NHSCA

EDITORIAL March 2012

The NHSCA was founded to stand up for the NHS and its principles. In our current activites we have been privileged to work with and assist outstanding people and organisations such as Harry Keen and the NHS Federation, Wendy Savage and Keep Our NHS Public and Allyson Pollock and her team.

In recent years we campaigned to expose the PFI for what it was - a device not only to give taxpayers' NHS money to for-profit companies but also to impoverish NHS institutions by paying prolonged high interest rates on expensive buildings so that help from the private sector appeared to be needed. Even the government now admits that PFI has been, to put it mildy, an extravagance and is trying to claw back some of the excess payments from businesses.

The Association is now assisting in the widening campaign to kill the Lansley-Cameron NHS and Social Care Bill. I venture to claim that we were very early in recognising that it spelt the end of the NHS and that in many ways we have assisted in the current groundswell of demand to drop it.

In the front of this current campaign are our two co-chairs, Jacky Davis and Clive Peedell both with irresistable energies and irrefutable understanding of the bill. They are both on BMA Council and their leadership on this issue led to the BMA actually realising the enormity of the bill and the necessity of action. There can be no doubt that they influenced the BMA attitude to the bill which changed from nonchalance to near-outrage and now to demanding the Bill be dropped.

A truly exceptional act in the NHSCA campaign against the bill was the Bevan run of 6 marathons in so many days from the Bevan statue in Cardiff to Richmond House and Downing Street. There were stops on the way for public meetings as at Witney for Mr Cameron's benefit and Oxford. Clive Peedell and David Wilson endured very considerable pain but gained great publicity for the fight against the bill.

I recommend the article by Professor Ashton published on-line in the Lancet February 23. He quotes Titmuss on ethics and medical care: "I happen to believe that the conflict between professional ethics and economic man should be reduced as far as humanly possible". He is able to stand back and see the broad view on efficiency and altruism.

I believe the UK public believe government to be basically a benign organisation and accept that errors are the exception and not part of the fundamental fabric of power. Was Vanessa Redgrave exaggerating when she said recently that politicians are 'all scoundrels'? It would be nice to have evidence to the contrary.

To put the principles of some of those governing us on the line, I must recommend Dispatches from the Dark Side by Gareth Peirce (Verso £7.99 2012).

She exposes some of the lies we have been told by government and the 'intelligence' services. Lies that have led to us causing unmeasurable suffering and cruelty by illegal wars in several countries at he same time as killing and permanently damaging the minds and bodies of many of our own armed forces. The tragic truth is that we still do not know the full truth, government has tried desperately to cover its traces and the conscienceless guilty still live a life of luxury.

We have been lied to by government, we are being lied to by government and will be lied to in the future. This is not just hypocrisy at which we excel but part of a corrupt failure of democracy. How can anyone pretend that a democracy can have a colonial empire without extreme exemplary hypocrisy?

The NHSCA is much needed to continue campaigning for the NHS - an organisation founded on belief in altruism and fairness.

We fight that our children and grandchildren will still experience its benign influence in the world.

Please visit or write to your MP again before it is too late. Better to have a mess now than a disaster that will take many years to correct.

It is not too late to drop the Bill. "Dictators ride to and fro on tigers from which they dare not dismount and the tigers are getting hungry" W S Churchill 1935. The Bill could well lead to massive changes in the minds of the electors at the next General Election and that for London Mayor, alienating the party which sold off the NHS and enabling the current opposition to move on from Blair's Thatcherism.

CHRIS BURNS-COX
Guest Editor

The Foundation Trust Hospital

The Trojan horse that carried the legislation designed to destroy the NHS

Early in 2011 I asked Peter Fisher to circulate a questionnaire to members asking them whether they would consider becoming governors of their local hospital. Only 34 responded i.e. about 5% of our membership. Whilst most of the respondents were interested in becoming governors, they showed a variable degree of knowledge about their likely role. Consequently I thought it might be of assistance to explain the situation and give my personal experiences of having served as a governor for a couple of years.

The Background

The legislation underpinning the transfer of NHS Hospital Trusts to NHS Foundation Hospital Trusts (NHSFHT) was launched in 2002 and implemented in 2003. Alan Milburn, the Secretary of State for Health, commended the plan saying that top performing hospitals would be *"liberated from Whitehall and managers of these hospitals will be able to set up not-for-profit companies with an annual cash-for-performance contract and no further management from central government"*.

The autonomy granted to NHSFHTs came with tempting incentives.

- Authority to retain year on year surpluses (profits).
- Freedom to raise capital on the money markets.
- The potential to treat unlimited numbers of private patients.
- Permission to earn money from other non-NHS activities.
- Freedom to set pay and conditions for staff.
- Freedom to advertise their services in order to attract custom.

In order to oversee the performance of NHSFHTs the government set up a quango called Monitor, which was primarily concerned with the financial integrity of the hospital. Monitor's board of directors were appointed by the Secretary of State for Health who also had the power to sack them. A special Code of Governance was part and parcel of this development and it included the necessity for NHSFHTs to enrol members of staff and the general public who would in turn elect Governors to take on the supervisory role relinquished by the Secretary of State for Health. In effect the governors become the guarantors of corporate accountability. This Code of Governance, which Monitor has revised and embellished over the years, now states that the Code is "best practice advice and not mandatory guidance. Accordingly, compliance with the provisions of the code will not in itself give rise to a breach of condition 5(2) of the terms of authorisation (duty to comply with the principles of best practice on corporate governance)".

Clearly, the advantage to the hospital's Board of Directors was considerable, in spite of the additional expense of having to support the membership and travelling expenses of the governors (the cost to an average sized NHSFHT may not be much more than £100,000 p.a. i.e. <0.5% of turnover). However this insignificant "cost" was acceptable provided that the directors could set their own Code of Governance to emasculate the Governors' powers of supervision. Thus the ability of governors to access and examine internal data can be made so convoluted that the decisions made by the hospital Board of Management could be announced before the governors have had the opportunity or the time to assess the accountability of the Directors' proposals.

Furthermore it is uncommon for members from the general public with medical or nursing skills, or experience of working in the hospital environment, to put their names forward for election.

Since the number of public members (they are the people eligible to vote for a public governor) only has to exceed a threshold of 1% of the catchment population and rarely exceeds 2%, there is little prospect of the Board of Governors being truly representative of the people for whom the local hospital was built to serve. Viewed from the other perspective, >98% of the local population are not represented and thereby have no say or choice regarding hospital care.

With the Cogwheel hospital management system, which antedated the "Hospital Trust" denouement, it was the aspiring politically motivated members of staff who ran the show and the Chairman of the Medical Executive Committee who could gain most

for his own department. Empire building doctors have always been part of the hospital management scenario. Minor specialties and the less vocal majority often felt side-lined. When the Cogwheel system was abandoned, many consultants felt that there would be a more equitable distribution of financial resources if management was freed of empire-building colleagues. This turned out quite differently. We had, at a stroke, given away the voice of clinical rationale to the jack boot of financial supremacy.

Whilst NHSFHT governors might be strongly motivated to make their local hospital a beacon of excellence, few of them would have had the knowledge or experience of working in such a complicated environment. Learning the ropes and getting to know how different departments work takes time. It is generally accepted that it would take a governor from a non-clinical background at least 2 years to understand these clinical complexities. With a fixed term of office of only 3 years it is little wonder that for most of the time the Board of Governors would be obedient disciples of whatever the Board of Directors "dictated". It is important to realise that the hospital medical staff is represented by only one governor and the nursing staff by just two governors, i.e. less than 10% of the governors come from an appropriate clinical background. This inherently weak system, installed to underpin the accountability of FHT management, was no oversight but a sop to the financial motivation of the system. However, when serious failures of management hit the headlines, as in the case of Mid-Staffordshire NHSFHT, the governors were reprimanded for not having realised what had been going on!

The Mid Staffs debacle is no isolated occurrence. The restraining directives inserted into the local governors' Code of Governance give a flavour of how this nominally supervisory body can be emasculated.

The following statements are in widespread usage and appear repeatedly in one form or another in Colchester's FHT Code of Governance:

- Governors have no right of access to the Trust's premises or the employees of the Trust unless agreed to by the Membership Office.
- The principal role of the Board of Governors will be to support the objectives of the Trust but without having any power to reject or alter any decision of the Board.
- Governors must act as ambassadors for the Trust.
- Governors must act in the best interests of the Trust and adhere to its values.
- The Board of Governors will cooperate with the Board of Directors and act in the best interests of the Trust and endeavour to promote the success of the organisation.

You might not be surprised to hear that I have been privately admonished by our Chief Executive and Chairperson. That dressing down was followed by a public humiliation instigated by our "lead" governor (encouraged by our Chairperson and Chief Executive). Now I am waiting to be hauled in front of our local version of the Spanish Inquisition, for complaining about the Hospital Trust's lack of transparency. As a public governor I have nothing to lose apart from my dignity. On the other hand employees, e.g. staff governors, could potentially lose their jobs for putting their heads above the parapet!

Tightening the Commercial Screw

As you can see, there is precious little about governors ensuring that the hospital pursues objectives which are in the best interests of the health and wellbeing of the catchment population. Furthermore, with so much emphasis on supporting the Board of Directors, who might be assumed to be the fount of all knowledge and wisdom, criticising their decisions could be interpreted as a breach of the governors' Code of Governance.

In this brave new world, or should I say cowardly compromise, it is the credit rating (1-5) of a FT Hospital that has become the Holy Grail pursued by the Directors. The credit rating relates to the hospital's projected annual surplus (profit). The target is 5. A value > 3 is recommended. Values < 3 will trigger a process which could ultimately lead to administration, takeover or sale to the private sector. Hospitals with debts, particularly debts to PFI consortia, are those at greatest risk and therefore risk-averse hospital directors will look for minimalist infrastructure enhancements instead of PFIs in order to avoid the sack.

This should not mean that meaningful capital developments cannot be embarked upon. Clearly any sizeable development would require money to be raised up front from the banks. The trick would be to find a way of paying back the loan without that impinging upon the hospital's credit rating. The answer could be to go back to the way in which capital projects were financed before 1948, namely, by raising the money from public "subscription". This was how the local community cemented its

connectivity to charitable deeds and the support of healthcare for the indigenous population.

Why don't we reinvent that wheel? It would certainly test the social consciences of the better off (including the medical profession).

With Barts and the London having to service a £1.2bn PFI debt, who better than the city bankers, working within the hospital's catchment area, to come up with that sort of charitable gesture? However bankers, wearing their usual clothes, might prefer to let this revered Trust go into administration, buy it for a knockdown price and then make bags of money by exploiting its facilities! Is it possible for the leopard to change its spots? All it needs is a bit of genetic engineering.

Abortive Attempts to Sanitise the Legislation

The new legislation before Parliament will change the title of the **"Board of Governors"** to the **"Council of Governors"**. Is there a subtle reason for this which hides another impediment to their effectiveness?

A proposal in the House of Lords to amend the Health and Welfare Bill, in order to give governors greater access to information, previously privy only to the Board of Directors, was dismissed by Earl Howe as unnecessary. The amendment, (296A, clause 148, page 148, line 34) would have read:

The governors shall be notified of and have the right to attend all meetings of the Board and its sub-committees and have access to all relevant documents and papers.

For this purpose, governors will be required to acknowledge their duty to protect confidentiality.

Earl Howe's repost on 15th January 2012 was:
My Lords, it will be open to governors to seek information from the boards of directors on the plans that they have for the trust. They will have access to key papers. There should be no difficulty about knowing what the board has in mind for the trust in that strategic sense.

In effect, the government doesn't want to change the existing legislation which so successfully restricts the access of governors to sensitive and often controversial information. In other words, gag the governors and maintain the blindfolds.

Another issue which has surfaced in Colchester relates to governors playing any part in the long-term strategy of the hospital. The Board of Management have argued that if governors are allowed to contribute advice or recommendations during this planning process then they would forfeit their right of holding the hospital to account if these plans subsequently proved to be flawed.

However this would deny governors access to the "rationale" underpinning future strategies and therefore there would be nothing on which to base a failure to achieve those plans.

If governors are required to find the needle in the corporate haystack then, if they don't know what a needle looks like, they won't find it! Very cosy!

This attitude was precisely the underlying reason why the problems at Mid Staffs took so long to surface.

When amendment 296A was voted on, in a House that was considerably under-populated with Lords, the amendment was rejected. One of those who voted against this amendment was Shirley Williams. Clearly she did not understand the gravity of this situation. Governors cannot be effective without substantial changes to the Code of Governance. Presumably that is what the politicians wish to preserve.

You really have to give the legislators credit for the way in which they can blindfold, gag, and emasculate the very people who should be the guardians of patients' welfare.

Summary

Although you might imagine that the Foundation Hospital Trust was something that we would want to get rid of, nonetheless it has the potential to improve the service to patients if only the legislation relating to the duties and powers of the governors were tightened up. Furthermore, unless the public governors include a substantial number of doctors and nurses who have worked in the local hospital, the expertise necessary to scrutinise the activities of the Board of Directors will be lacking. This would mean that retired local hospital consultants and nurses would have to put their names forward for election. The work is actually not particularly onerous but it does require people with a sharp eye for detail.

Finally, and most importantly, unless the current Code of Governance, which puts commerce before compassion, is radically changed, the Foundation Hospital "clinical trial" should be terminated on account of its unethical agenda.

MARK AITKEN
Guest Editor

The End of the English National Health Service

Parliament is about to pass a bill abolishing our National Health Service.

The bill would end the NHS as a national public service that meets all our health care needs free at the point of use.

The government claims it is putting family doctors and patients in control. This is not true.

The systems and structures that are there to make sure our NHS works for everyone are being removed. Commercial organisations will take their place.

In future no single person and no single organisation will be responsible for meeting all the health care needs of all the people living in England.

In the NHS since its inception doctors have recommended care and treatment based on their skilled assessment of need, and services have been planned around patients' needs.

A new health care "market" is being created. Groups of companies will have the main say about the care we are permitted to receive and where or whether we receive it.

Far from putting patients first, the new system benefits shareholders of commercial companies and further enriches their executives.

In future fewer NHS services will be available to fewer people. Many health services that are now free for us all will become chargeable. Where you live will determine what care you may receive.

A market does not and is not intended to provide for all our health care needs, and yet the government continues to insist that the NHS will remain the same.

In this pamphlet we show how the government's new market is designed to abolish our NHS as a public service for all the people of England. It is based on detailed legal and public health analysis and published legal opinions, which are referenced and available on **www.allysonpollock.co.uk**

Abolition of the Duty to Provide for all our Healthcare Needs

Since 1948 the NHS has been guaranteed by the health minister's legal duty to provide for all our health care needs, as required by parliament. That duty is being abolished.

Instead, clinical commissioning groups or CCGs, which can include company chief executives and GPs on the board, will cover a narrower range of services and have greater freedom to decide the care that is or is not provided free by the NHS.

Any of the following services could be excluded from NHS free services:

- Services and facilities for pregnant women and women who are breast-feeding
- Services for both younger and older children
- Services for the prevention of illness
- Care of persons suffering from illness and their after care
- Ambulance services
- Services for people with mental illness
- Dental public health services
- Sexual health services

This list covers all services currently provided by the NHS as a national service. Long-term care is no longer part of the National Health Service. Most of it has been privatised and is the responsibility of the individual and local authorities. Long term care is already subject to charges and local discretion, and is no longer offered on a fair basis throughout England as a national public service.

Abolition of a National Health Service

NHS services will no longer be national if the bill is passed. In future, some services would become the responsibility of local authorities. Local authorities would decide what services they provide and to whom. Those excluded will be left to buy their care on the open market.

As the House of Commons Health Committee pointed out in January 2012, families already face the catastrophic costs of adult social care. The bill will pass more costs on to the family.

The Bill Abolishes Primary Care Trusts, which have the Overall Responsibility for Meeting our Healthcare Needs and those of all People Living in an Area

The NHS covers us all because by law local NHS bodies must provide for everyone in their area as part of a national health service. The bill abolishes this responsibility.

Under the new system no single organisation will have overall responsibility for meeting the health care needs of all people living in clearly defined geographic administrative areas.

New bodies known as clinical commissioning groups or CCGs will replace local national NHS bodies. They will not cover administrative areas but will be free to select patients from anywhere in the country whether it be London, Hampshire, or Cornwall.

The head of the NHS, David Nicholson, has made clear that the new groups can choose which health services to provide and to whom.

So long as they meet limited responsibilities for the local populations around their headquarters, nothing in the bill prevents them from choosing to arrange care only for the fit and healthy.

These clinical commissioning groups may be led by or delegate functions to commercial companies. Profit-making companies will be able not only to provide your clinical care but also to determine the care you're entitled to under the NHS.

Not Patient Choice but Choice of Patients

The government claims it wants a patient led NHS and that the bill is about "putting patients into the driving seat" and giving them choice. This is not the case. Contrary to government pledges, it is not patient choice that will underpin the new system but choice of patients by commercially-minded bodies.

Responsibility for the following services would be split among a number of different organisations, including local authorities and the private sector:

- immunisation, cancer and cardiovascular screening
- mental health care
- dental public health
- sexual health services
- management of drug and alcohol addiction
- emergency planning and health protection services
- child health services

The government refuses to make absolutely clear in the bill

- who will be responsible for which patients and which residents
- who will be held responsible for patients who do not receive care or are denied it
- which free NHS services we will have to pay for privately if the bill is passed.

Introduction of Charges for Care

Under the present system local NHS bodies have to provide specific health services free at the point of use as part of a national health service for England. Clinical commissioning groups that replace these bodies will not have to provide specific health services. They will be able to decide for themselves what is provided through the NHS.

So the NHS will no longer be national. It will become a diverse and unequal service, the product of decisions of hundreds of clinical commissioning groups that cannot be legally challenged for any failure to deliver services.

Clinical commissioning groups will be able to charge us for services that they determine are no longer part of the NHS and they will be able to sell us health insurance for the services they exclude.

Entitlement to NHS care will be eroded under this system in much the same way as entitlement to long-term care has been replaced by charges and private insurance. As with long term care this will lead to enormous variation in provision and create unfairness.

Doctors Will No Longer be Advocates for us, their Patients

In our NHS today, doctors are free to prescribe drugs and treatments in the best interests of their patients and to refer to specialist doctors and services where necessary.

The government says that the new system will give GPs even more control because it will be "GP-led". **This is not true**. Under the new arrangements family doctors will no longer be allowed to arrange care for patients with the same freedom as at present.

The government wants care to be arranged by private "commissioning support" companies, not by NHS staff. These companies will specify which groups of the population will be entitled to which care from which care providers.

Companies will design and set the care targets that doctors must meet. Companies will be in charge. Companies may block your GP's treatment decision. You and your GP may have to engage in lengthy appeals in the hope of getting the care you need. This is already happening up and down the country as the new companies are being awarded contracts in advance of the bill becoming law.

Promoting Competition Above Access to Healthcare

The bill transfers government powers and responsibility for the new health care market to a body called Monitor. Monitor is a regulator like Ofcom or Ofwat.

But Monitor does not have an overarching responsibility to ensure everyone's health care needs are met. Monitor can decide on purely economic grounds whether our existing NHS hospitals can be broken up and sold off or whether or not an area loses its existing range of hospital services, including accident and emergency departments and elective surgery and maternity units.

Monitor has already decided that as of October 2012 NHS hospitals will be freed from any responsibility to set levels of NHS care or levels of training for doctors. This is not for the benefit of patients, but so that hospitals can compete in the new market if the bill is passed.

Wales and Scotland Have Abolished the Market

Wales and Scotland have rejected the market and the Welsh and Scottish NHS will continue to provide free all medical care to all residents equitably and on the basis of need. If the bill is passed citizens' rights to health care will vary substantially across the United Kingdom with by far the worst rights being found in England where the coalition government controls health policy.

Conclusion: This is a Bad Bill and What We Must Do

If passed the Bill will abolish the laws and organisations that ensure all our medical needs are met through the NHS and paid for by national taxes.

The new system is designed to limit NHS responsibility for health care and to allow commercial organisations that specialise in rationing and charging for care to take control.

Frequent users of the NHS such as the chronic and long-term sick, pregnant women and children will be especially at risk under the new system because the Bill does not protect services to them.
The Bill will lead to the denial of medical care in much the same way as dental and long-term care is now denied in many parts of England.

GPs will lose control of patient care in a system that will be neither patient- nor GP-led but run through a series of financial contracts.

This bill affects all of us and not just those people who currently use the NHS. It represents the most fundamental attack on NHS principles since 1948.

It is not too late. The damage can be repaired and the bill stopped. We must lobby parliament, write to our MPs and the Lords.

We must write to the press, join Keep Our NHS Public and 38 Degrees.

We must use every avenue open to us and spread the word so that more people challenge the government and really understand what is being done to the NHS.

We must ask our GPs our hospital consultants and health service managers to fight for our NHS. The British Medical Association, the Royal College of General Practitioners, the Faculty of Public Health, and the Royal College of Nurses oppose the bill.

Members of other colleges should campaign for their leadership to add their voices. Profits cannot and must not come before care.

The interests of shareholders and the coalition government's policies of inequality cannot prevail in health care.

We did not vote for this. We were not invited to vote for this. We must never surrender our NHS to the global market place.

Together we will and must fight for it. Aneurin Bevan, its founder, famously said the NHS will last as long as there are people left to fight for it.

ALLYSON POLLOCK

Political Activity

The battle against the Health & Social Care Bill has continued to gather pace.

The year began for NHSCA with Bevan's Run, a remarkable effort by two of our members, as described in the Editorial.

There are signs now that the general public is at last becoming aware of the dangers and making its views felt, as indicated by a number of surveys.

On the professional side, more and more organizations are calling for withdrawal of the Bill, including the BMA, RCN, RCM, Faculty of Public Health, Royal College of GPs, Royal College of Radiologists and the Chartered Society of Physiotherapists.

The key to this, certainly for the medical bodies, has been gathering enough signatures to force Extraordinary General Meetings of Colleges. Where a surveys of fellows and members has not been carried out by the College those eligible to vote have been directed to an unofficial website to record their views in order to inform the debate at the EGM.

Elsewhere in this edition are the speeches made by Clive Peedell and Jacky Davis at the RCR, on the motion that the College should call for the Bill to be withdrawn. As we go to press, the Royal College of Physicians has just held its EGM where Fellows present voted by a large majority to ballot all Fellows and Members , with similar majorities for motions that Council should call for withdrawal, form a united front with other like-minded bodies and join them in a press conference. EGMs are pending at the Royal College of Surgeons, the Royal College of Obstetricians & Gynaecologists and the Royal College of Pathologists.

The Prime Minister's hastily called Emergency Summit on 20th February, inviting only those organizations not calling for withdrawal seems to have backfired, attracting publicity for all the wrong (from his viewpoint) reasons, with the almost immediate addition to the "withdrawal" camp of one of the invitees, the RCPCH, following a rapidly conducted ballot of its membership.

Many individual members have written to their MPs and to members of the House of Lords. With the parliamentary activity now having moved to the Lords, Allyson Pollock and an experienced team have been preparing detailed briefings for them on the sections of the Bill as they have come up for discussion and amendment. These briefings have appeared on our website where there is much other information, regularly updated thanks to the hard work of Mark Aitken.

There have been numerous multi-signature letters to the press, House of Lords, College Presidents etc, some initiated by NHSCA members and all supported by many of us. Members' attention has been drawn to the petition by Dr Kailash Chand, well known medical activist in the North West. This has now received more signatures than any other since the government web site was set up.

To achieve all this has necessitated regular email contact with our members and it is still a source of frustration that we can only reach about 2/3 of you by this means, the others being effectively excluded from the opportunity to play their part. The pace of things is too fast for postal communication which is also becoming increasingly expensive as well as time consuming. **Once more, I would ask those who have not yet notified us of their email addresses to consider doing so, as whatever the fate of this Bill our involvement in trying to stop the destruction of the NHS will continue to be needed. In addition, would anyone who has recently changed their email help by informing us of the current one as each mailing out brings a crop of "failures"? Thank you.**

PETER FISHER

NHSCA Website

From February 2012 the website has been moved to a new server that can give us month to month statistics. I will now put these figures on the Home Page. The basic information will give us the number of separate visits to the site and the average number of pages visited on each occasion.

If members would like additional information I will try to extract it and display the results on a separate page.

M.A

Cameron's Kampf

In Adolf Hitler's *Mein Kampf* he explains how his political naivety, in the decade before the Great War, was awakened by observing the way in which the Austrian parliament (Hitler's own national parliament) conducted its affairs. Although Austria embraced democracy, no common language was used by the representatives of this multicultural multi-ethnic empire in their parliamentary debating chamber. When issues were raised they progressed slowly through interminable committees only for resolutions to be made by a handful of self-selected officials from the establishment. The aspirations of ethnic minorities, such as the Serbs, were systematically ignored and it was little wonder that this thorn in their side became the catalyst for the cataclysm of World War I.

Hitler appreciated that this system of government was fine when those at the top were men of integrity and vision but that could not be guaranteed by the electoral system. His mistake was to assume that he, Adolf Hitler, had that vision and the integrity to go with it.

When Herr Hitler became Chancellor of Germany in 1933, on the back of a propaganda blitzkrieg, he quickly set about stamping his authoritarian views on commerce. One of the plans was to amalgamate utility companies, but to do that would require draconian measures underpinned by new legislation.

An example of this can be seen from the fate of one Pomeranian electricity generating utility. Here the board of directors was constituted by the senior electrical engineers from the districts served by the company.

Hitler's first move was to try to remove the Managing Director by orchestrating a fictitious scandal. Unfortunately for the Chancellery the Managing Director fought his case in the Courts and won. That was before the Courts had been emasculated.

The next ploy was to outlaw the constitution of the committee structure of the board of directors so that all company policy decisions became the sole responsibility of the Managing Director, and he in turn became answerable to the Chancellery. This paved the way for creating mergers.

The Pomeranian company was set to merge with a NW German utility company which also had a manufacturing base. The propaganda claimed that this would reduce the price of electricity by 30%. No one could find fault with that. The problem was what to do with two Managing Directors. The solution was to demote the Managing Director of the smaller Pomeranian company. However, when the Chancellery found that the new Chief Executive did not embrace Nazi principles he was sacked and the erstwhile Pomeranian Managing Director, who was due to retire shortly, was installed in his place. He in turn found the Nazi philosophy difficult to go along with because orders from the bureaucrats in power would come down which lacked engineering rationality. Finding ways of implementing nonsensical projects was a challenge, but failure to comply would cause immediate dismissal and loss of long earned pension rights. Given the time the Chancellery were able to nurture a suitable Nazi stool pigeon to take over so that the elderly Managing Director could retire in "peace", but only to reap the whirlwind that followed.

Are there similarities between that flawed system and the way in which the NHS is heading today?

- Our patients have been given expectations which are unsustainable
- The workforce has been disenfranchised
- Healthcare policy is being designed by bean counters
- Bureaucrats lacking clinical qualifications are making the decisions

It looks as though Cameron has taken a leaf out of Adolf's book. In politics greatness is not decided by legislation enacted, but by admitting to mistakes when mistakes have been made.

Does David Cameron want to be remembered as the "Tory Blair" – the man who cherry picked data in order to support the US invasion of Iraq.

The Prime Minister's apparently wilful dismissal of clinical evidence, in order to privatise the NHS, is no different.

MARK AITKEN

Clive Peedell's Address to the Royal College of Radiologists EGM Supporting the Following Motions

The motions before the meeting were that the RCR:

a) welcomes the RCR statement that it cannot support, and must continue to oppose the passage of the Health and Social Care Bill in its current form;

b) considers that the Health and Social Care Bill, if passed, will damage the NHS and widen healthcare inequalities, with detrimental effects on patient care in England;

c) cannot support the Health and Social Care Bill without seeing the NHS reform Risk Register

d) calls upon the RCR to publicly call for withdrawal of the Health and Social Care Bill;

e) calls upon the RCR to seek an alliance with the BMA, RCN, RCM and other willing Royal Colleges and NHS stakeholder organisations to collectively call for the withdrawal of the Health and Social Care Bill.

f) calls upon the RCR to hold a joint press conference with the BMA and other willing Royal Colleges and NHS stakeholder organisations, to make a joint public statement calling for the bill to be withdrawn

"I would like to thank Council and the President for calling this important meeting

I am co-chair of the NHS Consultants' Association, a member of BMA Council and the Political Board.

This is not a party political issue. I campaigned against New Labour's market based NHS reforms because I believe that a publicly funded, publicly provided, and publicly accountable NHS is the most cost effective and equitable way of delivering healthcare to our population.

This is about defending the NHS from increasing marketisation and privatisation, which will inevitably undermine the founding principles of the NHS, leading to increasing healthcare inequalities, reduced access to care, increased healthcare expenditure, and the undermining of medical professionalism and the doctor-patient relationship.

I don't accept and I don't think anyone accepts the status quo. I think we all realise that the NHS has problems and we would all agree that the NHS needs to continuously adapt, change and improve to meet the current and future health needs of the nation. But this has always been the case and will continue to be so. It is part of the duty of being a doctor.

However, we will hear today why the Health and Social Care Bill is not the answer to the problems of the NHS and will in fact make things worse not better. We'll also hear why the case for such a radical change to the NHS has not been made.

Not only is the bill 3 times longer than the original bill and littered with 100s of new amendments, there is widespread recognition that something is deeply wrong with this bill. The level of opposition is unprecedented and ranges from the usual suspects of the unions, right through to members of the Cabinet of the Government. There are at least 23 professional groups in opposition including frontline staff as well as NHS managers. The highly critical joint editorial from the BMJ, HSJ and Nursing Times was a watershed moment.

Surveys of the RCGP have shown that the vast majority want the bill withdrawn.
Clare Gerada has stated:

"GPs don't think the bill is going to create a patient led NHS, they don't think it is going to increase autonomy, they don't think it is going to improve patient care, and they don't think it is going to improve healthcare inequalities"

Professor Lyndsey Davies, Chair of the UK FPH, which has just publicly called for withdrawal of the bill, has stated that: "the majority of our members now believe that the Health and Social Care Bill, if passed, will damage the NHS and the health of people in England".

There is also great confusion about what the bill actually means. Hamish Meldrum said it was "Hopelessly complex". The new Chair of the NHSCB, Professor Malcolm Grant, who is a lawyer, said it was "unintelligible".

However, experts in constitutional, public and commercial law, as well as health policy have written extensively about the bill and published their analyses in major medical journals to explain what the core underlying aim are.

There is little doubt that the intention of this bill is to denationalise the English NHS, by removing the duties and powers of the Secretary of State of state to provide a comprehensive service.

Thus the crossbencher Lord Owen has called this the "Secretary of State's abdication bill". This explains the furore around Clause one and related clauses on the Secretary of State's duties and powers. This is a red line he will not give up. Why not return it to the original 2006 Act wording?

In addition the bill abolishes the previous planning structures of the NHS, with creation of a regulated external market in healthcare, with public provision of healthcare increasing being replaced by private provision (through the AQP policy), driven by a competitive market.

The Public Interest lawyer, Peter Roderick has stated: ***"The fundamental legal basis for the NHS, which was put in place in 1946, will be removed by the Government's Health and Social Care Bill."***
He goes on to state that:

"a direct line of logic can now be traced in the Bill, which leads to the unavoidable conclusion that if the Bill was to be enacted, the legal stage would be set for private companies to be entitled to run much of the NHS and for market forces to determine the way many health services are provided."

The number of services provided by the NHS will decline over the next few years and increasing numbers of patients will take out health insurance to widen their coverage. This process will be catalysed by the QIPP efficiency drive as services start to fail and CCGs come under enormous pressure to reduce costs. This will then place enormous financial pressure on FTs, which will need to treat increasing proportions of private patients to stay afloat. This is why Private Patient cap is being uplifted to 49%.

Over a 5-10 year period we will see the NHS transformed into a mixed funding system.

This will have detrimental effects on professionalism and professional standards

Markets fundamentally undermine professionalism. The relationships between medical professionals and patients depend on trust rather than contractual obligations and attempting to reduce the provision of healthcare to economic transactions erodes the intrinsic motivations on which the doctor-patient relationships depend.

This strikes right at the heart of the social contract, which is fundamental to medical practice and professionalism. So it also strikes at the heart of this College. As Professor Kenneth Arrow recently stated about markets in healthcare "one problem we have now, is an erosion of professional standards".

It is therefore no coincidence that the American medical profession lost public support faster than any other profession during the rapid marketization of the US healthcare system in the 1970/80s

Doctors intrinsically want to work collaboratively. A MORI survey of doctors showed that competition was the biggest problem they had with the reforms.

This clearly leaves Mr Lansley with a huge problem with his reform agenda because as he stated in a speech to the NHS Confederation: "the first guiding principle is this: maximise competition…... which is the primary objective".

Another issue is that clinical leadership and clinical followership are crucial to successful healthcare reform. Mr Lansley has lost the healthcare professions.

The reforms are doomed to failure.

The Colleges should also be very concerned about the effect of market reforms on medical training and standards. The profession has already suffered the Modernising Medical Careers (MMC) debacle, which can in part be explained by the influence of market based policies. MMC utilised a competency based tick box approach to training and it is important to note that Competency Based Training (CBT) originated in the 1980s and was a politically driven movement with the aim of making national workforces more competitive in the global markets by focusing on discrete technical skills with an emphasis on outputs, performance assessment, and value for money. However, the professional skills of doctors are much more based on tactic and experiential knowledge.

Sir John Tooke's report on MMC, Aspiring to Excellence, clearly highlighted MMC's emphasis on achieving minimal standards rather than excellence. A prescient editorial in the British Journal of General Practice described how the proposals for the establishment of PMETB:

"… are clearly intended to enable the Secretary of State of the day to direct that standards can be lowered to meet the manpower demands of the NHS".

I will leave you with a quote from Arnold Relman, Emeritus Professor of Medicine of Harvard Medical School, and former editor of the New England Journal of Medicine:

"Medical professionalism cannot survive in the current commercialized health care market. The continued privatization of health care and the continued prevalence and intrusion of market forces in the practice of medicine will not only bankrupt the health care system, but also will inevitably undermine the ethical foundations of medical practice and dissolve the moral precepts that have historically defined the medical profession."

In summary:
This bill is flawed. It lacks a democratic mandate. The case for such radical change has not been made. NHS productivity is increasing and patient satisfaction is at the highest levels ever recorded. Bureaucracy will be increased, not decreased. The bill lacks professional and public support (YouGov poll). We haven't seen the risk register. It is not amendable due to the mutually reinforcing nature of the market policies, which are therefore the Coalition's red line in the sand.

Costs will go up and not down. The service will be fragmented and the transactional nature of the new healthcare market will undermine medical professionalism and the doctor patient relationship.

The latest amendments do little to address the fundamental underlying structural changes of the bill that will undermine the NHS.

For these reasons, the College should continue to oppose the bill, but more than that, the college should join with other professional organisations and call for withdrawal of the bill.

The fellows are ready to get behind the College to back them every step of the way. Please vote for the motion in all it parts to protect the NHS and the future interests of our fellows."

Quotes

And out of good still to find means of evil. - J.Milton Paradise Lost 1.165

Those who struggle often fail but those who do not struggle have already failed.
He who does not know the truth is only a fool.
He who knows the truth and calls it a lie is a criminal - B.Brecht

In a time of universal deceipt, telling the truth is a revolutionary act. - G.Orwell

Speech by Jacky Davis at The RCR AGM

Firstly I would like to congratulate the college on all the hard work it has done in relation to the HSCB, and acknowledge that it has tried hard to obtain significant amendments in the many areas of concern to our members. However there must come a time when the college recognizes that working as a 'critical friend' is not going to produce the radical changes that are needed to make the bill acceptable. After 18 months of advice and with the bill about to become law that time has surely come.
I want to outline today why this is a bad bill, why it is not necessary, why it is not too late to stop it and why it is important that this college take a more outspoken position on behalf of its members.

This bill is bad, bad policy and worse politics. It does not do any of the things it claims to:

- Cuts costs – no, costs will rise
- Cuts bureaucracy – replaces 3 layers of bureaucracy with 7
- Power to patients – patients will have less choice than ever
- Power to doctors – GPs will be answering to CSUs run by private companies at the same time as taking the blame for massive cuts in budget

It cannot fail to adversely affect teaching, training and standards, the core concerns of the college.

This bill is not necessary. We don't need this bill. Indeed 95% of it can be achieved without legislation. Commonwealth Study and other studies show the NHS is cost effective/equitable/popular with public.

The government have repeatedly lied and cherry picked statistics to justify their 'reforms'. New research shows outcomes improving rapidly, and we will soon overtake many of the countries with whom we have been unfavourably compared. The recent Lancet paper showed productivity going up.

What is the problem to which this bill is the solution?

The major concerns expressed by the college lie at the core of the bill
Duty of Secretary of State
Integration v fragmentation
Health inequalities
EU competition law
New provisions re. education/training/ research are weak

We are told the college is seeking amendments but these concerns appear in every bulletin with no sign that they have been met. It is helpful to list these concerns but we shouldn't confuse analysis with action. The one must lead to the other if it is to be useful.

These fundamental features of the bill are not going to change. Andrew Lansley told his backbenchers after the listening exercise that all red lines were still in place. The government has had 18 months to listen and they have failed to do so, despite claiming that this was about listening to doctors and patients.

It is not too late to stop this bill. The argument that is currently being used i.e. there is more pain in stopping than dropping the bill is nonsense. If you are in a hole you should stop digging. There are many coherent suggestions as to how to stabilise the situation we now find ourselves in. Having got us into a mess it is unacceptable to use the mess as an excuse to press on with the bill in the face of opposition from the vast majority of professionals.
It is common knowledge that the government has recently applied pressure to the Medical Royal Colleges not to come out publicly against the bill. How can legislation that is meant to empower us only be forced through by threatening us? This behaviour is indicative of how very afraid the government are of opposition from our professional bodies.

It is unfortunate that, when put under pressure, the college did not seek the support of its members via a survey, because we would have given it to you. Our unofficial survey attracted 622 votes, with 88% voting for the college to call for the bill to be withdrawn. You have the members backing to do this; we are here to help you.

I suggest that what was right 2 weeks ago i.e. calling for withdrawal, is just as right now despite pressure from politicians. The other colleges are all being encouraged to have EGMs. Some have been announced and others are in the pipeline. All colleges will eventually be backed by their members to call for withdrawal for the reasons we have heard today. We must stand firmly together for what we believe is right. We must stand firmly together against political interference in our clinical judgement. Only in this way can we gain respect from those we represent and those we deal with, only in this way will we gain real influence and only in this way can we protect the profession and our patients now and in the future.

The Power of Words and The Art of Tergiversation

My literary juices run thin as I sit to write my piece for the Newsletter. It's clearly not for lack of things to write about. Looking about me, the world is full of happenings, many of them dramatic, some deeply disappointing, often exposing the less reputable aspects of 'human nature', not infrequently the result of unforeseeable, unavoidable consequences of natural conditions like earthquakes, volcanic eruptions, floods, droughts or sunspots. So much a part of life have the recurrent, disruptive reorganisations of the NHS become that one is tempted to classify them to this last category of natural catastrophes.

Letters to the Guardian

It is perhaps reassuring that one has not become so inured to the organisational paroxysms of the NHS as to lose the urge to "write to the Guardian" about them. For example, a hastily composed riposte to a letter late last year from Baroness Shirley Williams and 30 or so of her noble colleagues (Lib Dems draw a line on the NHS, October 25th 2011) first commended them for their exposure of and opposition to the Health Secretary's attempt to divest himself of responsibility for England's health services. It then condemned them for their approval of the principle "…that any income from private patients is used solely for the benefit of NHS patients". This tacit endorsement of the 'Lansley liberation' of the private earnings capping of NHS Foundation Trusts implies approval of the inevitable sale of the best the NHS has to offer to private buyers. A surer way to create a two tier NHS with the cash customers getting fastest-tracking, topmost consultants, smartest test technology and the toothiest smiles, with a residual safety net service for the rest of us, is hard to imagine. The seeming sanctification of this sell-off by making the proceeds over to the NHS 'economy beds' is phoney too. Any significant access of such private cash will enable government to increase the squeeze on the treasury contribution and so seek electoral support by offering the public a tax cut.

That letter didn't see the light of page 27 and joined the impressive pile of rejected masterpieces. It did at least set me thinking again about the flexibility of politicians and particularly their agile use of words. Orwell's description of Newspeak articulated the deliberate political use of words to deceive rather than to inform. He based his dire predictions of linguistic corruption for 1984 on what he heard and saw going on around him in 1948, highly coloured by the semantic horrors of the totalitarian regimes and deliberate misinformation of the 20th century. This was but the most vivid and contemporary exposure of a much older process. The skilful and deceitful manipulation of language and meaning was well recognised in ancient times, both praised and castigated in Socratic dialogues, probably even represented in ambiguous Neolithic grunts . Lewis Carroll's oft repeated literary cliché from Alice Through the Looking Glass gave it memorable expression .

"When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean — neither more nor less."

"The question is," said Alice, "whether you can make words mean so many different things."

"The question is," said Humpty Dumpty, "which is to be master— that's all."

NHS Speak

The tortuous history of 'the NHS Reforms' has introduced us – one is almost tempted to say inured us – to the deliberate, often politically inspired, misuse of deceptively wholesome-sounding words and expressions, NHS Speak if you will. A great deal of our current medico-transactional vocabulary originated one suspects from US market talk, much bearing the public relations stamp of Wall Street

and Madison Square Garden. Imprecision and/or multiplicity of meaning has been used to exploit, distort or disguise the use of terms like privatisation, payment by results, entrepreneurialism , health centres. Even apparently constructive terms like modernisation, rationalisation, liberalisation,and all the 're-' words like redistribution, rebalancing, reallocation, reconfiguration, re-engineering, re-skilling have lost such innocence as they ever had and become loaded with secondary and tertiary meanings. Much could be written about the origins and evolution of many of these terms but a couple worth dwelling upon perhaps, are 'commissioning' and 'integration'.

Integration

Here is a warm and reassuring word with useful flexibility of meaning. Mainly used to describe 'a combination of parts or objects that work well together', it can also mean 'equal access for all', 'acceptance into community', 'personality at one with the environment' or, in mathematics, 'solving a differential equation'.

The pursuit of integration (presumably in its first or second definition above) has been a much cherished goal in the NHS ever since its foundation. Also known in earlier times as 'unification', it was chiefly concerned with much closer working between the three arms of the service, the hospital/specialist sector, general practice and public health. The involvement of health visitors/district nurses and the emerging social services was also sought. The grand design of the NHS foresaw what would have been a revolutionary – and visionary - change in primary care with Health Centres geographically disposed in the population replacing the largely one or two doctor-GP practices of the day. These community-based Centres would be closely interlinked professionally and organisationally (integrated) with diagnostic facilities and hospital services and would house pharmaceutical, paramedical and other linked services and be the planning base for the community public health service. This was the vision which inspired my campaigning support in 1946 and 7.

Sadly, both the politics and the economics of the day militated against that very promising new setting. The GPs of the era were whipped into a state of fearful opposition to the NHS by a party politically inspired, BMA-led campaign against the NHS legislation. A modified Bill was saved only by the astute support offered to Bevan (at a price) by the then President of the Royal College of Physicians, Lord Moran. This won for hospital consultants and specialists a powerful directing role in the inauguration and establishment of the new NHS and for Moran the lasting sobriquet of Corkscrew Charlie. Economically, it was very dubious whether the country, emerging bankrupt from 5 years of destructive war, could have really contemplated the complete rebuilding of the physical and economic structure of the NHS in 1948. It was not till 40 years later that the full re-establishment of the relative roles of the hospital service and primary care came up once more for review, this time not in the radical, community-conscious setting of the post-war years but in an era of monetarism and market ascendancy. Integration had come to be considered in quite new terms.

In this later, 'reforming' NHS speak, integration has come to include, almost to centre upon, the insertion of private sector (and some voluntary) organisations into all hitherto publically/professionally regulated parts of the service, including its clinical heartlands. Just how the inclusion of commercially competitive, profit seeking, problem-averse structures into the equitable practice of medicine can be reconciled with any of the definitions of integration offered above is difficult to see. Much more appropriate would be the term 'replacement' as the NHS essentially founded on a sense of social purpose is displaced by a structure appropriating the same name and high repute but driven by commercial ethos.

Chris Ham and Integrated Care

The last edition of the NHSCA Newsletter (December 2011) carried Chris Ham's thoughtful consideration of 'integrated care' and its application to the NHS. He identifies many levels at which integration may operate: the micro level as it involves the many and various needs of individuals and their carers; the meso level which takes account of groups of people with similar or complementary needs e.g. 'the elderly', those with long-term conditions, presumably high risk 'normals', etc; the macro level which addresses whole populations, defined on occupational, cultural, residential etc lines, and for which he takes the much studied Kaiser Permanente HMO as a prime example. What, who and how, at each level, he asks, should we best integrate the resources of skill, personnel, equipment, communication to say nothing of the flexible planning and innovative management. How do we combine the high specialisms, the broad generalists, the home-based and the institutional, the contracted and the voluntary into a smoothly operating system which brings health to the public and gratification to the health care provider. He points to the value in Torbay of greater integration of clinical and social care resulting in more care at home and significantly less dependence on hospital admission. This is catalysed in his opinion by the employment of a newish breed of 'coordinators'

to bridge the social/clinical divide and to oil the wheels.

What emerges most clearly from his analysis, to me at least, is that the key to an integrated service is the comprehensive ascertainment of need (at whatever level), the accurate inventory of resources, the setting of (reviewable) goals, short, mid and long term, the establishment of working links, pathways and networks with a robust, readily accessible information system at its heart and operated by a crucially important high quality, inspirational, flexible, committed management. He makes some play of the role of incentives and the use of the purchaser/provider mechanism but nowhere does he establish the case that this integrated system will perform better in a 'free market' than a rational planning environment. Lacking to me in Ham's account was the element of 'social integration', the active, often awkward and questioning role of the informed and concerned public in the policy making and running of the NHS.

Commissioning

Once upon a time, a monetaristically minded government tried to introduce a 'commercial corrective' to control the use of expensive hospital services by a feckless public. GPs were offered the opportunity of 'purchasing' hospital services by allocating a limited virtual purchasing fund. This could only be applied to a limited range of hospital services and mainly had the effect of enabling a patient to jump the long waiting list. There was little distress when the scheme was abandoned. The public instinctively recoils at the thought of converting their health care needs into a commercial transaction. The contemporary political answer has been to resuscitate the mercantile mechanism for the purchase of care but to sanitise it by renaming it 'commissioning'. The term has thus been appropriated for the marketisation of the NHS by making it synonymous with purchasing.

Commissioning is defined by the NHS as the process of " ensuring that the health and care services provided effectively meet the needs of the population". It is seen as a complex process with key activities ranging from assessing population needs and trends, responsibility for setting health outcomes in priority order, ensuring the provision of the skills, services and products necessary to achieve them plus effective management of the resulting plan and structure. Implicit here is the need for smooth , cooperative agreements, arrived at by joint discussions, best deployment of available resources and identification of future needs. The driver of today's concept of commissioning puts the transaction for the purchase of the service at the heart of the process with competitive tender taking the place of discussion and agreement between partners in pursuit of a common goal. This will firmly plant the purchaser/provider transaction at the heart of almost all professional and technical relationships in the NHS and introduce a major question of financial profit and loss into most if not all such clinical decisions. The potential for welcome for the simple and uncomplicated case, for aversion to the 'costly' patient, for the lubricating top-up and the money-saving short cut, for the lower-waged operative (and exceptionally for downright fraud) is apparent and evident in 'worked examples' in some commercialised health-care systems.

One of the major effects of the proposed objectives of the Lansley proposals for NHS reforms is to hand over £60 billion of NHS to general practitioners to purchase care is being to even further separate primary care from the hospital and specialist services. It is unlikely that many GPs will have the time or even the inclination to consider the details of hospital financing or management and the exclusion of the hospital sector from the commissioning decision-making will distort rational planning for the therapeutic organisation as a whole. One suggestion has been that commissioning is based upon care systems which set out to meet the totality of patient need and in allocating resources appropriately both primary and 'post-primary' care as well as social care needs require informed representation. This firmly plants the crucial role of 'integration' at the centre of 'commissioning' and illustrates vividly the potentially disintegrative impact of the artificial imposition of the transactional Punch and Judy of 'purchaser' (GPs or their hired entrepreneurial representatives) and 'provider' (the consultants – or their struggling finance department) on the sensitive heartland of therapeutic relationships.

The alternative is surely to plan the disposition of resources on the basis of need (as professionally and objectively assessed by those responsible for and equipped to ascertain those needs, in consultation with other resident and invited expertise and influenced by representation of democratically accountable representatives of the population being served which is not fundamentally biased to any interest other than maintaining and improving the health of the public.

HARRY KEEN

How the NHS Measures up to Other Health Systems

In a paper published last week in the BMJ (http://www.bmj.com/content/344/bmj.e1079.full; download available from http://eprints.lse.ac.uk/42050/), written by myself and three researchers from the European Observatory on Health Systems and Policies, we report the findings of two American surveys comparing the performance of health systems in high-income countries on a wide range of measures. The surveys showed the NHS outperforming other countries on many of these measures, despite spending much less than most of them. The main areas in which the NHS performed well had to do with accessibility – not just the absence of financial barriers, but the ability to get help when it was needed – and with the coordination and management of care, especially for chronic conditions. Patient safety and patient-centredness were also judged favourably. Overall, the NHS was found to enjoy the highest levels of public confidence and user satisfaction of all the countries studied.

Not all the findings were positive, however; a number of clinical outcomes were poorer in the UK than in other countries. However, improved outcomes were already visible as a result of policy initiatives and spending increases during the last decade. We conclude that like all health systems, the NHS has its strengths and weaknesses – but there seems to be little public support for fundamentally rebuilding the system. The data support a policy of continuing and extending the kinds of improvements already under way. Given that the cost of NHS care per person is 20% less than the average in the other countries studied, we suggest that increasing spending on diagnosis and treatment to more conventional levels would be likely to have a beneficial effect on outcomes.

The two reports on which this article was based were published by the Commonwealth Fund, a New York based policy institute, in September and November of last year. These reports in turn were based on a number of other publications. We performed a secondary analysis on the results, focusing on the contrast between the UK and other countries. The bulk of the results were based on interviews with a total of 37,000 adults in eleven countries, who reported in detail on their experiences as users of health care and gave their overall views on the system in their own country. Other data were compiled from OECD reports and published research papers.

DAVID INGLEBY
Utrecht University

From: Public Health for the NHS
Health and Social Care Bill: "Competition and Choice"

The Importance of Competition

1. Tomorrow (Wednesday 29th February) the House of Lords will begin discussing Part 3 of the Health Bill, which deals with the attempt to introduce market "competition" into the NHS. This briefing note examines what is proposed and sets out why the competition provisions of the Bill will damage the NHS.

2. The briefing is set out as follows:

- Paragraphs 3 – 4 look at the policy background
- Paragraphs 5 – 6 look at the relationship between competition and choice
- Paragraphs 7 – 25 look at problems with competition in healthcare: inequality in information between provider and patient (paragraphs 8 - 10); waste of money (paragraphs 11 – 14); the creation of perverse incentives (paragraph 15); the poor evidence base for the alleged benefits of market reform (paragraph 16 – 20); why claims that competition will be based on quality not price are wrong (paragraphs 21 – 23); and how the US model of healthcare offers a warning of how competitive markets will damage health outcomes (paragraphs 24 – 26)

Background

3. On 9th July 2005, then Shadow Health Secretary Andrew Lansley made a speech to the NHS Confederation, in which he said:

"So the first guiding principle is this:

maximise competition. There are, of course, potential benefits from privatisation in terms of access to capital, flexibility, and creating new markets; but private sector ownership is a secondary consideration to competition, which is the primary objective."

"Government proposals envisage limited competition in supply of elective surgical operations from the end of 2005 and, by 2008, in theory, full competition for those services. However, it is not full competition. There is no right to supply for new and independent providers."

This makes clear that creating a right to supply for new private sector providers through "full competition" is a critical element of the Health and Social Care Bill.

4. Under competition and trade law private sector market participants have legal rights to maintain that access on equal terms with all other providers, including the public sector. Such rights are enforceable in the UK and EU courts and through World Trade Organisation arbitration. The Bill as it stands would introduce a system creating such rights for any "qualified" for-profit provider of healthcare services, in a market of providers offered to patients as options for their health provision.

   In the 2005 speech, Mr Lansley also said "Much of what I have described is like the EU's developing framework for services of a general economic interest. I recognise this and I welcome it. A vital aspect of our relationship with Europe should be to encourage the EU to be concerned with promoting competitive markets."

   The process of creating such a market in healthcare provision has already begun: the 2012/13 Operating Framework for the NHS set explicit targets for NHS funds to flow to providers outside the public sector.

Choice and Competition

5. Liberal Democrat politicians have claimed that under the Bill competition would not be permitted unless it "is in the interests of patients". We have looked at UK competition rules, as currently practised in the NHS by the "Cooperation and Competition Panel", which will merge with Monitor after the Bill passes. This body has principles that set out the importance of "choice" for patients. Because of this, it acts always to "protect patient interests" through increasing competition, which is assumed to be good for "consumers" of healthcare. The Panel insists that any decrease in competition must be proved to benefit patients, but they merely assume without proof that competition is good for patients.

6. This is not the view of many patients. In a survey by the Future Forum last year, 580 of the 597 respondents who commented on the kind of choice offered by the Bill were opposed to it. Quotes included:

   "Unfortunately, choice and competition are mutually exclusive in the long run. If your local hospital isn't "chosen" by lots of patients, it will lose income and close down (in the unlikely event of politicians allowing these reforms to reach their logical conclusion). It follows that you will no longer be able to "choose" that hospital, any more than you can choose to watch Premiership football live on the BBC."

   "I don't want choice. I want a good hospital within reasonable distance from my home. Nationally, hospitals sharing best practice rather than competing with each other."

   "For the majority of people, in the most cases 'choice' is a myth. The main difference is between the rich and the relatively wealthy that choose private health and the rest who cannot afford to do this. Competition within the NHS may drive down costs for a temporary period but in the long term costs more and delivers a poorer service – ask any NHS manager or politician to be honest about this."

   "The problem with "choice and competition" is that private sector providers will compete for the choice services; the services that will generate the most profit. Typically, this means they'll choose the kind of services like hip replacement or cataracts, that are quick and profitable to deliver, leaving the NHS saddled with the complex, difficult services which are difficult to turn into revenue, thus exacerbating the NHS's financial difficulties and creating a two-tier system."

   "Choice & Competition is a means to having services provided by third parties, leading to privatisation with massive cost increases as with British Rail. More effort should be given

to retaining NHS as a public run non-private/non-mutual/non-partnership organisation run by NHS employees not 'carpet baggers'".

Problems with Market Competition in Healthcare

7. There are a number of critical reasons why market competition in healthcare will not produce the beneficial effects that characterise other markets.

Information and Power

8. There is an obvious inequality in information and expertise between the "buyer" (the patient) and the "seller" (the doctor or other healthcare provider). Patients commonly have no medical training and simply may not know enough to judge whether a healthcare professional's recommended course of treatment is in their interests, or is influenced by the need for the provider to make money or balance its books.

9. As in other countries where healthcare is subject to market competition (for example the United States) the new system would give a direct financial incentive to health care providers to exploit their superior medical knowledge to over-provide and also to overcharge. This is known as "supplier-induced demand": the treatments given to a patient may be more extensive than the patient's medical condition warrants, and the charges per item also get pushed as high as the market will bear. The NHS budget, already facing a severe financial squeeze, would have to meet this unnecessary cost.

10. There is also the severe danger that the relationship of trust between doctor and patient will be damaged. This is a particular problem, for example, if GPs are to be both primary healthcare providers and commissioners.

Waste of Money

11. The competitive market model requires that there always be a choice of provider offered. The new NHS operating framework sets targets for the proportion of non-NHS providers, in order to provide this choice. Before the Bill, waiting lists were both relatively stable and short, suggesting that the health system had sufficient capacity to meet demand. Extra providers add unneeded capacity: this is required if patients are always to be offered the required choice of at least three providers.

12. The existence of unused capacity in a market system will leave many providers cash-starved, with persistent difficulty in covering their overheads and paying their staff. This will give them a strong incentive to create supplier-induced demand, which tends to damage rather than heal patients. The NHS budget must cover such costs of having this redundant capacity provided only so that the market model may function.

13. A competitive market model would require that every transaction involving a patient must be billed, a heavy and unnecessary cost burden on the NHS. Research shows that extra costs attributable to marketisation in the English NHS already amount to around 14%, This figure can only rise if further market reforms are introduced in order to create opportunities for the private sector to provide NHS care.

14. Economic competition also requires advertising and marketing. This is expensive – it requires the use of agencies, purchase of media space etc. These costs will also have to be met by the NHS.

Perverse Incentives

15. When competition-based management and fee-for-service payment (payment by results: PBR) is used, there are financial incentives for overstating the severity of cases on admission, known as upcoding. Allocating codes indicating more serious conditions than are in fact present will raise the hospital's income, and where bonus-linked targets are in place as part of a competition-based management policy, may also increase the doctor's income. In 2006, when PBR was introduced, the Audit Commission found 11% of codes were incorrect, with some undercoding, but also "evidence of trusts actively working to optimise their income". In 2010, again 11% of codes were found to be wrong. A GP practice in London found that patients choosing one particular PFI-burdened hospital were resulting in PBR bills overall 30% in excess of what they should have been . In the USA, a study by Silverman and Skinner found twice as much upcoding in for-profit hospitals as in non-profits, with upcoding by non-profits increasing with the intensity of competition.

Studies Showing Market Benefits are Weak or Misleading

16. In 2010 and 2011, three UK-based studies were published which purport to the benefits of competition, of which two are authored by economists from the Cooperation and

Competition Panel. Advocates of the Health Bill have relied on them to make the case for the competitive "advantages" of the Bill. But all three have serious weaknesses, making them unsuitable evidence on which to base such a major change.

17. All used standard outcome data for heart attack mortality (30-day survival figures) as the measure of service quality, and all overlooked the possibility of upcoding. All treat geographical density of hospitals as a proxy for the level of competition from other NHS hospitals.

18. This gives rise to fundamental problems. First, the hospitals were not in fact competing to treat heart attack patients at all, since the accident and emergency departments were not part of the competition-based incentive scheme, which at the time only applied to planned surgery. Secondly, the choice of hospital was generally made not by the afflicted patient but by the ambulance driver, on the basis of proximity to the patient. The ambulance drivers were not part of any competition-based incentive system run by the hospitals.

19. Many other studies have not found a positive association (as explained in a review by the Canadian Health care Association).

20. In conclusion, none of these three papers provide good evidence that the market competition reform proposed will improve the NHS. The fact that they are persistently cited as the best proof available (even after their over-claims have been exposed in the BMJ and the Lancet) is significant.

Competition on Quality or Price?

21. Although the Government has declared that competition is to be on quality rather than price, in fact either a pure cost-based procedure, or the "Most Economically Advantageous Tender" (MEAT) arrangement is to be used. MEAT is recommended as combining quality and price, with contracts chosen at lowest price for some acceptable pre-declared level of quality. In other words despite repeated Government assurances that the Bill would not mean cost-based competition, no purely quality-based procedure would be allowed.

22. There is clear evidence to show that in healthcare, price-based competition produces a race to the bottom on quality of provision. Competition to cut overall bid prices to win tenders pushes the amount that can be spent on services down to levels which inevitably compromise their quality.

23. In 2011, medical negligence QC John Whitting has written that he expects negligence cases to soar as a result of the roll-out of competitive commissioning. He stated that in a competitive model: *"fewer doctors and fewer nurses will have to work longer shifts: in other words, the very environment in which mistakes are most likely to happen..... These proposals are patently driven by commercial imperatives rather than by consideration of patient wellbeing."*

Heading Down the American Road

24. Internationally, the healthcare system with the most developed competitive market is in the United States.

25. According to the World Health Organisation, in 2008 the United States spent 15.2% of GDP on healthcare, the highest spend per head of any country, while the UK spent 8.7%, ranking it 19th. Studies ranking quality of care and efficiency across different national health systems always list the UK system as giving better outcomes at under half the cost of the US system; they routinely find that the NHS is top or near the top on outcomes and is near unbeatable for value for money.

26. The British Medical Journal recently published "Competition in a publicly funded healthcare system: are the UK and other countries right to adopt a market based model for improving their health services?" Harvard academics Steffie Woolhandler and David Himmelstein concluded that the appropriate response to the US experience with such policies is "quarantine, not replication".

Conclusion

27. The competition-based reform of the NHS constitutes a reckless and dangerous gamble with the NHS, and with the health of this nation. The Bill is a chaotic muddle, based on a model that the evidence shows to be more expensive than the current system while producing inferior outcomes. It should be dropped.

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Depressing Perspectives

When the politicians are flagrantly letting the country down, who should take the blame?
The leader? The organ-grinder's monkey? Or the entire cabal?

CAMERON'S C V

A privileged education
That showed him how to grow,
Get one leg up the ladder
Not what but who you know.
Create a hybrid party
To take him to the top,
Then rob us of our NHS.
Will nothing make him stop?

THE BENEFICIARIES OF FRAUD

Sing a song of sixpence
Or is it somewhat more
That Cameron and Lansley
Are hoping they will score
When the Bill is sanctioned
And doctors start to wrong
Those countless queues of patients
Who cannot sing that song.

TWO CELEBRATIONS AND A FUNERAL (we hope)

May our Olympic athletes
Prosper and excel.
Let's toast the Queen in diamonds
Who would not wish her well?
Amidst these celebrations
There is an evil smell.
Let's roast the Coalition
And send their souls to hell.

M.A

Intelligent Kindness. Reforming the Culture of Healthcare.

John Ballatt and Penelope Campling

200 pages, The Royal College of Psychiatrists, 2011
ISBN 978-1-908020-04-8

Kindness means sympathy, helpfulness and forbearing. It expresses towards others an obligation and an understanding of our connectedness to them. When people are kind, they overcome narrow self-interest and do well for others. Nowhere is this more important than in the health service. The book "Intelligent Kindness" is a Royal College of Psychiatrists publication. The authors are John Ballatt who has worked as a social care manager and is currently in related work and Penelope Campling, a consultant psychiatrist and psychotherapist who is a member of the NHSCA.

The strength of this book, it seems to me, is in emphasizing the social context in which kindness is expressed as well as of course dealing with kindness as an individual attribute. One might contrast this with Martin Seligman's book "Flourish" which in its aim of promoting happiness and well being has much more of a focus on the cognitive processes of the individual. Ballatt and Campling consider "intelligent kindness" in such contexts as the NHS reforms, kinship, everyday clinical experience and psychoanalytic concepts.

NHSCA members will warm to this book's excoriation of the NHS reforms. Demoralisation of the workforce has occurred in the context of perpetual re-organisation with a strategic focus on the financial and business basis of a competitive market economy. The changes have lacked an evidence base and there has been no proper debate or consultation with those affected. Corrupting forces include the marketisation as commodities of need, skills and service, the mechanical delivery of processes and systems, and over-regulation of clinical care. The market undermines and replaces clinical governance. The authors give as an example the length of stay after a knee replacement. If the patient lived in the area covered by one PCT the patient would be discharged after two days, whereas if the patient lived in another PCT's area, the patient would be discharged when she was judged to be clinically ready. Economic measures become idealised and fracture the bonds between us as human beings.

Another context in which kindness is considered is kinship, a term which has an anthropological background. It is the extent to which society recognises and responds to its members as belonging together. Towards one's kin one shows kindness, attentiveness, empathy, trust and a therapeutic alliance. In contrast are patient groups seen as "the other" who might evoke ambivalent or hostile responses, or whom staff might be reluctant to treat. These might be migrants, asylum seekers, the drunk man haemorrhaging in A&E, the smoker with a smoking related ailment, those who self harm, individuals with learning disabilities and people living in poverty. Policies and programmes to deal with this might underestimate the complexity in the individual which underlies the manifestation of hostility and neglect. The whole of the NHS might be seen as an expression of kinship.

The authors' description of everyday experience rings true. For example the evidence base for clinical activity is often deficient so that the practitioner has routinely to cope with uncertainty and make decisions on the balance of probabilities. Less convincing in my opinion are some of the psychoanalytic concepts which occasionally make one tread gingerly. The authors suggest that the choice of a profession or of a client group might reflect, and offer a theatre for people to play out, wounded, unresolved, aggressive and sadistic elements of their personality. There is a specific training scheme, "compassionate mind training" which focuses on the components of compassion and techniques to enhance it.

The book is well referenced in dealing with fields related to kindness. References are apt and up to date. One problem is the lack of an evidence base for studies bearing directly on kindness and there are no studies of healthcare outcomes where kindness itself is the focus of study. All in all an enjoyable read though at £25 for a soft cover book it's not cheap.

MORRIS BERNADT

Early Notice

The AGM and Conference 2012

will be held in London
on Saturday 6th October

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