DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

DO SOMETHING: A CALL TO ACTION

This year's Paul Noone Memorial Lecture gave a very clear message: page 26

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DECEMBER 2016

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Published quarterly. Contributions welcome.

Where the hell are you and why aren't you doing *SOMETHING*?

The British are well known for the understatement and a shrug of the shoulders when things go wrong. The house burning down might get a "mustn't grumble".

Just how bad do things have to be to provoke a more spirited protest? Health inequalities continue to rise as they have done since neoliberal governments took over in 1979. Professor Bambra (see my book review, page 30) demonstrates the reasons and knows the answers, but does anyone care ?

Child poverty is rising and food-bank use is at record levels. The top 10% have 53% of the country's wealth and earn nine times as much as the bottom 10%. A typical CEO earns 120 times the median UK wage (340 times in the USA).

Refugees are drowning in the Mediterranean as you read this, ferried by "entrepreneurs making a quick buck". Orphaned children are disappearing to be sold into the sex trade. There is an obesity and diabetic epidemic fuelled by successive governments' unwillingness to take on corporate interests. Public health policy is in a parlous state because it has been defunded and captured by multinationals which along with their friends in government try to convince us that choice is the best way to tackle lifestyle issues and health inequalities. An evidence-free idea that we are all meant to swallow: certainly few are rising up against it .

I would argue over my lifetime we have become a less compassionate society – that thing Thatcher said didn't exist. She encouraged a selfish "I'm alright, Jack" attitude. I don't believe that a generation ago the British public would have just stood by and done nothing while homeless children died. Now though it seems more important to raise the drawbridge (after getting rid of "foreign" NHS workers, of course) and isolate ourselves from good but unfortunate people in trouble.

So does this explain why the NHS can be dismantled before our very eyes and there is not a collective "batting of the eyelid" ?

Other popular institutions like the BBC are under attack, and the public are rolling over to let it happen.

Scandals like MPs' expenses, cash for questions or honours or influence, organised paedophilia rings, Hillsborough, Orgreave and police corruption, and the Iraq War barely penetrate the collective psyche. The Leveson inquiry into the behaviour of the press is forgotten. At best a shrug of the shoulders.

Even when doctors do appear to be taking a lead in the fight for the NHS, little public support is at hand. The media and government did a good hatchet job on the junior doctors, but they were also undermined from within. The same happened with the Health and Social Care Bill when the BMA helped it through. As expected and as usual, just when the BMA could have made amends for its opposition to the NHS in 1948, its weak perfunctory defence of the NHS has let us all down. We've just learnt that in Durham GPs have had their right of referral taken away and what do we hear from the BMA GP spokeman? "I'm a bit concerned". Another British "shrug of the shoulders" when we really need radical action. When members of the BMA GP committee try to defend the NHS, they are told "we exist to defend GPs , not the NHS". Our glorious leaders haven't yet woken up to the fact they are not only the same war, but the same battle. In the West Country, GPs on a CCG have just decided to pay Virgin Care £700 million of taxpayers' money for a range of NHS and social services, after "extensive consultation with users, members of the public and professionals". Pull the other one. Do these GPs really understand what they are doing?

There are over a quarter of a million doctors in the UK, and more than 150,000 belong to the BMA. That should be a powerful force to save

the NHS. But at every step since the plot against the NHS really started with gusto in the 1980s our profession and in particular our leaders have ranged from full co-operation to that "shrug of the shoulders" again. Time and time again we "co-operate".

So if the public don't see doctors really fighting for the NHS is it little wonder they don't see the need? It must be safe, they reassure themselves.

We live in the *Post Truth Era* where government still denies that its goal is to impose an American-style healthcare system besides ample evidence this is underway, and then the main reason people feel proud to be British has disappeared. Only when it has been abolished will the public realise how valuable it was and miss it. Then the medical profession will be blamed for not defending the NHS with the passion and aggression needed.

So have we just become "desensitised" to tragic and scandalous events, which to me include the abolition of the NHS? Are the public so disillusioned with politics it feels nothing it can do will make any difference? So voting won't change a thing and protest is "not the British way"? It doesn't matter that we elect neoliberal "establishment" ideologues or populist liars to office? Are we all zombies now?

It's time to wake up, and those let down by the politicians, media and BMA who want to restore Bevan's NHS should join us or Keep our NHS Public or the National Health Action Party (preferably all three).

The message to all those apathetic or defeatist doctors out there is that if you join us, we could make a difference. Will it be on your conscience if this battle is lost, or don't you care ? Will you just shrug your shoulders?

A 100 years ago, a famous poster appeared saying "What did you do in the Great War, Daddy?" What will you tell your grandchildren when they ask "What was the NHS? Do you remember it? Did you try to save it? "

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This is the first question asked when NHS funding is debated. It is an understandable and obvious question but the wrong one.

Political debate about the NHS at the 2015 general election was pathetically superficial. All the main parties tried to outdo each other by claiming they would "spend more". The skirmishing never got deeper than that. There were few intelligent offerings of how money is spent on healthcare.

The wasteful "market" wasn't mentioned as all had colluded in its conception, birth and now dominance. The modern habit of using slogans without explanation to try to dupe the public prevailed. The most successful was the "Seven Day NHS" without any clear idea of what this meant, how much it would cost, and how it would be staffed.

Curiously, I don't remember any politician being asked where the money for this was coming from.

Only the government thinks the NHS is adequately funded. Everyone else lives on planet Earth. So the Liberal Democrats revive the dead corpse of a hypothecated tax, while enemies of Bevan's NHS want to get co-payments on the agenda, saying we have too many elderly for the NHS to cope and "we" can no longer afford a comprehensive and universal service. Strange where all these "elderly" have suddenly appeared from, and that it seems to be unique to England.

A more relevant question is what is meant by "can't afford it"? And who exactly can't afford it ? If the NHS is "unaffordable" to the country as a whole then the claim is that the sixth richest country in the world cannot look after the health of its citizens.

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ne from ?

If the claim is that the NHS is unaffordable to the exchequer then this exposes one's philosophy and priorities as to what is publicly funded (in over-simplistic terms, what our taxes are spent on). This is the political choice (not necessity, as claimed) of moving away from public funding of healthcare – which is the fairest, most effective and cheapest way – and towards a less efficient and more expensive system, as neoliberals (ie governments of the last 30 years) want. But all other systems are even less "affordable".

> "Rather than healthcare delivered based on clinical need rather than ability to pay ... we will end up with three tiers.... A worse, more inefficient and wasteful system."

So if the state "can't afford" healthcare for all , the cost must be devolved down to the individual citizen. Assuming the government, when it has achieved its goal, leave us with a basic core safety-net NHS for the poor, then top-up or full health insurance would be needed for good healthcare provision.

It probably won't bother the super-rich who would pay direct – they wouldn't trouble themselves with insurance although even they are in for a nasty shock when it comes to emergency care. The rest of us would be paying, from one trouser pocket, some general taxation towards what is left of a decimated NHS, like Medicaid in the USA; and from the other trouser pocket, insurance premiums. But the money all comes from the same pair of trousers. It will cost every individual more, with greatly increased administration costs and with money going to shareholders.

The problem is some people have no money in those trousers so would have to go without. Some will die which is what happens around the world to those whose governments have lacked the humanitarian vision of a Bevan. Even those lucky enough to be able to pay for the best insurance possible would soon learn that they need a third pocket – to fund the insurance companies "excesses" and the claims they reject.

So rather than healthcare being delivered based on clinical need rather than ability to pay – one tier – we will end up with three tiers. The elite would just spend their wealth and bonuses directly on healthcare (but at least they wouldn't have to pay for anyone else). The next tier would get their care through insurance, and the third poor tier would rely on the new Medicaid NHS. Add all that up and the nation's total expenditure on health would be much more for a worse, more inefficient and wasteful system where people at the top end

will get things done that aren't even necessary , but the poor folk at the bottom will die through lack of care.

Those who have never liked the NHS have peddled this "we can't afford it" nonsense since 1948. What they really mean is they don't want to pay for it. But it's worse than that. They don't want to help others in a time of need. This argument has prevented, from chronic underfunding through its entire history, the NHS from blossoming from the struggling duckling that many tried to strangle at birth into the wonderful healthy swan it should be.

When politicians want to sell us an idea like the HS2 railway, the Millennium Dome or new airport runways they bang on about the economic benefits of such projects outweighing the costs and always dodge the question "Where will the money come from?"

It is a little known fact that every £1 spent on healthcare actually benefits the nation's economy by a return of more than £3 (see further reading). I have never heard this stated in the media. Certainly not by the politicians who have another agenda, that is deviously and by starvation getting rid of the NHS. After 68 years they argue more forcefully than ever we can't afford an NHS.

But they are wrong.

The right question, to which the answer is undoubtedly no, is "Can we afford not to have an NHS?"

Further reading

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How to Privatise the NHS ... and hope no one notices

"That's the standard technique of privatisation: defund, make sure things don't work, people get angry, you hand it over to private capital."

– Noam Chomsky

It was easy to fool the public with this technique for the railways, energy, telecommunications and some other service industries. "If it moves, privatise it" seems to be government policy. But they knew it would be harder to apply to the NHS.

So a few more devious steps were needed:

Step 1

Separate the NHS from government and its obligation to care for the health of the nation, so that when things go wrong , the government can claim it's someone else's fault (but they can still claim credit when things go well).

Step 2

Starve the NHS of funds. No doubt here, surely...

Step 3

Cut training places and sell off land and accommodation.

Step 4

Run a smear campaign against the NHS, its staff, its safety and even patients. Demoralise staff by hitting working conditions and pensions, forcing many to leave.

Step 5

Facilitate a corporate takeover with private companies (often with links to the politicians planning all this) hiding under the NHS logo so the public don't notice.

Step 6

Reduce beds, downgrade hospitals, close A&E departments, reduce GP services and blame "lack of staff which puts patients at risk".

Step 7

Appoint a man who worked for US United Health to run the NHS. Tell him how much he should ask for to run the service , and when it proves to be inadequate, say "well, that's what the NHS asked for". Remind you of anyone...?

Step 8

Feed the media lines that are repeated parrot fashion to fool the public :

- Reducing services leads to better patient care
- We cannot afford a full health service
- It's the fault of the obese, immigrants and the elderly

Step 9

Brew the perfect storm: a cocktail of underfunding (called "overspending"), lack of staff, services unable to cope, longer waiting lists and poor safety.

Step 10

Get NHS providers (government appointed , but pretending to be independent) to declare an NHS crisis admitting it cannot provide services now with the funding it has, so something has to change. The government repeat the lie "we gave the NHS the money it asked for".

Step 11

So now tell the public we have no option but to introduce charges (but, like tuition fees , only a little and not for the poor ... to start with).

Encourage trusts to ration care, but deny supporting it as policy.

Step 12

Introduce universal private health insurance, initially as a top-up for services either now rationed, not available or charged for.

Step 13

Final move is to a full US system with compulsory insurance possibly through employer. NHS is now a basic safety net emergency service.

Step 14

Leading characters in this plan get very rich banking exceedingly large sums of taxpayers' money.

Final Step

Those involved, especially government supporting MPs, pretend to distance themselves. They have all been told to include the sentence below in replies to constituents when the closure of their local services, which they have to pretend they will fight, conflicts with government policy which they also have to support. They have to face both ways at once. This is how they bluff their way out of it:

"I am about to meet the Health Minister to alert him to this – remember this process is being run by NHS managers, not the government, so I want to ensure the minister can feed our concerns into the process at the highest level."

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Migrating Doctors

The "anti-immigrant" narrative could easily spell harm for the NHS

Thirty-six per cent of doctors working in the UK obtained their primary medical qualification outside the UK, a greater proportion than any other European country.

International medical graduates (IMGs) offer extraordinary service to the NHS, but how it is that the UK, the world's fifth richest country by GDP, is so dependent on international doctors trained in countries whose health needs far exceed ours and whose GDPs are way below ours? Yet these countries have contributed the equivalent of £15,000,000,000 to the UK taxpayer in saved medical school fees.

History provides clues. Following a long-standing disagreement, the GMC withdrew recognition of Indian medical colleges in 1930. Without GMC recognition, Indian graduates could not work in the UK or elsewhere in the British Empire. Recognition was re-negotiated but at the expense of Indian schools aligning their curricula with Western practice even though this was seldom appropriate for the health needs and culture of the majority rural poor. Doctors could not fulfil their aspirations locally so emigrated to practise the medicine they had been taught and recoup costs. Migration led to more migration as students studied medicine specifically to work overseas. By 1947, 1000 Indian doctors were practising in Britain.

The 1950s, perhaps as now, was a time of disillusionment with the NHS and many UK trained doctors emigrated; 7,000 leaving for the USA, Canada or Australia between 1952 and 1968. The gaps, particularly in general practice and geriatrics, were filled by IMGs and by 1968, 88% of registrars in geriatric medicine were IMGs.

Medical school places increased but the ready availability of IMGs allowed a skewed career structure to develop weighted in favour of junior doctors. Many were uneasy about the dependence of the UK on IMGs but economic and professional factors continued to drive doctors from developing to developed countries, and so long as UK junior posts were filled there was little incentive to train more doctors.

The situation changed dramatically in 2002 when the number of IMGs coming to the UK rose exponentially. This was driven by exceptional UK salaries and by an increase in graduates qualifying from overseas medical schools. Remarkably the GMC, rather than restricting places for the Professional and Linguistic Assessment Board (PLAB) exam, opened a new centre capable of processing 1,000 candidates a month. The result was IMG unemployment on an unprecedented scale. Experienced graduates were making more than 500 applications to obtain a pre-registration house officer post. Applicants for one post had wasted in total 800 'doctor years'; wasted in terms of professional development and time denied to their home country. It was a shameful period for the leaders of a caring profession and a bleak one for IMGs.

The Department of Health's eventual response was to withdraw the Permit Free Training Visa. A work permit would then only be issued if no UK or EU resident or doctor with "leave to remain" satisfied the person specification for that post regardless of merit. Applied retrospectively it resulted in hardship to many, especially those part-way through their training, but it did put an end to IMG unemployment.

What of the future? If we are to continue our dependence (some say overdependence) on

"healthcare", we must train more doctors and nurses (for whom the situation is even more critical). The recent promise from the Secretary of State of "up to 1500 extra graduates per year from 2018" is welcome; but how to manage for the next 10 years? Our current policies are unsustainable and risk harming fragile international health economies.

Doctors from Lower and Middle Income countries (L&MI) have as much right as UK doctors to be trained and exposed to high standard medical practice. Our primary objective should not be limitation of mobility per se, but ensure equity of health. For junior doctors, the Medical Training Initiative scheme set up by Colleges and Department of Health (DH) after withdrawal of the Permit Free Training visa is one such scheme. Doctors are recruited into paid UK training posts under a time-limited 2-year Tier 5 visa.

The Colleges facilitate the visa and GMC recognition without PLAB. Candidates are promoted by their home institution and interviewed to assess clinical and communication skills and ensure as far as possible that it is their wish to return home after 2 years in the UK. Over 800 IMGs are currently in the UK under this scheme. The drivers for the scheme are training and experience for the IMG, but the scheme also brings huge benefits to NHS trusts. It is a win-win scheme reflected in the comments and actions of international graduates on returning home.

In October 2016, a cap on the number of visas threatened to derail the scheme and drive trusts to recruit yet more doctors under the Tier 2 visa. Fortunately, the cap was lifted and the scheme continues, but many trusts still need to recruit under the Tier 2 visa to fill posts. Tier 2 doctors can apply for indefinite leave to remain after 5 years, precisely the opposite of the government's intention when it capped the Tier 5 scheme.

Also, unlike doctors on Tier 5 visas, Tier 2 doctors depend for their continuing visa on remaining in a paid post and they are outside the educational system with no guarantee of training, supervision or career progression; a true lost tribe of doctors. Is it not time for the education authorities and colleges to bring these doctors out of that educational wilderness?

As part of a responsible migration policy, UK doctors should also be encouraged to volunteer in resource poor countries with gaps in service being filled by doctors on the MTI scheme. The benefits to the volunteer and the wider NHS are self-evident but the rigidity of our training system does not lend itself to periods of volunteering. The DH have started to address this by establishing an NHS Volunteering Group to deal with revalidation, career progression and insurance.

Finally, doctor migration is not limited to movement between countries. The preference of doctors to work in cities leads to precarious under-provision in many rural areas. The financial rewards and kudos of, for example, an interventional cardiologist, will outweigh those of being a rural primary care physician even though globally the need for the generalist far exceeds the need for the specialist.

The same applies in the UK where the general practitioner and the hospital consultant doing the acute on-call are at risk because of recruitment problems.

Whether by coercion, education, financial reward or medical student selection, we must find a way of addressing this perennial mismatch of human medical resources to patient need as well as being aware of our ethical responsibilities to international recruitment especially during the next 10 years before the new cohort of medical students come on stream.

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AGM and Conference 2016 London

Saturday 1 October

Unite House London WC1

This year's AGM and Conference were held at Unite House, near to Holborn, central London. DFNHS is grateful to Unite for the use of their facilities at a very reasonable rate.

The following pages contain abridged reports of the talks given on the day, plus a short summary of the many interesting questions that they prompted afterwards.

AGM Reports

Opening address: Eric Watts, Chair

Eric reported that the major thrust of our activity has been through Health Campaigns Together (HCT) with a prolonged campaign in support of the NHS Reinstatement Bill.

The former shadow health secretary Heidi Alexander was not supportive as she was against what she saw as "a further top-down re-organisation of the NHS". Further tireless campaigning has led to increased support from the Labour Party including Rachel Reeve and Diane Abbot. The STP issue ("Slash, Trash and Burn!") has now to be tackled.

Eric had wrtten to Sir Terence Stephenson pointing out that the GMC's public statements did not pay due regard to the difficulties faced by junior doctors. It was felt that the response – which came from the Policy Manager – was inadequate.

The GMC has in the past felt it was not in their remit to comment on patient safety in particular institutions, so they have exceeded their remit in commenting on the junior doctors' strike and the impact on patient safety. This warranted another letter from DFNHS. A letter to the *BMJ* or *Lancet* should also be considered.

Evidence had also been submitted to the House of Lords Sustainability of the NHS Committee.

Treasurer's Report: Peter Trewby, Treasurer

Peter told the meeting that our financial position is steady at the moment.

The one-off appeal for donations last year (£4805 from 40 donors), and the introduction of life subscriptions (£5950 from 7 one-off subscriptions) have given us a reasonable buffer although the life subscriptions must be offset against reductions in regular subscriptions in future years.

To remain solvent we have had to cut our donation to Keep our NHS Public from £8000 per year to just £500 since December 2015 and we have given no money to the NHS Support Federation since December 2015.

Between September 2015 and September 2016, 17 members have resigned or died, but we have 17 new members, including 5 GPs with around 700 members overall. Thirty-nine members however are being actively chased for non-payment of subscriptions. Members' subscriptions remain by far the greatest source of our income. Apart from the importance to our organisation, from a financial point of view we must continue to do all we can to recruit new members and follow up defaulters. Five members are paying through PayPal which now thanks to Alan Taman, our Communications Manager, is available through the website.

Our principal outgoings remain £12,000 per year for our Communications Manager, with no significant alteration in income and expenditure between this year and last.

Figures 1 and 2 show our deposit account balance in historical perspective and the

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Figure 1 Historical Deposit account balance September 2011 - September 2016

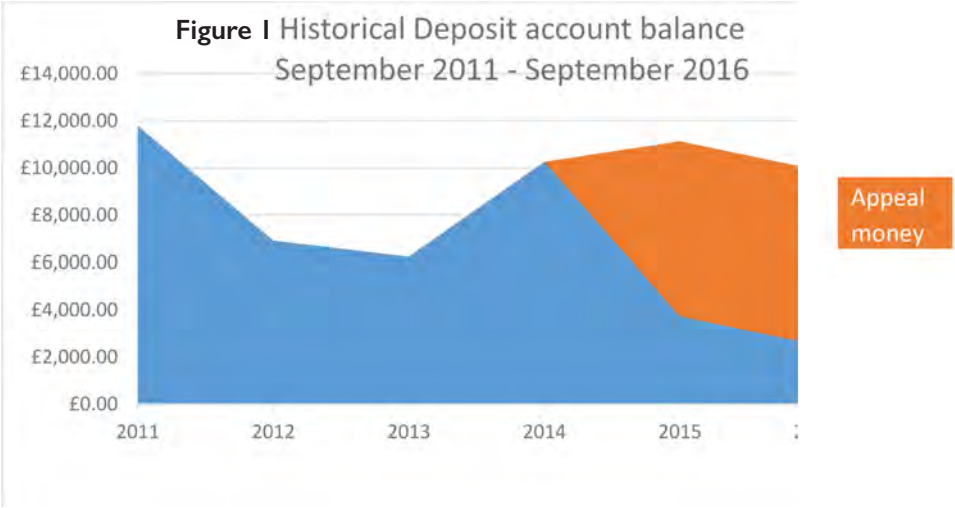
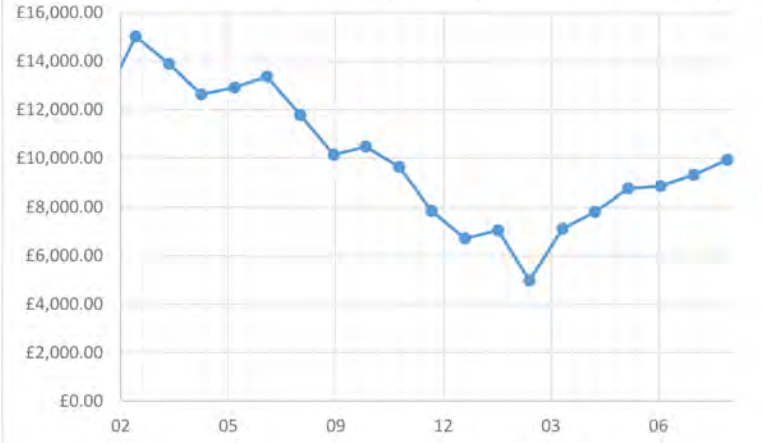


Figure 2 Deposit account monthly balance 02/15 - 09/16



AGM and Con

improvement in month by month figures, respectively.

Our current assets as of 9 September stand at £9939 (deposit account) and £3500 (current account).

Depending on the views of members we are now in a position to renew donations to KONP and/or the NHS Federation and/or other bodies to be decided on, but at a reduced rate*.

Peter's grateful thanks went to our auditor Mr Bob McFadyen who patiently turns Peter's amateur accounts into a professional balance sheet and to those members of the Association who pay their accounts promptly by standing order or respond quickly to letters from the treasurer when they fail to do so!

Peter concluded by reminding the meeting that we must do all can to reach out to friends and colleagues to recruit new members.

**The EC meeting in November elected to donate £2,000 to Keep Our NHS Public, £2,000 to the CHPI, and £2,000 to the NHS Federation as one-off donations, in line with the wishes of the AGM to consider this further at the next EC.*

Communication Manager's Report: Alan Taman

Alan told the meeting that this second year of his role has been one of consolidation and growth, with some needs emerging as a future priority. In particular:

- The newsletter had undergone a change in design and continues to improve as processes have become efficient and production costs reduced.
- The website had undergone further structural changes allowing for a blog and commentary, as well as online joining and renewal via PayPal.
- Twitter had continued to grow, with now over 1,000 followers. Facebook is also growing steadily.
- A regular e-mail letter now goes out to all members.
- A successful leaflet was co-produced with Keep Our NHS Public aimed primarily at doctors but proving attractive to the wider public.
- Press liaison was now being given more priority and had achieved recent success., notably with a letter published in *Pulse*, as well as quotes in the *Guardian*, enquiries from and a recent quote in the *Mirror*, and regional and national radio interviews.

Alan noted that there was a need for some caution when commenting on issues such as the Juniors' dispute, because DFNHS's aims are broader. But DFNHS has a unique point to make amongst health campaigns. Journalists were starting to recognise this 'USP' and DFNHS's unique strength as a medical peer-group campaign now consistent efforts were being made to keep them interested in the group following consolidation of all aspects of communication, such as the website and social media.

As immediate struggles continue within the NHS, more doctors were becoming politicised. Alan felt confident that most of them would remain politicised, and angry, and will then be looking around for some way of finding support and fellow doctors who still feel as they do. Which was an opportunity for DFNHS to makes its presence felt and is now a priority.

There were comments from the floor on the need for the many different NHS supporting organisations to work together and the need to include areas outside major cities.

Alan agreed, and said that use of social media should facilitate this., now that DFNHS had reached a "critical point" in having over 1,000 followers on Twitter.

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Plans for the future

Recruitment:

Peter Fisher described current recruitment methods. A rolling programme of communication with all consultants in a single hospital was carried out for many years but it is now becoming less effective. Targeted recruitment was a more effective method.

Peter appealed to all members to submit names of doctors. He is able to access contact data so the name alone is adequate. But he added that junior doctors cannot be traced by this method.

Other:

Arun Baksi (General medicine/Diabetology, Isle of Wight) shared his thoughts on the importance of formulating positive proposals for improving healthcare rather than merely identifying problems. Some examples were: election of Health Board members, re-instatement of the Ward Sister role, and re-establishment of medical/ward teams.

A suggestion from the floor was re-establishment of Consultant Committees directly engaging with managers. A change to the current "ossified" power structures was also indicated.

It was proposed that a small working party could take this forward and that Arun would write an article for a future newsletter.

Election of Executive Committee

Two members of the current executive committee – Jonathan Dare and Steve Olczak – felt they could not continue to serve on the committee and wished to stand down.

It was hoped that Hans Pieper could be persuaded to continue as a member of the EC.

Two new members were proposed. Arun Baksi (General Medicine/Diabetes. Isle of Wight) and Brigid Hayden (Obstetrics & Gynaecology, Bolton). Both agreed to serve on the EC and were duly elected by unanimous consent.

Keep Our NHS Public Report

Keith Venables, co-chair of KONP, presented the report to the meeting.

KONP was now running on a more even keel, following a period of internal dispute which is now resolved.

There are many groups campaigning for the NHS and some mergers are indicated.

Health Campaigns Together (which Keith is acting Chair of) has helped co-ordinate the activities of some of these groups and the HCT newspaper (produced by Dr John Lister and Alan Taman)* has been well received.

NHS Support Federation Report

Paul Evans sent a report prior to the meeting, which was sent to members.

In the report, he thanked DFNHS for its support over the years, and outlined the progress made by The NHS Support Federation before describing forthcoming research projects on effectively resisting outsourcing and NHS funding. "The Fed" is considered our research arm. It was agreed that future funding would be discussed at the next EC meeting in November.¶

**The latest issue of the HCT newspaper, Number 4 (Autumn 2016) can be seen online at www.healthcampaignstogether.com/pdf/HCTNo4.pdf Printed copies can be ordered for a nominal cost which covers printing and postage.*

Any member who wishes to receive a free copy should contact Alan: healthjournos@gmail.com

¶See previous page.

AGM and Con

DFNHS Constitution – Application for charitable status

Alan Taman outlined the advantages and disadvantages of such a move.

There would be a financial gain, but we would have to provide evidence that the organisation benefited the public, was educational and was not merely a campaigning group.

Some speakers felt that charitable status would give us more credibility and identify us as reliable and trustworthy but others felt it might constrain us, affect how the public view our professionalism and limit our relationship with political parties, and that increased funding should be pursued by increasing our membership.

Some members also felt that our involvement with the NHS Bill may be adversely affected. There would be considerable annual paperwork and we would have to call an EGM to adopt the new constitution which would be costly.

A vote taken by a show of hands showed 8 members in support, 15 members against while 8 members abstained. The proposal was therefore defeated.

Junior doctors' contract

Eric Watts addressed the meeting.

He said that at the legal challenge by Justice for Health, Jeremy Hunt changed tack and said he had approved the contract but had not compelled employers to adopt it. He was not going to impose the contract. In view of this the following motion was supported unanimously:

> **"We call on NHS Employers to continue with the present contract as they are not compelled to adopt the new contract."**

Financial Probl and Possib

Professor Sir Mike Rawlins

(Professor Rawlins is former Chairman of NIC Healthcare Products Regulatory Authority)

Report by Colin Hutchinson

There is no doubt that the NHS is in a total mess. As the Royal College of Physicians report, it is "understaffed, under-doctored, over-stretched" [1].

The United Kingdom is indebted to the tune of £1.75 trillion and this is increasing by £5 million pounds a minute. Simply servicing this debt is costing £43 billion pounds each year. The main problem is the budget deficit – the difference between the income of the government, from taxation, and government expenditure; the deficit is currently £69 billion. The Tories want to cut the deficit by cutting expenditure; Labour want to stimulate the economy to increase income from taxation.

Where does this leave the NHS? One of the founding principles of the NHS was that it should provide comprehensive health care. A House of Lords Commission is currently considering the sustainability of the NHS and the lack of an agreed definition of "comprehensive" gives them considerable wriggle-room. Very early in the NHS's history, charges were introduced for spectacles and dentures. Prescription charges raise £65 billion per year, even though 85% of prescriptions are exempt from charges.

The UK spends a lower proportion of its gross domestic product on health (8.5%) than many other developed countries, with a total budget

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of £115 billion. The deficit in the NHS accounts last year was £3.8 billion before a number of accounting fiddles were applied. During the Comprehensive Spending Review of 2015, Simon Stevens announced that an increase in funding of £8 billion was sufficient, if combined with large-scale efficiency savings.

> "There can be little doubt that current levels of funding and the consequence of poor work-force planning are incompatible with a high-quality NHS."

Much of this is planned to be delivered by year-on-year reductions of 2% in the tariff paid to organisations providing healthcare. This year, a 4% reduction of the tariff has been imposed which, even if it were met, would still leave a large deficit (£2.3 billion).

It is common for spending on the NHS to be regarded as a drain on the economy, but this is far from the case. The "fiscal multiplier" means that there is a four-fold return to the economy for every pound spent on the NHS.

Underfunding is only one aspect of the mess. The NHS is understaffed in many areas of work. The UK has 278 doctors per 100,000 population, compared with the EU average of 347.

We do not train enough medical students to meet demand. In 2010, the number of places available in undergraduate medical schools was cut by 3.6% and the number of undergraduate places available for nurses was cut by a massive 13%, so it is unsurprising that there are insufficient staff to fill vacancies, whether in hospitals or in primary and community care*.

There have been calls for a Royal Commission on funding in the NHS, proposed by the free-market think-tank, The Centre for Policy Studies. Likely options that could be considered include:

- **The status quo** – continuing the "Beveridge model", funded by general taxation, as in Spain, Scandinavia, New Zealand, Hong Kong and Cuba.
- **Hypothecated taxation** (an "NHS tax") – it is thought that this may be more acceptable to the public, but the Treasury have a history of hostility to hypothecated taxation.
- **The Bismarckian model** – funding through payroll taxation on employers

**See "Migrating Doctors", page 7, for a description of how this economic reality has determined medical migration in the UK.*

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and employees. The self-employed have to take out their own insurance policies. The government pays for care of children and the chronically sick, which is likely to account for 87% of the expenditure. Examples include Germany and France. There is uncertainty regarding the cost of the administration of such a scheme, compared with the Beveridge model.

- **Co-payments** – have little to recommend them, as they are inequitable and involve an enormous amount of bureaucracy, with its associated costs.
- **"Out of pocket" funding** – with payment by the patient for treatment administered from their own resources, which would be grossly inequitable.

In addition, the role of the private sector in the provision of health services needs to be considered. There have always been areas, such as aesthetic surgery, where there is broad agreement that they fall outside the scope of a state-provided health service. There may be some other circumstances in which the NHS is unable to provide the service itself, but these should be very much the exception.

No matter how deep the divisions of opinion on what the optimum solution might be, there can be little doubt that current levels of funding and the consequences of poor work-force planning are incompatible with a high quality National Health Service, so something needs to change.

Reference

[1] Royal College of Physicians (2016) *Understaffed. Underdoctored. Over-stretched. The NHS in 2016.* London: Royal College of Physicians [online] available at: www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016

Views from the floor

Several questions were raised by members. These included the additional costs of the Bismarckian model, and the costs to the NHS of administering the internal market, which Professor Rawlins said would have to be significant.

He pointed out that the idea of a Royal Commission comes from the Tories themselves, and conceded that Commissions had a reputation for taking years – but stressed again that something needed to be done, because of the parlous state of NHS finances.

Professor Rawlins agreed completely that the way trusts were resorting to use of locums and other temporary staff was "absoutely crazy".

The effects of privatisation were discussed and Professor Rawlins said he understood the arguments. He added that the Health and Social Care Act was a disaster.

On the question of loss of morale in the NHS, Professor Rawlins said that the destruction of the Firm system was partly to blame, and in his view this needed to be returned to. He also said that Regional Health Authorities were a good model, and he would suppport the reinstatement of area-based authorities, which the NHS Bill advocates **(see page 21).**

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Professional and Political: An MP's View

Dr Rosena Allin-Khan, MP

(Dr Allin-Khan is an A&E doctor and was elected Labour MP for Tooting in June)

Report by Geoffrey Lewis

Dr Allin-Khan initially described the difficulties she had in attempting to get a place to enable her to train in medicine, which were part of her motivation to join the Labour party.

She had initially applied to University College Hospital but was told "don't call us, we won't call you." She then took a degree course in Biochemistry (Brunel University) and an Aid Workforce Conflict Resolution Course which enabled her to help those in greatest need.

She obtained a place at Cambridge Medical School and subsequently went to the Royal London Medical College to complete her medical studies.

She decided to study Accident and Emergency Medicine and devoted some of her time to assisting Palestinians, taking a Masters in Public Health. At this time she had no plans to enter Parliament.

On returning to London she became a councillor in Tooting 2 years ago. She worked as a junior doctor at Homerton Hospital and St George's Hospital, Tooting.

She decided to stand for Parliament this year and won, becoming Labour MP for Tooting, London. She is now the newest MP in the House and at the time of speaking she had been in the job 21 more days than Sam Allardyce. She is Labour's only doctor MP and feels she has a duty to speak up for the NHS.

She is thus well aware that the NHS is in crisis and on the brink of disaster.

She wished to learn from the meeting what they considered the top issues which they felt were the most pressing:

- Inadequate number of doctors and nurses being trained.
- The loss of a holistic approach to medicine.
- The waste of the internal market.
- Absence of accountability in the NHS.
- Loss of professional control and the imposition of untested ideas.
- The marked loss of morale amongst the staff with perhaps the exception of senior management. The endless meetings in hospitals and in the community about things can be done differently.
- GP practices being run down.
- Mental health and learning disability functions are in disarray.
- The continuing loss of consultants.
- The purchaser/provider split was condemned and consequent moves had increased privatisation in the NHS.

Dr Allin-Khan noted that workforce morale is terrible. Looking at the junior doctor contract, juniors felt they were being controlled by someone who had no respect for their family life or for the role. Junior doctors are considered by the government to be about 24 years old

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and demanding more money. In reality (and she has been in this position) they are between 30 and 40 and usually are married with children. Hunt's claim that he was never going to impose the juniors' contract she found "quite laughable". But working out how we can now work with the NHS trusts and what we can do with the juniors' contract was critical. There needed to be a national contract.

Nursing students now are forced to go to food banks and fuel banks, and often at the completion of their training were £45,000 in debt. She had seen nurses in tears at her MP's surgery because they could not afford to carry on with their chosen career. This was completely unacceptable.

She also condemned the use of management consultants by companies whose staff are paid enormous fees to monitor health professionals and cause considerable stress, often by using pre-determined formulaic solutions. The fees being charged were the most insulting aspect.

The emergence of a "tick-box" culture had created a competitive environment which pitched colleagues against each other, making it harder for them to get the training they need and forced them to "explain" any shortfall. This is now being regarded as normal by the new generation of doctors, who felt under-valued by the government.

Care neglect for social care and those with learning difficulties is considerable, carried out by agencies with poorly paid staff. Mental health care has also been reduced to a series of tick boxes. This had been caused by the use of a competitive tendering process to award contracts. This meant patients could not be discharged safely.

Dr Allin-Khan concluded that entering medicine is a vocation and not a job and that workforce morale is now at an all-time low.

She is a hope for the future. She has worked as a junior doctor in what is the speciality (Emergency Medicine) under most pressure at the moment. She has experienced the problems of concurrently looking after children with the responsibility of looking after severely ill patients. She intends to support medicine as a vital necessity for the wellbeing of the people of this country. With regard to Labour, she felt it was now time to unite and heal, and go forward.

Dr Allin-Khan is married with two children.

Views from the floor

Dr Allin-Khan was asked how she saw her role not just for doctors but for the whole of the NHS, and about the NHS Bill. She replied that the key to this was for everyone to share their feelings in forums such as the AGM. It was important to support the Bill but it was presented often at times when a 3-line whip was not applied, so changing the time it was presented would make a big difference. The Bill needed to be absolutely robust to resist Tory undermining of it.

There was a need to formalise support between NHS colleagues. She agreed that there were some Tory MPs who might be more sympathetic but they were unlikely to stand up against their own government, though she was keen to talk to them because getting cross-party agreement would be vital.

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The Future of the Bill... and the NHS

Peter Roderick

(Peter Roderick is a barrister and Senior Research Fellow at Queen Mary, University of London's Centre for Primary Care and Public Health; he is co-author, with Professor Allyson Pollock, of the NHS Reinstatement Bill – currently going before parliament in its fifth version as the NHS (amended duties and powers) Bill)

Report by Colin Hutchinson and Peter Roderick

What does the Bill propose?

The Bill proposes to fully restore the NHS as an accountable public service by abolishing the purchaser-provider split, ending contracting and re-establishing public bodies and public services accountable to local communities.

The Bill would reinstate the government's duty to provide the key NHS services throughout England, restoring the Secretary of State's responsibility to provide, rather than to promote these services, and restoring democratic accountability for them:

- It would abolish the market in health services. The planning and provision of services without contracts would take place through Health Boards and local authorities. It would abolish the legislation underpinning this market and its regulation.
- It would integrate health and social care services.
- It would re-establish Community Health Councils to represent the interest of the public in the NHS.
- It would require national terms and conditions under the NHS Staff Council and Agenda for Change for relevant NHS staff.
- It would centralise NHS debts from the Private Finance Initiative in the Treasury.

For further details, see www.nhsbill2015.org.

The History of the NHS Bill so far

The Bill, under the title of the NHS (amended duties and powers) Bill, received its first reading in the House of Lords on 28 January 2013, being presented by Lord David Owen, who had suggested the need for such a bill to the authors. It progressed no further, but he presented a second version to the Lords on 13 May, 2013, which similarly failed to progress.

It was then adopted as a private members' bill by Caroline Lucas MP, the leader of the Green Party and extensively re-drafted. It received cross-party support from 78 MPs, representing five political parties, including Jeremy Corbyn and John McDonnell, under the title The NHS Bill. It was granted its first reading on 11 March 2015, just before the end of the parliamentary session, was not debated and progressed no further.

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Caroline Lucas tabled the Bill again following the general election and the NHS Bill received its first reading on 1 July 2015. It went on to its second reading on 11 March 2016. Unfortunately, it was scheduled second in the timetable that day and Conservative MPs filibustered the debate, by speaking for three and a half hours on unrelated topics, leaving only 17 minutes for the Bill to be debated. Only 40 Labour MPs turned up for the debate, although there had been a strong showing from the SNP – if the Labour Party had turned out in numbers, they could have moved a motion curtailing the filibuster. Private members' bills are always scheduled for Fridays, when many MPs have returned to work in their constituencies, so mustering support can be an uphill struggle, without the explicit backing of a major party.

Support for the Bill was initially offered by Rachel Maskell, MP for York Central (Labour), but it was Margaret Greenwood, MP for Wirrall West (Labour), who presented it under the Ten Minute Rule, on 13 July 2016, with an opposing speech from Philip Davies MP for Shipley (Conservative), who had participated in the previous filibuster. The Bill has the support of Caroline Lucas (Greens), and Labour Party MPs Stella Creasy, Peter Dowd, Liz McInnes, Marie Rimmer, Dawn Butler, Nic Dakin, Mike Kane, Yasmin Qureshi, Stephen Twigg and John Pugh (Lib-Dem). It appears that the SNP and Plaid Cymru were not asked to add their names to the Bill. It has been scheduled for a second reading on 4 November 2016*, but as it is fourth on the programme that day, it is unlikely to receive a reading.

Diane Abbott, in her then capacity as Shadow Secretary of State for Health, spoke at the Labour Party Conference in September 2016, but her speech did not include specific commitment to a "publicly provided NHS", although she confirmed the support of the leadership of the party for the Bill. She has also stated that she wanted a bill to abolish private finance initiatives (PFI), which is obviously a much more limited objective. Peter Roderick and Allyson Pollock have met with Diane Abbott and Margaret Greenwood to go through the Bill line by line, to find out what may be felt to be problematic, and what is not.

The Bill debate has since been postponed until 24 February 2017.

How real is the threat of privatisation in the NHS?

There has certainly been an increase in both the proportion of NHS spending and the absolute sums used to purchase NHS services from the private sector, but the current government denies that this shift is accelerating.

It can be difficult to get clarity on the volume of contracts between the NHS and the private sector, with changes in the definitions that are used (www.kingsfund.org.uk/projects/verdict/nhs-being-privatised). Table 1 does, however, show that there has been a four-fold increase in the proportion of NHS revenue expenditure that is spent on private providers, when the total NHS expenditure has only increased by 70%, over the period 2006-2016.

Questions may be raised as to how much the national interest is served by some of the fragmentation and the selling-off of elements of the NHS to private buyers. For example, the NHS-owned organisation Plasma Resources UK, which makes blood products from human plasma, was sold to Bain Capital, which was originally set up by Mitt Romney.

Bain renamed the company Bio Products Laboratory Holdings, and in August 2016, sold its (highly profitable) subsidiary, based in Elstree, Bio Products Laboratory Ltd – previously a

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Table 1. NHS England spending on purchase of healthcare from private sector providers 2006/07 – 2015/16

Year	Expenditure on private providers (£ millions)	Total NHS resource expenditure (£ millions)	Expenditure on private providers as % of total NHS resource expenditure	Percentage point increase on previous year
2006-07	2,192	78,617	2.8	-
2007-08	2,916	84,338	3.5	+6.7
2008-09	3,418	90,278	3.8	+0.33
2009-10	4,144	94,422	4.4	+0.60
2010-11	4,757	97,469	4.9	+0.49
2011-12	5,320	99,368	5.4	+0.47
2012-13	5,669	101,646	5.6	+0.22
2013-14	6,467	105,478	6.1	+0.55
2014-15	8,067	109,534	7.4	+1.23
2015-16	8,722	113,661	7.7	+0.31

Sources:
Expenditure on non-NHS providers
2006/07 to 2008/09 HC Deb 26 April 2011 C116W
2009/10 to 2012/13 HL PO 5389 11 March 2015
2013/14 from DH Annual Report & Accounts 2014-15 Table 9
2014/15 to 2015-16 from DH Annual Report & Accounts 2015-16 Table 10
Total resources expenditure: HMT Public Expenditure Statistical Analyses Table 1.3

part of the National Blood Authority – to the Chinese investment company, Creat Group Corporation.

Andrew Lansley, who drove the Health and Social Care Act through Parliament in 2011-12, has now been appointed Consultant to Bain and Company. His appointment was approved by the Chair of the Advisory Committee on Business Appointments, who is Baroness Browning. She, in turn, is a Consultant to Cumberlege, Eden and Partners, a "specialist consultancy to the health sector", and which is led by Baroness Cumberlege, who spoke against opposing the Health and Social Care Bill during its troubled passage through the Lords in 2011. Much has been written of the "revolving door" between parliament and the private sector, and there are many other examples in health and other sectors, which are in public records, but which attract very little comment or question in the

media. Such facts may give an indication of the difficulties likely to face the passage of any legislation aiming to abolish the market in the NHS.

Why is there opposition to the Bill?

The NHS Bill faces many challenges. One criticism that has been levelled at it is that there would be little appetite within the service or the general public for another major organisational upheaval.

This ignores the fact that the Sustainability and Transformation Plans that are being rolled out, at this very moment, in every part of England are more massive and far-reaching than anything that has been seen since 1948.

The structures and bodies that have been put in place could be adapted under the Bill, so that they are brought together in Area Health Boards, renationalising the commissioning of health services at a local level, in the interest of the health of the public and planning its delivery.

The current Clinical Commissioning Groups, for example, could continue as commissioning units within the Health Boards, as could the Commissioning Support Units. This would obviate the need for the flood of redundancies that have occurred, with their associated costs, only for the same people to re-emerge wearing different, but similar, hats in the new organisation, and minimise the disturbance to local services.

A transition period in which contracts return to public service provision as they come to the end of their term would allow a planned approach to the change of provider, and avoid the costs that would be incurred if such contracts were terminated early.

Public involvement in the monitoring of the quality of NHS services and the planning of service developments, was felt to be at its high point when it was delivered through Community Health Councils, which had real authority.

It is therefore proposed to restore them and give them oversight of the actions of Area Health Boards, Local Authorities and Public Health England within the area served by each Health Board. It may be that Community Health Councils could include a role for patient participation groups, which currently seem to have little influence.

Future chances for the Bill

What can be done to increase the chance of a future NHS Reinstatement Bill passing successfully through the parliamentary process?

Private members' bills can be useful in keeping issues on the political agenda, but are only debated on Fridays, when there are few MPs in Westminster, and when opponents are more likely to be able to use tactics such as filibustering to prevent debate. The parliamentary time-table is agreed between the government and the opposition, and if Labour were to adopt the Bill they could use one of their opposition day debates for it. The government does, after all, have only a small majority.

For any progress to be made, it is vital to increase public awareness of the Bill and its aims, and of the changes that are taking place under the current legislation, which are threatening the very continuation of the National Health Service in the form that has been so successful for more than 60 years.

It is important to use any access to the traditional media and social media to highlight these issues and to petition for support of the Bill at any events in which we might be participating.

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Views from the floor

In response to questions, Peter further described the difficulties facing the Bill in its parliamentary progress, such as the views of powerful people describing the NHS as "rotten'! He elaborated on how re-established Community Health Councils would work if the Bill became law, describing CHCs as the high point of acountability in the NHS while conceding they were not perfect in the past. He welcomed e-mails from members on this or any other aspect of the Bill (peterroderick@cjp.demon.co.uk).

He repeated that the best way for the Bill to get debated would be for Labour to use one of its oppostion day debates. The Bill would minimise redundancy payments. It abolishes the purchaser-provider split.

The CCGs would continue as commissioning units within the health boards re-created under the Bill. Services already privatised would be allowed to fulfil their current contracts but these would not be renewed.

He described the filibustering that had happened at the Bill's latest reading but added that this was an unavoidable risk in parilamentary processes, unless the Bill could become "mainstream".

He said the greatest challenge for groups such as DFNHS was to keep the Bill "alive" in the public consciousness as it was a solution to achieve the groups' aims.

The Paul Noone Memorial Lecture

"Efficient, effective, equitable"

Professor Neena Modi

(Professor Modi is Professor of Neonatal Medicine at Imperial College, University of London ; and President of the Royal College of Paediatrics and Child Health)

Report by Colin Hutchinson

In considering the extent to which the NHS is efficient, effective and equitable Neena Modi quoted from the Commonwealth Fund publication *Mirror, Mirror on the Wall* (2014) [1].

We need to consider whether the NHS has been efficient, effective and equitable since 1948 and how it should meet those requirements today. Professor Modi opened the lecture by flagging up some summary evidence to judge this by.

Efficiency

In terms of efficiency, *Mirror Mirror on the Wall,* the 2014 report of The Commonwealth Foundation [1], ranked the health services in the UK at or close to the top; we have the lowest spend per capita, (just over $3,000 per capita per year) and it is reducing; we are towards the lower end of the range in measurements such as the number of hospital beds, the number of CT and MRI scanners and the number of hospital discharges per thousand population. The NHS is frugal, not profligate with its use of resources. We are lean – we do not spend much money.

Effectiveness

But, are we effective? Life expectancy in the UK, which is 81.1 years at birth, matches the mean for the countries considered in the Commonwealth Fund report, although infant mortality is 3.8 per 1,000 live births, which is not as good as Scandinavia or Japan (though better than the USA at 6.7).

The percentage of the population over 65 years of age who have two or more long-term conditions is 33%, which is the lowest in this report, so we are keeping people alive and in better health.

The figures do show relatively high mortality in certain conditions, which has been used as an argument that the NHS as a whole is performing badly, but much of this variation has wider societal causes, rather than being directly related to the NHS. We do not yet have a population which is excessively weighted towards old age, so take what you read in the papers with a pinch of salt!

Inequities

But do we provide an equitable service? The prevalence of obesity in children, along with

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many other markers for ill health, shows a strong correlation with the degree of deprivation in the population.

There are indications of inequity of access in the system. More than 150,000 people who attended accident and emergency services in London last year without being registered with a general practitioner; there is now the possibility of patients being struck off their GP's list if they have not been seen in the previous 5 years; so there are risks of people facing barriers to accessing services when they need them, and being missed from screening programmes and other assessments of risk factors for future disease.

Fragmentation

Professor Moodi said that she no longer thought we had an entity that is the NHS in England.

She displayed a graphic from the King's Fund which showed the massiively over-complex (and already out of date) systems that the NHS in England had become.

The original NHS has been fragmented. As Allyson Pollock has said : "The NHS has now been reduced to a logo and a funding stream." This is not simply a matter of devolved services in the four nations of the UK. The organisational chaos arising from the Health and Social Care Act (2012) was, and remains, so profound that Professor Modi felt like weeping when she heard Heidi Alexander, then Shadow Health Secretary, say that she did not want to contemplate another reorganisation.

Sustainability and Transformation Plans have been promoted as the way of establishing co-ordination of the many inter-dependent elements of health, social care and the social determinants of health, such as housing and the environment, but the speed at which the planning process is being expected to operate is simply unworkable; the Academy of the Medical Royal Colleges needs to say, loudly and clearly, "This can't be done."

One in five 5 year-olds and one in three children over 10 is obese. The National Childhood Obesity Strategy, which has been so long awaited, is a travesty of a plan. We are spending £6 billion in dealing with the effects of obesity.

Incoordination

The left hand does not know what the right is doing.

There has been a completely uncoordinated approach to workforce planning. We have a shortfall of 1000 consultant paediatricians. There is a 28% vacancy rate in Tier 2 acute paediatric rotas. The number of applicants for paediatric training schemes has fallen by 12%, yet Professor Modi attended a meeting with Health Education England 8 days before this talk and they would not accept that their responsibilities might include that of ensuring sufficient workforce to run the NHS, claiming instead that this was up to "the employers" themselves.

Disillusionment in the Juniors

Another tragedy is the disillusionment and disenchantment felt by so many junior doctors. Despite their integrity and power of expression, they still have not managed to articulate their concerns; they can feel what is wrong with the NHS, but have been unable to describe it adequately. And, of course, Jeremy Hunt – after being taken to court by Justice for Health – has now professed that he is not, and never was suggesting that he was, imposing the new junior doctors' contract!

Doctors as a profession had perhaps been complacent or complicit in this.

Under-funding

The NHS is hugely under-funded by any international comparison. As the sixth largest economy in the world, of course we can afford to spend more; but, as a profession, so far, we have not put forward a strong enough case to the public.

Waste

But what about all the waste that there is in the NHS?

The Academy of the Medical Royal Colleges has agreed that unexplained variability in clinical practice may cost £2.2 billion, but this is dwarfed by the cost of the fragmentation and unproductive costs of the marketisation of the NHS – concentrating on medical wastefulness is a distraction.

NICE has been a tremendous vehicle for rational decision-making. The publication of *Practical Guidance for the Management of Palliative Care on Neonatal Units* [2], by the Royal College of Paediatrics and Child Health in 2014, has provided a very good basis for difficult, but necessary, discussions with parents, but such work has not been mirrored in, for example, the care of elderly people.

Presenting just a few inconvenient truths (figures are per year):

Annual NHS budget:	£ 120 billion
Savings sought:	£ 22 billion
Locum costs	£760 million
Medicines Use Review (Boots found guilty):	£ 66 miilion
Costs of administering internal market:	£ 5-10 billion
Costs of PFI (though a range of figures were being cited):	£ 2 billion
Costs of independent providers:	£ 7 billion
Cancer Drug Fund (no audit of effectiveness):	£ 1 billion

Health is economic capital

So the NHS could be funded, if the political will existed. If we park ideas as to whether there is a desire to privatise or profit from the NHS, and admit that as doctors we made a mistake in opposing the introduction of the NHS, and failed to mount effective opposition to the Health and Social Care Act (2012), we need to recognise that we are now in "the post-factual or post-truth era", as was seen during the Brexit campaign: the acceptance of bold, bare-faced lies as part of contemporanoues discourse. We should be having nothing to do with this.

As a nation, we have failed to recognise health as economic capital; it may operate over a long time-scale, but as doctors we have singularly failed to press this argument. Why don't our politicians realise this? In many low-income countries, their governments recognise the economic value of clean water and the prevention of epidemics. But governments in many higher income countries seem to have forgotten about the economic value of health.

A healthy nation adds to its economic prosperity. Healthy childhood directly leads to healthy old age. We all need to make the point for this investment; if this is not understood, it leaves the way open for healthcare to be regarded as simply another commodity, an industry, and a business opportunity. The commodity breeds an ideology, which in turn yields what we are seeing today. Nobody is pausing to say "we have got this fundamentally, cardinally wrong".

We are already hearing suggestions that care be provided for the most vulnerable and the rest

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is down to individual responsibility, which will inevitably lead to a multi-tiered and inequitable system, so we need to make the moral case for universal equitable care, but to back it up with the hard-nosed, financial arguments.

As an organisation, Doctors for the NHS needs to make a particular effort to attract junior doctors. Their morale is very low at present because they feel they are losing.

We need to help them understand that we realise their concerns relate to their worries about the current state of the NHS and the direction in which it is travelling. We need to give them as much moral and practical support as we can and, because we work within such a complex system with a degree of professional isolation, we need to keep each other informed of what is happening in different areas of practice and in different parts of the country.

We need to have confidence in our own expertise and exert our influence on firstly, the public and secondly, the Treasury, rather than concentrating on the Health Ministers and their Special Advisors, who tend to come and go and who are probably less amenable to influence from the medical profession.

Professor Modi would like to see the profession seize the imperative and the initiative in the way the juniors had; she would like us not to be complicit in the destruction of the great social justice that is the NHS.

There is a definite sense that we are losing the argument. We cannot afford to delay. We need to seize the initiative; as a profession we need to behave as leaders and take the public with us.

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[2] Mancini, A., Uthaya, S., Beardsley, C., et al. (2014) *Practical Guidance for the Management of Palliative Care on Neonatal Units* London: Royal College of Paediatrics and Child Health [online] Available at: http://bit.ly/1n8IdoB

Views from the floor

In answering questions, Professor Modi pointed out that most Royal Colleges were charities, not a trade union, so could not espouse a particular political point of view. The Colleges had to walk a fine line in not being seen to do this. It was up to indivudal members to let their college president know whether they support what is being done or whether they wish them to do anything different.

In discussing social care, Professor Modi questioned whether the funding streams for health and social care needed to be tied up "in one basket" and that this should to be discussed in a wider debate than a Royal Commission.

She repeated that, first and foremost, doctors should be looking to influence both the public and the Treasury. We needed to have more confidence in our own knowledge. Such as in pointing out the links between social disadvantage and ill health in the wider context.

Book Review

Health Divides. Where you live can kill you.
Clare Bambra (foreword by Danny Dorling). Policy Press.
256pp. £12.99 (paperback, Amazon), £6.71 Kindle edition

Professor Bambra's research focuses on the political, social, economic and environmental determinants of health inequalities , and the role of public policies in reducing them.

Americans live on average 3 years less than the French or Swedish. Across Europe, women in the poorest communities often live 10 years less than those in the richest. Northerners in England survive 2 years less than Southerners. Londoners in Canning Town at one end of the Jubilee line live 7 years less than those eight stops away in Westminster.

The USA does worse than comparable countries for adverse birth outcomes, injuries and homicides, teenage pregnancies and STDs, AIDS, alcohol and drug related deaths, obesity and diabetes, heart and lung disease and disability rates. This health deficit is despite the highest wealth and healthcare expenditure in the world. In the US life expectancy can vary by 25 years between places a few miles apart.

This is a very readable book. Professor Bambra replays the 2016 Football Euros using male life expectancy at birth as the way of scoring. This time England (79) just beat Wales (78) to win their group but they still lose to Iceland in the next round just like Roy Hodgson's team. Iceland get to the final against Switzerland. Both have average male life expectancies at birth of 81, so they draw, but Switzerland win on penalties as their female life expectancy is 85 compared with 84 in Iceland. France and Germany go out in the second round.

The chapter on the political economy is the most instructive for those of us fighting for better health policies. Bambra reminds us that inequalities had improved steadily from after World War I (till neoliberal policies prevailed) and in particular during the period of welfare state expansion and full employment. Since the 1980s the inequalities have worsened.

Politics can matter more than science in determining which strategies policymakers pursue to reduce health divides – or even if they care about inequalities at all. The individualistic nature of neoliberal and conservative ideology define health as an individual matter. Blaming people for their own health problems lets governments and businesses off the hook. There is little evidence that lifestyle interventions are effective in reducing health inequalities: more comprehensive measures are needed.

> "Neoliberal policies of the last few decades have had unequal impacts on the health of the nation.... Unemployment and its social consequences were ... a 'price worth paying'. "

Neoliberal policies of the last few decades such as welfare cuts, reducing the social safety net, emasculating the trades unions from fighting for better working conditions, local government cuts, and austerity in general have had unequal impacts on the health of the nation.

A key turning point was the elections of Thatcher, Reagan and Kohl (in West Germany) between 1979 and 1982, who all started to dismantle and restructure the welfare state with privatisation and marketisation. Unemployment and its social consequences were collateral

damage and a "price worth paying". The percentage of wealth held by the richest 1% declined steadily through the twentieth century until this time. In 1978 the top one thousandth of the population held 7%, but by 2012 this was 22%. During this period whilst life expectancy increased, the increases were greater and more rapid among the highest social groups, so inequalities increased.

Like Thatcher, Theresa May on the steps of Downing Street highlighted inequalities in the UK but the lessons from the past are not promising. If she continues with the same policies, she will not only fail to reduce health inequalities, but actually increase them.

The health inequalities reports commissioned over the last four decades – Black, Acheson, Marmot and *Due North* – provided a clear policy agenda for what should have been done, but the gap between these and what was actually done shows that good evidence is not enough – political support is required. But Bambra concludes by stating that ultimately if the electorate don't vote for these programmes, then geography will remain a matter of life or death, and where you live may well kill you. Those politicians who read this book and are then not moved to act are really not much better than those who don't care.

This book proves Rudolf Virchow (1821-1902), known for his advancement of public health, correct when he said "Medicine is a social science, and politics nothing but medicine at a larger scale". Its messages should be loudly broadcast and be compulsory reading for politicians.

Paul Hobday

Notices

New EC members

We are delighted to welcome and congratulate DrsArun Baksi (General Medicine/ Diabetes, Isle of Wight) and Brigid Hayden (Obstetrics & Gynaecology, Bolton) as the newest member of the Executive Committee (details overleaf). Both were duly elected at the AGM (without much "persuasion"!) and will make excellent contributors to EC.

Mail appeal from CHPI

At the EC in November it was decided to permit the Centre for Health and the Public Interest (CHPI), one of our "approved' organisations, to send an appeal to members (other than those who had requested their details were not passed on to other members) via our Communications Manager, Alan Taman (so that CHPI were not given your contact details). You should therefore shortly be receiving or will have just received their appeal, with their latest report. Rest assured that this does not herald the start of a "bombardment by 'junk mail' "; your details will never be passed on to anyone other than DFNHS members (unless you indicated not to on joining) or agents acting directly for us; nor will third parties be permitted to contact you in this way other than occasionally, with explicit EC prior approval.

EXECUTIVE COMMITTEE : Elected at AGM 2016

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

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