NHSCA

EDITORIAL December 2009

LEADERSHIP

Even as early as prep-school, reports usually included a comment on progress in this area. 'He is not yet showing signs of leadership', 'This term he has shown some leadership' or even 'not fit to be a leader'.

This leadership business was taken for granted by everyone and never questioned.
I later assumed it was grooming for life in the armed forces or empire – to be a leader of the lowly but also, of course, to accept orders.

There has recently been an epidemic of talk about professionalism. Competence in one's role is all that is needed and most people can understand competence and even more quickly incompetence. 'Professionalism' is a confusing distraction. Competence for a consultant includes the role as a leader.

When I worked abroad in the Colonial service and many other organisations I came to appreciate the necessity of the concept I had previously rather ignored.

As a full-time NHS consultant in 1971 I soon realised that again leadership was the key to a well run service. Not leadership by diktat and bullying à la Bernard Shaw but leadership by example - expecting everyone to aim for the very best and enabling other staff themselves to lead. My colleagues ran or were run by their units and people knew which worked well.

Over the years the younger consultants showed less interest in leading, running, managing and developing their units but tending to leave this to 'management', government instructions and nurses based in offices.

I suggest that a major cause of weakness in many hospital units is that the traditional leaders of Consultant and Ward sister no longer lead. Indeed they are discouraged from doing so. They no longer feel it is their responsibility to do so because of the layers of office workers who ignore and bypass them if they can.

Until the Ward Sisters and Consultants resume their naturally positioned leadership roles the disgraceful slovenliness and failures of care we hear of so very often from friends as well as the media will continue.

We cannot be proud of our service until and unless we contribute to leading it. Don't leave it to others to lead!

CHRIS BURNS-COX
Co-Chair, NHSCA
Guest Editor

THE AGM and CONFERENCE 2009

This event was held at Friends Meeting House, London on October 10th

Minutes of the AGM have been sent to the Executive Committee and all other members who attended. They are available by email or post to any other member on request.

The reports presented by the Co- Chairs and Hon Treasurer follow, together with reports on the various sessions at the conference, culminating in the Paul Noone Memorial Lecture.

After the Conference, those who were able to stay on enjoyed an informal buffet meal kindly hosted by Wendy Savage at her home.

Elsewhere in this Newsletter is the full list of members elected to the new Executive Committee, with their contact details.

At its first meeting, on November 12th the Committee elected officers:-

Co- Chairs - Chris Burns-Cox and Jacky Davis

Hon Secretary – Malila Noone **HonTreasurer – Jonathan Dare**

CO-CHAIRS' REPORT

In the last year the NHSCA has kept focused on its fundamental purpose and has some achievements.

There have been 5 meetings of the Executive Committee attended by 8 to 13 members and 4 Newsletters. Our thanks to those kind members who have written the minutes.

On April 25th 2009 we held a special meeting in York attended by 20 members to discuss policy – report circulated/accompanying today's agenda.

We have continued to support financially and in other ways KONP and the NHS Support Federation, two major organizations whose principles we share.

A major advance this year is that the BMA has come out very strongly against the NHS Healthcare market and privatization of services. We share the BMA's 8 principles for guiding the development of the NHS. Jacky Davis and Anna Athow are on BMA Council and I have no doubt they have stimulated this dramatic change. Harry Keen is working with the BMA Chairman whom the NHSCA has congratulated on his stand.

Jacky Davis has been responsible for counter-statements to the rabid lies put about in the USA by those who profit most from privatized health care. It has been sent to Senator Kerry. (*and reprinted elsewhere in this Newsletter*). We would want to aid the progress of the Obama proposals in any way possible even though they do not go far enough. Jacky Davis put forward a proposal to solve the topping up debate regarding expensive drugs not approved by NICE. The idea is to top slice every PCT budget so that there is a pool of money in each PCT with which to pay for these drugs if clinically justified. This problem is not common. Czar Richards' proposal would be wasteful of time and money and would create practical difficulties and inequalities in serving patients.

The NHSCA has produced a response to the Cooperation and Competition panel regarding the use of non-contracted time (published in the Newsletter).

Jacky Davis has spoken in Canada by invitation regarding changes in our health service.

Member Allyson Pollock has been very influential in researching and publishing the costs of privatizing acre and the discredited PFI programme.

Such is the nature of UK politics that although the arguments regarding markets, privatization and PFI have been clearly won intellectually, the influences on politicians are such that their actions remain irrational and wasteful.

As before, our President has kept up the momentum and with others published several letters in the national press. His work load has fallen slightly but only slightly! Our thanks to him.

Chris Burns-Cox Jacky Davis

HONORARY TREASURER'S REPORT

As far as the Honorary Treasurer is concerned this has been a fairly busy but unremarkable year. The "chasing up" of members failing to pay their annual subscription has occupied myself and our indefatigable President to a great extent. Unfortunately this has been required a great deal, combined with a poor year in terms of recruitment of new members this has produced very little net increase as is evident in the static Subscription Income seen in the attached accounts.

I am making my biennial appearance at the AGM to speak to the Accounts which means the President is relieved of this onerous duty in 2009. He does, however, continue to keep the finances flowing during my long sojourns in France. The Auditor Mr. Bob McFadyen has, once more, kept our accounts in impeccable order as witnessed in his accompanying report again produced in a very short space of time.

In overall terms the accounts are largely unexceptional. Thus the change in the Income is insignificant whilst the Expenditure drop is accounted for by an apparent reduction in our level of financial support to KONP. This is due to two factors; firstly an accident of donation timing around the start and finish of our auditing year and KONP reorganising its financial structures. Thus there is no lessening in our support for it and assuming it is the wish of the AGM we can continue our contribution at any reasonable required level. We can also carry on our support for the NHS Fed and Health Matters at the same intensity again if the AGM wishes.

The following points will help clarify some of the issues arising from the accompanying audited accounts:-

1] At nearly £1000.00 the net cost of the AGM is

about the same as last year although they are both double that of previous years. I acknowledge the democratic view of the minority who attend the AGM that supports such a level but continue to disagree that it is an appropriate use of membership subscriptions.

2] By contrast the, highly successful, Special Policy Conference attended by only marginally fewer members was a bargain at a net cost of only £200.00.

3] The cost of Committee meetings has more than doubled to about the £1,000.00 I have been forecasting over the past few years. This approximates to the historical figure and is due to a slight increase in the number of meetings as well as the attendance of committee members from longer distances.

4] The "Recruitment Literature" expenses have gone up this year due to their being comprehensively revised and includes the publication of the Special Policy Conference Report. Again currently the Health Policy Network is inactive so this item refers purely to our recruitment and promotional literature.

There are no other significant changes between comparable years.

JONATHAN DARE
Honorary Treasurer, NHSCA

ALTERNATIVES TO THE MARKET

Ms Ann Lloyd, Former Chief Executive of NHS Wales

Personal background
25 years as CE (close links with our co-chair Chris B-C when with N.Bristol Trust) with last 8 Years as CE to Wales culminating in implementation of major admin. changes from Oct.1st 2009

Financial and Demographic challenges
£6m Budget allocation; uneven population spread with majority in South East Wales, small towns with poor transport links in mid-Wales, the traditionally deprived valleys, although benefiting from monetary injection, showing pockets of depression and resistance to accept need to travel to larger centres for medical services. Variable GP service, which had progressed to a better quality salaried scheme. Establishment of North Wales clinical schools with recognition that needs of Welsh-speaking residents be met.

Chronological Milestones
1997 Devolution heralded under a Lab/Lib coalition
2001 AL found market system in force, backwards compared with England and, Trusts far too powerful. "Improving health in Wales" set targets to reduce inequalities with better partnerships, more effective and safe services. Need for structural change accepted ,but no performance management existed
"Health Challenge Wales" established Prof. Townsend (recently deceased) provided a vital analysis of deprivation in Wales.
2003 New Finance Minister complains of a "bottomless" pit and an unsupportable acute sector but they had not moved on said Ann.
A 1st Health Strategy was produced. This "Design for Life", based on actual descriptions from long-term patients of their illnesses and service needs and a realisation that 80% population over 65 had more than one chronic illness was the key to success and something of which Ann is most proud Implementation has not been without problems and personalisation issues.
2007 Election led to a Labour/Plaid Cymru coalition, a new Health Minister and a determination to remove the internal market –changes to include GP's and accountability and clinical engagement with Clinicians and an overall emphasis on "wellness" rather than illness Performance Management was introduced.
2009 From Oct1st Seven integrated organisations.
Proof of success:-Health has improved. Life-expectancy has increased, staff are not as disaffected as former colleagues

Questions from the floor
Will money be able to be diverted from bureaucracy to patient care, following the administrative changes of 10 days ago?
Yes, this will be well monitored.
Geoffrey Mitchell

SCOTLAND
Colin Leys

What are the costs of operating the current healthcare market in England? Would abolition of the market save enough to avoid the service cuts threatened by the recent McKinsey report? Colin Leys summarised the work done so far by Stewart Player in collaboration with NHSCA.

Colin asked whether the need for spending cuts has been exaggerated. There has been a massive scare campaign about public debt although the UK's debt, relative to GDP, is one of the lowest in the OECD. Tax reform is certainly needed and closure of tax loopholes and offshore operations for individuals and corporations would save billions. Current taxation is regressive, with the poorest 10% (av £9000/year) paying 44% of income in tax but the richest 10% (av £94000/year) only 35%.

Allyson Pollock has estimated that between £6 and £24 billion could be saved by scrapping the market but there is huge uncertainty as the government does not now publish data on administrative costs in England (unlike Scotland, Canada or the US). Previous figures show that NHS administrative costs rose from 5% of spending in the 1970s to 12% in 1997 after the start of the internal market. An eventual rise to 17% was predicted and this can be taken as a minimum estimate today. In England this must now be at least 20%.

Workforce figures show a doubling of administrative and clerical staff between 1980 and 2005 as well as a similar rise in clinical staff. Outsourced ancillary and domestic workers will not be included, nor will the administrative staff of private-sector providers such as ISTCs. The market has extended considerably since 2005 so current numbers, (not yet available) will be higher.

In the fully marketised US health system the administrative costs are 31% of spending even without including the costs of insurers. Canada has a 'single payer' system with block grants for hospitals and administrative costs of 17%. Costs in Scotland have reduced very slightly since the abolition of the internal market, possibly because of difficulties in getting rid of staff.

FOI requests have been sent to several PCTs to see how much has been spent on four main areas within the marketisation process, ie commissioning, performance management, contract management and marketing. The only one to reply so far has revealed very little. Moreinformation may be gained by studying the plans of private companies involved in healthcare and the amounts they are setting aside for these various functions.

The Government has clearly rigged the system to benefit the private sector but there are a few signs that attitudes may be changing. The DoH stated recently, to the annoyance of Alan Milburn, that the NHS is to be the preferred provider of services. A document on the Conservative party website is critical of New Labour's sellout to the private sector. The Conservatives, however, still appear to be committed to a market.

There is still massive public support for fair and inclusive health care so it is important that we should continue to raise questions about the effects of the health care market.

Matthew Dunnigan

This study compared the relative performance of the Scottish and English NHS between 1985-86 and 2007-8.

In the earlier period, Scottish hospitalisation rates for all specialties, acute medical and acute surgical specialties (inpatients, day cases and new outpatients) were moderately higher than English rates. By 2007-8, Scottish rates were slightly below English levels, the decline being rather greater in acute surgical specialties.

Health expenditure in real terms has increased greatly between these periods, from £582 to £1263 per capita in Scotland and £466 to £1142 in England. In 1990 Scotland spent 25% more per head than England but by 2008 only 11% more per head. While funding was increasing there was a marked decline in the rate of increase of hospitalisation and consultation rates in England. Scottish rates remained relatively constant.

Standardised mortality rates (SMR) are still approximately 20% worse in Scotland than England and have even increased for men, in spite of the large increase in funding.

There has been a slight decline in management and administration costs as a proportion of total NHS expenditure following abolition of the purchaser-provider split by the Scottish Parliament in 2003-4 but total management expenditure is still rising. Why is this? Most NHS expenditure is on staff and it is relatively hard to lose staff who are already in post.

There is therefore some concern that, despite a large increase in funding and the good intentions of the SNP government, NHS productivity in Scotland has not improved as much as in England. The reasons for this are not clear.

Robert Cumming
Chair Scottish Health Campaigns Network

Robert Cumming gave an account of the main developments in the Scottish NHS since 1991-2,when trust hospitals, general management and the internal market were introduced across the UK. The recent poll tax had been immensely unpopular in Scotland so there was suspicion of Conservative policies.

In terms of the geography of Scotland the DGH system worked well and competition seemed unlikely to improve care. Management consultants found it hard to believe that nobody knew the cost of, for instance, investigating iron deficiency anaemia. Clinical risks arose when blood tests were outsourced to entrepreneurial GPs.

In 1999, devolution resulted in different policies for the Scottish NHS. Health Minister Malcolm Chisholm abolished the internal market and, by 2004, Trusts had gone. 15 Health Boards were to cooperate and plan services, with local Community Health Partnerships responsible for health and social care. These were vulnerable to centrally-imposed council funding cuts.

In spite of devolution, some UK-wide policies were imposed. Topslicing of health budgets to pay for PFI/PPP projects appeared to be the reason for several threatened hospital closures which were opposed by SHCN. A Netcare ISTC was opened at Strathcathro; later analysis by Allyson Pollock has shown that 25% of the payments made to it were for surgery which was never performed. A clause slipped into the Tobacco and Primary Care Act 2004 meant that outside contractors could apply to run primary care.

In 2007, SNP Health Minister Nicola Sturgeon rejected new Labour policies. Hospital closure consultations were exposed as shams and it was decided that the Netcare ISTC contract would not be renewed. PFI/PPP was abolished and a large new Glasgow hospital was planned, to be built with public funding. Prescription charges are to be phased out in 2011 and a new Tobacco and Primary Care Services bill is being passed to ban the private sector from running primary care. The composition of Health Boards is to change so that a small majority will be elected.

Andrea Franks

PHAST - the Public Health Action Support Team

As I said in a 2007 Health Services Journal piece on reforming the NHS
"There is a body of professional specialised knowledge – public health and population medicine – with the skills and expertise to advise and train doctors and NHS managers on how to improve clinical cost-effectiveness in the NHS. But instead of strengthening the position of such experts, successive restructuring has in recent years weakened their position in the NHS. You need to change that. In the meantime, we have an organisation – the Public Health Action Support Team, hosted by Imperial College London – which provides support and training for NHS commissioning and management."
PHAST is a 'Community Interest Company' – a not for profit organisation of experienced public health consultants and senior managers, who mainly used to work in the NHS. It has a small management group, but most of its practitioners are independent associates.

PHAST has carried out a large number of commissioned projects ranging from assessments of need around health inequalities for primary care organisations and homelessness for the St Mungo's charity, through to supporting the planning of stroke services and 'World Class Commissioning' training for clinicians and senior managers in the NHS.
PHAST provides various other training programmes, including a revision course for public health specialists, courses in public health for non specialists and in critical appraisal. PHAST also provides support for health services planning at the local level, including in general practice and hospitals. The essence of the PHAST approach is collaboration, both between various professional groups and patients, and the different agencies involved in health and well being of the community.

David Lawrence MPhil FFPH
PHAST Associate and hon senior lecturer,
London School of Hygiene and Tropical Medicine.

PAUL NOONE MEMORIAL LECTURE

Musings on my NHS : Past, Present and Future

Dr Clare Gerada,
Vice Chair, Royal College of General Practitioners

Dr Gerada had changed the title of her talk from *"Privatisation in Primary Care"* to a more general topic: *"Musings on my NHS: Past, Present and Future"*

Past:

Dr Gerada talked about her childhood experiences as the daughter of a GP. She learned early that medical practice was an art and that it required a keen sense of observation.

Present:

She was fundamentally committed to the NHS but noted that a new breed of GP was emerging from the recent chaos. She herself was a Partner in a private group of practices employing 25 salaried GPs. The three practices cover Tower Hamlets, Lambeth and Southwark. She described the improvement in services since the 1990s when waiting times were excessive, communication with Consultants was poor and there were few guidelines and standards. GPs (in south London) often worked in poor premises, were shut in the evenings and on weekends.

She ran through the main events affecting Health Care: the 1990 GP contract, the Shipman Inquiry, and the introduction of Fund Holding. Although most GPs disliked Fund Holding, the system was beginning to mature when Blair reversed it and introduced his many reforms and this has caused greater problems and headaches. The mantra now is "privatisation" where money follows patients with an expectation of better care. There is a demand for Choice, Contestability and Competition. We are now moving towards a "Supermarket led NHS".

The introduction of Payment by Results was unfortunate as it is a perverse incentive –e.g. a patient with an urticarial rash could be seen and discharged home from A&E but it is more profitable to keep him in as a Day Case.

Practice Based Commissioning is a disaster for GPs as it is more expensive and time consuming than fund holding but the College supports it. Markets don't work in the NHS as patients are complex and do not fit into packages. On the other hand, GPs are not always good at managing the NHS and poor at innovation. She was not ashamed of the fact that she had become a private sector GP. She felt driven to improve the standard of primary care which was quite grim in some areas of south London. The Group won the tender for a walk-in centre in Southwark and the practice has moved from being one of the worst into one of the best - improved premises, better IT systems, guidelines etc. She works far harder now, has less autonomy, performance is scrutinised but is also less able to practice as a professional.

The future:

Dr Gerada wished to "Look back to look forward"

She found It difficult to understand the rationale for Darzi proposals for polyclinics but she felt that GP practices (particularly in London) needed better premises and IT systems.

She felt that "The Principles of a Modern Healthcare System" 1965 (I have no reference for this) should be implemented and that medical records should continue to be available for research and epidemiology.

Malila Noone

THE McKINSEY PLAN

means cuts in frontline NHS care and more privatisation

The McKinsey and Co report proposes cutting £20bn off the NHS budget and reducing the staff by 10% or 137,000 jobs.

The government commissioned this 100 page report at great expense and members of the public and trade unions cannot see it as it is " confidential". This is a disgrace.

The Department of Health (DH) circulated it to leading managers in the Strategic Health Authorities with an NHS Logo on it and David Nicholson, the NHS Chief Executive was quoting from it earlier in the year, so clearly the government plans to implement it.

When it was leaked to Health Service Journal (HSJ) at the beginning of September, Health Minister Michael O'Brien said that the government had no intention of cutting staff and this was just one of many ideas. By 19th September Andy Burnham, SoS for Health was quoted as saying he would " begin the process of showing how we realise the challenge of finding £15 to £20bn of savings" up until 2014.
HSJ itself is clear that managers must get on with "leading through it."
We can glean, from reading that journal, some idea of what the report contains.

Cutting £8.8bn on annual spending mainly pay
(i) £3bn by increasing staff productivity in NHS hospitals
(ii). £1.9bn in non- acute staff productivity
(i.e. in staff outside hospitals?)
(iii). £1.9bn from Supplies
(iv). £1.4bn from drug spending
(v). 400 m in Estates maintenance
(vi). £200m in reducing PFI interest rates.

£4.9bn, the largest chunk of this £8.8bn, would therefore come from sacking staff.
Cutting 10% of the staff would reduce the pay bill between 9 and 14%. The redundancy costs would be £530m over three years.

Cutting £8.3bn by selling assets
Land and buildings would be freed up and sold off.

Brunt to bear by acute NHS hospital staff
A third of savings is to come from making staff redundant in acute NHS hospitals.
HSJ says *" The report is clear that the bulk of savings would need to come from the acute sector. It says a third of the total savings will come from ' acute staff productivity." (Page 11. HSJ 10.9.09)*

Productivity
The word productivity is used to mean less staff to do the same work.
Productivity for them, means speed-up - seeing more patients, per nurse /doctor, per hour. Their approach is entirely quantitative. They evaluated the work of district nurses, GPs, and hospital doctors in outpatient clinics and operating theatres entirely in these terms.
They completely omit the question of quality.
Patients are not baked bean tins on a production line. They are all individual and different, having varying conditions. Some patients require more time than others if their condition is to be diagnosed and investigated and treated properly. The McKinsey approach, is that the quicker the better.
So, more McKinsey productivity = more redundancies.

Frontline clinical and admin support staff the main target
The report proposes cutting as many clinical staff as administrators. But by administrators it means those with average wage £20,000 per year. The latter are the salt of the earth, including low paid clerical workers so important in supporting frontline clinical care; secretaries, receptionists, staff in medical records, admissions, registration, ward clerks etc. 38,000 of these are to go. But for every eight of these 10 nurses and 10 healthcare assistants must go, and at least three doctors.

In primary and community care they say, that 3,500 GPs and 1,600 district nurses are surplus to requirements.
All this in the face of a national shortage of midwives, health visitors and paramedics such as radiographers and physiotherapists.

Other ways they propose to slash the work of NHS acute hospitals is by,
• stopping GPs referring patients to hospitals and reducing the numbers of new referrals to outpatient clinics.
• cutting follow up outpatients appointments

• stopping patients having certain operations, by saying they are not necessary. They list up to 30 surgical operations including inguinal, femoral and umbilical hernias, hysterectomies for bleeding, hip replacements and knee joint surgery, which they say are not needed.
• reducing the time that the patient stays in hospital by driving up day surgery rates.

The mechanisms by which these goals will be achieved is by instructing the commissioners, Primary Care Trusts (PCTs) to cut the purchasing of these operations, and to cut the tariff (the payments by results tariff which is the price of every procedure). These market mechanisms will be used to simply cut the funding to the hospitals and prevent certain procedures being carried out. The PCTs will refuse to pay for them.

Hospitals would be rendered bankrupt and McKinseys is clear that " *'clear "failure regime" for providers who are consistently failing. That would supplement the failure regime already announced last autumn.'* is necessary.

Hospitals would be closed, merged, or taken over by private management and their work parcelled out to competing providers.

Reconfiguration is the goal

McKinsey's aim is to shift hospital work out of hospitals and into the " community" on the one hand, and eliminate it, on the other.

'The rationale for both the workforce and space reductions is underpinned by McKinsey's analysis of the volume of acute hospital activity it believes can either be shifted into the community or – more significantly for the overall NHS budget and workforce reductions – cut altogether.' (HSJ 10.9.09. p13)

Patients will not have the care

McKinsey recommends that annual savings can be slashed by cutting money on the following areas, 38 per cent on the hospital sector, 28 per cent on community care, 13 per cent on primary care, 18 per cent on mental health and learning disability, five per cent on PCT and other overheads, and two per cent on central budgets.

Who are McKinsey and Co?

These proposals are breathtakingly arrogant. Who is McKinsey and Co? They are a wealthy US management consultancy firm, which specialise in advising big corporations how to make profit for shareholders. Their nickname is " the Jesuits of capitalism."

They have no interest in providing high quality universal healthcare for the British population.

They have been closely involved with New Labour's privatisation reforms of the NHS for many years, producing reports on such topics as foundation trusts, and how to introduce private companies to advise PCTs to give contracts to diverse providers. McKinseys are on the list of FESC companies, which specialise in "advising" PCTs on how to "stimulate the market".

The man that chose McKinseys to write the report was Mark Britnell, the erstwhile head of NHS Commissioning and system management who set up the "cooperation and competition panel" and invented" world class commissioning." His latest brainchild is Market Support Units for PCTs costing £20m, but he has now left to join KPMG.

Leading personnel from McKinseys helped Lord Darzi produce his 2007 *Framework for Action* which proposed that all high volume, non acute, less complex NHS procedures, should be taken out of NHS hospitals and performed by elective centres, polyclinics and walk in centres. On the back of this, Lord Darzi proclaimed that the day of the District General Hospital(DGH) is over, and that half to two thirds of London's DGHs would be run down or closed.

Some estimate, that McKinseys now gains a third of its revenue in the UK by producing management consultancy reports for the NHS!

Introducing a market in healthcare itself wastes billions. At great expense this government introduced from 2002 onwards, the purchaser -provider split, whereby 300 PCTs commission healthcare from a plurality of competing providers, including independent sector treatment centres (ISTCs) and foundation trusts run on business lines, social enterprises and commercial companies.

The method of funding was changed from block funding to payments - by - results tariffs for all procedures, which has led to an army of clinical coders. The transaction costs for all this contracting, competition, advertising, management bureaucracy, billing, the drawing up of business cases and accounting, has increased from somewhere around 6% of the budget before the internal market, to 12% with it, and heading towards 20%.

Corporate salaries are now paid to higher management in the trusts and PCTs.

The annual payments for PFI newbuilds is half a billion per year and rising. Long term the PFI debt is £70bn over the 30 year lives of these contracts.

The annual drugs bill for the NHS is £14bn, with the pharmaceutical industry making a healthy profit. Over £350m a year goes on private management consultants.

The policies of the Brown and Blair New Labour governments with regard to the NHS are identical to those of the private management consultants which they so frequently use to draw up their privatisation reforms. They are in bed together.

The McKinsey report is a privateer's charter, proposing the axing of £20bn of NHS spending on frontline care, while the massive waste on bureaucracy, PFI and the market will continue. The gravy train for the private health companies is set to expand.

Those that will suffer will be the patients and the staff. Patients will have to travel miles to access a proper hospital with all acute services on site. They will be fobbed off with walk - in centres and polyclinics, run by commercial companies, which will substitute nurse led care for proper GPs. ISTCs cream off the more straight forward surgery leaving the NHS to do the complex work and train the juniors.

It would become hard for ordinary people to get to see a consultant and get the opinion and operation that they need.

These New Labour/McKinsey plans must to totally rejected. The report must be made public, so that it can be exposed and torn to pieces.

ANNA ATHOW
General Surgery, London

STOP PRESS

Meeting with Health Minister Mike O'Brien on 2nd December

This meeting had been offered following a letter written to the Secretary of State by Wendy Savage in her capacity as Co-Chair of KONP. For the meeting she was joined by her other Co-Chair, John Lipetz, with NHSCA represented by Jacky Davis as Co-Chair and myself as President.

The main issue raised in the letter had been concern at the government's continuation and extension of market policies in the NHS and we began by pointing out that the NHS Federation was saying that £20bn cuts were going to be needed and that by abolishing the market this money could be saved. He said the money was for investment not cuts and dodged the question of the cost of the market. We went on to say that the market was not something the public had wanted nor had the opportunity to vote on to which he made the breathtaking response that there wasn't actually a market! Having reminded him of the separation into Purchaser and Provider, the tenders, contracts, and competing providers both public and private which were indisputably market features we gave our opinion that a commitment to reverse these policies would reap great electoral rewards, particularly when weighed against the alternative of cuts in services. One of his officials disputed the requirement for PCTs to outsource 15% of their purchasing and later in the corridor said that John Reid had only suggested this figure. ISTCs were mentioned and he claimed they (and the premium tariffs) had been necessary to bring down long waiting lists. We replied that this should only have been for a limited period whilst NHS capacity was built up. His position was that it was not mainly a lack of capacity and that ISTCs were not necessarily permanent as NHS organizations could bid for the contracts when they came up for renewal. *(Action point – if there is a first wave ISTC in your area ask your PCT whether renewal is essential – January 2010 is the deadline)*

Mr O'Brien saw his responsibility as getting the best deal for patients and had no ideological problem with using the private sector if it met appropriate standards, even bringing out the tired old cliché that GPs are themselves in the private sector, something we rejected with vigour. When the question of the NHS being preferred provider came up, this appears to go only as far as giving NHS institutions a second chance to improve but after that they would have to take their chance against private competitors. He did not accept that it was his responsibility to ensure that the NHS had adequate capacity and standards, classing this as "micro-management" and in conflict with the local decision making which we said should have been exercised in such matters as whether a GP led (Darzi) health centre was the best use of funds in a particular area.

There was some disagreement about the current degree of private sector involvement but we maintained that if the principle was there the NHS was left in a very vulnerable position when a different government was elected which it surely would be sooner or later. When we suggested that people might well ask how it is that Labour dominated coalitions in Scotland and Wales had abolished the market in those countries whilst Labour in England was still wedded to it, he countered that waiting lists in Wales were rising – not a very convincing argument as the decision to abandon the market had only been taken there a few weeks ago.

We had to agree to differ on virtually every topic except that patients' interests were the prime consideration. It was clear to us that the only factor that might bring a change of policy would be the public making clear that it was the only way of avoiding electoral disaster.

It would appear therefore that our efforts in the coming months must be concentrated on keeping the issue of the enormous and costly bureaucracy of the market system in the public arena.

PETER FISHER

THE AGM and CONFERENCE 2009

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

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THE POLITICS OF ENGLISH HEALTH REFORMS

"Services are coming to dominate the economic activities of countries at virtually every stage of development, making services trade liberalisation a necessity for the integration of the World economy"[1]
International Chamber of Commerce [1]

"The commodification of public space has now become an aggressive Blairite objective"
Roy Hattersley, Labour MP (quoted in the Guardian, 7th November 2005)

"All public services have to be based on a diversity of independent providers who compete for business in a market governed by Consumer choice. All across Whitehall, any policy option now has to be dressed up as "choice", "diversity", and "contestability". These are the hallmarks of the "new model public service" **John Denham MP, former Health Minister quoted in 2006**
http://www.chartist.org.uk/articles/labourmove/march06denham.htm

Introduction

According to former Health Secretary, Frank Dobson, the creation of the NHS was: "Labour's greatest achievement. It is a working example of the best interests of the people in this country. It is the most popular institution in Britain"[2].

Neglect of the NHS was a principal cause of the Conservative government's downfall and a major issue that helped New Labour mobilise mass political support for a landslide election victory in 1997. Labour's election manifesto in 1997 warned that only Labour could "save the NHS" and a decade of New Labour in government has resulted in the largest ever sustained increase in healthcare spending in the history of the NHS. The King's Fund has since reported that significant improvements have been made in quality of care, with "huge progress" in the reduction of waiting times and "more and better services"[3].

However, the reform of the NHS has been described as "Labour's greatest domestic political challenge over two terms in power" [4], with NHS reforms proving to be highly unpopular both within and outside the mainstream Labour party. In 2001, David Hinchcliffe, the Labour Chair of the Health Select Committee warned that if pushed to their logical limits, the reforms could amount to "a complete betrayal of everything that the Labour Party stood for" and "would cause outrage within the mainstream Labour party circles"[5]. At the 2005 Labour Party Conference a resolution was passed that attacked the Government's move "towards fragmenting the NHS and embedding a marketised system of providing public services with a substantial and growing role for the private sector"[6] and in April 2005 more than two thirds of signatories to a 1997 statement in The Times backing Labour's policies on health announced that they would not do so again.[7]

The Government continues to deny systematic piecemeal privatisation of the NHS and are always quick to point out that healthcare remains "free at the point of delivery". However, despite the rhetoric, it is clear that a market-based approach has become central to healthcare delivery and the role of the private sector is expanding. Labour MP, Michael Meacher summed this up well recently[8]:
"Equity, equal rights according to need, public accountability, a professional standard of care and integrity are being replaced by targets, cost cutting, PFI top slicing of public expenditure - a service fragmentation by private interests. This is the case for health and education housing, pensions, probation, rail, the Post Office and local government"

Why have New Labour taken this controversial and unpopular route to the delivery of public services? Writing in the New Statesman, two Labour MPs, John Cruddas and Jon Tricket recently provided a succinct explanation[9]:
"After years in opposition and with the political and economic dominance of neoliberalism, New Labour essentially raised the white flag and inverted the principle of social democracy. Society was no longer to be master of the market, but its servant. Labour was to offer a more humane version of Thatcherism, in that the state would be actively used to help people survive as individuals in the global economy - but economic interests would always call all the shots"

Stuart Hall, Emeritus Professor of Sociology at the Open University, argued that whilst the Labour Government has retained its social democratic commitment to maintaining public services and alleviating poverty, its "dominant logic" was neo-liberal: to spread "the gospel of market fundamentalism", promote business interests and values and further residualise the welfare system[10].

New Labour and Global Neoliberalism - the "new reality", and the "logic of accommodation"

The early 1980s saw the rise of neoliberal globalisation through the world wide abolition of capital controls, removal of trade barriers, and computerisation. This facilitated the freedom of movement of capital and goods and services across national borders. Heavy influence promoting this approach has come from the World Trade Organisation (WTO), World Bank, the Organisation for Economic Co-operation and Development (OECD), the European Union, and the World Economic Forum. However, it is now generally acknowledged that this reality has significantly eroded the capacity of the nation-state to command its own destiny because governments must retain the confidence of international asset holders by whatever policy modification is deemed necessary [11-12], otherwise they face the risk of massive capital flight with potentially very serious economic consequences[13].

After 4 successive election defeats (1979, 1983, 1987 and 1992), Labour's social democratic model of Keynesian demand management economics, progressive taxation, extending welfare spending and redistribution was no longer seen as a practicable solution[14].
This was described as the "New Reality" by New Labour "modernisers" like Peter Mandelson and led to the jettisoning of traditional "Old Labour" social democratic policies in favour of a variant of neoliberal Thatcherism[15]. This approach would accommodate the global financial markets by promoting economic growth through the introduction of business friendly supply-side policies aimed at freeing up markets and expanding choice, ensuring economic stability for the private sector's planning environment, strict financial management and control of public expenditure, the defeat of inflation, privatising state-owned enterprises and premises, privatising the provision of a vast array of public services, and remodelling the state's internal operations along business lines (New Public Management)[16]. This was inherently unpopular with the centre left and left, and has therefore been described as the "logic of accommodation"[17].

Thus the Labour party understood that achieving the trust of investors and market credibility was crucial to their election hopes. In opposition in the early 1990s, the Labour party went on the "Prawn Cocktail offensive" to convince the City that Labour were "the party of business". Labour's Political risk premium* went from 2% in 1992 to 0.5% in 1997, thanks mainly to the promotion of policies such as the Private Finance Initiative (PFI)[15].

The abolition of the Labour party's constitutional Clause IV further appeased the City, by denouncing nationalisation and emasculating the power of the Unions and the policy making ability of annual Labour party conference. For many commentators, this symbolised the end of Old Labour and the start of New Labour. Thus, the 1997 Labour Election manifesto stated:
"In economic management, we accept the global economy as a reality and reject the isolationism and 'go-it-alone' policies of the past"

Whilst in power Labour further achieved the trust of investors and market credibility by reducing the capacity of government to steer economic policy by a strategy of "depoliticisation". This took 2 main forms: Firstly, the control of interest rates was transferred to the Bank of England's Monetary Policy Committee and secondly, a binding framework of rules to govern fiscal policy designed to tie all government departments to rigorous expenditure limits was adopted. In his Mansion House Speech in 1997, Gordon Brown said that for a government to succeed it has no option but to, "convince the markets that they have the policies in place for long term stability."

Professor Anthony King described the Blair government as the "first ever Labour government to be openly, even ostentatiously pro-business"[18]. Thus, the New Labour leadership had been "converted" from tolerating private enterprise to actively promoting it; a significant political U-turn.

(*Political risk premium. This is the additional interest that investors take into account for political parties in power and is a measure of how business friendly they are.)

New Labour's change in direction for Healthcare policy and the English NHS

Labour's 1997 election manifesto was opposed to privatisation of clinical services within the NHS. However, we now have a policy agenda promoting a market driven approach to healthcare delivery with active encouragement of the private sector to deliver clinical services in competition with NHS organisations, through the mechanisms of patient choice, plurality of provision, and payment by results. Thus, current Government policy appears to be sympathetic to the World Trade Organisation's (WTO) General Agreement on Trade in Services (GATS), which aim to opens up service provision like health and education, (which account for approximately 15% of GDP in most European countries) to direct multinational competition and ownership[19]. This is despite a statement in 2002 from the UK Government that it would not take on WTO commitments that would compromise public service delivery via the NHS.

This represents a major U-turn in healthcare policy and it is therefore important to understand from a historical perspective how and why this happened.

Prudence and PFI

In Labour's first term in office, the 1997 White paper "*The new NHS: Modern, dependable*"[20] actually pushed the "divisive" internal market aside a little by recasting relationships between contractors onto a longer term basis, and by consolidating local purchasing into primary care groups, abolishing GP fundholding in the process[21]. In addition , Labour opposed patient choice. Alan Milburn stated in June 2000 that "we are not prepared to trade off being free and fair, for efficiency and responsiveness to the demands of patients"[22].
Health policy at this stage was about continuity and incremental changes, not radical reform. This was essentially a Fabian approach and the role of the private sector was extremely limited, with the word "private" hardly mentioned in policy documents[4]. The only real evidence supporting a neoliberal approach to healthcare delivery at this time, was the Private Finance Initiative (PFI), which has been a key long term attribute of the government's broad political strategy[23].

The PFI was the brainchild of Tory MP, David Willetts and was introduced by the Major government in 1993, although very few schemes actually went ahead. It was initially bitterly opposed by frontbench and backbench Labour MPs, but most were eventually "converted" to the ideology of PFI to the extent that the 1997 Labour Party manifesto promised to "overcome the problems that have plagued the PFI". This U-turn came about because the PFI enabled public capital spending projects to be undertaken without adding to the Public Sector Borrowing Requirement (PSBR), thus keeping public borrowing "off balance sheet". This allowed continued public service investment whilst still conforming to the Treasury's strict fiscal rules, a key part of the Government's "prudent" economic strategy. It also helped New Labour to win the confidence of the financial and business institutions. The NHS Private Finance Act of July 1997 removed the last doubts that the private sector had about the PFI and paved the way to billions of pounds worth of contracts.

Gordon Brown's acceptance of PFI was a deliberate attempt to distance the Labour party from the past[24], upholding its new found reputation for "sound finance", whilst at the same time building an unprecedented "vote winning" number of new hospitals and schools. He wooed financiers in 2000 when he was quoted as saying that they would be investing in "core services which the government is statutorily bound to provide and for which demand is virtually insatiable. Your revenue stream is ultimately backed by government. Where else can you get a business opportunity like that?"[25].

However, the PFI has been highly controversial and the criticisms are well documented elsewhere, mainly through the work of Professor Allyson Pollock and colleagues. Further problems are likely with the introduction of international financial reporting standards (IFRS) to the public sector, which could put billions of pounds worthy of PFI deals back on the balance sheets. According to the Audit Commission, in the case of the NHS, "reclassification of PFI assets will potentially have significant financial implications for individual organisations". If current rules are not amended, NHS trusts would have to pay not only the annual service charge for their PFI buildings, but also an annual capital charge on top[26]. Unsurprisingly, the Treasury have managed to delay introduction of the IFRS until next year.

An important effect of PFI has been the significant recruitment of private sector business advisors/consultants into the big tent of government e.g Partnerships UK and the NHS Commercial Directorate. People who were not neutral referees but interested players were located centrally within the decision making process. By 2007, the Commercial Directorate had a staff of 190, of whom just eight were civil servants, the other 182 being recruited from the private sector [27].

The road to privatisation, marketisation and consumerism

In keeping with strict fiscal policy, the first 2 yrs also saw Labour keeping to Tory spending plans. Unfortunately, the continued chronic underinvestment resulted in the Winter crisis of 2000 and prompted Tony Blair to appear on the BBC's "Breakfast with Frost" show and famously promise that UK health spending would match the EU average within 5 years. The highly ambitious 10 year NHS Plan[28] was announced soon after and Gordon Brown commissioned Derek Wanless to report on the financial state of the NHS. The report concluded that between 1972 and 1998, the cumulative underspend on the NHS compared to EU average spending was £267billion [29]. A massive injection of money was delivered to the NHS increasing GDP spend from 5.6% to 9.4%, but strings were attached in the form of a performance driven managerialist assessment framework, which included a "target culture" and a new ratings system for NHS Trusts[30].

The subtitle of the NHS plan, "A Plan for Investment, a Plan for Reform", is important

because it suggested that the government wanted something in return for its money ("Investment") i.e significant changes to the way the NHS operated ("Reform"). A pivotal moment came when Alan Milburn signed the NHS Concordat with the Independent Healthcare Association in November 2000 that stipulated that the private sector should be considered alongside NHS bodies as potential providers of clinical services. At the time Milburn, explained to *the Guardian* (30th May 2001) that private sector would only be used to increase the capacity of the NHS and this was "not about introducing a mixed economy into healthcare". However, by 2002, the plans for a market driven approach to healthcare delivery had become clear. In the document *Delivering the NHS Plan: Next steps on investment and reform*, it was stated that increased patient choice was to be accompanied by a market for healthcare. Moreover, Alan Milburn told the Health Select Committee that as long as care and treatment were freely provided by the NHS, whether it took place in a private sector hospital or a NHS hospital was frankly a secondary consideration.

Since then, the private sector has played an ever increasing role as the government took to the mantra of "what matters is what works". There would be "no ideological barriers" to NHS modernisation and this was born out with publication of the *NHS Improvement Plan* in 2004, which prompted former Director of Strategy for the DH, Professor Chris Ham to state in an interview with the Financial Times:

"The foundations have been laid for the complete transformation of health care delivery. We are shifting away from an integrated system, in which the National Health Service provided virtually all care, to a much more mixed one, in which the private sector will play an increasingly major part. The government has started down a road which will see the NHS increasingly become a health insurer"[31]

Choice, competition and diversity are now creating a patient led consumerist healthcare market in the English NHS, resulting in the most radical departure from previous Labour policy[32]. Two recent Labour Secretaries of State for Health provide further evidence for the increasing privatisation and marketisation agenda. Patricia Hewitt said that "no arbitrary targets should be set for limits on one provider or another"[33]. Following placement of an advert in the European Journal by the DH Commercial Directorate inviting expressions of interest in managing the purchase of clinical services from health care providers in the UK, Frank Dobson said:

"If this is not privatisation of the Health Service, then I don't know what is"[34]

The decision to open up the NHS to the healthcare market has lead to a recent rash of policy initiatives, which has attracted much criticism from across the political spectrum and within the healthcare sector. Politicians are at the bottom of the MORI veracity index and it is therefore of no surprise that the government has started using influential members of the medical profession (who rate at the top of the MORI veracity index) to promote their policy agenda.

The drivers of the healthcare market

The "choice" agenda is about turning patients into consumers. Choice, accompanied by Payment by Results (PbR), is the main driver for market-driven healthcare and privatisation, and is seen as a mechanism to increase institutional efficiency, overcome producer/provider interests and empower the public. PbR (or more accurately payment by activity) has been described as the reform "which makes everything else possible"[35].

To make Choice work, the NHS needs to provide reliable and relevant information to patients to help them make informed market choices between hospitals and clinicians etc. This information is made available through the obsessive data collection of the performance management framework of audits, inspections, monitoring and evaluation. Crucial to this whole process is the National Programme for IT (NPfIT) with its Choose and Book system and the Extended Choice Network (ECN), which allows patients to choose which hospital they want to be referred to. The Extended Choice Network is essentially a national choice menu (for England) containing all Foundation Trusts and accredited Independent Sector providers. Unfortunately, NPfIT has been plagued with problems and The Public Accounts Committee (PAC) of the House of Commons issued a damning report, which concluded that despite a probable expenditure of £20 billion, "at the present rate of progress it is unlikely that significant clinical benefits will be delivered by the end of the contract period"[36]. The Chairman of the PAC claimed NPfIT "is the biggest IT project in the World and it is turning into the biggest disaster"[37]. However, it is obvious that the government's choice agenda can only work with a successful IT system in place and this may explain why Tony Blair appeared to rush through NPfIT and is probably the main reason why this expensive debacle has not been shelved[38].

Another important development is the step towards privatisation of practice based commissioning (PBC) through the Framework for procuring External Support for Commissioners (FESC). This is backed by Lord Darzi's *'Our NHS, Our Future'* report, which suggests there should

be "extensive use within every SHA of the new Framework for procuring External Support for Commissioners (FESC)". Fourteen Private companies have now been approved (see box 1) to support PCTs in their "world class commissioning" role, but it is clear that some of these firms are also healthcare providers and there are obvious potential conflicts of interest. However , the uptake of FESC has been very poor so far[39].

FESC Approved Firms

Aetna Health Services (UK) Ltd
AXA PPP Healthcare Administration Services Ltd
BUPA Membership Commissioning Ltd
Partners In Commissioning
Dr Foster Intelligence
Health Dialog Services Corporation
Humana Europe Ltd
KPMG LLP
McKesson Information Solutions UK Ltd
McKinsey & Co, IncUK
Navigant Consulting, Inc
Tribal Consulting Ltd
UnitedHealth Europe Ltd
WG Consulting

Other initiatives aimed at promoting market based healthcare and increasing privatisation

A detailed discussion of the full range of initiatives and policies promoting the marketisation of the NHS is outside the scope of this article, but the following list provides plenty of examples:

1. Independent Sector Treatment Centres (ISTCs). Please refer to the recent article by Pollock and Godden in the BMJ for a detailed analysis[40].
2. I(CATS) - ((Integrated) Clinical Assessment and Treatment Services) – These units act as intermediate steps between Primary Care and Secondary care, but importantly have power to refer on to ISTCs
3. Privatising GP services through Alternative Provider of Medical Services (APMS).
4. Darzi Polyclinics, which are likely to be built and run by the private sector, although some Foundation Trusts may build and run Polyclinics to ensure a guaranteed supply of referrals.
5. Unbundling of Primary Care. Services are being broken up into saleable commodities. GPs provide core services which can be "topped up" either by GPs or private providers
6. Privatisation of NHS logistics (sold to DHL (Novation)), Oxygen supplies, pathology services (£1 billion over 5yrs), ambulance services, and offshore medical secretaries
7. Advertising of health services
8. Independent sector use of the NHS logo. Private companies providing services as part of the Extended Choice Network can now use the NHS logo: (http://www.nhsidentity.nhs.uk/ExtendedChoiceNetwork/index.htm)
9. Individualised health accounts/vouchers. This is clearly another ploy to promote the market by encouraging patients to become consumers.
10. Top up fees for new drugs and technologies. The recent Richard's review has suggested that patients should be allowed to top up their NHS care in the private sector.

Conclusion

It is clear that the government is pursuing a market driven approach to healthcare delivery in the NHS (in England) with increasing use of the private sector. There are no signs that the new Prime Minister is going to reverse this process, and in fact we are actually seeing policies with greater emphasis on privatisation through the introduction of Polyclinics and new GP Health centres that will almost certainly be procured and delivered by the private sector. This should come as no surprise when considering the importance Gordon Brown placed on the neoliberal agenda to ensure economic stability. In addition when he was Chancellor of the Exchequer, Brown had significant control over public services through the Public Service Agreements and Public Spending Reviews. Hence, much of New Labour's health policy over the past decade has his fingerprints all over it. Those hoping for a slowdown in the pace of change are likely to be disappointed.

The late Robin Cook summed up this situation, shortly before his death:
"The history of social democracy can be expressed as the struggle to set limits to the market and to define those areas where priorities should be set by social policy rather than commercial forces. Yet this government is dismantling the barriers that its predecessors had erected to keep those commercial forces off the public-service turf".[41]

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References

For reasons of space, the extensive list of references is not reproduced here but it is available on request.

PRACTICE-BASED COMMISSIONING

...questions over GPs holding their own budgets follow national primary care director David Colin-Thomé's admission last week, revealed by HSJ, that efforts to reinvigorate practice based commissioning have so far failed. He described the policy as a "corspe not for resuscitation". Social Market Foundation head of strategic development David Furness said it was time to stop ploughing money into expanding GP commissioning. Mr Furness said at least £100m had been spent on trying to reinvigorate practice based commissioning through entitlements, and it was time to "turn off this tap".

This passage in a report in the *Health Service Journal* of 22 October 2009 on Conservative ideas about the future of 'practice-based commissioning' seems to call for some reflection on the background. What is practice-based commissioning – or what was it supposed to be – and what has led to its apparent failure?

Before the 1990s the NHS was a single organisation responsible for organising and directly providing nearly all our healthcare needs. Except for GPs, all NHS clinical staff were salaried, and although GPs were 'self-employed' they were all under contract to the Secretary of State for Health, and were paid mainly on the basis of the number of patients who were registered with them – in many ways like being salaried.

In the 1990s the Conservative government introduced an 'internal market' within the NHS. One part of the NHS was designated as 'purchasers', whose job it was to 'buy' services from the people who actually provided health care, the 'providers'. The idea was that this would make the system more economical by having one part of the system concerned with 'value for money', and also that it would make the other half, the 'providers', more responsive to the needs of patients, since this would be one of the things the 'purchasers' would be looking for in judging 'value for money'. Some GPs became purchasers as well as themselves being 'providers'. They were given the funds needed to purchase most hospital-based care needed by their patients. They were called fund-holders. Before the Blair government came in and abolished fund-holding, more than half of all GPs had become fund-holders.

After 2000 the internal market was converted into a real market, with private companies invited to bid against NHS hospital trusts to provide surgery and other health care, as well as diagnostic tests, imaging, pathology and other services; to bid against GPs to provide primary care; and to bid against NHS community health staff (district nurses, speech therapists, etc) to provide community health services. This made the task of purchasing – now called 'commissioning' – much more complex.

Moreover the work has become more challenging, because when the NHS purchases or commissions services from private providers, as opposed to providers within the NHS, legal contracts must be drawn up in what is essentially a 'caveat emptor' situation. A successful bidder is bound to do only what is contained in the contract. Purchasers must therefore be able to foresee, on the basis of their knowledge of the service in question, and of past experience, all the circumstances that may arise, and provide for them in a detailed document; and they must also be able to find out all the information needed to assess the qualifications and records of bidders, in relation to a wide range of different kinds of service.

Government policy for England is that all this should be done by the NHS's 149 Primary Care Trusts. This means that the planning and management of all health services, which used to be done as part of the integrated work of the Department of Health and its regional and district health authorities, is now devolved down to the smallest local units of the system, none of which has the expertise and knowledge that used to be at the disposal of the NHS at one level or another. For this reason the government decided to try to replace that expertise and knowledge with expertise bought in from private healthcare companies. A 'Framework for procuring External Support for Commissioners' (FESC) was established, comprising 14 private companies chosen by the Department of Health, from among which PCTs can choose one or more to, in effect, do their commissioning for them.

Practice-Based Commissioning (PBC) was supposed to ensure that GPs were also – and centrally – involved in the commissioning process. It differs from fundholding in two key respects. First, fundholding GPs actually held and spent the funds, whereas under PBC PCTs retain the funds and make the contracts with service providers. Practices are meant to influence – in theory, to decide – what is commissioned and from whom, but the actual commissioning is done by PCTs assisted by their FESC 'advisers'. Second, fundholding GPs were only concerned with purchasing a more or less predictable range of needed secondary care for their patients, whereas under PBC GPs are supposed to be involved in commissioning the whole range of services that are now being commissioned, from tertiary care to community health services, and from a growing variety of providers.

GPs I have asked about PBC say that the main point of it appeared to be to involve them in suggesting ways to reduce costs, for example by reducing referrals, or by bringing specialists, or GPs with special interests, into primary care. One said:
"In the first year of commissioning we were expected to reduce hospital outpatient follow-up by writing to cnsultants asking them to discharge our patients if we thought they were being followed up unnecessarily in outpatient clinics. I refused to engage with this particular exercise as I felt that it was not up to me to try to override a consultant's opinion"

The comments by Dr Colin-Thomé and Mr Furness cited above suggest that few GPs have felt they could do much for their patients by getting involved in what is now, all things considered, a thoroughly irrational and expensive substitute for the way the NHS used to get health services provided.

COLIN LEYS

MORBID SYMPTOMS : HEALTH UNDER CAPITALISM

Socialist Register 2010 (www.socialistregister.com) Edited by Leo Panitch and Colin Leys

Morbid symptoms is a collection of 17 informed and well-referenced essays by 19 authors, two of whom are well known to many NHSCA members – Julian Tudor Hart and Colin Leys. Nine of the authors are affiliated to academic departments in the US or Canada, seven to European departments and one each to departments in India, Tanzania and Hong Kong.

The authors come mainly from social science departments – using that term to include political science, sociology, social administration and medical anthropology. Three authors are medical doctors and one comes from a department of public health. With one exception all the authors write clearly and interestingly.

The book is the *Socialist Register* for 2010 and is being published on-line for the first time along with all the 45 previous volumes. This publishing achievement happily coincides with the renewed interest in socialist writing since the international financial chaos.

The first and longest essay is a masterly overview by Colin Leys entitled *Health, health care and capitalism*. To illustrate the style and scope – and to whet the appetite - I quote the first paragraph:
"There is a widespread belief that capitalism is responsible for the huge improvements in health that have occurred over the last century and a quarter. Capitalism is seen as the supreme engine of growth, and growth is seen as the crucial condition for health improvement. But it is not. Poor countries can and sometimes do have better health than rich ones. The US is held up as a 'world leader' in medicine when it is really a world leader in healthcare market failure, spending almost a fifth of its huge national income to produce overall health outcomes little better, and in some respects worse, than those of neighbouring Cuba, with a per capita income barely a twentieth as large. 'Breakthroughs' in health science and technology – in nuclear medicine, genetic medicine, or nanotechnology - are treated as triumphs of capitalist investment in research. But most innovative medical research is actually done in state-funded medical schools and research laboratories..."

The other 16 essays include discussions of big pharma; US health reform; the marketisation of healthcare in Europe; the capitalist food industry and obesity and hunger; medical TV dramas; and several country-specific essays including maternal mortality in Tanzania; Cuban health politics; trends in Chinese healthcare; and trends in Indian healthcare. The volume ends with a characteristically thought-provoking essay by Julian Tudor Hart on *Mental health in a sick society: what are people for?*

I should be surprised if most NHSCA members did not find several essays interesting, informative and insightful – and a refreshing change from a market and privatisation perspective that hugely undervalues the NHS as a public service.

Peter Draper

RORY NICHOL

It is with great regret that we have to report the death of Committee member Professor Rory Nicol, a very longstanding and active member of the Association.

Rory was professor of psychiatry in Leicester, moving to London on retirement.

He served for a number of years on the Executive Committee and was Honorary Secretary until failing health forced him to stand down from that office. Despite his progressive illness he maintained an active interest in the work of NHSCA and his support for the principles of the NHS, even managing to attend the recent AGM.

Dear Senator Kerry,

Your reported call for "lies" about health care reform to be refuted is essential and requires an urgent response. To that end, may we – British health professionals and patients - respectfully expose those "lies" which are about our National Health Service, a service which our experience shows to work successfully for the benefit of all in this country.

PATIENT CHOICE: There is NO "death panel" in the UK NHS or anywhere else in the UK health care sector.

-Termination of a pregnancy is a personal decision if approved by two doctors. NO board or organization of any kind makes any decision about termination for fetal abnormality. Such decisions are personally made by those seeking such procedures after counselling by medical and other health professionals.

-Elderly people can get counselling and advice to help them determine *their* requirements for *their* future care, but only if they wish it. It is a service that provides information about issues such as living wills. This is similar to the US proposed Section 1233, which provides counselling and assistance to those wishing *voluntarily* to make their own arrangements for their future, medically and physically.

-Patients are normally registered with a family doctor practice of their choice. A patient is able to see a doctor immediately for urgent care in general practice although seeing his or her own family doctor for non-urgent care may require waiting a few days. If the patient requires referral for specialist opinion or treatment, they can choose whichever hospital they prefer.

CARE FOR THOSE WITH PRE-EXISTING CONDITIONS: In the US, people with pre-existing health problems are rarely covered by private insurance companies for those problems. Many do not change jobs for fear of losing cover for such conditions from their new insurers. The NHS is literally a life saver for those with pre-existing health problems - they are not denied care. It is vitally important that the NHS, and any government financed health plan anywhere, undertakes the care of such people.

CARE FOR THE ELDERLY: There is NO cut-off age for health care in the NHS. Senator Kennedy, *like anyone else of that age,* or older, and with health problems such as his, would have been treated by the NHS with the same high levels of care as someone younger. Care for the elderly includes free flu vaccinations, free medication, free operations as needed, nursing care visits, and help and adaptions for the home. Many hospitals now offer "hospital to home" programs for palliative and end of life care to enable very ill people to remain at home.

CARE FOR THE DISABLED: Professor Stephen Hawking of Cambridge University, recently awarded the Presidential Medal of Freedom by President Obama, is disabled and has always been under the care of the NHS. Professor Hawking is an outspoken admirer of NHS care. Like thousands of others who are disabled, he is entitled to free medical care and medicine, and he can get adaptions, equipment and home care to allow him to live at home.

FREE MEDICATION: NO ONE is denied medicine if they need it. All children up to the age of 16, pregnant women and adults over the age of 60, unemployed people, patients with cancer and many with chronic conditions, don't pay for their medication from the NHS. 88% of medicines are dispensed without charge. For the minority who pay there is a standard charge of $11 dollars per prescription, regardless of the real cost of the drug. Some parts of the UK have abolished prescription charges altogether.

INSURANCE: Like the Healthy San Francisco medical plan, those in the UK can also take out private insurance, if they can afford it, although less than 1 in 8 currently do so. The co-existence of public and private coverage ensures complete freedom of choice.

THE COST: The NHS is funded by taxes and provides universal coverage while costing 8% of UK GDP. The US system currently costs 16% of GDP but leaves 45 million without insurance and a further 25 million underinsured.

BACKGROUND: The NHS was created in 1948. Its goal was to provide comprehensive medical care through taxation, universal coverage for the population which is free of charge at the point of care. It still does that despite the huge, and increasing, demands on its financial and practical resources.

The NHS is available free of charge to all regardless of ability to pay, and does not discriminate against those with pre-existing conditions. Importantly it gives freedom from fear of the financial consequences of illness.

Survey after survey shows that British patients express a high degree of satisfaction with the care they personally receive from the NHS. On average, British users of the NHS live longer and have a lower infant mortality rate than the US.

The NHS has shown itself to be open to – and often the source of - innovation. How the US manages its own health care reform will doubtless provide us with new ideas about how to improve some aspects of our own NHS service. In the same spirit, we respectfully draw to your attention what evidently works well here

Yours sincerely,

Sir George Alberti MD, PhD, PRCP
Past President of the Royal College of Physicians
Dean of Newcastle School of Medicine

Professor Alan Maryon-Davis FFPH FRCP
President, UK Faculty of Public Health

Professor Anthony Costello FRCP FRCPCH
Professor of International Child Health
Director of Institute of Child Health, UCL

... and more than 100 others.

The letter was co-authored by
Dr Jacky Davis and Barbara Rafaeli

RECRUITMENT

This was a topic discussed at the AGM and subsequently at the Executive Committee. Probably the most effective means is by personal knowledge and we are grateful to those members who send in names of colleagues who, from the opinions they express, might respond positively to an invitation to join. Please continue to do so.

Other than this and opportunistic mailings to those judged sympathetic through their letters to medical or lay press, our main recruitment method has been to target hospitals on a rolling basis, using the Medical Directory for consultant lists.

Unfortunately the annual editions of the Directory appear to be getting more and more out of date, listing consultants at hospitals where they have long since ceased to work and even more problematically for our purpose, not listing those who have been appointed in z years. This is not necessarily the fault of the Directory. I have taken the matter up with the publishers on more than one occasion and they tell me that every year they submit their current list to each hospital, asking for it to be updated with additions and deletions but frequently they receive no reply.

In what now seems like a Golden Age when all consultant contracts, apart from those at large teaching hospitals, where held by a small number of Regional Authorities our Hon Secretary used to write to those authorities annually and received lists of new consultants, to whom we sent a special mailing. Nowadays of course that falls into the growing category of "information no longer held centrally". To approach each individual hospital would be a major task and likely to meet with even less response than the Directory gets. We are exploring other ways of accessing new appointees, through the Deaneries or specialists societies but none of these are proving straightforward.

We are therefore asking you to help by notifying us of colleagues, in any specialty, who have been appointed to your hospital in 2009 and then in the future as they occur.

In these days of much more tightly written contracts, job plans etc we appreciate that it is increasingly difficult for consultants to be able to attend meetings, serve on the Executive Committee or as Officers so that much of the routine work falls, of necessity, on those who are fully or partly retired. Notifying us of new appointments would be a simple but extremely helpful way of supporting the aims of NHSCA without any significant time commitment.

PETER FISHER
President

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