DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

At the crossroads

"A tax-funded, free-at-the-point-of use NHS should remain in place as the most appropriate model for delivery of sustainable health services" – Page 11

Also in this issue:

JUNE 2017

CONTENTS

Managing Editor – Alan Taman
healthjournos@gmail.com
Published quarterly. Contributions welcome.

How Will the NHS Fare in the Election That Was Not Supposed to Happen?

Predictions, the weatherman said, are always difficult. Even more so in politics. Before the 2010 election we were promised no top-down reorganisation followed by the biggest changes in the life of the NHS. In 2010 when the coalition government was formed they planned a fixed 5 year term for stability and to avoid crafty politically motivated elections. The plan lasted 7 years.

Therefore I shall not make detailed comments on the manifestos (summarised on pages 19-21) as experience tells us that the government of the day will find ways of doing what it chooses.

We can look at manifestos and broken promises and wonder why, when the NHS is so popular, so many vote for a party that undermines it. Few politicians would openly say that they want to dismantle the service and replace it with a more expensive and less efficient one so they invent new terms, indeed a whole new language to disguise the facts.

We now see performance figures showing increased waits and missed targets that would shame any normal person or party. At present we are waiting for the current deficit figures to be published. The situation is worsening with the very people we need to build up the service, junior doctors, student nurses and other trainees increasingly disillusioned. Fewer junior doctors than ever going into training schemes and nurses reduced to going to food banks in order to be able to continue in their chosen career of caring.

It is some relief to know that despite the current mood of cynicism and despair there are politicians bold enough to make the simple statements that we need to pay for our NHS and we need to raise taxes to pay for it. Last year a survey for the ITV programme 'The Agenda' showed that a majority of people would be prepared to pay an extra 2p on the pound if it were to go to the NHS. Such an hypothecated tax is popular with the public but chancellors do not like anyone telling them how to handle the country's money. It would limit "flexibility" of power, the very essence of political purpose.

Veteran politician Ken Clark recently explained "chancellors take appropriate action to grow the economy – taxes sometimes have to go up and sometimes they go down ... you spend on public services as much as you can tempt out of the taxpayer". He added that the chancellor should not be bound by whatever had been written in the manifesto.

We now have an election where many campaigning groups are standing up and making their points on news programmes and the social media. It is good to see that the newly formed Health Campaigns Together (see page 22) has developed into an effective association of pro-NHS groups and have just released an 8 page pre-election special.

This newsletter outlines the election manifestos of the main parties and focuses on the dangers of ill considered STPs, and has a summary of the effect of closures and downgrading in North West London. We look at the struggle to set up the NHS and find good news in the House of Lords report on sustainability. This is a valuable reminder of the benefits of the work, culminating in establishing the NHS as a vital part of the British identity.

The House of Lords have shown that there is a clear consensus in favour of the NHS core principles: the best example of political consensus for decades. Their report has come at a good time as the next government will need to respond to it. We and many others will continue to remind them that we are proud of our NHS and call on them to support it.

Eric Watts
Editor
eric.watts4@btinternet.com

In History, Hope

To see what could lie ahead for the NHS, we have only to understand its past

A common perception, used by our opponents, is that "doctors were against the formation of the NHS" but in truth many were in favour of it. Many different versions can be found in a plethora of books on the subject and the accounts vary with the political view of the author.

Here's a précis of some relevant events with comments, one easily accessible source is through your TV or computer.

'The NHS, A difficult beginning' a BBC Factual History Broadcast, now available on YouTube [1] is a brilliant dramatisation of the determination and skill of Nye Bevan managing to achieve what no one had done before, or since.

The dramatisation shows Bevan committing, in parliament in January 1948, to establish the NHS in 6 months against fevered opposition. Not only from the Conservatives and the much of the press but also from many doctors.

The BMA, dominated by GPs at that time opposed it because they did not want to become salaried state employees. Many consultants in hospitals with great prestige but old, sometimes crumbling buildings saw the benefit of a nationalised service with secure funding; especially when it came with the added bonus of keeping their private practice.

The programme portrays Winston Churchill as the greatest opponent and credits Nye with the audacity of going into enemy territory, directly to WC's personal physician to win support. This was Lord Moran, at that time the President of Royal College of Physicians of London. Lord Moran Junior recalls the meeting and that they had expected a firebrand but found a charming and intelligent man keen to do business and that his Lordship warmed to Nye and then supported him.

This put Moran in a difficult position as until then his re-election to the presidency with a 10:1 vote against Lord Horder had became routine. Horder was an opponent to the NHS, who had "when still quite young, successfully made a difficult diagnosis on King Edward VII which made his reputation. His patients included every British monarch from Edward VII to Elizabeth II".

In April 1948 the vote was tense and close at 170 to 165 in Moran's favour. Once re-elected Moran advised Nye to soften the approach to GPs and delay plans to make them salaried employees. The BMA stance was changing and changed further when Nye launched a public information campaign calling for people to register with GPs who would see them on the NHS. The campaign specified that women and children would now be covered and by May 75% of public had signed up.

This meant that GPs who did not opt in would have few patients and therefore little income. The cold wind of reality convinced the BMA Council to advise members to join up.

It shows Nye at his brilliant best, faced with the argument that the country lacked the resources he replied "all the more reason for being intelligent in using what we have" and he then went on to recruit and train 30,000 nurses.

What I found most moving in the programme was the account by one doctor of how he changed his mind in favour of the NHS after seeing children being admitted with burst appendices and peritonitis as their parents had delayed seeking medical attention; treating abdominal pain with cod liver oil which is cheaper, in the short term.

The improved access to treatment with improved health is well documented, how doctors welcomed it less so. One account from Harry Keen, when a GP, was that he decided to pay a return visit to a family with a sick child on the morning of 5th July to be told by the

mother that he couldn't come in as she could not afford the bill "Madam", he replied proudly, "from today you will pay no more bills, the NHS has arrived".

One account from a GP was that he noted his income going up fourfold but the workload tenfold. A testament to the scope of unmet need before the NHS.

The programme is a gripping drama but even at 1hour 18 minutes it does not tell enough of the earlier times.

The Earliest Beginnings

Mankind has generally taken the view that illness and suffering are bad and to take steps to avoid them but belief that a system could be set up to treat one and all required more thought.

Amongst those credited with the concept of a universal service are Queen Elisabeth the First, Adam Smith (of 'Wealth of Nations' fame) and the London City Council.

One of the key moves in establishing the consensus that the state is responsible for the nation's health was the Public Health Act of 1875. The Act meant that every public health authority had to have a medical officer and a sanitary inspector, to ensure the laws on food, housing, water and hygiene were carried out.

The acceptance that social determinant of health should also be the state's responsibility was enshrined Under the National Insurance Act 1911, introduced by David Lloyd George.

A small amount was deducted from weekly wages, to which was added contributions from the employer and the government. In return for the record of contributions, the workman was entitled to medical care (as well as retirement and unemployment benefits) though not necessarily to the drugs prescribed. To obtain medical care, he registered with a doctor. Each doctor in General Practice who participated in the scheme thus had a "panel" of those who have made an insurance under the system, and was paid a capitation grant out of the fund calculated upon the number.

Lloyd George's name survives in the "Lloyd George envelopes" in which some primary care records in England are (still) stored. This imperfect scheme only covered workers who paid their National Insurance Contributions and was known as "Lloyd George's Ambulance Wagon". Most women and children were not covered.

Dr Benjamin Moore, a Liverpool physician, in 1910 in *The Dawn of the Health Age* [2] was probably the first to use the words "National Health Service"' He established the State Medical Service Association which held its first meeting in 1912 and continued to exist until it was replaced by the Socialist Medical Association in 1930.

Prior to the Second World War there was already consensus that health insurance should be extended to the dependants of the wage-earner, and that the voluntary and local authority hospitals should be integrated.

A BMA pamphlet, "A General Medical Service for the Nation" was issued along these lines in 1938. However, no action was taken due to the international crisis. During the war, a new centralised state-run Emergency Hospital Service employed doctors and nurses to care for those injured by enemy action and arrange for their treatment in whichever hospital was available.

In 1941 the Medical Planning Commission set up by the professional bodies recommended a National Health Service with General Practitioners working through health centres and hospitals run by regional administrations. The Beveridge Report of December 1942 included the idea. However when conservative Health Minister Henry Willink prepared a white paper endorsing a National Health Service, it was attacked by many Conservatives and Lord Beaverbrook; resignations were threatened.

However the Cabinet endorsed the White Paper which was published in 1944. Willink struggled on but did not make progress against opposition from Local Authorities and the BMA. Everything changed with the Labour victory of 1945.

Most of us know the ups and downs of the service since then; the scale of the problem had been underestimated as the millions came forward with long neglected needs. The public have been grateful and the politicians have noticed. For 60 years they made cycles of changes without threatening the basic structure. Given the moves towards integration with social services now it is interesting to note that in 1988 there was a department of Department of Health and Social Security which lasted until 2001.

...but an uncertain future

Yet there were always the seeds of destruction. Right from the start, the NHS has had its detractors – and the BMA must shamefully admit to its part in opposing the foundation of the NHS in 1948 in its "state medicine" comments at the time, though of course not now – and fundamental destruction of the NHS now lies within the grasp of those proclaiming the virtue of its demise.

Healthcare was never universal and completely comprehensive and its borders with what we now call social care has always been somewhat porous. Starting as early as the 1980s with progressive legislation which undid the founding principles of the NHS and clouded the clarity with notions of "marketising" it, the trend to undo the NHS gathered pace under the Blair government, ironically, and reached its zenith with the passage of the Health and Social Care Act in 2012. If the NHS and the government could be likened to a connected train of carriages, this Act uncoupled them. The Secretary of State for Health would no longer have overall responsibility for NHS provision. Only for "promoting" it. Competition for health contracts was made compulsory.

This has led us to where we are. GP practices folding and buckling. A&Es driven to stacking people on trolleys, and people driven to them in increasing despair as services around them collapse or extend their waiting times effectively to eternity. NHS staff divided and under the yoke of fear and bullying ushered in with years of cuts both to funding and decades of rights at work. Hospital services deliberately and systematically cut and under-funded as a policy, all the time masked with the obtuse language of the management consultant: "centralisation" for forcing people to make a 50 mile journey to an A&E; "encouraging wellness" as plans are made to shift to non-existent community care – the list is as endless as it is opaque.

A masterful piece of connived social mis-engineering, founded in ideals that could not be more hostile to the concept of shared responsibility and healthcare. Yet still the public are not seeing this simple truth: without the NHS, most of us will suffer more, as the legacy to this monstrous denial.

History, it has been said, does not repeat itself but it does rhyme. If the ugly verse of mass suffering is not to frame the future, all of us have a responsibility to know the harsh lessons of the past, and proclaim the hope instilled through the undaunted efforts of visionaries like Bevan. There is and must be a better way.

References

[1] BBC (2008) *The NHS: A Difficult Beginning* [online] Available on YouTube http://bit.ly/1inuaLA

[2] Moore, B. (1910) *The Dawn of the Health Age*. Churchill: London. Available as a facsimile online at: https://archive.org/details/dawnofhealthage00moor

Eric Watts
Editor
eric.watts4@btinternet.com

What Are STPs Really About?

Integrating care is the declared intention but the plans so far fall well short

STPs are now established as part of the health & social service planning machinery but they are a mixed blessing.

While it makes good sense to plan health and social services together the basic problem with STPs is that they are designed to limit spending and the better approach would be to provide the funding required for a high quality service.

There are many potential benefits of integrating health and social care and they have been used to justify changes but good evidence is hard to find:

"Integrating the health and social care sectors is a significant challenge in normal times, let alone times when both sectors are under such severe pressure. So far, benefits have fallen far short of plans, despite much effort." [1]

Within the NHS most of the proposals rely on a standard response as explained by one DoH official, who said "Everyone knows that treatment in hospital is more expensive than by GPs usually by a factor of 10, so we should move as much care as possible out of hospitals and onto GPs". This said with a straight face with no regard to quality of outcomes nor the simple fact that most patients are in hospital because they were sent there by their GP to benefit from more specialised care.

GPs are well used to taking over the care of patients previously treated in hospital as a means of cost control in the NHS. More recently PCTs and CCGs have tried ways to discourage referrals including hiring GPs to act as second gatekeepers, ie scrutinising referrals and delaying some of them, resulting in patients deteriorating before their appointment.

As ever the language reveals the opinion/stance of the speaker. Announced by Simon Stevens and talking of improvements and naming 3 areas as "success regimes" when all the changes will in fact be an experiment. Whereas experiments can be useful means of learning they require comparisons with standard care for the best learning outcomes.

I have just read *Designing Care* by Richard Bohmer, physician and faculty member at Harvard Business School, a champion of operational management [2]. He makes the point that, whilst there are similarities between some aspect of health care and industrial production there are many more differences and that only those areas that have been adequately researched with the treatment then organised into protocols and the new systems thoroughly tested can health care be seen as a delivery system.

Much more of health care is diagnosis and assessment, followed by observation of the response to treatment, often a complex iterative process requiring critical thought and evaluation at each stage.

Such a complex process does not lend itself to a production line approach, as stated by the author himself but ignored by many of his disciples.

The STP plans I have read do not follow a well researched plan but are the old plans based on cost reduction through fewer hospital beds and expecting care in the community to fill the gap. Over the last few years local authority spending has been cut making care in the community harder to provide.

Two excellent articles have been published by the Centre for Health in the Public Interest (see page 9 for a summary of A&E services in North West London). Members will I'm sure be pleased to know that DFNHS has contributed to CHPI funds to support their research.

The King's Fund, at first, stated that STPs are "the only game in town" but have recently been more sanguine with a more thoughtful piece stating there are seven big questions facing STPs, all of them arising from the issues described in

this newsletter [3].

It is no surprise that some Local Authorities have rejected them. The decision by Hammersmith & Fulham and Ealing councils to refuse hospital closure plans was backed by hundreds at a packed town hall meeting in December. Waltham Forest Council turned down plans in January, and the leaders of five councils in West Yorkshire have written a letter to NHS England saying they have not been given proper scrutiny of the West Yorkshire and Harrogate STP.

Centralisation of services

Centralisation of services goes in and out of fashion with the regularity of changes in the seasons.

It's clearly not one size fits all – the issue needs to be assessed according to the merits of the case. In my area, Essex, we have a population of 1.2 million, served by three DGHs each with an A&E.

The proposal (pending a business case and due protocol, ie formal public consultation and sign-off by CCGs) is to have one specialist emergency hospital and to downgrade the other two A&E departments. This has caused some alarm and tens of thousands have signed petitions to defend local services. They have asked the obvious questions specifically: will patients be harmed by longer ambulance journeys?

And the evidence is yes; some will, as has been shown by six studies that looked directly at the effect of travel distance and time to hospital and they showed that for journeys over a mile there is a clear and consistent relationship showing increased mortality with increased travel time and distance, summarised neatly as a 1% increase in mortality per 10k travelled [4].

The planned change to admissions will involve two-thirds of patients moving from having a 10-20 km journey to a 20 km + one. The statistics indicate this will move them into the higher mortality group.

In my limited discussions with members of the team they claim services should be centralised for better care, so where is the evidence for that?

The classic example is percutaneous coronary endarterectomy so most patients with a STEMI type of myocardial infarction are now taken to a cardiac centre rather than to DGH. And quite rightly too – those who benefit from high tech interventions should receive them. But this poses the question: what proportion of emergencies need these high tech interventions that justify the extra travelling time?

To my surprise, the planners did not have a breakdown of emergency admissions classified in a way that allowed a useful analysis. The ambulance service advised that I needed to submit an FOI and they responded with details of their emergency journeys to the local hospitals.

The commonest category was admission ordered by a doctor at 16%, falls 12%, breathing difficulties 11%, unspecified 9% 'sick person' 7%. The categories most likely to be surgical, ie abdominal pain and trauma, were just under 2% each. This shows the majority of cases required further assessment followed by standard DGH treatments rather than super-specialist interventions

It is possible that a centralised A&E could provide a better service but unless there is coordinated care out of hospital some will benefit but as well as winners there will be losers. The experience from North-West London demonstrates how care deteriorates when A&E departments are downgraded without improved community services.

What can we do?

In September 2016 NHS England, with its partner organisations in the *Five Year Forward View,* stated that Clinical Commissioning Groups (CCGs), local authorities, NHS trusts, NHS foundation trusts and NHS England all have separate, but similar, obligations to consult or otherwise involve the public.

It's the usual situation, stand up speak up and make your voice heard. CCGs and local authorities are under no illusions – this is

primarily a cost cutting exercise and we must show that health care will suffer unless genuine improvements in community care are made in order to make the changes to hospitals safe.

Our colleagues in HCT have an STP Watch panel on their website we could use this to report problems [5].

Peter Fisher is keen to collect data where MPs may be threatened by plans for cuts and closures to local services so we can compile a list of MPs who may be prepared to form a parliamentary cross-party group to review the effects of the STPs to avoid withdrawing services.

Do you know your MP's views? Please send comments to Peter (nhsca@pop3.poptel.org.uk or to Hill House, Great Bourton, Banbury, Oxon OX17 1QH).

References

[1] Morse, A. (2017) *Health and Social Care Integration.* London: National Audit Office [online] Available at: http://bit.ly/2rkYVIS

[2] Bohmer, R. (2009) *Designing Care*. Boston, MA: Harvard Business Press

[3] The King's Fund (2017) *Seven Big Questions Facing STPs* [online] Available at: http://bit.ly/2kU6GxY

[4] Nichol, J. et al. (2007) 'The relationship between distance to hospital and patient mortality in emergencies: an observational study' *Emergency Medicine Journal* 24(9):665-8 [online] Available at doi: 10.1136/emj.2007.047654

[5] Health Campaigns Together (2017) http://www.healthcampaignstogether.com/STPgeneralinfo.php

Eric Watts
Editor
eric.watts4@btinternet.com

CHPI Report

Can we afford to close any more A&E departments? Evidence from North West London . CHPI

Closing A&E departments has led to a deterioration in the performance of those that remain in North West London. This analysis warns of the risk to patients if further A&Es are closed.

Across England NHS Sustainability and Transformation Plans (STPs) are proposing the closure or "downgrade" of up to 24 emergency departments.

This analysis shows how A&E performance suffered following the closure of two emergency departments in 2014.

Performance against the 95% 4-hour wait target dropped to as low as 60% shortly after the closures, meaning that up to 40% of patients requiring serious treatment had to wait over 4 hours to be assessed and admitted to an appropriate bed. Since then the performance of North West London hospitals has been some of the worst in the country, sometimes managing to treat fewer than half of the patients within 4 hours. For time-sensitive conditions such as sepsis or respiratory failure such delays are life-threatening.

Since the A&E closures in 2014 the bed occupancy rate in all hospital trusts in North West London has been above 85%, compromising clinical safety through overcrowding. The report also highlights growing health inequalities in the area.
http://bit.ly/2qQ4LRI

Hedge Funds and the NHS: Profit Before People?

Privatisation has long been held up as a panacea to the NHS's problems. The first "PFI" (Private Finance Initiative) schemes in the 90s were hailed as a possible solution to the NHS's difficulties in funding large capital projects, like new hospital buildings, under the Major and Blair governments.

Since then, it's been estimated that taxpayers' money will be used to pay more than five times over what those PFI assets are worth, at £57bn. Private money into the NHS meant public liability, many times over, for no private risk.

But far from taking the lesson that private money to fund the NHS causes it greater problems, the NHS leadership's most recent move to meet its under-funding is to approach City hedge funds to borrow £10 billion. This marks a great leap forward in privatising our NHS.

> "Billions of taxpayers' money will be siphoned off for years to come into the pockets of the wealthy."

Hedge funds are investment companies using private wealth to invest in a wide range of businesses and ventures. Their most striking characteristic is their almost completely unregulated nature. They are set up deliberately to avoid most financial regulation and are by their nature far from transparent. They exist for but one purpose: to make a profit.

Many now think the NHS is "inefficient" and the City will be its salvation. Benefit for all, it is assumed, will somehow trickle down as capital is invested and profits returned. Yet it will not. It will stay firmly in the deepening pockets of the wealthy fund investors, who are not accountable to the public in any way. The only ultimate benefactors of any deal between City hedge funds and the NHS will be the very few with the privilege and fortune to be a part of the machine. The rest of us will keep paying, through our taxes, for years to come.

Billions of pounds of taxpayers' money will be siphoned off for years to come into the pockets of the wealthy backers of organisations that could not be more opaque in their dealings. They would then command unparalleled influence on policy making by this country's greatest service – our NHS. How much easier will it then be for private contracts to be awarded on a widening scale and further cuts to be made, as market "norms" replace those precious to the NHS and on which it was founded? Patients will suffer as profits are upheld.

That the NHS should be forced to consider borrowing like this is the greatest indication that there is something deeply flawed in the way public services are now seen. Public services are paid from our taxes. Some feel politicians should grasp the nettle and advocate an increase in taxation of the better off to properly fund the NHS. We should not delude ourselves into thinking "private money" or "private know-how" is the answer.

David Wrigley
David works as a GP in Lancashire and is Deputy Chair of the BMA
Views expressed are his own
dgwrigley@doctors.org.uk
(This article first appeared in the *Independent* 'Voices' column on Tuesday 9 May 2017 [http://ind.pn/2qpT4BX]
Reproduced with permission.)

The Lords' Inquiry on the Sustainability of the NHS

The Lords has ruled in favour of the NHS: will the government listen?

The NHS has been underfunded for most if not all of its 69 years, it is generally agreed that if we had more resources we could do more for the nation's health.

We have made the limited funds reach a long way whilst reminding the governments of the day that resources are insufficient. The argument that the NHS is too expensive shows the intellectual poverty of those who make that case. We have always maintained that the NHS is more than a necessary expense or drain on the public purse, it is, in fact an asset. An investment that more than pays for itself; a resource so vital to our country that we can't afford not to have it as all the alternatives are more expensive.

Spending on health brings benefit and rewards over and above healthcare itself. A healthy nation is a secure and prosperous nation. Economists can measure the effect and the World Bank endorsed the view back in 1993 [1]. We need to remind governments that funding the NHS is a top priority and not an optional extra.

Is that naive idealism having a rant? No, it's the verdict of that most sober institution in our establishment, none other than the House of Lords Select Committee on the Long-term Sustainability of the NHS [2].

This long awaited report states that the NHS and adult social care system is sustainable. They do advocate changes which are natural given the changing nature of our world and increasing knowledge but as far as the founding principles of the service go they are clear and firm:

> **"We strongly recommend that a tax-funded, free-at-the-point-of use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future."**

This will not come as a surprise to serious students of health or economics but it may surprise the floating voter confused by so many reasonable sounding people saying that the NHS is overspent.

The report – along with the Royal Commission Report of 1979 [3] and other authoritative reports which have looked at alternatives and taken the time and effort to consider them in detail – have all concluded that the fundamentals of the NHS are sound. That the priorities should be to create policies that enable it to work better, not to undermine a system struggling to cope with increasing work and inadequate funds.

The committee was chaired by Lord Patel, obstetrician and cross-bench peer, and had four Conservatives, four Labour members, two Lib Dems, two cross-benchers and a bishop, five of these doctors.

The first meeting was 25th May 2016, and they collected evidence from numerous bodies (including DFNHS). The details are on the website with the full report.

They begin by acknowledging that in 2017 the "extreme financial challenge" for the NHS and the adult social care system is on the brink of collapse but stress that they are thinking beyond current crises, doubtless thinking that the report could be implemented in the new term of parliament then due to start in 2020. There has to date not been a government response and it may take some time.

There is an unfortunate precedent in that the Royal Commission (Merrison) on the NHS, set up by Harold Wilson in 1975, reported in 1979 when Margaret Thatcher was in charge [3].

Out of a range of recommendations she chose to implement one – the abolition of area

health authorities. There is much to recommend in the report which is presented in sections on Service Transformation, Workforce, Funding, Innovation, Public Health, and Towards a Lasting Political Consensus.

A brief summary of this latest report is that many problems are the result of short-term thinking and too much time is absorbed in day-to-day struggles. There should be realistic funding, ie an end to the current real terms decline and, having achieved a political consensus, an Office for Health and Care Sustainability should be created with sufficient powers to oversee planning. They also call for long-term workforce planning, better innovation, and improved public health. Important excerpts are displayed on the following pages.

What they did not include was the submission sent to them by DFNHS Chair, Eric Watts:

> "It is becoming clear that one of the greatest motivational factors for staff is to work for the NHS itself: for the pride and fulfilment that comes from working for the best known and most highly respected health brand in the world.
>
> "NHS workers are, or have been, seen as having a commitment that is admired by the public and it is the overriding sense that is publicly owned and publicly accountable that drives staff to deliver the best they can... In short, to recruit and retain staff it will be essential to restore the founding principles of the NHS and to value all working in it as dedicated professionals and public servants."

References

[1] World Bank (1993) *World Development Report 1993: Investing in health* [online] available at: http://bit.ly/2pKm1bL

[2] House of Lords Select Committee on Long-Term Sustainability of the NHS (2017) *The Long-Term Sustainability of the NHS and Adult Social Care* [online] available at: http://bit.ly/2nWtZdW

[3] Merrison, A. (1979) *Royal Commission on the National Health Service*. London: HMSO (Cmnd. 7615)

From the Report

(3) The NHS has been serving the nation well for almost 70 years. We were told that it is increasingly effective, affordable and a net asset for the country as a whole. Remarkably, the founding principles which underpinned Aneurin Bevan's pioneering NHS of 1948 are taken to be as valid today as they were then—that the NHS should provide a comprehensive service, available to all. The service one receives should depend on clinical need, not the ability to pay.

(5) The House of Commons Public Accounts Committee (PAC) recently reported on the financial sustainability of the NHS. It found that the financial performance of NHS bodies had 'worsened considerably'. NHS trusts' deficits had reached £2.5 billion in 2015/16, up from an £859 million deficit in 2014/15. According to the PAC two-thirds of NHS trusts (65%) and NHS foundation trusts (66%) reported deficits in 2015/16, up from 44% of NHS trusts and 51% of NHS foundation trusts in the previous financialyear. This downward spiral cannot continue.

(13) The public is committed to the NHS as a service which is tax-funded and free-at-the-point-of-use. However, a recent opinion poll conducted by IpsosMORI showed that the future of the NHS is an increasing concern, with 55% of people—the highest figure they have ever recorded—saying they expected the NHS to deteriorate over the longer term.

There has been an entrenched

reluctance to engage in a serious conversation with citizens about how the system they have grown used to will need to change to meet new challenges. People need to be educated to take responsibility for their own health. Politicians need to be honest that with patient rights come patient responsibilities.

• Radical service transformation:

The needs of patients have changed and so the system needs to change with them. There is widespread agreement on the vision—integrated health and care services delivering more care in primary and community settings—but service fragmentation and volatile funding allocations are making the necessary service transformation difficult.

• Long-term funding solutions for the NHS and adult social care:

Funding for both health and social care needs to be more stable and predictable, with better alignment between the allocations for health and social care. This should help to support longer-term, strategic planning for both services.

• Immediate and sustained action on adult social care:

The funding crisis in adult social care threatens to overwhelm the NHS and will undermine any efforts to transform the system as a whole. A long-term financial settlement — preferably one on which the political parties can agree—is needed to put social care on a sustainable footing. A long-term programme, with clear leadership, governance and accountability for the better integration of health and social care, is the single instrument that would do most to enable the NHS to break through to a sustainable future.

"Funding for both health and social care needs to be more stable and predictable, with better alignment between the allocations for health and social care"

On Service Transformation and STPs

(40) Despite the assurance that the *Forward View* would be revisited we were concerned that there appeared to be a significant lack of long-term thinking around how the momentum on service transformation will be maintained. As the Health Foundation emphasised:

"Delivering the vision and funding set out in the *Forward View* is a necessary step towards a sustainable health care system but not a sufficient one. Beyond the *Forward View*, action will be needed to secure a high quality, sustainable health and care system for the 2020s."

(44) *The Five Year Forward View* appeared to be the only example of strategic planning for the future of

the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the *Five Year Forward View* will be put at risk.

(45) The Department of Health and NHS England, in partnership with the Department of Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation.

> "STPs have no statutory basis....There is considerable ambiguity around the governance of STPs which threatens... the ability of STP areas to drive changes to services"

Lack of governance

(50) Currently, STPs have no statutory basis. However, several individual statutory organisations, such as clinical commissioning groups, will be involved in each Plan. There is, therefore, considerable ambiguity around the governance of STPs which threatens to undermine the ability of STP areas to drive changes to services. Sir Robert Naylor, former Chief Executive of the University College London Hospitals NHS Foundation Trust, said:

"There are, however, a number of challenges that STPs will need to overcome if they are to deliver the improvements that the NHS needs. The first is about governance and engagement. STPs have been set up relatively quickly, with multiple conflicts of interest and without a statutory basis. That will not give them the authority they will need to drive through difficult decisions about service changes and distribution of financial risks. They will be unable to deliver significant estate changes, including investment in primary care, because the majority of assets are 'owned' by the acute foundation trusts who are not responsible for the whole patient pathway."

(67) The Royal College of General Practitioners highlighted the most pressing issues facing general practice:

- Despite an increase in demand, investment in general practice has declined. Since 2005/06 the level of investment in general practice as a proportion of the NHS budget has declined from 10.7% to a record low of 8.4% in 2011/12.
- The failure of GP recruitment to keep pace with demand is set to leave a shortfall of 9,940 GPs across the UK by 2020.
- RETE. The ratio of practice nurses is failing to keep pace with increased demand and complexity with 2.7 Full Time Equivalent nurses for

every 10,000 patients in England in 2014/15, the same ratio as in 2010/11. As well as this, the practice nurse workforce is ageing, with 31% of practice nurses aged 55 or over in 2014/15.

(68) These challenges are frustrating efforts to deliver more care in primary and community settings in order to reduce pressures in the acute sector.... The *General Practice Forward View* acknowledged this, highlighting a report by the Primary Care Foundation and the NHS Alliance, and stated that:

"The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."

"Over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped"

(80) We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation.

On integration with social services

(94) Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda.

On Competition

(98) The King's Fund recently highlighted, in its report *Delivering Sustainability and Transformation Plans*, that amendments were needed to the aspects of the Act that were not aligned with the aims of the *Five Year Forward View* and STPs. It suggested that:

"The sections of the Act relating to market regulation would particularly benefit from review, both in relation to the role of the CMA [Competition and Markets Authority] and requirements on commissioners to use competitive processes in procuring new care models. There is also a need to recognise more formally the role that STPs are expected to play alongside the boards of NHS organisations and local authorities."

Overseas workers and Brexit

(113) The NHS and social care workforce draws on global talent and relies on a steady stream of immigration. The Recruitment and Employment Confederation told us that: "The latest data from the Health and Social Care Information Centre (June 2016) reports that 57,608 staff employed in NHS Trusts and Clinical Commissioning Groups in England declare their nationality to be from a European Union member state—71,510 staff are from non-EU member states; collectively accounting for around 11% of all staff."

Morale, pay and retention

(147) Dr Mark Britnell, Partner and Chairman at the Global Health Practice at KPMG, told us that one of the most important things for a sustainable health system was staff morale and he exhorted us to "love your workforce and motivate and direct it properly."

(148) We were particularly concerned to hear from Sir Cyril Chantler that there was a climate of fear amongst the workforce which was being created by excessive levels of top-down accountability and over-regulation.

(153) There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament *[2020 at the time of publication – Ed]*, pay will have been constrained for almost a decade.

> "When we move towards an election time, people are doing sounbites around the NHS because it is so important to the public and we are not moving forward"

Alternative funding models

(163) We heard a range of evidence regarding the different funding models that were employed by different health systems around the world including: general taxation (UK); social insurance through employer/employee contributions (France, Germany); compulsory social insurance (Switzerland); and voluntary insurance (USA). We also received evidence about the options for mechanisms to raise additional funding.

(164) The advantages and disadvantages of moving to an alternative funding model were explored over the course of the inquiry. However, there was general agreement that this would not be a viable solution for the UK. Lord Willets informed us that, in a previous role as a policy adviser to a past government, he had considered alternative arrangements for health funding including "copayment, private insurance—all those conventional options" but concluded that: "a nationwide risk pool to fund healthcare was a perfectly reasonable arrangement, and that the costs of moving from what

we had to some other system were very high."

(165) John Appleby, Director of Research and Chief Economist at the Nuffield Trust, also highlighted some of the issues related to alternative sources of funding for health, stating that:

"If you want to switch the proportions of funding from different sources—from public to private, from collective to more individual—that raises a whole lot of distributional and equity issues. From the evidence and from looking at other countries, there is, in a sense, a trade-off between different sources of funding."

NHS funding levels

(184) Across countries, regardless of the health care funding model, populations have increasingly chosen to spend a growing share of national wealth on health.

(187) The strongest advantage of hypothecation appeared to be the greater transparency it would provide of the link between taxation and government spending, which witnesses suggested could help improve the public's understanding of expenditure on the NHS. This could help to facilitate a better debate about how much the electorate were willing to pay for the health service. The key disadvantage we heard was that hypothecation could potentially undermine the ability of governments to deal with the economic cycle, restricting the flexibility they have to allocate resources as they see fit.

Building political consensus and engaging the public

(326) A lasting political settlement for the NHS and social care was highlighted by a number of witnesses as the main solution to many of the current problems.

(327) Toward the end of the inquiry, we invited the health spokespeople for the three main opposition political parties in Westminster to appear before us; we are grateful for the time they took to speak to us. Norman Lamb MP, the Liberal Democrat Health spokesperson, told us about the failures of the past:

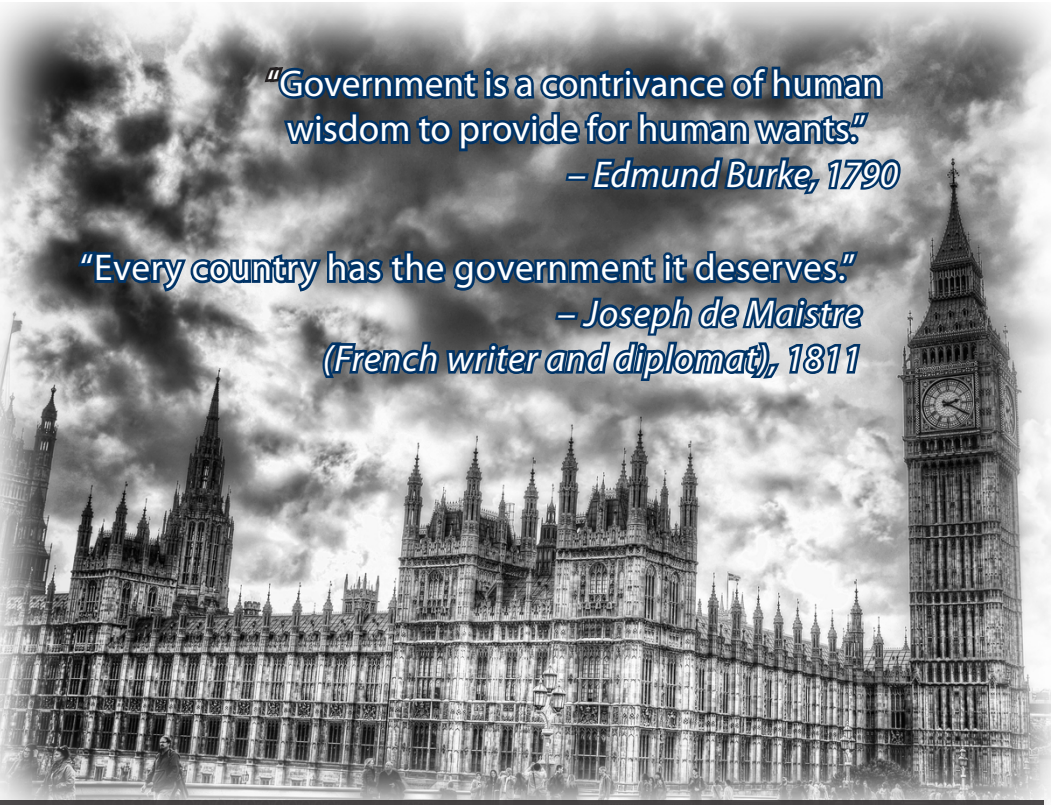
"None of the political parties at the last election had a solution for the long-term funding challenges of the health and social care system"

"The brutal truth is that none of the political parties at the last election had a solution for the long-term funding challenge of the health and care system..."

(329) Despite this specific example, from the evidence we received we were far from convinced that the political parties have truly bought into a longer term approach that would inevitably curtail their room for manoeuvre at election times. Dr Philippa Whitford MP, the SNP Shadow Westminster Group Leader (Health) told us:

"When we move towards an election time, people are doing soundbites around the NHS because it is so important to the public and we are not moving forward …"

General Election 2017



"The NHS will last as long as there are folk left with the faith to fight for it"

– Aneurin Bevan, 1948

As the parties declare their manifestos, two things are certain.

The first is that this election will determine the fate of the NHS like no other since the General Election in 1945, heralding the creation of the Welfare State. Now mostly history.

Yet the idea of healthcare for all, when they need it and without the terror of not being able to pay, remains a core belief in how the UK defines and holds itself. All the parties promise much, yet for close to 20 years the NHS has been under increasing strain. The second certainty is that this cannot and will not continue for much longer.

Hard choices have to be made: but as a nation we can afford them. Whatever the government on 9 June, its overriding responsibility must be to give the people the NHS they want. We summarise the manifestos of all the main parties on the following pages. And ask all our members: vote for the NHS. Vote for a future we all deserve. #VoteNHS

Labour

Labour's Manifesto – *For the Many, Not the Few* – devotes 10 of its 162 pages to the NHS (Chapter 7).

The opening section outlines the party's intentions in some detail beyond the expected statements about ensuring NHS patients "get the world-class quality of care they need and that sataff are able to deliver the standards that patients expect".

The manifesto pledges to uphold the 18 week access limit to treatment and restore the 4 hour A&E waiting time; deliver the Cancer Strategy for England in full by 2020, and restore ambulance service levels. A new model of care taking into account primary, social care and mental health is promised. GP service funding is to be increased. Pharmacy cuts are to be stopped. Labour will "tackle the growing problem of postcode lotteries". Though, as you might expect from a broad manifesto, details on how this is to be achieved are not given.

Action to prevent infant deaths is promised in a section on public health, as well as a commitment to invest in children's health. Here there is some detail: a £250 million Children's Health Fund is promised. As are more health visitors.

The section on NHS staff promises to scrap the NHS pay cap and put decisions back into the hands of the independent pay review body. The rights of EU workers employed by the NHS are specifically mentioned.

The section on funding states an extra £30 billion over the next Parliament for the NHS, and boosted capital funding. Labour promises to *halt and review* STPs. And to "reverse privatisation of our NHS" and reinstate the Health Secretary's overall responsibility (scrapped by the Health and Social Care Act in 2012).

The chapter sensibly includes sections on social care and mental health, outlining Labour's intentions. These do contain a fair amount of detail for funding and proposed change.

Lib-Dem

The Lib-Dems' manifesto – *Change Britain's Future* – devotes 8 of its 100 or so pages to the NHS and social care.

The one-page summary at the start of the chapter puts their principal points in short form:

- Saving the NHS by putting a penny in the pound on income tax.
- Transforming mental health care with waiting time standards to match those in physical health care.
- Home not hospital: better integration of health and social care and limiting the amount elderly people have to pay for social care.

The prerequisite of the Lib-Dems' argument is that the NHS is in a state of crisis, engineered through under-funding.

They propose "five steps" to remedy this, which includes an immediate 1p rise on the basic, higher and additional rates of income tax which would be ringfenced for NHS and social care.

A cross-party health and social care convention is promised, to carry out a comprehensive review of the longer-term sustainability of the health and social care finances and workforce.

A statutory independent budget monitoring agency for health and care is also promised. This would report every 3 years on how much money the system needs to deliver safe and sustainable treatment and care.

The next section addresses the rights of NHS staff, including a pledge to restore nursing bursaries and protest the rights of EU citizens working for the NHS. Sections on mental health and proposals to link health and social care more closely then follow, with some detail.

The chapter ends with a range of actions "to keep people healthy", a mixture of health promotion and restored public health measures, including a "National Wellbeing strategy".

Conservative

***Forward Together: Our Plan for a stronger Britain and a prosperous future* taps into the Conservatives' chosen stance of "strong and stable".**

At around 90 pages long, it focuses primarily on principles and values, as opposed to listed detail.

The manifesto opens by listing five "giant challenges" – the need for a strong economy, Brexit, "enduring social divisions", an ageing society, and fast-changing technology – which it then follows up by promising to "govern from the mainstream" by showing leadership: this is a manifesto playing on values and sticking to one core message.

The principles those values build into, according to the Conservatives, are given a fair amount of space. A vision for a stronger Britain, a prosperous future.

Each of the five challenges is then taken in turn, addressing them in some detail but, again, very much from a "broad principles/single message" starting point.

Mental health is covered, in "the mental health gap", where glaring shortfalls are acknowledged and some specific figures to remedy it given. A further £1billion is promised by 2020-21. Social care for the elderly similarly receives some attention and proved controversial over the issue of how much people would have to pay.

"Our National Health Service" appears on page 66 and is 4 pages long. Five ways of "giving the NHS the money it needs" are then listed. Increasing spending to £8 billion but over the next 5 years is promised. EU staff working for the NHS are to be "given priority" in Brexit negotiations. An investment programme in NHS estate is promised (though avoiding funding details; is PFI still to be with us?). Further action to recover NHS costs from non-UK residents is promised. NHS leaders "will be held to account" and clinical outcomes in NHS organisations made more transparent.

FOR THE NHS NOT PROFIT

Green Party

The Greens' manifesto – *The Green Party for a Confident and Caring Britain* – is shorter at 26 pages than the main party manifestos but the party commits itself to broad reforms of the NHS and social care.

The manifesto states that the Greens would:

"Roll back privatisation of the NHS to ensure that all health and dental services are always publicly provided and funded, and free at the point of access, via the introduction of an NHS Reinstatement Act.

"Scrap NHS Sustainability and Transformation Plans.

"Bring mental health care in line with physical health care and ensure people experiencing mental health crises are supported close to their home and support networks.

"Introduce mental health awareness training within the public sector and encourage a more open dialogue on the issue in wider society.

"Close the NHS spending gap and provide an immediate cash injection, to ensure everyone can access a GP, hospitals can run properly, and staff are fairly paid.

"Major investment in social care for the elderly and all those who need it."

Green MP Caroline Lucas tabled the NHS Bill as a Private Member's Bill in the last Parliament.

Progressive stand against Hunt

National Health Action Party's Dr Loiuise Irvine is standing as a parliamentary candidate for the Progressive Alliance in Jeremy Hunt's constituency of South West Surrey.

An alliance of non-Conservative parties, including the Greens, agreed to support Louise in their campaigns, and the Green Party candidate agreed to stand down in favour of Louise who is standing against the current Secratary of State for Health.

Louise stood in the same constituency against Jeremy Hunt in the 2015 election.

This is reminiscent of NHAP's Dr Richard Taylor's actions in Kidderminster in 2001, where a similar cross-party alliance gave Dr Todd a victory.

Plaid Cymru

Plaid Cymru's manifesto devotes a section to the NHS, in Wales "A healthier, happier Wales".

The bold statement that the party is the only one in Wales people can entrust the NHS to is followed by promises to train and recruit 1000 more doctors and 5000 more nurses for Wales.

They also pledge to introduce a social care rescue plan which sees an increased role for community care hospitals, improve mortality figures by better diagnosis and public health, and continue to call for increased mental health funding, and more staff for mental health provision.

Scottish National Party

The SNP hadn't released their manifesto by the time we went to press, unfortunately, so we couldn't list it here. (We had to go to print earlier than usuaul, to get your copy to you before the General Election.)

But their current pledge on health indicates much:

"The SNP believe the NHS should remain a publicly funded, publicly-delivered service. We will not follow the privatisation agenda of the Westminster government. The staff who work in our hospitals, communities and health centres do an amazing job. They deserve our unreserved praise for the fantastic results they have produced over the last few years.

"...The SNP has met its commitment to protect the NHS budget."

You can check their webiste at:
https://www.snp.org

Doctors for the NHS supports no political party but does support the political will to save the NHS from privatisation and under-funding

Health Campaigns Together
Defending Our NHS ● www.healthcampaignstogether.com ● @nhscampaigns ● FREE

HCT Update and Election Special

Health Campaigns Together, the alliance of health campaigns formed a little over 18 months ago, has now had its first formal AGM and continues to grow in strength.

HCT was formed at the behest of Keep Our NHS Public when it was realised that individual campaigns were growing in number, many of them effective locally, but nationally there was a risk of "the movement" becoming too dispersed and thereby wasting its most valuable resource: committed people and the connections between them.

DFNHS was a founding member as well as KONP. Since then, HCT has established a very effective quarterly newspaper, *HCT News*, the circulation for which now numbers well over 15,000 and is growing.

The health unions and the TUC are now discussing with HCT what more can be done to mount coordinated, cooperative action following HCT's highly successful co-venture with the People's Assembly (also a member organisation), the 4 March NHS demonstration in London (see last issue of this newsletter).

Further coordinated events are being planned in July for the NHS's "birthday", and of course allied local groups up and down the country are busy getting their messages across leading up to the General Election.

HCT's constitution means that individuals cannot joint it – only groups, and one group has one vote at a meeting although any can attend and comment with the Chair's consent. A rule which was set up to prevent any one group having too great an influence on the organisation as a whole.

HCT meetings are amiable and constructive, and the expertise present is genuinely impressive. There are differences of opinion, of course: but the values and aims are shared, and that is its strength.

With the announcement of the General Election, HCT rapidly produced an "Election Special" 8-page issue which proved very popular with groups, trade union branches and individuauls througouth England. You can still order copies via the HCT website, and also download the PDF (www.healthcampaignstogether.com).

Other parties allied to HCT also acted to meet the challenge. The NHS "Roadshow" was set up by the Junior Doctors' Alliance, a nationwide group of Juniors who have become increasingly politically active since the Juniors' dispute, who have offered to attend local meetings and rallies to present the case for the NHS. They can be contacted via social media (Facebook: https://www.facebook.com/groups/433327747027976).

HCT is a "rainbow" organisation which contains an astonishing spectrum of long-established and newly launched groups who share the aim of saving the NHS, as well as local and national health unions.

Whatever the result on 8 June, HCT's role will remain: to unite us in defence of the NHS against the greatest threat it has ever faced.

The Threat to Patient Confidentiality: If They are "Immigrants"

The government seeks to use patient data to track people: you can stop this

One of the founding principles of professional ethics and the NHS itself is the absolute respect paid to the confidentiality of patient records.

Of course there are exceptions: if a doctor suspects a murder is about to take place or has done so, for example, there is a clear precedent for passing on such information as may be necessary to prevent it or bring the perpetrator to justice. Or if public health is at stake, it would be poor practice not to pass on vital information, in someone's professional judgement, to preserve safety even if the patient has asked that this not be done.

But what about allowing anonymous, increasingly powerul government agencies to access whatever information about patients they thought fit, for their purposes, whenever they sought to do so, for reasons of "security" and without asking or telling another soul? There has been no crime. There is no evidence of a threat to public health, only a vague "association" that a certain, illl-defined group "might" at some stage pose some equally ill-defined "risk". What then?

If this were a hypothetical question posed to a medical student or trainee, the answers might prove useful but no one need worry that this would ever happen in the real world. Unfortunately, it is all too real.

Through the sweeping expedient of a "Memorandum of Understanding" (ie, not requiring any referral to the Commons or a court) [1], the Home Office, the government department in charge of immigration, has permission to access NHS Digital records of a patient's last known address, date of birth, GP's details and the date registered with a GP. In other words, the government is using NHS patients' personal information for immigration enforcement.

It gets worse. The immediate consequences of such information tapping can include patients' homes being raided, sometimes leading to them being detained and deported.

Then there are the longer term consequences. One of our most vulnerable, persecuted and under-privileged groups – those seeking asylum or immigrants who have few resources and often arrive here with nothing – the very people a civilised health system should be designed to help protect and keep safe, are discouraged from seeking help because they fear the very persecution, state-sanctioned oppression and even detention they in many cases fleed from. Here. On our doorsteps and in our surgeries and wards.

Small wonder, then, that a group of doctors seeing the problems these people face have taken a stand and decided to do something about it.

Doctors of the World Safe Surgeries Toolkit

Doctors of the World (DotW; www.doctorsoftheworld.org.uk) are a small charity who, as the name suggests, focus primarily on getting help to people in what could often be called the less civilised parts of the world. It may surprise some to learn that they now hold regular clinics here in the UK, catering for people who would otherwise have little to no care: asylum seekers and impoverished immigrants.

DotW regard the Home Office's use of the MOU to siphon off personal data as highly undesirable. So much so that they have brought

out a "Safe Surgeries Toolkit" for GPs to use if they want to ensure the Men (or Women) from the Ministry don't get their hands on patient information which, they believe, will almost certainly only be used for ill purpose. Locating then detaining immigrants and asylum seekers.

The toolkit can be viewed online (http://bit.ly/2oCu7Pi) and is very clearly set out.

Its opening words give a clue as to the calibre of the content:

"How to make your GP practice safe for everyone:

"This is a toolkit for healthcare professionals and GP practices who want to provide confidential and welcoming services for all their patients including refugees, asylum seekers and undocumented migrants. This advice complies with NHS England guidance on GP registration [2] and NHS guidance on secondary care [3]. Taking the suggested steps in this guide will also help GP practices demonstrate to the CQC that their service is responsive to patient's needs."

They continue:

"This sort of information-sharing threatens patient confidentiality, a core tenet of the NHS, and undermines the doctor-patient relationship. .... Immigration offences do not present a risk of death or serious harm and there is no case-by-case assessment of the public interest. [4]

"Deterring refugees, asylum seekers, victims of trafficking, and other vulnerable people from getting healthcare has serious health consequences. At Doctors of the World's clinics, we regularly see pregnant women avoiding antenatal care, as well as cancer sufferers and parents with unwell children who are afraid to see a doctor. Ten per cent of our patients already do not access NHS services because they fear arrest. We fear this will now get worse.

"Patients who don't have a GP are more likely to end up going straight to A&E and to leave conditions until they are more advanced and more expensive to treat. And, of course, when more people are treated for illnesses, society becomes healthier for everyone. The patient information that doctors and healthcare staff input into their database in good faith is, ultimately, proving detrimental to people's wellbeing."

Having established the rationale, the Toolkit then outlines six simple steps GPs can take to ensure a patient's information does not end up in the Home Office's vaults. This includes what to tell patients and staff, what to be aware of as a GP, and what to do if challenged directly.

The plight of many of the people the Toolkit seeks to protect may surprise some; what is perhaps as sobering as it is surprising is that a country like the UK, which prides itself on being a rich and civilised nation, should find the need for such a resource at all.

References

[1] Memorandum of Understanding between the Home Office, NHS Digital and the Department of Health [online] available at http://bit.ly/2kwJavx

[2] NHS England, 'Patient Registration Standard Operating Principles for Primary Medical Care (General Practice)' [online] available at http://bit.ly/1MMTEND

[3] Department of Health, 'Guidance on implementing the overseas visitor hospital charging regulations 2015' [online] available at http://bit.ly/1symDOX

[4] GMC, 'Confidentiality' [online] available at http://bit.ly/2qNKgDv

Alan Taman
Managing Editor
healthjournos@gmail.com

Book Review Revisited

NHS For Sale: Myths, Lies & Deception
Jacky Davis, John Lister and David Wrigley Merlin Press, 2015
392pp. £12/bulk discount via Keep Our NHS Public (www.keepournhspublic.com); Kindle edition, £6.50

***NHS For Sale* is a muscular mission of a book. In little over 300 pages its three authors – aided by a small phalanx of researcher-activists – offer solid and sharp analysis and explanation of how the marketisation of our healthcare is rapidly proving both unsustainable and corrupt.**

This authorial mixture of practitioners and analysts is potent: the arguments are clear, the evidence consistent and precise and the writing lean, crisp and restrained in its evidently powerful commitments. Despite being multi-authored, the style has a vivid cohesion that is never dull or committee-toned – even better, it is frequently sprinkled with laconic humour.

NHS for Sale is certainly polemical, yet the quality and intelligence of writing and argument keeps it well away from mere rhetoric, rant or diatribe.

It is worth extracting here some extended quotes. All are good enough to serve as essential caveats or foundation stones for a counter-cultural manifesto restoring our NHS: *the cruciality of public ownership*:

> **"Complaining that the private sector maximises profits at the expense of public services is tantamount to complaining that cats kill birds. It is in their nature and the answer is not to try to legislate against the behaviour of cats but to recognise it and take appropriate precautions. No-one would leave their cat in charge of the canary. Equally, private companies cannot be trusted to behave well when delivering public services.**
>
> **"The malign effects of privatisation on those who provide healthcare are insidious and multi-faceted, as the corruption of the 'industry' in the USA demonstrates. The medical profession no longer offers an intellectual leadership or the example of social conscience informed by science and humanity. The professional covenant with the patient is reduced to explicit contracts. Doctors become mere sessional functionaries. Loyal company men and women, whose prime responsibility is to their employers, deny patients treatments that do not make a profit while, as front office salespersons, they recommend interventions that may not be in the patient's best interest …. Medicine as 'business' places the responsibility on its practitioners to shift as much product as can be paid for."**

Such skilled eloquence has caused me to change sides. Previously I had been – mostly – a cock-up theorist rather than a conspiracy theorist. I attributed our NHS follies and impasses to misunderstandings rather than malfeasance; our loss was of human sense, not human concern. I thought that corruption – if and when it occurred – arose secondarily, and later, as a wish to conceal folly, rather than, primarily, as a wish to conceal opportunistic greed.

NHS For Sale has opened my eyes. The writers portray a political-economic oligarchy who mostly conceal the revolving door from those determining the architecture and regulations of our NHS – with easy passage, both ways – to major investors in private health provision and Big Pharma: the "healthcare industry". In particular, those behind the conception and protection of the Heath & Social Care Act – the turbo-charging of NHS marketisation – are likely to be major financial beneficiaries of the system's trade.

Ideology may be recruited to justify, but this

disguises stark self-interest.

The evidence offered is so detailed, specific and precise that it is hard to see how it could be inaccurate – any error would invite punitive libel litigation.

So, *NHS For Sale* does sterling work in helping us more clearly to see and understand this: how employing the market as a principal incentivising and organising force within healthcare leads to markedly negative results – to often perverse incentives and fragmentation of services. Clearly this cannot have good economic or human outcomes.

And what of the vital personal hinterlands of vocational experience and relationships – with both colleagues and patients – that may develop from these mistracked systems?

Late on in the book we find this:

> **"Professionals by and large are not interested in competing on a financial basis but are easily motivated by professional pride. Nobody sets out in the morning to do a bad day's work, but the NHS has never exploited the natural pride that health professionals have in doing a good job. This is something that has been largely overlooked by management consultants, politicians and others who speak endlessly of 'incentivising' professionals, usually with non-clinical incentives such as targets-with-menaces."**

This is a fundamental point that – I agree – seems to be less and less understood by those now steering and regulating our NHS.

Put another way, we could say: "people who are happy in their work and working relationships will –with rare exceptions – want to do it well, both for themselves and others. Mostly such motivated good work requires relatively little regulation and management. But the converse is equally true: that the lack of such happiness is a sure path to the kind of demotivation and poor work that no amount of sticks and carrots, regulators and inspectors, commissioners or managers can ever rectify."

The latter is what we have now, and increasingly. In human terms what has NHS marketisation brought us? Corporation rather than vocation, contractual compliance rather than personal satisfaction, much data but little dialogue. That marketisation has brought frustrated alienation to both professionals and patients can be clearly seen from multiple vantage points.

NHS For Sale produces massive evidence for the economic and administrative inefficiency brought us through complexity, fragmentation, nepotism and corruption. This last quote alludes only briefly to the consequent destruction of our healthcare's human heart and spirit. Yet this is quite as important as the earlier issues that this book engages so fully and robustly.

But even this very substantial book can take us only so far: for the loss of such humanity cannot be quantified or documented by the kind of schemata and language that serve so well in *NHS For Sale*. From where this leaves us we need, at least, another path and another book.

David Zigmond
http://bit.ly/2q2e8yM

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.

Mrs A. Athow
General Surgery, London
0207 739 1908
07715028216
annaathow@btinternet.com

Dr A. Baksi
General Medicine/Diabetes, Isle of Wight
baksi@baksi.demon.co.uk

Dr M. Bernadt
General Adult Psychiatry, London
020 8670 7305
07510 317 039
mbernadt@hotmail.com

Dr C.A. Birt
Public Health Medicine, Liverpool
01422 378880
07768 267863
christopher.birt@virgin.net

Dr C.J. Burns-Cox
General Medicine, Bristol
chris.burns.cox@gmail.com

Dr J.C. Davis
Radiology, London
0780 17218182
drjcdavis@hotmail.com

Dr M.G. Dunnigan
General Medicine, Glasgow
0141 339 6479
matthewdunnigan@aol.com

Dr P.W. Fisher (President)
General Medicine, Banbury
01295 750407
nhsca@pop3.poptel.org.uk

Dr A.R. Franks
Dermatology, Chester
0151 728 7303 (H)
01244 366431 (W)
Roger.Franks@btinternet.com
andrea.franks@nhs.net

Dr B. Hayden
Obstetrics & Gynaecology, Bolton, Lancs
brigid.hayden@doctors.org.uk

Dr P.J. Hobday
General Practice
paul_hobday@btopenworld.com

Mr C.H. Hutchinson
Ophthalmology, Halifax
01422 366293
colinh759@gmail.com

Dr D.A. Lee
Paediatrics, Whitehaven
01946 820268
Lee535877@aol.com

Dr D.G. Lewis
Cardiac Anaesthesia, Leicester
0116 270 5889
geoffreylewis@outlook.com

Dr M. R. Noone (Secretary)
Microbiology, Darlington
01325 483453
malila@ntlworld.com

Dr M. O'Leary
Psychiatry, Sheffield
jm.czauderna185@btinternet.com

Dr H.J. Pieper
General Practice, Ayr
hansandphil@icloud.com

Dr P.N. Trewby (Treasurer)
General Medicine/ Gastroenterology
Richmond, North Yorkshire
01748 824468
Peter@Trewby.fsnet.co.uk

Dr E.J. Watts (Chair)
Haematology, Brentwood, Essex
01277 211128
07876240529
eric.watts4@btinternet.com

Dr C.P. White
Paediatric Neurology, Swansea (Morriston Hospital)
CPWhite@phonecoop.coop

Dr D.G. Wrigley
General Practice, Carnforth
dgwrigley@doctors.org.uk

Dr P. M. Zinkin
Paediatrics, London
02076091005
pamzinkin@gmail.com

Communications Manager (paid staff)
Mr Alan Taman
07870 757309
healthjournos@gmail.com
aptaman@aol.com

If you like what you see but don't like what you are hearing – pass this on

Doctors for the NHS works for the NHS all of us deserve and believe in. Join us to keep it.

www.doctorsforthenhs.org.uk