
NHSCA

September 2014

Under The Radar

the quiet revolution in NHS pathology services provision in 21st century London

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Introduction

The passing of the Health and Social Care Act 2012 (HSCA 2012) and its subsequent enactment on 1st April 2013 has highlighted the increasing role of private healthcare providers in the NHS. The trend towards increased private sector provision of NHS services has exercised campaigning groups like Keep Our NHS Public^[1] and public sector trade unions including the British Medical Association^[2].

Whilst the perceived threat of “privatisation by stealth” of NHS clinical services has generated news articles, petitions and indeed protests^[3], there has been a less well publicised revolution in the way pathology services are delivered in London since 2006.

As the trade unions grew increasingly concerned by the looming major reorganisation/“privatisation” of NHS clinical services from about 2011 onwards, NHS pathology services in London were already undergoing major change. The scene for this quiet revolution was set by two independent reports into pathology services in the NHS (2006, 2008), both led by Lord Carter of Coles^[4,5].

In brief, the Carter Reports laid the foundations for the consolidation of pathology services in England into pathology networks with a large hub laboratory typically based in a large teaching hospital and smaller spoke laboratories typically based in district general hospitals. In addition, the Carter Reports opened the door to private sector involvement, which has manifested itself in London in the form of public:private pathology partnerships.

Consolidation of NHS Pathology services in London

At the time of writing, there are three NHS pathology networks in existence. The first two are linked to the merger of several NHS hospitals to form one large NHS Trust so could be seen as a hybrid internal pathology network. The first is my own Trust, Barts Health NHS Trust,

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with a large hub laboratory based at the Royal London Hospital in East London. This hub supports 6 sites: The Royal London Hospital, St. Bartholomew’s Hospital, Newham University Hospital, Whipps Cross University Hospital, the London Chest Hospital and Mile End Hospital sites. There are “hot labs” at Newham & Whipps Cross which provide urgent blood testing services to support the local A&Es.

The second London NHS pathology network is at Imperial College NHS Trust which has a hub lab at Charing Cross Hospital serving Charing Cross Hospital, St. Mary’s Hospital in Paddington, the Hammersmith Hospital and the Western Eye Hospital. These are the constituent hospitals of Imperial College NHS Trust.

Finally, there is a pathology network formed from a partnership between independent NHS Trusts, South West London Pathology (SWLP) [6]. This is a partnership between St. George’s Healthcare NHS Trust, Kingston Hospital NHS Foundation Trust and Croydon Health Services NHS Trust. The central hub laboratory of SWLP is based at St. George’s Hospital. SWLP partnership went live in April 2014.

Public:private pathology partnerships in London

More controversially for some, there are two significant public:private pathology partnerships in London. The first was a joint venture between Guy’s and St. Thomas’ NHS Foundation Trust and Serco PLC, a highly diversified global support services company. This partnership was initially known as “GSTS” and went live in February 2009. Serco/GSTS also entered into a joint venture with King’s College Hospital NHS Foundation Trust in 2010. This tripartite joint venture was subsequently renamed Viapath[7]. Viapath also provides pathology services to Bedford Hospital.

Serco is an interesting company. It has an extremely diverse range of activities around the world which are listed in table 1 (not an exhaustive list):

Table 1: Serco PLC business activities

Docklands Light railway (DLR, 1997-2014)	Ballistic Missile Early Warning System, RAF Fylingdales
UK prisons	UK Atomic Weapons Establishment
UK immigration removal centres	UK Passenger rail services (Abellio joint venture)
Electronic tagging of criminals	NHS facilities management services
UK speed cameras	Suffolk Community Healthcare
Air traffic control: UAE, USA, Canada	Viapath pathology services

In August 2014, Serco announced its intention to withdraw from “clinical health services” due to under-performance of contracts in this sector[8]. It is not clear to me whether Serco regards pathology services as “clinical services”. As a medical virologist I regard many pathology services as “clinical services” but the Board of Directors of Serco may disagree.

The other major private provider of pathology services to the NHS in London is The Doctors Laboratory, more commonly known as TDL. TDL is a subsidiary of a multi-billion dollar Australian multinational diagnostics firm, Sonic Healthcare Limited[9].

In July 2014, TDL, University College London Hospital NHS Foundation Trust (UCLH) and the Royal Free Hospital NHS Foundation Trust (RFH) formed a tripartite pathology joint venture, Health Services Laboratories LLP[10].

Independent of this tripartite arrangement, TDL also has a contract to provide pathology services to London Northwest Healthcare NHS Trust Hospital, with a hub lab based at Northwick Park Hospital[11].

In most if not all of these pathology “modernisations”, there has been a reduction in the workforce overall (especially of biomedical scientists); reduced laboratory footprint and/or outright closure of some NHS laboratories.

The number of NHS pathology laboratories in London has fallen dramatically in the last decade. The slimmed down state of pathology in London in 2014 would have been almost unthinkable at the turn of the century.

Out of sight, out of mind, pathology services appear to have been an attractive target for consolidation and hence cost savings. Perhaps more significantly, a sizeable proportion of London pathology testing is now being carried out in private or public:private partnership laboratories (see table 2).

Table 2: London NHS Trusts with pathology services delivered by public:private pathology partnerships as of 1st November 2014.

NHS Trust	Private pathology partner
UCLH NHS Foundation Trust	TDL
Royal Free NHS Foundation Trust	TDL
London Northwest Healthcare NHS Trust	TDL
Guy's & St Thomas' NHS Foundation Trust	Serco PLC
King's College Hospital NHS Trust	Serco PLC

In addition to having undergone massive reorganisation, pathology services in London have been in the vanguard of the shift towards private provision of NHS services. The radical changes in NHS pathology service provision have enjoyed less mainstream publicity than contracts awarded for clinical service provision e.g. the outsourcing of the management of Hinchingsbrooke NHS Trust in 2011. This novel contractual arrangement received significant media coverage at the time ^[12,13].

Perhaps understandably, well-meaning NHS campaigners have been so busy watching out for perceived threats to the front door of the health service e.g. patient-facing clinical services, they have neglected the back door, e.g. pathology services. Should they take a closer look at the state of pathology services in London in 2014, they may not like what they see.

DR GEE YEN SHIN

Declaration of Interests: I work for Public Health England and am therefore a civil servant. I am an elected officer of the BMA London Regional Council (2013/14 & 2014/15 sessions). The BMA

is broadly speaking opposed to HSCA 2012 and NHS privatisation. Any opinions expressed are my own and not those of my employer, nor the BMA. I may have indirect financial interests in some of the companies in this article e.g. Serco by dint of owning shares in a FTSE All Share passive tracker fund which seeks to replicate the FTSE All Share index.

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General Practice in Meltdown

Jackie Applebee is a salaried GP in Tower Hamlets. She is Chair of the Local Medical Committee, Chair of the Tower Hamlets BMA Division and Hon Sec of London Region BMA. Dr Applebee co-founded the Save Our Surgeries campaign with other GPs, practice staff and patients when it became clear that at least 22 practices in East London were under threat of closure due to funding cuts. The campaign, by being vocal and high profile, has won a temporary reprieve, but the battle is far from over and the fight will continue.

General Practice, like the whole of the NHS, is in crisis. Nicholson's £20 billion efficiency savings has brought the NHS to its knees and now Simon Stevens says that there will be a £30 billion per annum short fall by 2020/2021. This, in tandem with the relentless drive to privatization and the madness of the NHS market which has resulted in administration costing 14% of the NHS budget as opposed to 5% before the advent of the purchaser/provider split, puts the very existence of the NHS in peril.

Yet only a few months ago the NHS was again recognized as being the best performing health system of 11 developed countries studied by the Commonwealth Fund. It is a testament to staff, in both primary and secondary care, who continue to provide excellent healthcare in increasingly difficult circumstances.

There comes a point, however, when something has to give, and this is in danger of happening in general practice very soon.

Recent reviews by the Centre for Workforce Intelligence and the GP Taskforce both concluded that we have too few GPs and those that we do have are stressed, burning out and feeling increasingly unable to deliver healthcare safely. While GPs carry out 90% of all NHS consultations, GP funding as a percentage of the NHS budget is at an all-time low at 8.3% and the number of GPs per capita is falling. The RCGP have said that at least 11% of the current NHS budget is needed to allow GPs to provide an adequate service.

GPs routinely look after patients with chronic illnesses like diabetes, asthma, COPD, cardiovascular disease and hypothyroidism, all conditions that used to be the preserve of the

General Medical Outpatient Clinic. GPs are not averse to this, but resources need to follow.

The number of hospital beds is falling and the call is for more care in the community. There is little evidence that this so called "integrated care" leads to fewer hospital admissions, while there is no doubt that it uncovers much unmet need and district nurses, vital to this plan, are in short supply. Only five qualified in London last year.

GPs often work from very poor premises. Ara Darzi's report "Better Health for London" called for £1 billion for rebuilding and repairs to GP surgeries in London alone. GPs are demoralized. Some are retiring early or emigrating and there has been a 15% fall in younger doctors applying to GP training.

Politicians complain that GPs do not provide enough appointments and David Cameron has said that patients will be able to see their GP from 8am-8pm seven days a week. However practices already offering this service have had their budgets cut and been told to reduce their opening hours. Other practices predict losses of up to £1 million over seven years due to withdrawal of the Minimum Practice Income Guarantee (MPIG).

General Practice funding is complicated. From 2004 it has been based on the Carr Hill formula, which takes into account the way in which practice demographics affect workload. It is very heavily weighted for age, so practices in areas with very elderly populations do well under this arrangement. It is undeniable that older patients require more GP time, but this formula does not account for the fact that in deprived areas such as East London morbidity and mortality are much higher. People develop chronic illness up to fifteen years before people in more affluent areas, and die up to eighteen years earlier. This means that GPs in deprived areas are working with a younger, chronically ill population that they are not being remunerated adequately for. MPIG was introduced in 2004 to address this.

The current Government has withdrawn MPIG with effect from April of this year, leaving many practices with extreme demographics unable to balance the books. The MPIG money has been left in the General Practice pot, but has been distributed

to practices with older patient populations, destabilizing others. This is not just a problem in deprived areas, but also for very rural practices, who have small list sizes but cover large geographical areas, and GPs in areas with large numbers of students, due to their high turnover.

At least 98 practices in England may close as a result of the withdrawal of MPIG, with 22 of these in East London alone. This could leave hundreds of thousands of patients without a GP, making AE departments their first port of call, further increasing the pressure on a system about to blow and potentially opening primary care up to the private sector.

Hospital services are also in crisis. I do not believe that scarce resources should be diverted from secondary care to primary care, or from practices that are coping financially at the moment to those that are not. Billions of NHS money could be saved by following the example of London Underground and pulling the plug on obscenely expensive PFI contracts, or abolishing the costly and divisive purchaser/provider split.

Secondary and primary care colleagues must not allow ourselves to be divided. GPs and hospital doctors, together with our patients, should unite and campaign for proper funding for the whole of the NHS.

Politicians want to keep the NHS out of the headlines but continued pressure from NHS campaigners can make it the number one election issue. Ed Miliband has promised 8000 more GPs and an extra £2.5 billion for the NHS. David Cameron has dared anyone to question his commitment to the NHS and promised to ring fence the budget. London

Region BMA is developing a pledge for the NHS. Members can use this to hold politicians to account by asking their MPs and Prospective Parliamentary Candidates to sign it.

In East London we have set up the "Save Our Surgeries" campaign in response to the threat to practices from the withdrawal of MPIG. Over thirty GP Surgeries in Hackney and Tower Hamlets now have 4 meter banners festooning their buildings with the wording "Save Our Surgeries, a Threat to one is a Threat to all!" With patients we have had two marches. The second on July 5th, the 66th anniversary of the founding of the NHS attracted over 1000 people, including local MPs and councillors. Our 38 degrees petition attracted over 150,000 signatures within days and we received national press coverage when we handed it in to Downing Street.

Our very visible campaign has forced NHS England to allocate extra money to the worst affected practices. It is not enough and only a temporary reprieve for two years. Cynics might say this is just enough to get us past the general election, but it shows that campaigning works. We will continue trying to get sustainable funding for the threatened practices, but also for the others who are not much better off for and keep pointing out that this is just one problem adding to the crumbling edifice of the NHS.

In the words of Aneurin Bevan, "there will only be an NHS while there are folk with the faith to fight for it". We may be overwhelmed by our workload but we owe it to future generations to take up his call.

JACKIE APPLEBEE

TTIP and the effect of the Scottish referendum on honesty and truth.

I was so impressed with the changes in the feelings recorded in the NHSCA magazines going from Dec 2013 through the next two, that I felt something had to be done. I tried writing something myself, but it was going to be too long and I was caught up with other things. I therefore photocopied copied the three of them and sent them to the Scottish SNP Health secretary and to the Sunday Herald which had just decided to support the YES campaign. A couple

of weeks later the paper put out an excellent item by Iain Macwhirter on 13/07/14 "Forget the latest scare story... the real threat to our health service is a 'NO' vote". In it he quoted Garcia Bercero, the EU Commission official with responsibility for TTIP and described TTIP, and it's special threat, excellently. There was also a splash on the front page. I wrote a supportive letter emphasizing the TTIP risk and another letter published on the same page also

emphasized TTIP. This must have hit the nerve on the NO side because there was an outpouring of items written by professors and others attacking the facts in the article. Unfortunately the majority of the Scottish newspapers (10 out of 12 papers) were on the NO side. The Herald (Daily) was also on the NO side and I feel that pressure was put on the Sunday Herald to stop pushing the TTIP part. Other papers made a great effort to ignore the letters, which supported the risk. One result was that an article in the Sunday Herald on 14/09/14, by Sir Harry Burns, who had been the head of the Scottish Health Service, and was moving to a professorship, was printed on an inside page with no editorial comment. It went into great detail of the development of TTIP and emphasized that only a YES vote could guarantee the NHS in Scotland. No other paper even referred to his article.

Alistair Darling denied that the NHS in England was privatized even though he had been in the Chamber during the months of the passing of the Health and Social Care Act 2012 which officially DID privatize it. This point was made by Sir Harry Burns but ignored. Suggestions were made that the NHS in Scotland was already privatized because Health Boards were using, and paying, for operations to be done privately to avoid breaking waiting time limits. They also claimed that GPs were working in a private capacity. Eventually Gordon Brown burst onto the scene saying that he was going to “kill” this claim of a risk. He blasted out for the people to rely on him and he would ensure that the NHS was not privatized and he would also ensure that the pensions would be OK. Priceless when you think how Brown ‘destroyed’ the NHS in England with PFI and killed the ‘works pensions’ contributed to by employers and employees. However the accumulation of lies meant that after the referendum was over, a contributor from the NO side was able to write that “one of their successes was killing off the idea that the NHS in Scotland was at any risk”.

Even this length of time after the referendum is over, people and newspapers are still denying the risk. In response to a letter that stated that those who raised the risk to the NHS Scotland from a NO vote were employing “a cheap political scaremongering stunt”, Colin Weatherley (Scotsman, 18 October) quoted Professor Allyson Pollock, who with her status and relevant expertise, considered the NHS in Scotland to be at risk. A few days later the original writer responded that this was just her opinion and therefore no better than anybody else’s.

I wrote the rest of this document as a letter in support of Weatherley and Professor Pollock. The Scotsman didn’t print it!!

Another person who is an “an expert on the issue” (according to the Herald of 8 October) is Sir Harry Burns, Scotland’s former chief medical officer (now professor). Interestingly in the preceding editorial (8 Oct) “Criticisms must be based on facts”, the NHS was described as being a political football used by the YES supporters. The fact that the sister paper, The Sunday Herald (14 Sept), the same Sir Harry Burns had given a very detailed assessment of the risk to the NHS in Scotland and in England. He stated that the greatest threat came from the Transatlantic Trade and Investment Partnership (TTIP). “If agreed, this will give transnational companies such as American health care providers the legal right to bid for all government spending, including spending on health, where private companies are already running those services.” Since the passing of the Health and Social Care Act, the NHS in England is vulnerable. If Scotland had become independent, the Scottish NHS would NOT have become vulnerable since the Scottish NHS was still nationalised. Since Scotland voted NO it remained part of the UK and the NHS in Scotland is vulnerable. TTIP “also includes provision to allow companies to sue countries if they take action which adversely affects future profits. Such actions might be the imposition of regulations to improve safety in hospitals, protection of public health or the environment and protection of the rights of those working in the privatized industries.” Gordon Brown’s optimism that he can protect the NHS is unlikely to be justified. The UK Health Secretary, Jeremy Hunt, has said that TTIP will not affect the NHS, but the attractive aspects of this treaty for those intent on privatization is the fact that ending private contracts would render a future Labour Government liable to be sued for loss of profits. Privatization is therefore locked into the future.”

TTIP is being negotiated in Brussels under conditions of such secrecy that MPs are not allowed access to the discussions. The autumn/winter edition of War on Want’s Up Front magazine is focused on the widespread dangers of the TTIP as it will affect huge areas of society. However their main focus is on its potentially devastating effect on the NHS in the UK. This occupies four pages compared with two on Palestine, one each on Kenya and China, and two covering multiple problems. War on Want obviously believes that the NHS is at great risk.

The NO result of the referendum means that nothing can be done about the NHS in Scotland. This letter can have no effect, except to clear YES supporters of the charges of using the NHS as “a cheap political scaremongering stunt”.

We now have to hope that the campaign by War on Want is successful.

EVAN LLOYD

Books

The Establishment: And how they get away with it.
Owen Jones. Penguin books.

“This is the most important book on the real politics of the UK in my lifetime, and the only one you will ever need to read.” This is how the Scottish author Irvine Welsh summarised his analysis of The Establishment.

Personally, I also found this book both unusually enlightening and stimulating. It is shrewdly analysed and well written – and carefully researched. Its basis is an impressively large collection of well-digested and broadly-based interviews. Owen Jones’s background as a young Oxford historian shines through. He is a Guardian columnist and the author of Chavs.

Jones notes that ‘the Establishment’ is a term that is often used to mean “those with power who I object to”. He mentions that the Daily Mail “regularly rails against what it sees as the Establishment” and he considers various definitions - that he observes

are all pejorative. He gives his own definition over several pages and the book consists of chapters which consider his way of looking at politics in different sectors such as the media, Westminster, banking and the city. (The NHS is only briefly mentioned.)

It is very satisfying to have a detailed and critical analysis of contemporary politics that rings true. It is not the least depressing to have undesirable features clearly exposed. Rather, careful critical consideration is outstandingly useful and convincingly suggests precisely what changes are needed.

The concluding chapter on Jones’s suggestions for change – essentially for a ‘democratic revolution’ – is much richer and more persuasive than most final chapters. It makes a book that is not only enlightening but also actively constructive. It would make an excellent present.

reviewed by
PETER DRAPER

AGM & CONFERENCE 2014

This was a successful event attended by 50 members

AGM REPORTS FOLLOW

**The minutes have been sent to those attending and to all the E.C. members.
They are available to any other members on request - electronically or in hard copy.**

NHSCA Co – Chairs’ Report 2013 - 2014

The year has been spent in the traditional way ie fighting the political assault on the NHS. The threats have increased under this government and their Health and Social Care Act. Amongst the problems discussed this year were

US/EU free trade agreement (TTIP): This was felt to be a huge but poorly understood threat with little agreement from any organisation on how best to tackle it. Morris Bernadt responded on behalf of the organisation

Care.data project: Caused concern amongst

professionals and patients. It was largely thought that the government had taken an important matter and caused distrust and fear because of their mishandling of it. A pause has been announced and we await the outcome

Clause 118: Now clause 119. This controversial measure allowing the government to close hospitals went through after a poor fight from politicians purportedly opposed to it. Paul Burstow withdrew his amendment when he was assured that the clause would only rarely be used.

Plasma Resources UK sell off: 80% of state owned plasma services were sold to Bain capital despite the opposition of experts which included an article by Eric Watts. Vince Cable expressed some concerns following pressure from a constituency member whose late husband was a haemophiliac, but was reassured that the sale would be good for patients and tax payers. Eric disagreed, pointing out that the company had cost the NHS £540 million to set up but was being sold for £220 million, but the sale went ahead

Pathology services reconfiguration: concerns emerged about the way the new public private consortium was running pathology services. There were reports of poor infrastructure and overcharging amongst other problems. Malila wrote to the RCPATH president suggesting that it would be helpful if the College undertook a review of the changes including whether predicted long term savings been achieved. His response was negative - "the College does not run the NHS".

Seven day working: concerns were expressed that the intention was to run an "asset sweating" system with weekend elective surgical lists and clinics

Commonwealth Fund Survey: finally some good news. This survey naming the NHS as the best health service was reported in the BMJ. Although results may not reflect the current situation, it helped confirm that the NHS is basically sound , a fact which forms the backbone of our campaign.

Meetings and events

Meeting with Andy Burnham 8th July 2014: a helpful meeting was attended by Peter Fisher, Jacky, Wendy, Eric Watts and Chris Birt. Burnham was clear about his aspirations: repeal the Act, restore the duty of the Secretary of State to provide health care, abolish section 75, and restore private patient income to previous levels. There was a commitment to integration of Health and Social Care. We said that whilst we supported his plan to repeal the 2012 Act it must be only the first stage in full removal of the market. Health is going to be a major battleground in the run up to the elections.

Meeting with German doctors. (VDAA): Mark Aitken had attended the Association of Democratic Doctors and Wendy spoke at one of their meetings. They visited London and Wendy invited members who were interested to join them on Friday 2nd May. Jacky and Tamasin Cave gave them a tour of lobbying companies in Westminster

People's Assembly March - June 21: although an estimated 50,000 people, including NHSCA members carrying the banner, took part in the Peoples' Assembly march in Manchester it was not reported by the BBC. There is a possibility that a D-notice was applied

Jarrow March Saturday 16th August 2014: this successful march was organised by the "999 call for the NHS" group which was started by young mums in Darlington. NHSCA members took part but carrying the banner was largely abandoned as its size precluded unfurling it on most of the narrow pavements. We need to think about a smaller banner once we have decided on a new name.

Internal matters

Jonathan Dare resigned after a long stint as Hon Treasurer and the role was taken over by Peter Trewby. Peter thanked Jonathan for the well-ordered system and immaculate ledgers he had inherited and Jacky thanked Jonathan for all his hard work on behalf of the NHSCA for his .

Thanks also went to Geoff Mitchell and Robert Elkeles who left the editorial team and to Andrea Franks, Morris Bernadt and Mark Aitken who remained.

Editors of the newsletter during the year included Mark Aitken, Pam Zinkin, Eric Watts, and Andrea Franks.

Steve Olczak took over chairing the meetings

A special meeting was held in February to discuss membership after it was suggested that members felt that the NHSCA no longer had the political influence it once had. It was also noted that the rate of recruitment had fallen over the last few months. Membership includes Associate Specialists and has been extended to include SpRs who are potential consultants but trainees have been difficult to reach as they are difficult to identify and move between hospitals. We have had a few co-opted GP members but general recruitment of GPs would be new for the organisation. It was felt that it would be a pity not to include them as they have no comparable body and their voice needs to be heard. There was a general approval for widening membership to include GPs and junior doctors.

There was also discussion about renaming the organisation. Several alternatives were proposed and the name "DOCTORS FOR THE NHS" was

thought to be the most appropriate. Fourteen members responded to Peter Fisher's e-mail about a possible name change. All supported extending the membership to the wider medical fraternity and were happy with the change of name. It may be assumed that those who did not respond were in agreement with our proposals. There was some discussion about the implications of a change of name for the bank account and current standing orders.

Thanks go as ever to the president whose indefatigable efforts hold the organisation together, but who would understandably like to hand over his duties in the near future.

Other news

NHS Reinstatement Bill: has been drafted and is about to be launched by Prof Allyson Pollock's team. Clive Efford's private members bill will be debated on November 21st

BMA Council elections: Voting took place in March 2014. A list of sympathetic candidates was circulated. Jacky was re-elected, along with several other campaigners.

National Health Action Party: Clive Peedell moved ahead with his new political party. Louise Irvine stood in the European Parliament elections in May 2014. NHSCA members were kept abreast of developments via the newsletter.

JACKY DAVIS
co-chair

Honorary Treasurer's Report to AGM

First my apologies for not attending the meeting and presenting my report in person. This is because a holiday booked before I became Honorary Treasurer coincided with the AGM. My predecessor Jonathan Dare who has maintained the Association's accounts in such excellent shape for over 10 years has kindly agreed to present the accounts again this year.

Our overall financial position this year is marginally better than a year ago. This is mainly due to our decision to put on hold this year's contribution to the NHS Support Federation and instead to muster our reserves for any publicity deemed necessary for expanding our membership.

Our membership subscriptions, by far the greatest source of our income, have fallen again this year for the 3rd year in a row albeit only by 1.4% and this is despite the sterling work of Peter Fisher and Jonathan Dare in chasing up defaulters, recruiting new members and pleading with those thinking of resigning. Our subscription income is still higher now than it was in 2010, but subscriptions peaked in 2011 and have fallen slightly year on year since. Chasing up defaulters is time-consuming. We

currently have 25 defaulters this year (to the end of August) on the active chase up list.

Conference income was less last year but so was conference expenditure, both these reflecting the difference in attendance and pricing between York and London venues. Publication costs were also less this year for no apparent reason but probably just reflecting year-on-year fluctuations.

We have been able to maintain our £8000 annual contribution to KONP.

Our current assets stand at £9435 which is £3499 more than in 2013.

Points for discussion:

- Should we contribute again this year to the NHS Support Federation?

or:

- Should we keep our reserves in case of need before the next election and/or to fund publicity for increasing our membership to general practitioners?
 - Should we consider a life membership
-

subscription. Although this might dent income slightly it would help keep our membership numbers up by ensuring members remained members after they had retired when many seek to cut their expenses and resign?

Lastly, my thanks and indeed the thanks of all members of NHSCA should go to Jonathan Dare who for over a decade has kept the accounts with meticulous accuracy. Thanks also go to our auditor Mr Bob McFadyen who has been able to bridge the gap between Jonathan and me without falling into the chasm caused by our banker's deficiencies. These deficiencies included a 4 month hiatus before the bank accepted a change of signature and change of treasurer. We are now again up to speed and even have access to a limited form of Internet banking which makes it easier to

check subscriptions. However as a "club and society" we cannot use BACS.

I am assured by our bankers that changing the name of the association will not cause an issue and that existing subscriptions need not be changed.

In summary the Association's finances are in good shape but constant pressure is needed to keep up subscriptions. There is a small reserve which could be used to support the NHS Support Federation or finance initiatives before the next election or fund the publicity that would be needed to increase our membership base.

PETER TREWBY

Report for KONP AGM 30.6.14 with addition for NHSCA AGM 4.10.14

Report for KONP AGM 30.6.14 with addition for NHSCA AGM 4.10.14

1 Key activities during the year since the last AGM

The Manchester march in September. Large numbers of KONP members attended the march and the KONP balloon was very much in evidence. There were lessons about the importance of good press work to make the most of campaigning opportunities such as this. Coverage by most national newspapers and particularly by the BBC was very poor. **Amendment of the constitution.** The Steering Group agreed to update KONP's constitution. Key changes were the removal of the provision which allowed the original founding organisations to over-ride Steering Group decisions, the limit of 6 months on the co-option of those who were not representatives of local KONP groups or affiliated groups, and the decision to allow all affiliated groups to send a representative to the Steering Group. These changes were primarily a response to the growing development of KONP as a national network of local and affiliated groups.

Establishment of a joint Unite / KONP working group on TTIP. This has been a very successful working group which has been able to get to grips with a complicated issue and produce a line for us to take, with campaigning materials to support the campaign. The core group worked with a set of TTIP experts, who sometimes agreed with each other and sometimes disagreed. This enabled the group to settle on a way forward. Thanks to John Lipetz for chairing the group and the members and experts who contributed. **Strategy development day.** A special meeting of the Steering Group was held in London on 11 January, with 40 people attending. The agenda for the day had been developed by a small group, consisting of leading thinkers, about KONP's issues, and this was then used to design the day, with a plenary session on the issues in the morning and some workshops taking forward individual items in the afternoon. Of particular note was the work on a political strategy, which agreed a priority to defeat the current government at the general election, while not giving up our status as not aligned to any party. It was agreed that the Steering Group would produce a position statement, which

could then be used by local KONP groups to run hustings, get signatures or refusals to sign from their candidates, and publicise the result. It was also agreed that cuts in NHS funding should be included in our position statement, and not only privatisation. Excellent work was also done on working out how to improve the effectiveness of how national and local KONP's work together. See comments about this in the section below.

Ongoing office activity. The office worked hard to respond to press inquiries, questions from KONP members and others, to purchase and supply campaigning materials and to keep accounts and to process payments and receipts.

2 Campaigns

General support for activist campaigns. For example, we have expressed our intention to support the new Jarrow marchers, marching to save the NHS in August and early September. Will produce Campaigning material for local KONP groups on or near the route. **TTIP** Sub-group developed campaigning materials, including briefing paper and leaflet. Letters written to all MPs and replies noted. A list created of email addresses for all candidates at the Euro-elections and emails setting out our case sent. New material emerged from letters written by civil servants on behalf of ministers, revealing clearly that the NHS very much in the TTIP, going beyond the obfuscation of previous ministerial statements. This material was included in letters to the BMA and other organisations. Reply from BMA indicated a strengthening of their awareness of the dangers. Hard to know whether the plan has been pushed off course, but ISDS now more under question.

Care.data. Thanks to Terry Mandrell of Solihull KONP for pioneering with this issue. We took a strongly oppositional stance on the extraction of personal medical records from GPs, working with other campaigners, especially Medconfidential. Opposition to our stance from some KONP supporters from the public health community for fear of damaging data collection, but press revelations about transfer of hospital based medical records to insurance industry showed that safeguards not working. This soon made the issue toxic for the government and reaffirmed that we had taken the right stance. A successful campaign as little likely to happen until after the general election. Some GPs will provide pilot testing of the process in the

autumn, and should be opposed by local groups when we find out where they are.

Hospital closure clause (Clause 119 in the Care Bill considered earlier in 2014). Reaffirmation that KONP not only opposes privatisation, but also the squeezing down of expenditure on health that forces many people into private healthcare. Much reconfiguration of hospitals is finance-determined, including the proposed reductions in service at Lewisham hospital. Save Lewisham Hospital campaign led on this and we supported.

PFI. A sub-group of the Steering Group has been set up to work on our campaign on this issue. So far had not resolved conflicting views within the group, but has agreed to propose running a series of regionally-based workshops, asking the organisation Corporate Watch to provide training for KONP groups in areas which are PFI hotspots. Have also agreed to produce a leaflet.

3 Organisational issues

People issues.

Staffing resources were very stretched during the last year. Our staffing budget runs to 1.25 full time equivalent people, with a Campaign Manager (Adeline O'Keeffe - 60% - 80%), administrator (Camilla Giambonini -50%) and finance administrator (Helen Cagnoni -20%) During this time, the Campaign Manager has had to cope with severe and unplannable caring responsibilities. We granted leave for time off throughout this period in the hope that the issues would be resolved, but very sadly Adeline's mother died shortly after Easter. Adeline naturally took time off work but was unable to return after a month or give a date so reluctantly we decided that it was no longer possible to continue with the arrangement. Other staff members had been untiring at picking up the extra work but it was not fair to them or to the cause of KONP to continue. A meeting of staff, Officers and two members of the steering group has been arranged for 2 July to decide whether to restructure the tasks and how to go forward. It is fair to say that KONP press work has suffered most during this period of reduced capacity. John Milligan has started work as campaign and media officer on 22.9.14

Website

We are committed to improving the way our web-site looks and functions. One of the workshop groups at the January Strategy day worked on this issue and made helpful suggestions for going forward. We have made a start on this, and there is now less text on the home page, but much more is needed. KONP's website was created by and is maintained by a volunteer who runs a one man web support business. We are enormously grateful to him for his work and the tireless way he sorts out any IT problems which arise, but we know that his time is too limited for major changes. The website functions as a filing cabinet, and if you know what you are looking for you can usually find it, but it does not bear comparison with some other campaigning websites, and we are determined to make a change. This will inevitably involve spending some money but we believe that the increase in supportive donations could over time pay for this, provided we are careful with costs going forward. Our thanks to Paul Lister who acts as webmaster free of charge.

Accessibility of Steering Group meetings

Another unresolved suggestion from the strategy day was running the Steering Group as a webcast so that people could join in on line. This came from a view that those KONP and affiliated groups outside of London found it harder to make a contribution than those who live nearer. We made some initial investigations

and came across such services with quite high costs, but then the idea fell victim to our limited staff resources. This remains an important issue, as illustrated by Tameside KONP's desire to change the constitution to equalise the influence across regions. This may have a bearing on live interactive web-casting solutions. This remains an unresolved but important issue

Sue Richards Co-chair KONP

Since the KONP AGM on 28.6.14, which was well attended with the free Unite venue full to capacity (100 people), Subgroups have continued to work on PFI and TTIP. Financially we are viable and thanks to NHSCA.

Shirley Murgraff ensured the KONP banner was at the beginning and the end of the Jarrow March which was supported by KONP members in several places during the march. Sue Richards spoke on behalf of KONP at the rally in Trafalgar Square. On 11th October there will be a meeting in Leeds to discuss campaigning and the Constitution. Sue Richards also sat on the People's Enquiry into London's NHS earlier in the year. WDS 24.9

WENDY SAVAGE
President KONP

Report to the NHSCA AGM 2014 NHS Support Federation

In January of this year the BBC published our second report on outsourcing of NHS contracts. By that time we had compiled a comprehensive log of NHS services that had been put before the market. Our lead finding was that the private sector had won 70% of all contracts for clinical services. It was the first time that an overview of privatisation had been reported extensively across BBC radio and television. We followed this with further contract research, published in the BMJ in April. It provided proof of how NHS outsourcing has risen significantly since the introduction of the competition regulations (section 75) in 2012.

Our contract research is part of a project to collect evidence about the impact of the Health and Social Care Act. The idea of creating a central store that could be accessed by the public and the media was raised in discussions at the NHSCA AGM two years ago. Indeed we are grateful to the NHSCA for helping us with funding to get this effort off the ground. Since then we have worked with a team of researchers to compile a community database of articles and reports, themed around the original criticisms of the Act. This has been updated over the last year and has become a powerful source of examples and evidence.

The database is on-line at (www.NHSforsale.info) and allows users to leave intelligence and experiences about their local NHS. Campaigners have confirmed that it provides them with valuable information that they haven't the time or resources to collect. The website has received over 1.2 million hits since its launch and involved over 60,000 unique visitors. It has stimulated stories in the media including direct coverage in the outlets listed below over the last year. In June the Guardian published a front-page story on the potential privatisation of cancer services on the back of information from this contract database.

Media organisations that have reported information from our site over the last year

BBC TV news	The Guardian
BBC breakfast	Daily Express
Radio 4 Today programme	Daily Mail
Radio 5 live news and phone in	British Medical Journal
Radio 6 news	Health Service Journal
File on 4 (BBC)	The Lancet
The Independent	5 local radio stations & range of local papers

Our strategy is focussed on collecting the evidence about the NHS changes and presenting this in ways that attract a wider audience to the debate. We have used creative design to publish a range of info-graphics and maps to highlight key trends and statistics. Twitter has proved a powerful tool for disseminating these and our partnerships with organisations like Unison and Unite has meant that these publications are being shared widely.

Ways forward on PFI

We have recently produced 2 new documents about PFI. These involve our own investigations into what has happened to the ownership of PFI hospitals and how much profit is now being made. In the first report we aim to produce an accessible guide to the evidence about PFI and to explore the options for reducing its burden on the NHS. The second document seeks to persuade politicians that taking no action on PFI, is simply not sustainable. Not least because of the rising debt and the expense of using PFI for future schemes. We selected the most powerful evidence and examples to present a new view of how and why we must find a way out of PFI. We aim to publish these documents in October and to take part in a public conference on the issue.

An Insight into ambulance services

The state of our ambulance services puts the impact of the NHS changes and the cuts into sharp focus. We have recently carried out research around the performance of ambulance services, producing new statistics about the growth of private providers and impact of cuts in funding. This report includes a survey of ambulance staff and will be published shortly.

Working with other organisations

Through the TUC we are coordinating our election work with Unite, Unison, the SHA, and Keep Our NHS Public

We are working with Allyson Pollock and Peter Roderick to help them publish an alternative bill to remove the market from the NHS

By talking to local campaign groups we are finding ways to improve the resources that are available to them in the approach to the election

By working with staff organisations and community groups on surveys we aim to collect qualitative data and examples of the impact of the NHS changes.

Through Freedom of Information requests and other research we are producing work to extend the current understanding of the costs of the market.

Resources for the election

We aim to publish a document summarising all the evidence that we have collected about the affects of privatisation and the use of the market. We plan to translate this into briefings and info-graphics that can be used by all groups and individuals campaigning on the NHS in the run up to the next election.

The NHS Support Federation would like to express its thanks to the NHSCA and its members for its support over the last year. We look forward to working together to protect and support the NHS at this crucial point in its history,

PAUL EVANS
Director, NHS Support Federation
paul@nhscampagn.org

Conference 4th October 2014 - First session

The NHS in our Four Countries and effects of the Health and Social Care Act.

1. ENGLAND

Comparing performance of the four National Health Services in the UK: how easy is it and which does best?

Professor Nicholas Mays: Director, Policy Research Unit in Policy Innovation Research, London School of Hygiene and Tropical Medicine.

This comparison is very hard to do, even with the help of the Nuffield Trust or Health Foundation websites.

There are significant political differences. In England health policy is determined by Westminster, while it is devolved with a block allocation to the Scottish Parliament and Welsh and Northern Ireland Assemblies. The dominant ethos in England is market-based but in Wales and Scotland is left of centre or nationalist. Sectarian tensions affect policy in Northern Ireland. Sanctions for failure to meet targets were imposed in England in 2000 and in Scotland from 2005, but not in Northern Ireland or Wales. There is a purchaser-provider split in England and Northern Ireland but this was abolished in Scotland in 2004 and in Wales in 2009. Competition is promoted in England but not the devolved nations.

Professor Mays attempted to compare the performance of the four health services using the most recently available information, to establish whether the divergence of policies was reflected in a divergence of performance. This is made more difficult by devolution as comparable indicators over all four systems, over a period of time, are not available. It is possible to compare the situation now with what prevailed before devolution, but the comparability of data has declined since then. England has a much higher population than the other UK countries. The population of North East England is similar in size and socioeconomic makeup to Scotland, Wales and Northern Ireland and has a similarly low use of private sector health care, so is useful for comparison.

Between 1991 and 2011 there has been little

relative change in life expectancy between the four nations but a slow and steady increase in all. During this period, England spent rather more on the NHS than the others, although this decreased after 'austerity' began. Allocation for the devolved nations is governed by the Barnett formula but there is a different spending pattern in the devolved countries where more is spent on, for instance, nursing care and free prescriptions and rather less on other NHS services. England has the highest total staff numbers, with a small increase in Wales, while data from Scotland is incomplete. Scotland has more NHS doctors and dentists than elsewhere, but numbers in NE England are increasing. Nursing numbers are very low in England compared with the other countries. The number of day case procedures is rising slowly and is similar across the UK, while inpatient admissions per doctor or dentist are slowly falling.

Targets have had a significant impact. Response time of ambulances in Wales and Scotland was much lower than in England where targets had already been in place, but improved greatly when they both introduced targets as well. Waiting times for outpatient appointments also improved in Scotland when targets, already in place in England, were started. In all three countries, delays for procedures such as hip replacement fell greatly with improved funding combined with targets, but are rising again since 'austerity'.

'Amenable' deaths (those which could have been prevented) have fallen slowly in all UK countries, with little difference between them. There is no obvious effect of devolution or marketisation, but data is so far unavailable after 2010 so the effects of all the changes since then are unknown.

Overall, the performance of the four health services has improved significantly between 1992 and 2011 at more or less the same rate, with no change in their relative positions. Spending and resources have increased greatly during the period, but much less since 2010, and there have been variations between the devolved nations. Nursing numbers are much lower in England although

waits are generally shorter in England (because of targets) and longer elsewhere, especially in Wales which has different priorities.

The information available so far provides no evidence that the different policies in the UK are resulting in significantly different overall performance. Professor Mays stressed, however, that comparisons of the different health services are becoming much more difficult. Clinical audits rarely cover all four UK countries, while comparable figures are increasingly hard to obtain.

2. SCOTLAND

Dr Matthew Dunnigan: retired consultant physician

Devolution of health care to Scotland (also Wales and Northern Ireland) has created a case control study between health care based on cooperation and integration and the increasingly neoliberal English NHS based on competition and choice with growing opportunities for private providers.

A Nuffield Trust report in 2010 compared NHS performance in England and Scotland between 1996-7 and 2010-11. More rapid increases in inpatient and day case rates and outpatient attendance rates in England were interpreted as increased productivity driven by market reforms. A closer look at this, however, shows that some apparent differences resulted from perverse incentives caused by 'Payment by Results' which increase recording of activity.

After initial problems, the performance of NHS Scotland has significantly improved and was found by the Commonwealth Fund to be the most efficient system. Many improvements in NHS England are in some ways continuing as there is still more money than in the past as well as more staff and many new buildings. Austerity and an effective cut in expenditure, however, are likely to affect this in future.

Is the neoliberal model more or less sustainable than the public sector NHS Scotland? In 2010-11, NHS Scotland had 8% more funding per capita than NHS England but employed 19% more doctors, 27% more GPs and 31% more qualified nurses per capita than England. It also had 81% more staffed hospital beds. This suggests that the Scottish NHS has obtained better value for money than England.

Managed clinical networks are an important component of NHS Scotland and the policy preserves the effectiveness of DGHs which in England are threatened by transfer of services to private providers. There are no 'failing' hospitals in Scotland so there is much greater organisational stability.

It is important to continue to compare the public sector health care model with the neoliberal English NHS in the face of increasing austerity.

3. WALES

Dr Catherine White: paediatric neurologist, Swansea

Wales is very small compared to England, with under 5% of the UK population, and most of those live around Cardiff, with rather fewer in NE Wales and small numbers in central areas. Health, like most other functions (except defence, tax, foreign affairs, policing and law), is devolved to the Welsh Assembly which is elected by PR; surveys show good general satisfaction with the Assembly.

Funding is via a block grant allocated by the Barnett formula and is lower per capita than in Northern Ireland or Scotland. The annual shortfall in Wales is around £300 million, and NHS funding is not ring-fenced so has now fallen slightly. A big funding gap is predicted with continuing austerity.

Health spending per capita is less than in NE England, but in Wales there is relatively high unemployment and low earnings. 19% are over 65, more than elsewhere in the UK and health is relatively poor. There is more obesity in Wales, 33% of adults have at least one chronic condition and 20% feel they do not have good health.

David Cameron recently described Offa's Dyke as 'the line between life and death', while Jeremy Hunt said the NHS in Wales is 'walking into a Mid Staffs tragedy', but this is unjustified; the Nuffield Trust concluded that 'no one country is emerging as a consistent front-runner on healthcare performance'. Satisfaction is generally good, even though waiting times tend to be longer than in England.

In Wales there is a Minister for Health and Social Services and seven Health Boards which plan

and provide all health services, with no internal market. There has been extensive consultation about the programme for South Wales, reducing seven hospitals to five (three of which will be major acutes) although there are problems with covering North Wales from Cardiff. The programme called 'Prudent Healthcare' focuses first on prevention and then on joined-up working. The emphasis is to do no harm, to use the minimum appropriate intervention and to promote equity between professionals and patients.

Health Boards plan and deliver all services in Wales. There is no market and only limited choice, with no private sector involvement, and Community Health Councils still function. There is better integration of primary and secondary care than in England as everyone is employed by the Health Boards. There is over-reliance on hospital care, in part as there is a crisis in GP recruitment. The consultant contract is different and includes 2 ½ SPAs.

Wales was the first in the UK to introduce a smoking ban, opt-out organ donation and an Active Travel Bill to improve public health. Other differences from England are there is no cancer drugs fund, free prescriptions and free hospital parking. The waiting time target for treatment is 26 weeks and waiting times are also greater for outpatient visits and for ambulances.

Dr White concluded that the main strengths of NHS Wales are that it is easier to join up services, management costs are probably lower and there is a greater emphasis on public health. A weakness is that there is no real drive to reduce waiting lists, and there is overreliance on hospital care.

NHS Northern Ireland

David Eedy: Consultant Dermatologist, Belfast; President of British Association of Dermatologists. Dr Eedy outlined the political background affecting health services. Northern Ireland has a violent and murderous past which cannot be ignored, and during the Troubles local surgeons became world experts in trauma and vascular surgery. Belfast is now prosperous, but tensions are still present. Stormont is an enforced coalition of the two main parties, elected by proportional representation. They must agree about major decisions or policies cannot progress. If this happens Stormont may be suspended in favour of direct rule from Westminster. This has happened

periodically and during one of these episodes between 2002 and 2007 Peter Hain introduced policies such as commissioning and the use of the private sector.

There are now targets for time to treatment, and patients can be dealt with in the private sector if these are not met. 'Care Closer to Home' and GPs with a Special Interest were also introduced as were PFI schemes, but these are only for car parks and not for the hospital buildings. A positive feature is that there is a single Health and Social Care trust.

Northern Ireland does not have a Cancer Drugs Budget, prescription charges or Choose and Book, and NICE implementation is patchy. Services are commissioned by block contract; there are no tariffs. There is constant micromanagement and staff are overworked and demoralised. Many consultants are retiring early or are on long term sick leave and there is a feeling that doctors are just seen as technicians.

Stormont is currently deadlocked over budget and welfare reform and there has been an growing crisis in the last few weeks, resulting in a huge increase in waiting lists. The Chief Medical Officer has stated that any further NHS cuts would be catastrophic. There has been bullying and manipulation around targets for cancer and outpatient visits, and cancer targets are now being missed as there is no money for the treatments to be done in the private sector. Staffing is a problem as most doctors want to work in Belfast; services are very pressurised and wards are closing.

NHS Northern Ireland is now three years into a five year programme 'Transforming Your Care' though there have been few pilots of the plans and too much reliance on unproven methods such as teledermatology.

A new Health Minister has recently been appointed. He is a Creationist who believes the world is only 6000 years old, and has taken the National Trust to court for claiming that the Giant's Causeway was formed 60,000,000 years ago.

**reported by
ANDREA FRANKS**

Conference 4th October 2014 - Second session

The NHS Reinstatement Bill

Peter Roderick, barrister and senior research fellow, centre for primary care and public health, Queen Mary, University of London.

Over the last few months Allyson Pollock, Peter Roderick and David Owen have been putting together a Bill aimed at reversing the adverse effects that successive governments have imposed on the NHS. Time is short.

Another Tory administration would effectively see an end to the NHS, as it was originally intended and formulated by Nye Bevan in the Labour administration of 1946.

Socially sensitive healthcare would be dead, and subsumed by a financially driven system that provided minimal healthcare for those who could not afford to pay. This is unacceptable.

The story so far

On 28th January 2013, Lord David Owen introduced a modest Bill in the House of Lords under the constraint of 'no major reorganisation', which would re-establish the Secretary of State's legal duty to provide the NHS, re-instate overall government control and downplay competition.

That Bill – known as the NHS (Amended Duties and Powers) Bill – fell at the end of the Parliamentary session, and so was re-introduced on 16th May 2013. The two versions were essentially the same. But the second version included two additional Clauses – to establish public registers of contracts and, in light of the proposed Transatlantic Trade and Investment Partnership, to require approval of Parliament and devolved legislatures of any treaty affecting the NHS. Neither Bill went beyond their formal first readings, and so were not debated.

The proposed NHS Reinstatement Bill goes much further than Lord Owen's two previous Bills because:

- It would reinstate the government's legal duty to provide the NHS in England
- It would re-establish district health authorities with regional committees and modified functions
- The District Health Authorities would be coterminous with local authorities and have family health services committees to administer arrangements with GPs, dentists, and others
- It would abolish competition and marketised

bodies such as NHS trusts, NHS foundation trusts, and clinical commissioning groups, as well as Monitor, the regulator of NHS foundation trusts and commercial companies

- It would end virtually all commissioning and allow commercial companies to provide services only if the NHS could not do so and that otherwise patients would suffer
- It would re-establish community health councils to represent the interest of the public in the NHS
- It would prohibit ratification of the Transatlantic Trade and Investment Partnership and other international treaties without the approval of parliament (and the devolved bodies) if they would affect the NHS.

This Bill is a vital public health measure. It will both restore the NHS in England and reverse more than two decades of policies which have been intent upon privatising NHS services and funding, ultimately leading to its demise.

The Bill has been drafted by barrister Peter Roderick with the assistance of Prof Allyson Pollock. They have benefitted from discussions with individuals and organisations concerned about the increasing role of the market over the last 25 years in the NHS in England. They wish to consult on the Bill with those who share their concern and commitment to reinstating fully and as smoothly as possible the NHS as an accountable public service with only a minimal and exceptional role for commercial companies.

Get your skates on!

If you have suggestions for inclusion in this Bill then contact Peter Roderick at: p.roderick@qmul.ac.uk The consultation period runs until 15th December, and then we will reconsider a possible new version of the Bill in the light of consultation responses.

Read about the progress of this venture at: http://www.allysonpollock.com/?page_id=1860#sthash.9Xtrzy5F.dpuf

The full reinstatement Bill can be seen at: <http://www.nhsbill2015.org/wp-content/uploads/2014/09/NHS-Reinstatement-Bill-and-Notes.pdf>

reported by
MARK AITKEN

The Paul Noone Memorial Lecture 2014

“Never Waste a crisis – the coalition government’s attack on the postwar welfare state” By Prof Martin McKee CBE, European Centre on Health Societies in Transition – LSHTM

This talk was a revelation to me – the wider context of how our NHS fits into the broader picture of health and the factors that have been affecting our patients long before we see them. It was delivered with enthusiasm and suffused with the wit and wisdom of a true expert in many fields.

It brought alive Marmott’s aphorism that ‘medicine is failed prevention’. This record is my take on his talk and he published a summary of the issues “Austerity: a failed experiment on the people of Europe” in the RCP journal *Clinical Medicine* 2012, Vol 12, No 4: 346–50 and also in “The assault on universalism: how to destroy the welfare state” *BMJ* 2011;343:d7973 from which I have quoted.

He began his lecture on the state of health in the 19th century, illustrating the lot of the poor ravaged by overcrowding, infectious disease and the dread of cholera with threats to polite society, not only of cholera but of communism.

Division in society was shown with Disraeli’s quote “Two nations between whom there is no intercourse and no sympathy; who are as ignorant of each other’s habits, thoughts, and feelings, as if they were dwellers in different zones, or inhabitants of different planets. The rich and the poor.”

Different countries on differing continents have developed responses to the challenge of poverty in line with their cultural values.

European countries have mostly developed systems underpinned by a concept of solidarity – i.e. a system of transfers from rich to poor now known as the welfare state – generally accepted as working for the common good although the very word ‘welfare’ is becoming stigmatised.

In the USA ‘welfare’ has generally been seen as a

pejorative term with 71% of Americans believing the poor can escape poverty through hard work compared to 40% Europeans (yet over a nine-year period 60% of the poorest Americans were likely to remain poor whereas only 45% of the poorest Germans were likely to remain poor).

There is a similar divide in opinion over trust in government as 26% of Americans favour more government ownership versus 48% of Europeans and this is most vividly seen in the attacks on ‘Obamacare’ with vicious attacks that it would lead to communism ignoring the fact that 46% of US spending on health is currently government provided through Medicare and Medicaid.

Divided societies spend less on the welfare which benefits everyone – the issue appears to be one of identity summarised as ‘Who are we?’, conversely ‘Who are we not?’. The effect can be seen when maternal and childhood mortality rates remain high in spite of increasing overall wealth. (Ref.: *Democracy and growth in divided societies: A health-inequality trap?*, *Soc Sci Med.* 2011 Jul;73(1):33-41. doi: 10.1016/j.socscimed.2011.04.013. Epub 2011 May 17).

Different experiences of conflict on the two sides of the Atlantic can explain part of our differing perspectives

John Rawls in the ‘Theory of Justice’ (1971) proposed a theory in which “*no one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like. I shall even assume that the parties do not know their conceptions of the good or their special psychological propensities. The principles of justice are chosen behind a veil of ignorance.*” Rawls hypothesised that if an individual does not know how he will end up in his own conceived society, he is likely not going to privilege any one class of people, but rather develop a scheme of justice that treats all, and in particular the disadvantaged, fairly.

Because of the upheaval in Europe leading to, during and following World War II, Europeans have known loss and uncertainty on a scale not

seen in the USA. People lost their lives, relatives and communities with dramatic suddenness, making them more aware of their vulnerabilities, knowing they could lose everything overnight. They put in a system that could look after people dealt a bad hand by fate. The US perspective seemed to be that the worst situation was to be black, and white Americans knew that whatever misfortune may occur they would not go to bed white and wake up black.

Racial division adds a further dimension to anxiety about welfare provision – ie transfers from Us to Them. In US states spending on welfare measures is inversely related to racial division. More homogenous societies are happier to spend money on welfare. Support for welfare in the USA is higher among people who live near to many welfare recipients of the same race, but lower among people who live near to welfare recipients of another race. People have a hostile reaction to recipients of another race, but sympathetic reaction to recipients of the same race. Support for welfare is greater among whites who “have ...had a black person for dinner in your home in the last few years?” Geographic isolation may be a cause of “separate-group” thinking, but in many places racial and geographic isolation go together.

How the attack on the welfare state is orchestrated

- Create identifiable ‘undeserving poor’ – being careful not to be obviously racist; word association can do the trick; ‘illegal’ to go with innocent; ‘bogus’ to go with asylum and ‘scroungers’ to go with benefit – and don’t sections of the press do this well?
- Create a system in which the rich see little benefit flowing back to them from their taxes e.g. increase tuition fees and set up a student loan system that costs more than what it replaced and remove child benefit from higher rate taxpayers so 500,000 more people have to complete self-assessment forms.
- Portray the poor as paying no tax but everyone pays VAT and the recent increase in VAT means the poorest decile spend 19% of their budget on VAT but the richest spend only 9% - an example of Welfare for the Rich
- Do it in a way that attracts as little attention

as possible, putting in place policies whose implications are unclear and whose effects will only be seen in the future.

Vilification of the undeserving poor is not new. What is changing in the United Kingdom is the progressive exclusion of the middle classes from the welfare state through incremental erosion of universal benefits. The logic is appealing, but highly divisive: Why should the state pay for those who can afford to pay for themselves? Why should “ordinary working people” pay for “middle class benefits”? The economic crisis has given the government a once in a lifetime opportunity. As Naomi Klein has described in many different situations, those opposed to the welfare state never waste a good crisis. (Klein N. The shock doctrine: the rise of disaster capitalism. Penguin, 2008.) The deficit must be reduced, and so, one by one, benefits are removed and groups are pitted against each other, as the interests of the middle class in the welfare state wither away.

Affordability of the NHS and the National Debt

We are repeatedly told we can’t afford the NHS with paying off the National Debt cited as the top priority – but is this so and what’s so bad about borrowing money? The National debt was almost two and a half times our GDP in 1949 and is now 70% Adam Smith (arguably the architect of capitalism) said “Great Britain seems to support with ease a debt burden which, half a century ago, nobody believed her capable of supporting.”

In their analysis of the recent austerity measures, the IMF have re-assessed their position to state the benefits of investing for growth. (“Growth Forecast Errors and Fiscal Multipliers” www.imf.org/external/pubs/ft/wp/2013/wp1301.pdf).

One of the best examples of European system of transfers from rich to poor is in Scandinavia. Taxes are high but, in return, the rich obtain a comprehensive package of high quality benefits either free or at minimal cost, including child care, healthcare, social care, and university education. There is a clear trade-off: you pay higher taxes, but you get more back in return as well as living in a more harmonious, safer society. (Esping-Anderson G. The three worlds of welfare capitalism. Princeton

University Press, 1990).

The NHS still represents civilised values as well as excellent value in the material sense. Most European countries have welfare states in effect if not in name. Whilst the NHS is particularly British, welfare the world over has been threatened by the banking crisis and the usual suspects have made the most of the opportunity. With the change of heart of the IMF, the austerity lobby have lost a major advocate and the case for welfare can be reaffirmed.

Martin concluded with a tribute to Paul Noone:

- "All forms of prejudice were anathema to him and he fought many battles against discrimination in the health service"

- "Paul was an idealist whose deeply-felt frustration with social inequalities channelled his radical views."

- "Above all, Paul was a passionate believer in a comprehensive health service, available to all on the basis of need"

- "The NHS has lost one of its greatest and most charismatic supporters at a time when the need for such champions has never been greater"

Author's Footnote I have represented the comments on the National debt and deficit as best as I can – those interested can find more in Martin's extensive publications. I Googled "To whom do we owe the national debt" to get some interesting answers: in short it's an investment vehicle.

**reported by
ERIC WATTS**

The NHS is in your hands why your vote in 2015 is more exciting and important than ever

As we demonstrated in Wyre Forest in 2001 when I was elected as an MP for the first time, the ballot box is the ordinary person's ultimate weapon against authority that has acted against the wishes and needs of local people.

Abraham Lincoln put it gloriously and timelessly in 1858: "To give victory to the right, not bloody bullets, but peaceful ballots only, are necessary."

The National Health Action Party (NHAP) was founded and registered as a political party in 2012 with the purpose of putting up candidates at forthcoming elections to allow voters to register their disapproval of the coalition Government's un-mandated and inappropriate reforms to the NHS. These reforms will damage the NHS by increasing the involvement of the private sector in parts of health care where it has had little impact until now. This will threaten the uniformity of the NHS across the country,

and make the integration of constituent parts very difficult.

At the general election in 2015, by obtaining MPs, independent of the main political parties, we will show the outgoing Government how inappropriate and unpopular their reforms to the NHS are, and we will influence the incoming Government, of whatever colour, to recognise this and to make appropriate changes to restore the NHS to the publicly funded, publicly provided and publicly accountable service that we have known and loved since its foundation.

To get elected as an MP, independent of a major political party, one needs three conditions:

1. An unpopular sitting MP who has taken the wrong line on an important local issue or whose party has acted similarly on a national issue.

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2. To have a well-known local person as the candidate.
 3. The candidate must have a personal manifesto that will show undecided voters which way he or she will vote on important issues, whether with the government in power or against it.

In my own experience, it helped to be representing a registered local political party, "Independent Community and Health Concern", with a track record of success at council elections.

If we campaign largely on a health ticket we risk being accused of being single issue candidates – the NHS. However, when elected, nothing could be further from the truth. As an MP you have to take on all problems brought to you by constituents, and, as an independent, without a whip instructing you how to vote at every division, you have to understand all the issues coming up for votes. You then have the unique privilege of voting with the Government of the day if they are right, and against them if they are wrong. To do this necessitates regular, close communication with representatives of one's constituents to learn their views and to share yours with them.

But health is indeed crucially important to us all. In its widest sense it transcends all fields of human existence – poverty, housing, employment, education and even aspects of international relations. In the NHAP constitution we describe the NHS as more than just a structure for the delivery of healthcare but also a social institution that reflects national solidarity; expresses the values of equity and universalism; and institutionalises the duty of government to care for all in society. We also write that the NHS marks out a space in society where the dictates of commerce and the market are held in check so as to give expression to socially directed goals, for individuals and society as a whole. No wonder the NHS is the envy of the world! It is up to us to save it and improve it where necessary.

After election as an MP, it is perfectly possible to function effectively, independent of the main parties. One has the same ability to help one's

constituents and the same access to speaking in debates, asking written and oral questions and obtaining adjournment debates in the House of Commons as a main party MP. Soon after I was elected the first time, my youngest daughter then aged eight years, suggested that the letters 'MP' really stand for 'Magic Pass'. She was correct. They are immensely powerful and will open all doors for necessary meetings and contacts.

Even as the only independent MP from 2001 – 2010, I was able to influence local affairs and to affect national policy particularly regarding health. As one of a small number of medical MPs I served on the Health Select Committee for all of my nine years as an MP. I still refer to the reports of the inquiries held by the Committee. They are of great importance and relevance to the NHS now. During the last few months on that Committee we wrote reports on patient safety, commissioning, and the use of overseas doctors in providing out-of-hours services to name only three. We worked also on how to improve value for money in the NHS.

My greatest disappointment at not being re-elected for a third term in 2010 was that I was not in the House to point out the value of these reports. They told the incoming Government all that was needed to be done to improve aspects of NHS care without the need for the Act of Parliament that was passed, without effective resistance, to bring in the coalition's damaging and unnecessary reforms.

Thus I plan to stand again as a candidate in the 2015 general election for my local party which is affiliated with National Health Action. I hope and expect that NHAP will put up a number of candidates in different parts of the country. Remembering the scandals of MPs' expenses, we will require all our candidates to work and live according to the seven principles of public life: honesty, integrity, openness, objectivity, selflessness, accountability and leadership.

For anyone looking for an alternative to the main political parties for their vote at the next election, and who is reluctant to support UKIP for whatever reason, NHAP will provide that alternative.

RICHARD TAYLOR

Two families in England PLC just after the 2015 General Election

I was a GP Principal in the English NHS for 30 years until I resigned in 2013, partly as I did not want to work in a privatised healthcare system.

The work below is a satirical piece designed to bring home to the public what will actually happen to them.

The Bevans live just off Lansley Road , in a house build in 1948, whilst the Cameron-Cleggs occupy a huge hotel-like mansion in a prime site on the private road behind gates manned by *Protecttherich4Security*.

The Bevans inherited their house from Nye's grandparents who had worked hard for it . It suits their family perfectly and was paid for long ago as it was built at cost with no "middle-men" taking a cut.

The Cameron-Cleggs have a large loan from Cheatem & Grabbitt Bank . They are tied into a 30 year mortgage at Loanshark interest rates but don't see the problem as they have shares in the bank. Letwin, Osborne and Crook, their accountants, who by coincidence happen to be bank directors, insisted this was a good deal. Their large support staff occupy most of the rooms protected from the poor further up the street by room entry swipe cards. They park their two Jags in the private car park which C & G Bank recently sold off to a Mr "Ginger" Alexander.

The Cameron-Cleggs pay extra for this but appreciate charging for everything is now part of life and rightly so. It must be better if paid for as this discourages scroungers. However their loss of control hit home when both cars were clamped recently. No problem though as they can recycle the fine when negotiating the next contract , and claim expenses on their next tax return issued from the Cayman Islands.

The Bevan's day starts with Nye helping Jenny with the children and getting them off to school. They've always co-operated and shared the chores. They take turns with the shopping, cooking and cleaning and run a happy house

very efficiently. They wish they could earn more but Nye's boss is very mean. Fortunately their overheads aren't much. They have enough time and money to see to their childrens' every needs, even if they have to wait sometimes.

The Cameron-Cleggs meanwhile have an early family business meeting in the Hunt room with their commissioners. Their accountants goes through the agenda which starts with the news of the arrival of a new 56 page contract for Breakfast Provision after the successful tendering process. This had to be renewed after a poor satisfaction survey which singled out the muesli as not fit-for-purpose.

It is indeed a day for celebration as breakfasts for the children can start again after a break of three months. Lawyers for a US-based cereal company had challenged the bidding process but lost on appeal.

Item 2 (from 32) concerned Governance issues raised by their 4 year old daughter, Deloitte, who was challenging the authority of her parents on a technicality, and because her copy of the Teddybear Repair Contract had not arrived. Deloitte's own lawyers were confident of victory.

Other contracts involving their son, McKinsey, (who had been awarded to the Cameron-Cleggs for 3 years, renewable once only, subject to CRB checks) end soon and so would be put out to compulsory tender. The School outsourcing had always caused concern as the Transport contract only provided for 3 miles of the 5 miles needed and , due to a drafting error, his secondary school became available before his primary. Barry the Butcher supplied the children's clothes, as his bid was lowest . Unfortunately the bedtime stories service disappointed both children when it arrived as it was in Greek. The translation service had recently been abolished because of "efficiency savings" .

The meeting ended with a review of all their 42 compulsory insurance policies but this was "rubber stamped" as they had been brokered by a company called Letwin, Osborne, Crook,

Cheatem and Grabbitt (no relation) from Jersey.

After tough negotiations involving Kaiser Associates, Dave and Nicky signed a marriage contract 6 years ago, and had achieved a decent spell of continuity after Dave had passed his appraisals with her. His Revalidation will be a hurdle however as Nicky is asking for a Judicial Review of Dave's plans to reconfigure the kitchen. He wants to centralise the crockery to the other side of the dishwasher where he feels he can provide a better service but Nicky thinks it'll be too far away from the sink. They both dread an unannounced inspection from the Can't Quite Cope Commission.

However Dave wants to re-negotiate the frequency of their love-life and is threatening putting this out-to-tender producing his annual satisfaction questionnaires as evidence. He has been tempted by offers from the US who specialise in targeting the "low hanging fruit". He feels his wife could have more productivity and a lower price is appropriate, but for a higher frequency. Nicky thinks she will win on quality but wants to include an interference clause.

The Light-Bulb changing service was selected via a "Choose and Book" clinic, but they had recently received a letter after the appointment saying they had missed it and had to be re-referred. This meant that, at the moment, they were in the dark but they had the consolation of knowing that Light-Bulb England had guaranteed 5 choices of appliances. They had been reassured that they could force better quality through competition, although they had found out on the *MarketSolvesEverything* 111 website that 3 types aren't compatible.

They never had to worry about other house maintenance issues as they were tied into a company owed by the Bank, and were persuaded choice wasn't important here.

They couldn't wait for the new USA-EU Trade agreement which is specifically designed to make compulsory 549 types of bulbs from across the Atlantic. An added bonus is they play "The Star-Spangled Banner" when switched on. This would put all the English bulb makers out of business but as they were not shareholders this was of no concern. Even better it is irreversible and the Government can be sued if they don't

stick to the 99 year contract so Dave's brother, Vince, who works for the US Bulb company will do well.

So, the Cameron-Cleggs, being ambitious, are quite content with their lifestyle which the BBC tells them on the News every night puts them firmly in control with lots of choice and a market that guarantees quality. They are very pleased they had voted Conservative, especially as the manifesto promised a top-down, see it from outer-space, plan to buy up without compensation the Bevan's house so it could be converted into another badly needed lawyer's office. This they thought was justice as hadn't they stolen their great Auntie Teresa's private hospitals in 1948?

Fortunately, at this point, Jennie Bevan woke up. She was sweating with fear but realised she'd had an awful nightmare. She knew her way of life was so sensible and British that no politician would ever get away with changing it, and why on earth would they want to? She knew that the Cameron-Cleggs were never going to really tolerate such a stupid, corrupt, wasteful, expensive, inefficient and Orwellian system that she had dreamt they were living. It couldn't possibly happen in such a fair and well-functioning democracy with reliable, truthful, balanced and in-depth media scrutiny. The BBC would ensure that by living up to its Charter, and no political party would implement a policy not clearly laid out in a pre-election manifesto. They wouldn't be so deceitful as it might damage the politicians' reputation of being honest, open and full of integrity. She could go back to sleep content in that certainty.

But the twist is this is a true story. This is the story of what the Coalition Government is doing to the English NHS. It used to be run like the Bevan's household but now it operates like the Cameron-Clegg's, Americanisation is their middle name.

Which household would you prefer to live in?

Unlike in Jenny's nightmare the General Election hasn't actually happened yet, so the English could still avoid having to live like the Cameron-Cleggs with the Bevan's way of life having gone forever.

DR PAUL J HOBDAV

The AGM and Conference 2015

will be held on
Saturday 3rd October
venue to be decided