NHSCA is not attracting sufficient new members of working consultants to be great force for change.

Why are we not attracting enough new members? – is it that new or working colleagues do not perceive the threat? Do they not value the NHS? Are they more concerned about their own prospects? Do they fear the consequences of political involvement?

My personal view is that most colleagues do value the NHS but feel powerless in the face of what is seen as an irresistible tide of increasing change that we have seen since the 70s; the view of most working doctors seems to be let's do what we do best and get on with caring for the sick while the politicians slog it out.

A fair point - medicine is a noble profession and politics is a messy business with low cunning and deceit all too prevalent – better to keep out of the mess. For those of us who have put our toes in to test the troubled waters of political engagement it can get worse - I could spend a morning seeing 20 to 30 patients and make a real difference or I could go to a meeting and come away with nothing of immediate benefit; worse still, I could have cancelled the clinic inconveniencing patients or left it to my colleagues causing discontinuity in patient care and understandable resentment from colleagues seeing the committee man having time off at their expense. So, better to keep your head down and stick with the day job. This is true to a point because the service needs to improve and who best knows what we need to do and what we could do? Those of us working

in the system and those using the services, everyone involved, will know areas for improvement and the challenge is how to empower them to get involved to make the necessary changes.

How can we best bring about the changes we seek ? Do we have influence? We may have some – we have sapiential authority i.e. we are experts in our field but how much is that worth today? The days of deference are gone and we have become foot soldiers, rather than generals in the war to protect services.

As a small body we cannot wield much power, we can combine our efforts with the many other groups seeking to save the NHS or we could aim to be a bigger group i.e. not a consultants organisation but one that represents all doctors. This has been discussed at committee meetings this year and will be an item at the AGM.

Do we want to be an organisation for all doctors ?

Doctors4NHS is a snappy and modern title and it could be our future. There are GPs who have spoken but they have many problems with their contractural arrangements and very few know about the NHSCA. To be successful with a new organisation we will need to have good publicity and use all the media from newsprint to twitter.

Some GPs have spoken out and recently Azeem Majeed blogged that GPs should give up their independent contractor status and become NHS employees and this was reproduced in the print version as "Blog of the week" – at bmi.com/blogs.

Clare Gerada was enthusiastic about the proposed change saying it will give all doctors something to stand behind. GPs are feeling beleaguered and betrayed having been put in the frontline by Lansley's reforms and now being denigrated by government. There is much to be gained by all doctors working together to re-assert why we went into medicine – to do good for our patients rather than to act as the rationers of limited resources.

Since we this was mentioned in the previous edition we have received 14 replies, generally supporting the change. The arrangements for the suggested change will be finalised in June and will probably involve a voting slip with the AGM invitations in August and a vote at the AGM with a postal vote option.

Shared objectives

One organisation with similar aims is the Socialist Health Association www.sochealth.co.uk, which began life as the Socialist Medical Association and campaigned for the formation of NHS.

Their statement of purpose is "The Socialist Health Association is a campaigning membership organisation. We promote health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action."

They have benefitted from a wider membership with politically astute nurses, academics and other health professionals. They also have access to Labour's policy making machinery as they are affiliates of the party and I am grateful to Martin Rathfelder, their director for his article on that subject. In June four of our committee will meet with their director and chair with a view to discussing how we can best influence health policy.

E. W.

Political Activity

We have requested meetings with key members of political parties in order to stress to them the need for radical change in the way the NHS is currently being driven and to suggest ways in which this could be done.

For Labour, we now have a meeting scheduled with Shadow Health Secretary Andy Burnham for July 8th.

For the Liberal Democrats, we have had a response from Norman Lamb indicating willingness to meet and we are currently awaiting date(s).

Following the local election results we hope both will be in receptive mood.

We have in the past met Conservative politicians but we did not feel at this time, with the Health and Social Care Act freshly on the statute book, that there was any possibility of meeting of minds.

Peter Fisher

S/EU Transatlantic Trade and Investment Partnership (TTIP)

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This UK campaign is part of an international campaign to oppose the TTIP
Join the elist: StopTTIP-request@lists.riseup.net

1. Point form information
2. Expanded information
3. Resources

1. Point form information

a) The US/EU Trade and Investment partnership (TTIP), called Transatlantic Free Trade Agreement (TAFTA) in the US, is a bilateral 'trade' agreement between the US and the EU. (The EU shifted from a primarily multilateral WTO focus to a bilateral agreement focus in 2005).The TTIP goes much further than any previous EU 'trade' agreement in deregulating, in establishing the rights of transnational corporations and in undermining the ability of governments to control corporations. It is set to completely change our society, and is already in process, as with the NHS.

b) In parallel to the transatlantic TTIP, there is a Trans Pacific Partnership agreement (TPP), with similar aims and inclusions to the TTIP. The US is party to both.

c) 'Trade' and 'international trade agreements' are different. While most people would consider trade to be good thing, international trade agreements give rights to transnational corporations while reducing states' rights to regulate them, thus reducing democracy.

d) All free trade agreements include goods and services and intellectual property rights but the additional elements of the TTIP that are the main part of the agreement are much more far-reaching. These are regulatory harmonisation, investor state dispute settlement and the intention to establish global rules via these trade agreements.

e) 'Regulatory harmonisation' means 'harmonising' regulation between the EU and US downwards to the most lax form, across all areas, to suit transnational corporations. This will mean the degrading of regulation on health and safety, food, environment, labour standards, privacy and much more, including financial services regulation. The NHS is now already 'harmonised' with the US corporate-access public health model.

f) TTIP and TPP will also include Investor State Dispute Settlement (ISDS), allowing transnational corporations to sue governments directly for the loss of any future profits resulting from any government action, at any level, such as new legislation. Where ISDS is already included in 'trade' deals, it is shown to lead either to big pay-outs from governments to transnational corporations or to deter governments from legislating – the 'chill' effect.

g) TTIP and the TPP are intended to set global 'trade' rules which will eventually become the norms for the multilateral WTO, but formulated outside of a structure that allows other countries to jointly resist the corporate-dominated agenda.

h) As with all bilateral 'trade' agreements, TTIP and TPP negotiations and agreement texts are secret until the negotiations are completed.

i) Trade agreements are effectively permanent.

j) Although international 'trade' agreements are negotiated government-to-government (by the Trade Commission for EU member states), they are promoted and driven by transnational corporations, which benefit from states being bound by international trade law.

k) The main corporations are the same transnational financial service corporations that caused the global financial crisis. The City of London is the world's main international financial services centre, with transnational banks and insurance corporations, the Big 4 accountancy firms and other financial service firms based there. The City of London has a major influence on the EU's international 'trade' agreements.

l) As part of the TTIP, a framework for the ongoing 'harmonisation' of all future regulation is being put in place with the setting up of a Regulatory Co-operation Council. This non-elected Council will be

able to override national and EU legislating.

m) 'Public procurement', that is all government spending, is a major target in the international trade agenda.

n) The TTIP is being rushed through, with the aim of completion by the end of 2014.

o) TTIP will include provision for the movement of temporary workers across borders. This will inevitably mean cheap labour, and the undermining of working conditions and labour rights, especially in a context of degraded regulation.

p) The Trade Commission has set up a particular communications ('spin') unit to manage public opinion on the TTIP.

q) Once TTIP negotiations are completed, the European Parliament will only have the right to say yes or no, to the deal, with no amending. It will then, as with all EU 'trade' agreements, be provisionally implemented before it comes to member state parliaments for ratification.

r) In the US, the government is seeking 'Fast Track' provision or Trade Promotion Authority (TPA) from the Congress. If granted, US representatives will similarly only be allowed to pass the agreement or not, without amendment.

s) The WTO is being used in an ongoing way to further the deregulation agenda.

How to formulate Health Policy the Labour Party process

The Labour Party has opened the consultation process which leads up to the production of the manifesto for the General Election with 8 policy documents. Most of them are a bit bland. The best way to think of them is as a framework on which more interesting ideas can be pinned. Now is the time to produce ideas which need to be short and to the point, because they have to be turned into amendments to these documents.

The process from here on is:

- Each Constituency Labour Party and affiliated organisation may submit up to ten amendments in total, and up to four on any one paper. The deadline is 13th June. There could be more than 6000 amendments in play.

- National Policy Forum representatives will meet on a regional or sectional basis to discuss which amendments to bring forward for discussion at the final NPF meeting. Each NPF rep may bring forward 6 amendments in total, and up to three on any one paper. There are about 200 NPF members, so there could be 1200 amendments brought forward.

- The NPF meets to debate the papers and amendments brought forward from 27th to 29th June in Milton Keynes.

- Following debate and a vote at Annual Conference in September the document agreed will be adopted as Labour's policy programme in the Spring.

The Socialist Health Association can submit up to 10 amendments, but to get anywhere with them we will need support from other NPF members.

We are not just interested in the document about health. That is, as you might expect, mostly about the NHS, illness, care and treatment. We are also interested in health, and in a healthy society. So we may want to say things about economic inequality, taxation, local democracy and participation, community development, travel and exercise, food, drugs and all the other things which keep people healthy or make them ill.

You will already find on the Socialist Health Association website http://www.sochealth.co.uk/category/labour/yourbrit/ a lot of proposals, some formulated as amendments, and some just ideas. Some are ours, and some are from people like the Labour Party Disabled Members Group who we work with. Please add more ideas, and comment on those that are there already, so that when our Central Council comes to make decisions at its meeting on 7th June we have a good idea what our members think. I will add more as they come in, and do my best to organise them.

The AGM and Conference 2014

will be held in London
on Saturday 4th October at **Hinde Street Methodist Church Hall, Marylebone**

The Conference programme is currently being drawn up and full details with application forms will be sent to all members in August.

It will be a particularly important AGM due to the proposed changes to the membership and title covered elsewhere in this edition. Also, of course, it will be the last one before the General Election.

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