DFNHS

EDITORIAL March 2015

A name change; now for the game-change

Readers will have noticed from the heading that we are now officially DFNHS (Doctors for the NHS).

For some time we had felt that we needed to work jointly with the many colleagues in General Practice who share our concerns about the health policies of successive governments and the NHSCA Executive Committee discussed this on a number of occasions. It was decided towards the end of last year that the best way of achieving this would be to expand our own organisation to include them. At the same time we have taken the opportunity to include all doctors in training and the new title reflects this wider membership. As before, we welcome also our colleagues in Academic and Public Health Medicine and those who have retired.

With this enhanced membership, covering all sections of our profession, we expect to be able to bring greater pressure on those who make policy, both directly and through the force of public opinion.

One important point to make is that although the title has changed the ethos remains the same, as do our objectives, which can be best summarised as returning the NHS to its original principles of being publicly funded, publicly delivered and publicly accountable, confirming it as a vital public service, not a business subject to the whims of the market.

Peter Fisher
President

Since becoming a member of the NHSCA I have been impressed by the vision of our members and the scope of our articles and presentations at our meetings, which has gone far beyond the concerns of hospital medicine. Whilst consultants have enjoyed sapiential authority we cannot bring sufficient influence to protect the NHS on our own.

If it were ever in doubt that the massive burden of illness originates outside the hospital and that consultants see the results of the social determinants of disease then Prof Marmot's work has made it clear that much illness represents failed prevention.

Improving the nation's health will require the concerted efforts of all health professionals as well as the contribution to wellbeing made by all aspects of the Welfare State - presented so well in Martin Mckee's Paul Noone memorial lecture at last year's AGM.

That is the great strength of the NHS, put succinctly by one of the Darlington mums in last year's Jarrow march: 'The NHS represents humanity and co-operation'. It was good to be reminded of this simple truth.

Throughout the world healthcare systems are appreciating the benefits of integration – how perverse that the potentially most fully integrated system in the world is in danger of disintegration.

In my editorial of the June 2014 I said: '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'.

We have made the change and can now co-ordinate campaigning with colleagues from all branches of the profession.

Eric Watts
Co Chair

A new name, a new future for the NHS

There has never been a more critical time for all doctors to stand together and fight for the NHS. There's no doubt it is in mortal danger and its future will be decided at May's General Election. So this is exactly the right time for a new organization. *Doctors for the NHS*, launched in March in succession to the *NHS Consultants Association* to encourage doctors from the whole profession to pool our resources.

But isn't this the role of the BMA? You might think so but I believe the previous leadership's policy of 'critical engagement' in the Health and Social Care Bill was a fundamental error, second only in its potential consequences to the BMA's opposition (despite the BMA trying to re-write history) to the founding of the NHS.

I believe that this recent failure was so great that without further action, the BMA, which had the power to halt a seismic undemocratic change, could be accused, along with some of the Royal Colleges, of being responsible for colluding with the end of the NHS.

Our alliances must therefore be forged with great caution and only with organisations that will not be compromised on principles. Other worthy non-politically-aligned organisations include *Keep our NHS Public* and the *NHS Support Federation*, which are open to all. *Doctors for the NHS* is the only group exclusively for doctors.

The *National Health Action Party* was also formed in response to this Coalition Government's assault on the NHS. I leapt at the chance to join a group of committed, like-minded professionals who felt passionate about the NHS.

Now, with more than a dozen others, I am standing as a NHA Party candidate on May 7th.

However, I found it difficult to understand the contrast between my friends' and colleagues' equally strong feelings and their inability or unwillingness – or both – to act in support of their principles. Both inside and outside the profession I was repeatedly told how disgraceful it was that the Coalition could privatize without mandate one of the institutions that defines what it is to be British; but words weren't translated into actions, and words were almost never expressed publicly. A few of us charged into battle, looked over our shoulders and realised there was no-one following. Strong leadership from those individuals and organisations with influence and the means failed us.

At the anniversary of the start of World War One, we all recall the poster slogan: 'What did you do in the Great War, Daddy ?' If you are genuinely passionate about the NHS and want to be able to tell your grandchildren what you did to save it, you'd better get cracking.

Join *Doctors for the NHS* or, better still, ALL the groups I've mentioned.

Paul Hobday

Elephants not in rooms:
The aging population - and the disgrace of mortality in our young people

Please read VERY carefully:

> The UK has gone from being one of the most aged countries in Europe in the mid-1980s to one of middle ranking among the EU-27 countries. It is projected to be one of the least aged countries in the EU-27 by 2035.
>
> *Office of National Statistics, 2012*

The explosion (usually illiterately referred to as 'exponential') of elderly people in this country threatens, as we are warned pretty well every day, to 'overwhelm' the NHS, and has allowed governments for the past 30 years to do pretty well anything they like because they have convinced us all of the unaffordable numbers of elderly people to house, and provide with hospitals and decent pensions **(Figure 1).**

I don't see exponential here:

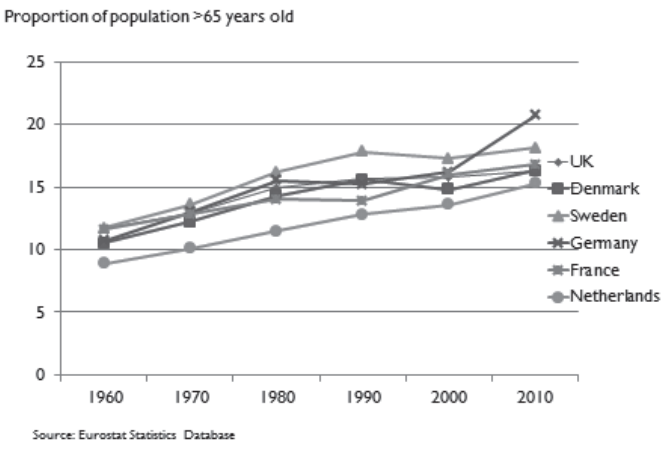
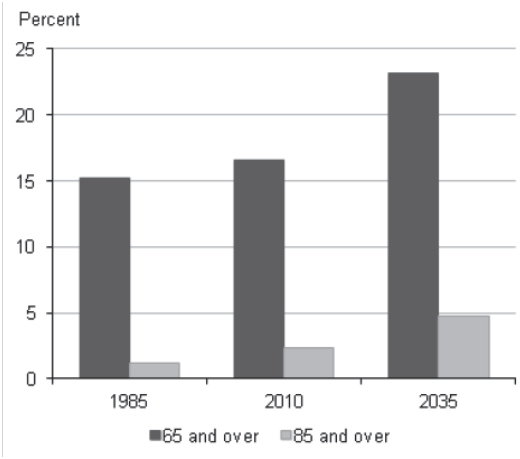


Figure 1: Proportion of the population aged over 65 over the past 50 years in countries comparable to the UK.

Admittedly there has been more than a linear increase in the number of over-85s (1% in 1985, 2% in 2010, and projected 5% in 2035) – but it is very likely that the same trend is occurring in all comparable European countries, and it sounds like they are coping quite well. Could the number of doctors, nurses, oncologists, CT scanners, and hospitals beds in the UK have something to do with our headless chicken panic?



Source: Office for National Statistics

Figure 2: Proportion of the UK population 65 and 85 and over

Failing our young people

At the other end of life, an important, and so far as I recall almost ignored, Lancet study from the WHO Mortality Database (September 2014) reported that in 1970, UK total mortality in the under-25s was in the lowest quartile, with infant mortality near to the median of the European 15+ (that is EU member states plus Australia, Canada and Norway).

By 2008, however, total mortality in the 0-4 year age group was in the worst EU15+ quartile; mortality from non-communicable diseases in all young people was in the worst quartile. Annual excess deaths compared with the median were:

Infants	1035
Ages 1-9	134
10-24	280 (Non-communicable diseases)

I'd consider this a more worrying set of statistics than failure to meet 4 hr standards in A&E. But which dominates the headlines and the political argy-bargy? The elephant in the room here is likely to be progressing inequality. As the authors conclude:

The UK needs to identify and address amenable social determinants and health system factors that lead to poor health outcomes for infants and [young people] with chronic disorders.

David Levy

Don't believe the false reassurances about NHS privatisation

The Kings Fund has at last criticised the government's NHS 'reforms' as costly and 'damaging' to the NHS. Their intervention is welcome - though begs the question, what is the point of a 'think tank' that is 4 years too late in telling us what everyone else knew all along.

But there is a bigger problem with the Kings Fund report. While noting that the reforms have resulted in greater marketization of the NHS they conclude that 'claims of mass privatisation' were exaggerated. In this they are wrong.

Accusations of privatising the NHS are highly toxic to any government and the Coalition leaders have stoutly denied it. But their argument - that there is no privatisation because the service is still free at the point of need - is disingenuous. You can have privatisation of a service that still delivers services free at the point of need - or indeed, of a service that has never been free (such as British Rail). As Dr Clive Peedell's important article in the BMJshows, the Health and Social Care Act meets the World Health Organisation definition of privatisation. According to the WHO definition, privatisation involves merely the increased outsourcing and/or sale of public services to the private sector.

The Health and Social Care Act contained all the levers to enforce the market in the English NHS and when section 75 was passed (requiring compulsory competition) the final piece of the jigsaw was in place. Privatisation has advanced in primary and secondary care and in community services. In primary care private companies like Virgin are taking over GP practices and compulsory competition has led to the outsourcing of entire services such as musculoskeletal work and dermatology. Capita - along with United Health offshoot Optum - have just been awarded a massive £5billion contract for administrative support and even the commissioning decisions themselves - theprivatisation of privatisation. Contrary to the claims made by the Kings Fund the privatisation of areas once viewed as unimaginable, is now not only possible but under way.

The collapse of the privatisation flagship Hinchingbrooke hospital has sounded a warning to the private sector. But even as Circle walks away from the challenge of running an entire acute hospital, more insidious changes are taking place in our cash-strapped hospitals. Some are taking advantage of the provisions in the Health & Social Care Act that that allow them to increase the number of private patients. Internationally reputed NHS hospitals such as the Royal Brompton and UCH now make up to 39% of their income from private patients. Others are encouraging 'self-funding' patients who are prepared to pay for care but at the NHS tariff (cheaper than the private sector), which means they can queue jump ahead of those without the means to pay. Hospitals are being encouraged to become so-called 'mutuals', cast adrift from the NHS andvulnerable to take over by private capital. The boundaries between public and private are increasingly blurred, which suits those who want the NHS to move towards top up payments and an insurance based system.

Community NHS services has been particularly quick to be privatised. Large contracts covering everything from mental and sexual health to physiotherapyand podiatry have been awarded to names not previously associated with clinical services including Virgin and Serco, from Cornwall to Surrey. Other particular targets have been patient transport, diagnostic and lab tests, and out of hours care - though often under the NHS logo.

Those who argue that the overall percentage of NHS care delivered by the private sector is still small miss the point. The private sector is not interested in delivering all or indeed most of the NHS. They are interested in profit which is hard to come by in the acute sector (as Hinchingbrooke has showed). They tend to avoid emergency care and anything that involves complex patients and have focussed their efforts mainly on elective (planned) care, community NHS services and mental health. It is thus misleading to look at their share of the total market and more accurate to quote their share in the areas in which they are interested. For example John Lister of Health Emergency has estimated that the private sector is now delivering about 18% of elective surgery.

And by cherry picking what they hope will be profitable, the private sector undermines local NHS services, which will always be left with responsibility for core services. In Sussex local health bosses in the Clinical Commissioning Group (CCG) have had to reconsider its decision to outsource musculo-skeletal services to Bupa after the local hospitals said they could no longer guarantee emergency trauma services in their A&E departments. Nottingham has lost its adult acute dermatology services after a

CCG awarded the contract for the planned (and thus profitable) bits to Circle, the same firm who made such a mess of Hinchingbrooke.

Some of the private companies who have tried to make a profit from the NHS have already given up, an acknowledgement that the NHS is run in a very cost effective way. Instead they - alongside Capita and Optum - are moving into administering the NHS market itself, which is estimated to cost at least £5-10billion a year to run. The 'market' grew under Labour as a way of promoting private involvement, and has been pursued with gusto by the coalition. Serco for example has already declared its intention to back away from clinical work, seeing more money in administering the unwanted market than caring for patients.

The amount of money diverted to the private sector may not be the majority of NHS funds at this stage, even in the areas in which it wishes to expand, but the direction of travel is clear. A third of contracts tendered out since the Health and Social Care Act have already gone to the private sector. Large private companies are well placed to win these public contracts. They have experience in tendering, bevvies of lawyers and deep pockets for loss leaders (the government promised that competition would not be based on price but that turned out to be another lie). Having won the contract by undercutting local NHS organisations the multinational is then left to deliver clinical care of which it may have no previous experience, with inevitable consequences for patients. As Margaret Hodge MP, chair of the Public Accounts Committee, remarked of Serco – 'it's pointless being good at getting contracts and then hopeless at delivering the services'

The evidence is that a publicly funded, publicly provided and publicly accountable NHS provides the best care for patients and the best value for money, so the question remains – why are politicians pushing it down the road to privatisation? The public didn't vote for it and polls repeatedly show that we don't want it. Privatisation is an ideological luxury which wastes money and destabilises the NHS and has no purpose other than diverting money to shareholders and enriching some MPs, peers and political donors. But whatever their motivation the evidence is unequivocal - the coalition's legislation has put all the levers in place to privatise the service and it is going ahead. The Kings Fund should reconsider their verdict, and not leave it another 4 years to stumble across the truth

Jacky Davis

First published on the website Open Democracy/Our NHS https://www.opendemocracy.net/ournhs

Jacky is co author, with John Lister and David Wrigley, of a new book NHS FOR SALE obtainable from Merlin

http://www.merlinpress.co.uk/acatalog/NHS-FOR-SALE.html The profits go to KONP

GPs now in the organisation

"No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means" Nye Bevan

I was a GP in Sutton Valence near Maidstone for 30 years until 2013. Contributing to my decision to retire was the commercialisation of our NHS and the need I have to fight the coalition's undemocratic, clandestine privatisation, driven by my anger that the public are being kept in the dark.

With all the main political parties promoting a market in healthcare, the electorate who believe in Nye Bevan's founding principles are disenfranchised. The National Health Action Party is fighting for those principles and in standing for election, I hope to be able to alert the public to the terminal threat to our NHS.

In my own locality the effects of commercialisation and corporate mentality have been depressing. I saw deaths from C difficile when past management tried to run down Maidstone Hospital to pay for the new hospital at Tunbridge Wells. We lost the fight for our maternity unit despite 95% of GPs (and the public) being opposed to its closure - wholly inconsistent with the government's claim to be giving power to GPs and patients. We've endured a South African firm running Maidstone's new Treatment Centre, which was a financial disaster from which they just walked away, audiology outsourcing where the company disappeared overnight, and a psychology privatization one of whose therapeutic mainstays was to telephone patients and advise them to buy a book from Waterstones. This, presumably, is what the government means by its much-vaunted emphasis on enterprise and innovation. There are many more examples from all over England and this will be the future unless this damaging and dangerous policy is changed and those who are so vigorously promoting it, often for personal gain, are removed from driving our NHS to the cliff edge and over.

Paul Hobday

The Commonwealth Fund report: is the news really that good?

The Commonwealth Fund report (2014) on the healthcare systems of 11 wealthy countries provided a splash of good news headlines about the NHS, which emerged from their survey as the best of the lot; the USA the worst. Everyone signed up in unison to this hurrah-boo conclusion, and we must treat the report with considerable respect; the Commonwealth Fund is a private, philanthropically-funded American think-tank that now focuses on equity of access to healthcare, and is impeccably staffed with high-level academics. Of its recent board members, only Simon Stevens, then of the UnitedHealth Group, would raise a collective eyebrow among DFNHS members (see Anna Athow's article below).

The matrix from which the headlines emerged is shown at the foot of this page. It's worth examining. The matrix is not an established tool; the sources of information on which it is based include two of their own, Commonwealth Fund, reports; and it is heavily skewed towards 'soft' outcomes, such as 'patient-centred care', 'access' and 'equity', all of which we applaud and recognise as great and worthy characteristics of the NHS, but which are very difficult to quantify and are apt to mislead (for example, given Norway's near-top position in nearly every one of the OECD objective health outcomes, it's not plausible to relegate it to bottom position for 'Patient-Centred Care', and 'effective', 'safe' and 'coordinated' care). But take a look at the bottom line. We rank 10th out of 11 for 'Healthy lives' (still fortunately just – just – above the USA), which is the most important characteristic of a healthcare system; most of us would willingly concede a couple of places in the league table for some of the other characteristics studied if we could ascend the Healthy Lives ranking. The terrible hazards of league tables, star ratings and all the other favoured methods of control and command economies in thrall to pseudo-quantification should be obvious. As the proponents of 'big data' never tire of telling us, we have unprecedented access to information and considered opinion. That means we must read reports and not uncritically accept, gush and re-Tweet breathless headlines. Even when they apparently support our cause and aims, the case can often be made more powerfully if the data behind the headlines are properly considered.

David Levy

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2013; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

Five year forward view
a plan for NHS destruction

The NHS five year forward view was presented by Simon Stevens, the new Chief Executive of NHS England (NHSE) in October 2014. It is a 39 page propaganda document, written in code to disguise a blue print for ending the NHS as a publicly provided service in 5 years. The main proposals are that *"new care models"* and a *"modern workforce"* must replace *"out dated models of delivery"*. The stated aim of these changes is to reduce patient demand, and to *"unleash system efficiencies"* so as to save £30 bn a year by 2020, and enable *"productive investment"*.

Translated, this means that clinical care is to be packaged into vehicles attractive to take-over by multinational corporations. Behind the appearance of wanting to make the NHS sustainable, it hides a fast track 'journey' to the American model.

This plan is to be implemented by the commissioners brought in by the H&SC Act 2012: NHSE, Monitor, Health Education England (HEE), Trust Development Authority and the Care Quality Commission supervising the Clinical Commissioning Groups. Draconian methods will ensure *"care models change, rapidly and at scale"*, including payment mechanisms, and regulation. It comprises the biggest ever top down national structural reorganisation of health services in England.

The main five new care models are:

Multispecialty Community Providers (MCPs). These out-of-hospital providers will provide primary, secondary, mental health and social care. GPs will federate into networks and become salaried. Other personnel include 'new roles', nurses, carers, physios, psychologists, podiatrists, social workers and consultants. The leadership will be by various staff and 'others'. Work includes the majority of hospital outpatients, and ambulatory care such as chemotherapy and dialysis. The MCP may take over a local community hospital or even a District General hospital (DGH) as it matures and could refer patients into beds run by a *"new cadre of resident hospitalists"*.

"In time" the MCP could *"take on delegated responsibility for managing the health service budget for their registered patients"*, or even a combined health and social care budget.

Primary and Acute Care Services (PACs) are similar, but formed by vertical integration of a hospital taking over GP care. They are modelled on Accountable Care Organisations (ACOs) in the US and Spain. [1,2]

COMMENT
MCPs and PACs supersede GP surgeries, and require changing the GP contract. Networks would cover thousands of registered patients.[3,4] As they take on a budget, they will commission and provide, like Health Maintenance Organisations (HMOs) in the U.S. The ACO allows prime contracting from multiple subcontractors. 'Integrated care' means integration around the contract's performance management requirements, ie to keep within budget and reduce hospital care. The ability to charge for social care which is means-tested, will transfer to healthcare, under the guise of 'integrated care'.

Urgent and Emergency care networks. These comprise strengthened triage and advice, ambulance service with paramedics trained to treat and refer, 379 urgent care centres, and out-of-hours community hubs. It mentions 185 hospital emergency departments. (There are only 141 major emergency units at present.) It wants "networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres."

COMMENT
The last sentence refers to Sir Bruce Keogh's 2013 Emergency and Urgent Care review in which only 40-70 A&E departments are to remain as major emergency centres. The rest will be minor A&E units, with ambulances dangerously ferrying sick patients between them. Around 20 DGHs have already lost their

A&E, and many more are in the pipeline. 23,000 beds have been closed in the last 4 years and Stevens is committed to continuing this trend.

Viable smaller hospitals. These could be: (i) part of hospital chains e.g. Germany; (ii) satellite sites for a specialised provider eg for cancer care; (iii) as described by the Royal College of Physicians Future Hospital Commission with new models of medical staffing; or (iv) part of MCP or PAC.

Specialised care. For cancer services, elective orthopaedics, some other services and other specialised surgery, the View advocates consolidation in *"specialised providers"*, through *"a programme of 3 year rolling reviews"*. These would develop networks *"over a geography, integrating different organisations, and services around patients, using innovations such as prime contracting and / or delegated capitated budgets."*

COMMENT
Outpatients, elective surgery, specialised surgery, and specialised services, ambulatory care, and minor injuries, i.e. all the profitable bits, are to be shifted out of DGHs and put in dumbed-down smaller hospitals and specialised providers.

Proper A&Es, paediatrics, maternity and acute surgery are being stripped out of DGHs and re-sited so far away that many patients will not access them in time.

The plan is to obliterate DGHs and drastically reduce acute hospital medical care.

The modern workforce. The *"innovative"* new care models *" ... won't become a reality unless we have a workforce with the right numbers skills values and behaviours to deliver it."* New measures are to be brought in to help employers to *" increase productivity and reduce waste of skills and money". "We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries."*
" … NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign,..etc."
"HEE will … identify the education and training needs of our current workforce, equipping them with the skills and flexibilities deliver the new models of care, including the development of transitional roles"… "This work will be taken forward through the HEEs leadership of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come."

24 hour services and local pay are to be introduced.

Chapter 2 demands a dramatic increase in the use of volunteers and voluntary organisations within the 'new care models', and patients taking responsibility for their own care with the use of technology.

COMMENT
This means a frontal attack on health unions to abolish national terms and conditions and bring in a vastly reduced, cheap and compliant workforce, so as to make the ' new care models attractive for incoming private companies. The degradation of training is vandalism designed to make these changes irreversible.

IN CONCLUSION.
This article can only touch on some points in the View, but if the reader understands that our general practice, DGHs and organisation of tertiary care are being dismantled in order to open the way for private health corporations to run American-style HMOs, hospital chains and prime providers, based on a denial of hospital care for millions of patients at the expense of staff, they will have got the gist of the five year forward view.

Instead of welcoming it, as the three main political parties have done, we should launch a major offensive to expose the View as a pack of lies in its spin, and a very dangerous plan in its substance. Trade unions and other organisations must be alerted and mobilised. Only the removal of this government and its replacement by a socialist one can save the NHS as a publicly provided service.

Anna Athow

References are available from Anna Athow (annaathow@btinternet.com).
These are her own views.

Elephants in rooms

Cancer and our not-very-many oncologists

Fifteen years on from the NSF cancer strategy, why are UK cancer outcomes persistently so poor in comparison with other comparable health systems?

Nobody dares go anywhere near this. All governments have avoided it like the plague for obvious reasons, and the profession tries to ignore it – despite the convincing and consistent evidence – because we masochistically believe that it reflects on us as individual practitioners. The literature is full of frantic rationalisation: socio-economic status, late presentations, non-compliance with two- week waits, countless others. None stands up to proper scrutiny: for example, a sound analysis of waiting times in early breast cancer (Redaniel et al. Br J Cancer 2013) found there was no impact on outcomes up to a referral time of 2 months (62 days). The evidence-based outcome should be to scrap the hundreds of people the NHS employs to shoe-horn cancer patients into two-week waits – and to use the money to fund medical, surgical and nursing specialists, radiologists, oncologists – people who really make the difference in prognosis.

Oncologist numbers across Europe

In 2008, the best ratio of oncologists to cases of cancer across Europe was 1:113 in Hungary, and the worst in the UK at 1:1067 – a 10-fold difference. The growth of oncologists in the UK is, admittedly, planned to be the most rapid in Europe, but as Table 1 below shows, even using these projections – and we all know what happens to them – in 2020 the UK will still have by far the lowest number of oncologists in Europe, and because everyone else is training more oncologists as well, the difference in case-load between Hungary and the UK will still be 7-fold.

We claim to be evidence-based practitioners, yet in the face of proper peer-reviewed evidence published in high-grade journals, we still persist in battling with politicians on essentially meaningless evidence and on their feeble populist agendas. Have the British Cancer societies demanded an explanation (or do we just accept that medical oncology isn't an important specialty?), and a guarantee that the number of oncologists will be the European mean by 2020 – preferably way before, as clearly thousands of people are dying prematurely as a result?

We can all agree with Clive Peedell, though, that outsourcing cancer care and end-of-life care, as proposed in Staffordshire and Stoke-on-Trent, to the tune of £1.2 bn is – null hypothesis – rather unlikely to change cancer outcomes in that part of the UK; and of course there is a real risk that disruption of our highly efficient cancer networks may act in the opposite direction.

Country	**Ratio cancer cases to Medical Oncologists**		
	2008	**2015**	**2020**
Austria	125	94	77
Belgium	292	308	304
Bulgaria	458	341	284
Finland	159	139	123
France	539	458	416
Germany	279	182	146
Hungary	113	88	79
Italy	184	137	114
The Netherlands	364	270	229
Portugal	209	184	175
Sweden	136	117	108
UK	1067	697	569

Source: de Azambujal E, Ameye L, Paesmans M. Ann Oncol 2014

David Levy

Reviews

Capital in the Twenty First Century.

Thomas Picketty. Harvard University Press. 2014. 685 pages. £29.95.

Thomas Picketty, now aged 43, is a professor at the Paris School of Economics. His family origins are relatively humble; both parents held left-wing views. When he was 22, Picketty's PhD on wealth distribution won a French award for the best economic thesis of the year.

Capital in the Twenty-First Century has been hugely influential and became the greatest ever sales success of Harvard University Press. By January 2015 it had sold 1.5 million copies in five languages. The economist and Nobel prize winner Paul Krugman declared it a landmark. Its considerable length can be summarised by three symbols:

$$r > g$$

where r is the rate of return on capital and g is the rate of economic growth. Thus those who have large capital assets will accrue disproportionately more wealth from those assets than employees will ever earn from their rise in income resulting from a country's economic growth. He defines capital as the sum total of non-human assets that can be owned or exchanged on some market. His thesis is based on extensive historical and comparative data (available on the internet) covering three centuries and more than 20 countries.

Picketty also gives simple equations constituting the First and Second Fundamental Laws of Capitalism, but these hardly feature in the book. It's r>g that counts. Each year Bill Gates's capital grows more than Rupert Murdoch's whose capital grows more than your run-of-the-mill billionaire. Gates's capital grew from $4 billion to $50 billion between 1990 and 2010 which is an increase of 10 to 11% per annum allowing for inflation. Liliane Bettencourt who inherited the cosmetics form L'Oreal from her father and has never worked a day in her life had her fortune increase from $2 billion to $25 billion. The assets of the richest 0.001% proportion of a country's population grow more than those of the next 0.01% ... more than the next 0.1% … more than the next 1% ... more than the next 10% ... more than the rest of the population. Picketty shows this exhaustively in different countries and in different centuries. The exception is the period during and between the two world wars and reasons are given for this. In many European countries the richest 10% own around 60% of national wealth and the poorest 50% only 4%. This concentration of wealth causes social and economic instability and is economically dysfunctional. With respect to income, countries vary. In Scandinavia the top 10% earn about 20 per cent of labour income whereas in the USA it is 45%. In different countries and time periods capital has accrued on average at around 4-5% per annum whereas the rate of economic growth (and wages) has been around 1- 2%. If the difference r minus g exceeds a certain threshold, there is no equilibrium distribution and inequality of wealth will increase without limit.

The solution is a progressive annual tax on capital whereas in the past the focus has been on income. The mansion tax is an example of a tax on capital and the Guardian reports this book as being a favourite in the Miliband inner circle A progressive annual tax on capital would contain the unlimited growth of global inequality of wealth which is currently increasing at a rate which cannot be sustained. With globalisation the solution requires a high level of international cooperation and regional political integration.

Should you read this book? You must want to do so! Picketty wrote that he wanted to make the book accessible to people without any special technical training and that the book together with the technical appendix should satisfy the demands of specialists in the field. For the layman the first third of the book contain some interesting basic economic facts. The middle third is quite turgid with innumerable graphs illustrating r>g and other points. The last third contains convincing political argument and is easiest to read.

Morris Bernadt

We welcome reviews, and also suggestions for books of general interest to DFNHS members.

Recommended reads:

Two books by the brave and almost last-standing academic anti-neoliberal American Philip Mirowski:

- **Never Let a Serious Crisis go to Waste: how neoliberalism survived the financial meltdown.** Originally published 2013, paperback version (Verso) 2014.

A voluble and heart-felt critique, dense in places, but occasionally laugh-out-loud, of the consolidation of neoliberal economics after the financial meltdown of 2007-8. Despite being an academic economist himself, Mirowski is almost completely scathing of their trade, and has no difficulty mentioning names, nearly always 'Nobel Prize' winners.

- **Science-Mart: Privatizing American Science.** Harvard University Press, 2011

Mirowski turns his formidable analytical talents to a comprehensive hatchet-job on the state of science in the USA. There is a lot on biomedical sciences, and a brilliant survey of the biotech industry, which, as others have pointed out, has produced almost no valuable medicines, but which is a massive money-spinner for investors and the intellectual property industries, and which has been taken on uncritically by American academic departments. I found the section on the Human Genome Project eye-opening; but most depressing of all is Mirowki's quantitative analysis of the degradation of the quality of American science in the era of Research Assessment Exercises and the unstoppable drive to publish anything, anywhere. Have you recently received multiple emails inviting you to sit on the Editorial Board of a plausible e-journal in your specialty that almost certainly charges 4-figure 'access' fees?

- **Colin Crouch. Making Capitalism fit for Society**. Polity, 2013

Crouch, recently emeritus professor of Governance and Public Management at Warwick University, writes a deeply thoughtful and highly readable book on the possibility that an assertive form of Social Democracy, if embraced by sufficient numbers, stands some chance of challenging the neoliberal hegemony. This is a fine sequel to his earlier book, The Strange Non-Death of Neoliberalism, 2011.

- **John Lister. Health Politics Reform: Global Health versus Private Profit**. Libri, 2013.

A masterpiece of analysis that places the UK NHS 'reforms' in the context of global health that is marching – with notably few exceptions – to the beat of neoclassical economics that has progressively ensnared the World Health Organisation, The International Monetary Fund and World Bank in its 'thought collective' (to use Mirowski's term). Lister's command of the historical narrative is unparalleled, and his account of the medical philanthropy 'industry' (especially the Gates Foundation) is compelling. The restrained writing adds substantially to its poignancy and authority. I hereby prescribe reading 3 pages a day of this wonderful and massively referenced book, and there will be an MCQ test in the next Newsletter.

Finally a film:
Sell-Off: a documentary by Peter Bach (2014). A superb independently made documentary. This systematic film contains in-depth interviews with, among others, Allyson Pollock, Clive Peedell and Jacky Davies, and cameo appearances by many others. None of the arguments will be other than fully familiar to members, but it is a powerfully made and systematically thought-out programme running for nearly an hour. It's available in full on YouTube.

David Levy

The Foundation Hospital Hoax

In 2003 Tony Blair's Thatcherite Government proposed changing the way NHS hospitals were run by shifting the responsibility of providing healthcare from Whitehall to the local community. In this way bureaucracy and red tape would be reduced. To achieve this, Hospital Trusts were persuaded to become Foundation Hospital Trusts (FHT). The only guarantees needed were to:

- Maintain financial viability (i.e. make an annual surplus).
- Deliver risk-free and compassionate nationally approved standards of healthcare.
- Maintain an elected Board of Governors from the local community.

The menu looked very enticing for those who saw competition between hospitals as a means of improving efficiency and thereby reducing costs. You might have expected the Tories to have jumped at the chance of limiting expenditure on healthcare, but initially they voted against these changes. It was only after a number of minor amendments had been made that the bill was passed, although it did allow the NHS in Scotland to remain unchanged. The canny Scots saw right through the murky waters circulating around the Blair administration.

Naturally this new initiative required policing. A new quango, Monitor, was set up to oversee the financial affairs of FHTs – but not the delivery of services. It was only after the Mid Staffs FHT was investigated because of their apparently high mortality rates that the Care Quality Commission (CQC) was set up to assess clinical performance.

The reality

However, neither Monitor nor the CQC had the remit to ensure that FHTs honoured their commitment to the local population by giving their Governors the authority to be involved in forward planning or the setting of clinical priorities. Instead the Boards of the pre-existing Hospital Trusts quickly realised that unless they defined the role of Governors more explicitly, in their submission to become a FHT, the Governors would have the potential to disrupt their bookkeeping activity. Consequently the Boards fabricated Governors' Codes of Governance and Conduct in advance of the first elections. There was nothing in the legislation to prevent the Board from taking that initiative. It meant that Governors could be bullied into accepting a submissive role or be debarred from taking up office.

It is unlikely that members of the public, submitting their names in the Governor Elections, realised this flaw in the legislation. Furthermore, unless Governors had substantial previous training and experience of working in the local hospital's clinical environment, they would have difficulty in understanding the deluge of carefully crafted reports put before them by the representatives of the Board. The Chairman chaired the Board and the Council of Governors and was therefore able to keep a tight rein on governor activity.

Keeping a grip on Governors

In Colchester, emails from the public to individual governors were routinely opened by the membership secretariat and redirected without the knowledge of the intended recipient; governor requests for information had to go via the Chairman's PA for authorisation. All Governor Council meetings were held in public with most of the agenda set by the Chairman, but members of the public were not permitted to ask questions until 2012. Eventually we succeeded in setting up private Governor Council meetings, but the Chairman insisted on chairing them.

Rocking the boat

In 2011there were only two public Governors, myself and a retired Charge Nurse who had both worked at the hospital for decades. We were

marked as a pair of wrecking balls, rather than gullible patsies to add to the already submissive Governors' Council. The Board was desperate not to expose their own collective ignorance on clinical matters, and the Chairman took it upon herself to silence dissenters.

When the Board boasted about the creation of a large number of additional nursing posts, my ex-nursing colleague pointed out that these nurses represented replacements for those who had left or who had been employed as bank nurses. The up-staged directors blinked and swallowed hard. My turn came when I had the temerity to challenge the Board's plans for a new outpatient radiotherapy facility, which I described as a 'dodgy dossier', because of its dearth of valid facts and abundance of deceptive distractions. Unfortunately my misdemeanour was too much for the Board to bear and culminated my sacking, although I did succeed in being re-elected in 2014 after foiling an attempt to disqualify me. However the pernicious Code of Governance gagging the governors remained unchallenged. An example of how our Chairman's PA controls communications, reminiscent of East Germany's Staatssicherheit, is illustrated below.

Outsourcing pathology services

The outsourcing of pathology services had been set in motion by the PCT and CHUFT without seeking advice from the pathologists or informing the public of their intentions.

Following the rumour that this denouement would deprive Colchester of any microbiology service, I was asked to seek clarification about what would happen in emergencies. The CCG advised me to ask the hospital, because emergency work did not concern them.

I emailed our Interim CEO (a previous Consultant in Public Health), but received no reply. At the next CEO/Chairman Governor Briefing, I repeated my request verbatim, but the Chairman dismissed my request as irrelevant. The CEO remained silent. It was only at the following monthly CEO/Chairman Governor Briefing that the CEO agreed to seek an answer.

Within two days I received a reply from one of our consultant microbiologists, to whom I replied and added a few criticisms of the way in which the Board operated.

Unfortunately I had not appreciated that the microbiologist's reply was part of a chain, and that instead of my reply going directly to my former colleague, it finished up in the in-box of the Chairman's PA. I immediately emailed the PA asking her to delete it, but she had already passed it on to the Company Secretary, who was in fact not part of the original email chain.

Clearly the 'system' appreciated that they had breached the 'rules' on confidentiality and decided to get access to the contents of my email by a more official but devious route. The Chairman's PA contacted my colleague asking her to copy any reply she might receive from me to the CEO.

My comments about the Chairman were seen as a breach of the Governor's Code of Conduct, and I was sacked for a second time!

The FHT legacy

In 2011 Colchester Hospital University NHS Trust (CHUFT) Board had a majority of directors who did not reside in NE Essex. The local hospitals of these directors were Chelmsford, Bury St Edmunds and Ipswich, but the Chairman claimed that this did not represent a conflict of interest in spite of obvious competition between these hospitals for patient services.

In the seven years since our hospital has been a FHT, the directors have squandered over £60m on potentially lucrative surgical and radiotherapy projects instead of addressing their unprofitable Emergency Service. In 2014 they spent a paltry £3m on a token refurbishment of an inadequate and understaffed Emergency Service that had already lost 30 Emergency beds to the new Radiotherapy Department. This was coupled with a failure to fund the continued use of 50 community beds.

Was it any surprise that in 2014 CHUFT recorded the worst A&E performance in the whole of the

UK or, that it in its role of embracing localism, it has just appointed a new Chairman who lives in Yorkshire?

Complicity of the profession

Among our doctors there were those who cashed in on the opportunity to enhance their own departments. The Pharisees looked the other way and the tiny number of Samaritans looked on in dismay. If you go to bed with a tart you are likely to get out of bed with jam on your face. If the doctors in our hospital had stood together and forgone personal or departmental gain, the Board would have collapsed and our FHT status with it.

Solution

The flirtation with FHT status must now be stopped. Reverting to previous Trust status would not require complicated legislation, although it would require a change in culture. It would be even better if we returned to the Cogwheel system of hospital management where the medical staff played a meaningful role in hospital management and the prioritization of clinical decision making. The profession has to own up to its negligence, put the patient at the centre of our universe, and reinstate the importance of clinical prioritisation over financial expediency.

Mark Aitken

Elephants in rooms

Practising doctors, hospital bed numbers and deferred operations

The numbers of doctors in the UK have been increasing rapidly and linearly since 2000, with just a hint of tail-off in the past two years. Overall, numbers have increased by about 50%. However, other countries (apart from France) are hardly flat-lining: there has been a 35% increase in the Netherlands, and about 20% in Germany over the same period, both starting from a much higher baseline. So (Figure 1) we still have the lowest number of doctors for the size of our population than any other comparable European country.

Everyone – apart from government, and seemingly most of the major political parties – knows that apart from Sweden (which outdoes us on almost every healthcare measure) the UK has the smallest hospital bed-base in Europe (Figure 2). This is bound to shrink further under the combined pressures for PFI hospitals to shed about 20% of existing bed numbers, and the new slew of hospital mergers, which is also traditionally accompanied by a bed cull. Interestingly, over the past few years there has been a sharp upward tick in the bed numbers in Sweden, suggesting it has recognised something that has so far eluded the UK. Roger Franks drew my attention to robust work by Rodney Jones. He has analysed bed occupancy in Scottish hospitals and showed that medical bed occupancy at midnight correlates linearly with the number of cancelled surgical operations for each cohort of hospital size. Jones estimates that seven cancelled operations per day in each hospital could be reinstated if bed occupancy was around 85%, a figure exceeded by 80% of Scottish hospitals. In England, this would allow surgery lazily farmed out to the private sector because of recurrent deferrals as a result of overcrowding to be repatriated, with no doubt considerable cost savings.

Once you get your surgery, though, things are not too bad by European standards. With Germany, the UK has the lowest postoperative sepsis rate, we are middling on the rate of foreign bodies retained during procedures, and though postoperative pulmonary embolism and deep vein thrombosis rates were high in 2011, no doubt the vast amounts of money spent on VTE thromboprophylaxis tick-boxes will pay off in subsequent surveys (and not harm more people from bleeding than are saved from pulmonary embolus).

David Levy

Expert patients

Introduction

In some common conditions, patients are able to manage their own chronic situation after training or guidance. This approach could and should be applied more widely. It would enable a more effective deployment of expensive and precious professional personnel and acknowledge the role and responsibility of patients in their own healthcare.

At a time of great pressure on general practices, on accident and emergency and other hospital services (and with a new and severe epidemic – obesity) it is particularly useful to examine arrangements that recognise and harness the role of the patient and/or relatives. This sometimes goes so far as to justify the label self management (though we prefer to avoid this term as it oversimplifies).

Many patients, such as people with diabetes or high blood pressure, are already actively involved in a partnership to manage their own health needs. They manage their own chronic conditions after training and with supervision and support. This approach could and should be applied more widely. It is the ethical development of patient-centred consent which starts with what the patient needs and wants from their healthcare, and goes on to offer shared or partnership management. This partnership may involve, besides the GP – but not all at the same time! – hospital specialists, nurses, health visitors, dietitians, pharmacists, psychologists, social workers and others.

Most patients have 'expertise' in respect of their own body – knowledge of their own lifestyle and symptoms, what health outcomes they want, treatment preferences, and responsibility for following the treatment. This is "equal but different expertise" (Sir Ian Kennedy, Bristol Royal Infirmary enquiry report 2001). Thousands of these patients should be recognised and developed as expert patients.

This article looks at arrangements which apply the concept of expert patients. The training involved may be given by doctors, nurses, or, for example, by dietitians – and it may be organised for small groups - and it may involve the internet. Our focus is on the training of bipolar patients as a significant potential resource. It draws on the unique perspective of author PD as a retired public health doctor with a bipolar condition.

It is crucial to recognise that there are already in community care in the NHS literally thousands and thousands of expert patients. Perhaps the best known examples are diabetic patients and patients with high blood pressure who have special expertise. Not only do diabetic expert patients assess their current state but where appropriate they go on to inject the insulin they judge to be required. Great skill and courage are needed - very serious mistakes can be lethal. In passing, it is worth noting that self prescribing by doctors for themselves is usually actively discouraged.

In the training of diabetic patients, specially trained nurses are often the main teachers as well as doctors. The teaching of patients can usefully be done in small groups. Once expertise has been gained, doctors' time (GPs' and consultants') is saved.

Bipolar affective disorder

Untrained bipolar patients typically go to see their GP whenever they experience a significant change in mood, (such as depression), and the GP then prescribes the appropriate drug. With delays in seeing a named GP under present conditions it may be 10-14 days before the patient starts taking the antidepressant or antipsychotic drug. Typically, bipolar patients not unnaturally resent such damaging delays and want to have the power to 'activate the dispensing of their prescribed drug or drugs when they need them'. This is not 'prescribing for themselves' – it is activating an agreed list compiled by the GP or the psychiatrist.

Delays in the treatment of bipolarity are wholly undesirable: clinical depression and hypomania typically worsen during the delays. Depression can lead to self neglect and suicide. Hypomania can lead to recklessness and self harm, or even harm to others.

The key to good control is agreed signs for early, firm but gradual action. For instance, an early danger sign of hypomania is lack of sleep. Typically, mania is preceded by several nights of little or no sleep at all. This severe lack of sleep should be tackled the very next night, eg by an already prescribed combination of stabiliser and sleeping pill. For clinical depression an early danger sign could be unusually prolonged hours of sleep and low energy. This should be tackled within a day or two by an already prescribed anti-depressant. Delays to treatment because of the time taken for a GP appointment to get a prescription could lead to a much more severe condition needing to be treated.

The training by the patient (and by written material) of a patient's helper (such as a partner or good friend) can be very helpful in assessing the patient's state and need for treatment. Training for the helper focuses on recognising the agreed signs for early action. Training for a helper should also include recognising the extreme state of elevation - mania. Mania is florid and not hard to recognise by the trained observer but persuading a manic patient to seek help is another matter. Professional help is vital here. Full-blown mania involves a lack of insight and is by its nature beyond self treatment.

It should be emphasised that not all bipolar patients are suitable for training as expert patients. Unsuitable would be patients who do not accept that they are bipolar, or patients who are very unstable.

If most bipolar patients were expert patients, with their own agreed stock of prescribed anti- depressants and mood stabilisers, there would be considerable savings in GP and psychiatric consultations. Personal experience (PD) suggests that GP and psychiatric consultations can be reduced to a quarter or less than normal consultations. The prevalence of bipolarity in most countries is about one percent. In a GP practice with five partners each having about 2,000 patients there would be no less than about 100 bipolar patients in the practice. These are conservative figures. Some epidemiologists use a broader definition of bipolarity giving ten times the number of patients.

Bipolar patients are sometimes trained as expert patients and even if untrained they learn a lot about their care – but it is rare for them to be involved in self medication. The bipolar charity (Bipolar UK) used to run excellent 3-day courses in self management (but not self medication) and one of us (PD) attended one of these courses in London some years ago. Numbers were restricted to about 12 in order to encourage full involvement of all participants. The courses were very much appreciated by those who attended. Funding

for short courses in different parts of the country should be found and should include self medication from the schedules set by the consultant or GP.

Other chronic illnesses and expert patients

There are other illnesses of a chronic kind that would be very suitable for the training of expert patients. One of the most obvious and serious is obesity. At present, expertise is mainly given by groups such as Weightwatchers – they function as part of a greater healthcare partnership. Sarah Boseley of the Guardian has recently written a very readable book (THE SHAPE WE'RE IN: How junk food and diets are shortening our lives). The book examines the biological, social and economic factors in the recent rise of obesity. It is very relevant to the prevention and the treatment of obesity.

Another large and important group is that of patients who are drinking more alcohol than is good for them. Only a small minority of such patients are involved with Alcoholics Anonymous – which can also be regarded as another - though controversial - branch of a greater healthcare partnership.

Other chronic and serious illnesses are appropriate for the further development of expertise. Examples include arthritic diseases; migraine and headaches more generally; peptic ulcer; and asthma, including chronic obstructive pulmonary disease (COPD) more generally.

Conclusion

Discussion of the future of the NHS currently tends to be depressed – it is often all about additional burdens of care needing large increases in scarce resources. Typically there is nothing about people living longer, healthier lives as expert patients.

At this time of growing demands on our family doctors and hospital specialists there are thousands of patients who have "different but equal expertise". Thousands of these with chronic conditions should be recognised and developed as expert patients.

Thinking in terms of expert patients as an additional resource, despite their chronic illnesses but often with added years of active life, can restore a much-needed public sense of balance. It can also give hope.

Peter Draper,
Richard Draper and Carol Draper

A note on the authors

PD is a public heath doctor who is supposed to be retired but he follows the advice of his former tutor, the late Sir Douglas Black, and 'doesn't do it'. He enjoys shorter hours, regular vacations and days off. His bipolarity was diagnosed 31 years ago.

RD is a GP and is PD's nephew.
CD is an ex-NHS manager and an ex-patient representative. She is PD's wife.

Executive Commitee - Elected at AGM 2014

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The AGM and Conference 2015

will be held on
Saturday 3rd October

venue to be decided

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