
NHSCA

EDITORIAL September 2009

As I write this the NHS is back in the news. Unprecedented attacks on the service from the USA have led to an outpouring of support in the UK, and the site set up for those who wished to join in crashed under the weight of contributions. In the forefront of those eager to be counted were politicians, leaping to the defence of our 'best loved institution', with party leaders fighting to participate in the general twittering and tweeting.

It is deeply ironic to see the likes of Gordon Brown and David Cameron defending the self same NHS that they have been enthusiastically tendering out to the private sector for the last few years. And that private sector of course will increasingly consist of the very US health corporations who are behind the co-ordinated campaign of misinformation currently stoking the outcry in the USA. The health industry there is fighting for its life. It sees its trillions of dollars of profits in danger from President Obama's health care plans, which in truth are hardly very radical. And of course millions of dollars of those profits find their way into the coffers of both political parties, and into the pockets of individual politicians. For those who are in doubt I refer you to Peter Wilby's excellent article in the Guardian

(<http://www.guardian.co.uk/commentisfree/2009/aug/14/nhs-healthcare-business-interests-lobbyists>)

which outlines the relationship between the health industry and politicians on both sides of the Atlantic. It is a sobering read, describing as it does the huge global forces (the health equivalent of the 'military industrial complex') which are behind the UK 'reform' agenda and the scare tactics of the American campaign.

It is these forces that have come together to persuade the American public that our evil 'socialist' health system denies care to the elderly, and forces patients in front of death panels. We particularly have to thank ex governor Sarah Palin for her insights into how the NHS works, a subject on which she is clearly well informed. It is extraordinary that any of this nonsense gains a foothold in the public imagination, but unfortunately this is a country

where in some places the description 'liberal' is an insult, and where socialism is equivalent to godlessness or worse.

We would not of course dream of telling the Americans how to run their health care but we can try to help them to have an informed debate on the subject. To this end the NHSCA and KONP are offering to work with US organisations, and we are trying to get as much publicity as possible for the facts about the NHS. It is by no means a perfect system but is certainly one that delivers healthcare for all its citizens at half the price of the US system – where 1 in 5 people have inadequate or no insurance. Freedom from fear is the byword when talking to Americans, many of whom live in dread of illness in the family. And while the disinformation campaign has constantly referred to rationing of drugs, Americans are amazed to hear that 90% of drugs in the UK are dispensed free of charge, and that the charge for the remainder is a fixed \$11 regardless of the actual cost. They can only dream of such a system.

There is some good news from the other side of the Atlantic however. Earlier this year I was invited – as co chair of the NHSCA - to speak at a conference in Montreal on PFI and payment by results . This offer was the result of open letters that our president Peter Fisher and I had written to the Canadian Medical Association, at their invitation, outlining the problems we as doctors have encountered with our government's 'reform' agenda. This country seems to be exporting its failed policies abroad with great enthusiasm, and what is more extraordinary is that Canadians were being told by their politicians that these policies had been a success over here.

PFI is now totally discredited in the UK, having been revealed for the smoke and mirrors accountancy that it really is, so it is bizarre that other doctors are watching their own governments make the same mistake. Montreal was facing a PFI build of their university hospital, and MQRP (Medecins Quebecois pour le Regime Publique), a group similar in its aims to NHSCA, had rapidly organised to combat this. Luckily they had the example of our experience to help them, and armed

with Prof Allyson Pollock's shocking figures on the amount of money wasted on PFI programmes it was not too hard to demonstrate that they needed to fight the Pernicious Financial Idiocy (or PPP as it is known over there).

They were a splendid group of people, totally dedicated to the battle for a publicly funded and administered health system in Canada, and they made me very welcome. The only problem was that the conference was Francophone, meaning that I had to provide my Powerpoint presentation well in advance for translation, and then had to take questions from the audience, a serious challenge to the remnants of my 'O' level French, especially given the heavy accent of the Quebecois. However the day was judged a great success as it received a lot of publicity and the government appears to have stepped back from the PFI plan, so giving everyone a breathing space to look again at the finances. Allyson Pollock has estimated that the UK PFI hospital programme is going to cost the taxpayer £70 billion for £12 billion's worth of hospitals (Guardian, 20.8.09) so they are wise to have second thoughts. Unfortunately we are now tied into these contracts, which have given us expensive and inflexible hospitals at a time of great upheaval in hospital planning.

So your intrepid officers continue to brave new countries and speak in many tongues to defend the NHS. (As evidence of bravery or perhaps foolhardiness I have accepted an invitation to speak against Karol Sikora at the Athenaeum later this year – tickets are going on e-bay for inflated sums, I shall be donning my tin hat before going forth)

Another topic that continued to appear in the headlines was the vexed question of top up payments. The NHSCA submitted evidence to the health select committee looking at the recommendations in Prof Richards report, and thus I found myself appearing before them along with the ubiquitous Professor Sikora, and the CEO of Bowel Cancer UK. This gave me the chance to hear evidence from a number of other people, and I was struck by the oft repeated observation that it was not really 'a big problem'. It had of course been made into one by the case of a few unfortunate patients who were exploited by Doctors for Reform. This is not to underestimate the difficulties faced by those individuals but it did not seem appropriate to turn the system upside down to solve the dilemma.

After hearing what everyone had to say I submitted extra evidence suggesting that the expensive and

elaborate solution proposed by Prof Richards be replaced by a central fund for top up drugs. This would be funded by the money that would have been spent on the Richards proposals plus the money spent at the moment by PCTs on holding exceptional funding reviews for individual patients. I am not sure whether this met with any takers, but certainly there are already complaints that the new system is both unwieldy, expensive and unfair. This one will run and run.

'Reform' in this country continues apace despite evidence that the money is not being well spent and that the commercial sector is not doing a good job. The government ploughs on regardless, with scans on vans and operations off the back of a lorry, insisting that PCTs divest themselves of their provider function, handing over primary care to US corporations and generally selling off the family silver. One PCT in Hull has already begun outsourcing its provider functions in earnest, while Hinchingsbrooke hospital is to be offered for sale to the private sector. Here in north London two big private contracts have recently been awarded. One is for local physiotherapy services and the other for daycase surgery - £1.4 million to Clinicienta. The latter money was top sliced from the commissioning budget without discussion with the local GPs, who now fear they will be under pressure to divert patients to Clinicienta to achieve value for money.

The effect of these private contracts, and the subsequent loss of funds, on local hospitals and GPs has yet to be seen. Luckily we have an active KONP group in Camden, who are busy issuing lawyers letters accusing the PCT of failing to consult, but the PCTs are under the cosh from the Department of Health to move towards the final stage of the 'reforms' – the NHS as a logo, awarded to the highest bidder offering the cheapest service.

And if that isn't bad enough there is now on top of these changes an extra layer of confusion. A combination of Lord Darzi's plans for primary and secondary care and the cuts demanded as a result of the financial crisis have added to the chaos caused by the government's original reforms. Hospital budgets are being slashed, both as a result of work being diverted to polyclinics and specialist centres, and because of the general cutbacks. Closures and shotgun marriages between trusts are on the horizon.

When the 'reform' agenda first began and looked particularly incoherent we were told that the intention was to generate 'constructive discomfort'.

That has certainly been achieved. It was also said that 'the box was being shaken' and that when the pieces of the jigsaw finally fell to ground they would serendipitously rearrange themselves into a brand new NHS. Well it hasn't quite worked out like that. Now it appears that some pieces of the jigsaw don't fit neatly together and some pieces are from a different puzzle altogether. And yet still, surrounded by the wreckage of their failed policies, the government continues to talk about change – 'change, change, change, aren't things bad enough already?' (a small prize for anyone who can identify the source of this favourite quote on the subject of health policy).

The other good news is that, after a slow start, the BMA has finally begun a campaign against the commercialisation of the NHS. The title hardly sets the pulse racing (Look after our NHS) but it is a step in the right direction, and Hamish Meldrum has been publicly outspoken against the government's 'reforms'. If you haven't signed up in support already please do via the website and

pass the address on to any medical friends and acquaintances.

It is a year since I wrote that black clouds loomed over the NHS, and it would be wonderful to be able to say that things have improved, but the forecast remains one of stormy weather. However the recent events in the US may be a warning to our politicians not to make too much of a hash of it, as the message is that public will be unforgiving if they destroy the NHS. The public remain as ever our most important ally, and we have to make sure that they understand what is happening in their name.

Thank you for your continuing interest,

please continue to support the NHSCA and KONP, the latter financially if you can. Let's hope next year's 'Co-chair's blog' can be more upbeat – we are doing our best to make sure it will be.

JACKY DAVIS
Co-Chair and Guest Editor

BMA 8 Principles

Those who are BMA members will be aware of the Look after our NHS campaign and the 8 principles to which individual members are invited to sign up.

We are fortunate in having several NHSCA members active on BMA Council and other committees

Our Executive Committee agreed that we should respond to the BMA as follows

Dear Hamish,

I am writing on behalf of our Executive Committee to give the full support of the NHS Consultants' Association to the recently published 8 principles.

We were particularly pleased to see No 2 – that the NHS should be publicly funded, publicly provided and publicly accountable. This has long been NHSCA policy but we have not previously seen it so clearly stated by the BMA.

There is one point we would wish to raise. We firmly believe that, in order to ensure that the NHS is publicly provided and based on cooperation not

competition, as stated in another of the principles, we must follow the lead of Scotland and remove the artificial and costly separation between purchaser and provider.

Is the BMA prepared to campaign for this as well?

We would urge you to invite other bodies representing health workers, both professional associations and trades unions, to sign up as organisations to the 8 principles.

This would make a very powerful coalition to achieve our common objectives.

With best wishes
Yours Sincerely

PETER FISHER
President

Dr Hamish Meldrum
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KONP Report for NHSCA Newsletter

Campaign funding:

The grant from the Joseph Rowntree Reform Trust and Wainwright foundation paid for a campaign manager one day a week (Bronwen Handyside), and an administrator 3 days a week (Joe Forster) from December. The further 18 months we had originally applied for and were promised orally by JRRT would be forthcoming if there was a satisfactory campaign plan has not been granted. Bronwen and Dot Gibson presented the plan but were unsuccessful and I have not got a clear answer to whether this was shortage of their funds or they thought the campaign plan was unsatisfactory. We have enough money to keep Bronwen and her assistant employed for another 6 months. Joe Forster got a full time job in Manchester and left in mid-August and has been replaced by Anna Kharbanda.

Informing the public, unions and other affiliates and KONP groups about NHS privatisation

Newspaper

3 issues of KONP paper produced and distributed to groups – print runs totalling 21,000

Email updates

- Regular fortnightly email updates to KONP groups
- Set up of email distribution software for regular bulk emails.

Responses to consultations

- Response to consultation on the Cooperation & Competition Panel, circulated to KONP groups, National Pensioners' Convention, and all union contacts before mid April.
- Response to consultation on reorganisation of Stroke and Trauma services (organised

by Healthcare for London and the Patients' Forum for the London Ambulance Service mid March) circulated to London KONP groups.

- Response and evidence given by Jacky Davis on behalf of KONP to Health Select Committee, followed by a press release on government rule change on top-up fees creating inequality – picked up by the Yorkshire Post.

Other literature distributed

- 10,000+ postcards "Patients not Profits: Keep Big Business out of your local GP surgery" distributed to KONP groups and GPs
- Mailing of all unions with a request for them to take bulk copies of the pamphlet "Patchwork Privatisation" was unsuccessful. Only one union replied.

The BMA has agreed to distribute 8000 KONP leaflets in conference packs to Facebook group set up to coordinate Valentine's Day demonstration and other activities of the campaign – now 133 members.

Website

Continues to be maintained free of charge by Paul Lister. It is a very rich source of information for campaigners. KONP groups should post their activities on the site.

Talk and answer sessions since May 2009

- Bronwen spoke to Lewisham KONP along with Dot Gibson and Jonathon Tomlinson,
- AGM of the national LINKs Association (NALM) Joe deputised for WDS,
- Camden Cooperative Party Bronwen.
- Camden meeting about proposed Gpled health centre WDS June.

Demonstrations

National Office coordination of national Valentine's Day demonstration "We love the NHS" - 12 KONP groups participated with marches, petitions, stalls, a mobile demonstration outside four hospitals in Birmingham etc

Conferences

One-day national Keep our NHS Public Workshop to develop a positive vision of the kind of health service we want (to be produced as a pamphlet by KONP) 15 November 2008. Booklet produced which can be obtained from KONP, printing paid for by NHSCA.

Public meetings

National public meeting combined with AGM "Patients not Profits" 6 June with Mark Serwotka (General Secretary PCS), John Lister (Director of Health Emergency), Jonathon Tomlinson (GP Principal in Hackney), Sally Ruane (Senior Lecturer and Deputy director of Health Policy Research Unit at De Montfort University, Leicester). The AGM was successful with over 80 people present and good speakers and lively discussion.

Parliamentary activity

WDS arranged to meet Clare Short and she suggested a meeting in the House of Commons. Meeting sponsored by Ian Gibson on 9th June was affected by expenses row which led to Ian's resignation. Dr Richard Taylor (Wyre Forest and NHSCA member) kindly stepped into the breach and chaired the meeting. Bronwen introduced the meeting with a short talk about KONP and Colin Leys, Jonathon Tomlinson, Sally Ruane and WDS spoke. Powerpoints or text available if anyone who wants them (email wdsavage@doctors.org.uk in September). The meeting was sparsely attended but Kelvin Hopkins expressed interest and WDS and BH met with him in July and he suggested another meeting in the autumn,

KONP group activities

Energetic campaigning helped Camden Keep Our NHS Public succeed in fending off plans for a polyclinic based at University College London Hospital — but further threats to put local GP services out to tender are still in the pipeline.

They are busy organising a referendum on privatisation of GP surgeries, and have succeeded in getting the Labour and Liberal Democrats groups on board.

Haringey campaigners have kept up a very powerful and organised onslaught against their PCT's privatisation plans. Fifty patients occupied the PCT Board meeting in November last year to ensure public concerns were heard about highly controversial privatisation plans for GP surgeries. Despite the efforts of the PCT, including closing the meeting to reconvene elsewhere, they were not able to stop the patients making their point. They condemned the 'unwanted, unacceptable and unlawful' privatisation of the GP surgery at The Laurels Healthy Living Centre in South Tottenham.

Tower Hamlets KONP organised a public meeting on the theme "Unite to defend Jobs and Public Services" in March. Speakers included Jane Loftus, Vice President of the Communication Workers Union, Matt Wrack, General Secretary of the Fire Brigades Union, and John MacInally Vice President, Public and Commercial Services union.

Camden and Haringey KONP groups have continued to campaign very actively against the privatisation of GP services, with public meetings, lobbies and demonstrations. Camden is calling for a local referendum on the issue.

Sam Semoff of Merseyside KONP was granted permission to challenge Liverpool PCT and the Royal Liverpool Broadgreen University Hospital on their proposal to rebuild the Royal Hospital using the Private Finance Initiative (PFI).

Finally - Welwyn Hatfield has really pushed the boat out and is standing a candidate in the County Council elections on 4 June - on the

platform "Support the Welfare State", which includes the demands of their three year long campaign to defend local NHS services. This proposal generated some controversy within the steering group as to whether we can support candidates standing against official Labour party candidates as a non-party political campaign and a statement about the position is being drafted for circulation to the groups.

Financial position

The income from individual subscriptions and affiliations is not enough to pay our running costs of approximately £1000 a month and without the generous support of the NHSCA we would not have been able to continue functioning. WDS has ring-fenced the grant money so it is not used for day to day administration and has paid the admin assistant some money from this for campaigning activities but efforts to raise money from the Unions have so far been unsuccessful. Unite has given us £2500 a year since 2007. WDS and

BH went to speak to the RMT London Regional meeting in July and hope to get some affiliations from them. The RMT have given us a free room in their headquarters for our monthly meetings of the steering group which is a great help as hiring rooms in London is expensive.

WDS has started writing letters to her personal doctor friends to ask them to take out a monthly standing order. We have seven standing orders from NHSCA members following Peter Fisher's appeal in December 2007. I have added a standing order form at the end of this paragraph if any one else could take out one of these. Jonathon Tomlinson a GP in Hackney who is on the steering group has given us £100 a month and we just need 40 people to give us £20 a month to reach the target of £1000. This covers the media monitoring and administration of the membership list and chasing up affiliations, sending out leaflets and arranging for speakers etc.

Please photocopy the form below and complete

To the Manager:

Your bank.....

Bank address.....

Please pay the sum £5 (five pounds), £10 (ten pounds), £15 (fifteen pounds), £20 (twenty pounds) or other amount..... **(Please ring chosen amount)**

To the account of:
KONP (Keep Our NHS Public) at
Co-operative Bank Ltd. PO Box 250, Delf House, Southway, Skelmersdale WN8 6WT.
Sort code: 08-92-99 Account number: 65280535
on 1st October 2009 and monthly thereafter and debit my account herewith.

Please cancel any previous standing orders made out to Keep Our NHS Public at the Unity bank.

KONP has set up a twitter group to contribute to the recent flurry of activity relating to the US system
<http://twitter.com/keepnhspublic>
Please visit and follow with a message.

WDS has responded to Gordon Brown on twitter and to Andy Burnham's Labour party e-mail and got an auto-response which I will follow up.

WENDY SAVAGE

Privatisation of Primary Care Services in South East Essex

Stewart Player in an excellent Quarterly Review written for KONP about a year back, outlined the government's plans to privatise primary care services. I will deal with SE Essex's PCT's policies for privatisation of primary care services and the reaction of Southend KONP to these policies.

In 2008 SE Essex PCT proposed building a primary care centre in the grounds of a school in St Luke's Ward, which is a poorer area of Southend. The building of this primary care centre like the others, will be financed and constructed by SE Essex LIFT (Local Improvement Finance Trust), a public/private sector partnership, with majority shareholding to the private sector.

The contract for running this centre has been awarded to a Colchester based company. The company has acquired temporary premises in a portakabin in the grounds of an Intermediate Care Centre. It is open for 12 hours a day, 365 days a year and no appointment is necessary. Patients from anywhere in SE Essex can register at the centre. This arrangement is to last for 2 years until the new primary care centre is built in the grounds of Temple Sutton School.

SE Essex PCT has a 5 year plan to build 8 primary care centres of different size and complexity. Each at its core is to house one or more GP practices. The smallest ones are to offer in addition, such services as community nursing and blood taking. The medium sized centres will be able to commission services such as specialist community nursing, chiropody and physiotherapy. The largest centres are to provide specialist services, traditionally provided in a hospital setting, including day cases, outpatient clinics and diagnostic services such as X rays. The PCT proposes releasing £33 million from hospital spending to the primary care sector for taking over services from the hospital. Nowhere is there any mention of the potentially destabilising effect this might have on the finances of the hospital, which has to compete with private and other state providers for revenues derived from care of patients. Nor is there mention in this plan of the privatisation of primary care services. Southend KONP, in submissions to the PCT, criticised it for awarding a contract to a private company to run the

primary care centre in St Luke's Ward. The proposal of the plan to reduce the current 81 premises that deliver GP services to 48 over 5 years, inevitably will lead to the disappearance of practices and GPs have expressed concern about this. Patients are concerned that the continuity of care provided in an NHS GP surgery will be lost in a primary care centre. We also criticised the shifting of services from hospitals to primary care centres without setting up pilot schemes. Finally, we expressed concern about future plans for the creation of a competitive market for community services. We handed over petitions we had collected from the public at our Valentine Day stall in the High St, protesting at the privatisation of GP surgeries. The chairman of the board in reply stated that they were legally bound to consider private companies in the procurement process together with other applicants.

Since the board meeting in June another private health care company, Chilvers McCrea which was awarded a contract to run the GP surgery in Northumberland Ave, Southend and the GP services for students at the University of Essex campus in Southend, had to give notice of termination of its contract, because of financial problems associated with the recession. It was due to run the GP practices until February 2010 but the PCT was forced to step in and take over the running of the practices, because patients at the Northumberland Surgery were dissatisfied with the level of services provided. The PCT says it will run the practices until it can get another company to provide GP services. We wrote to the local paper attacking the awarding of contracts to private companies to run GP surgeries.

Recently, the PCT announced it was awarding a contract to a private company, Parkwood Healthcare to provide a team of 3 nurse health trainers, who will provide practical support to people who want help with healthy eating, to stop smoking and to improve their physical fitness. Southend KONP attacked the decision to award the contract to the private sector, pointing out that it was in keeping with government policy to develop the NHS as a commercial healthcare market.

NORMAN TRAUB
Secretary, Southend KONP

Primary Medical Care Services in Scotland

The report by Norman Traub about the granting of a contract to a commercial organisation to provide a GP service in Southend was very reminiscent of a similar situation which arose in Scotland in late 2006.

Following the dissolution of a partnership in a GP practice in the village of Harthill, North Lanarkshire, to the north east of Glasgow, the relevant Health Board advertised the vacancy without excluding tenders from commercial parties.

The legislation then, as now, provided for this, though in practice had seldom, if ever, been effected.

This took place in an environment where health related issues were still sensitive following a vigorous and well-publicised campaign to retain Accident and Emergency services at Monklands Hospital. This had been faced with closure under the former coalition of Labour and Lib Dem in the previous administration. That decision was reversed when the SNP led government took over the reins. (Ref.1).

An application was submitted by Serco in November 2006. It was noted that two former members of NHS Lanarkshire Health Board worked for that organisation at that time.

A public meeting was held in January 2007 at which concern was expressed by local residents about the implications of introducing commercial interests to the provision of medical care in a GP setting.

Within days of the meeting a motion was lodged in the Scottish parliament calling for a review of the interpretation of the law relating to the tendering process.

The same MSP subsequently asked if NHS Lanarkshire was entitled to exclude GP companies limited by shares, from the tendering process for providing GP services in Harthill.

After the tendering process had been completed, NHS Lanarkshire carried out a public vote which involved representatives from the protest group. The outcome was that the contract was awarded to two GPs with no commercial interests, a conclusion which appears to have been welcomed by the local community.

However the need to amend the legislation under The Primary Medical Services Act 2004 remains and

this was raised with the Cabinet Secretary of Health and Wellbeing, Nicola Sturgeon, when delegates of the Scottish Health Campaigns Network met with her in 2008.

A consultation document, Eligibility Criteria for Providers of Primary Medical Services was produced by the Scottish government and responses were invited by 17 December 2008. (Ref.2)

The responses were published in March 2009 (Ref 3)

The Scottish Health Campaigns Network was one of the organisations which, in principle, supported the recommendations contained within it.

Pollock et al, in their response noted that the proposals to control entry run contrary to competition law frameworks in the UK and EU and they were of the opinion that the proposed changes were unlikely to succeed.

The same responders also noted that the commercial sector already operates in such spheres as long term care, pharmacy and dentistry, and questioned whether, in a commercial environment, companies involving GPs would adopt policies different from companies not involving practising GPs.

The Cabinet Secretary for Health in the minority led Scottish government has clearly stated that her intention is not to extend the private sector within the NHS north of the border.

We shall have to wait until parliament resumes before learning if the change to exclude the commercial sector from providing primary medical care within the NHS will pass into legislation.

Ref 1 - Scotland's National Health Service, A Review. NHSCA Newsletter Sept 2006, Dr Robert Cumming, Chair Scottish Health Campaigns Network.

Ref 2 - Scottish Government Consultation on Changes to Eligibility for Providers of Primary Medical Services.

[www.scotland.gov.uk/
Publications/2008/10/21161426/4](http://www.scotland.gov.uk/Publications/2008/10/21161426/4)

Ref 3 - Consultation Responses.

[www.scotland.gov.uk/
Publications/2009/03/12164146/0](http://www.scotland.gov.uk/Publications/2009/03/12164146/0)

MALCOLM ALLAN
Scottish Health Campaigns Network

Condition Critical

Health Care, marketising reforms and the media

Coventry June 2009

While we are only too well aware of the turmoil and upheavals of NHS changes over the last few years, it is not always easy to find out what is happening to healthcare elsewhere in the world. And why is there so little informed and critical debate in the UK media about NHS policy? This most interesting conference, organised by John Lister for the International Association of Health Policy in Europe (IAHPE), provided many insights.

John Lister, and a later speaker from the National Union of Journalists, mentioned the increasing lack of specialist journalists in the mainstream media as journalist numbers are reduced in a quest for increased profits. This inevitably means that NHS topics may be covered by journalists without much background knowledge and also that those working on a health story have little or no time to research it. All too often the result is that a DoH or PCT press release is just rehashed uncritically as a news item. On the broadcast media it appears too that the news items are becoming progressively shorter and therefore dumbed down, as there is less time for explanation of the issues. Too frequently, as well, documents from the DoH or from PCTs are written in a boring and convoluted way which obscures the issues because few people have the patience to read them. If the Department of Health introduces a major policy with no press release at all, it is likely to escape the notice of most of the media and few people will become aware of it. Recent examples with no press release include the proposals for "World Class Commissioning" and 'Transforming Community Services' as well as the more recent Co-operation and Competition panel.

Anna Marriott, the Health Policy Advisor for Oxfam, presented a carefully researched paper "Blind Optimism", published by Oxfam's Policy Unit in February 2009 and available on the Oxfam UK website. The brief of this paper was to look at 'what works in the provision of equitable and effective healthcare'. She pointed out that international organisations such as the World Bank, the EU and donor countries are increasingly promoting the financing and delivery of healthcare and other basic services by the private sector, mainly for profits. Ms Marriott mentioned six commonly repeated assertions used to justify this:-

1. 'The private sector is already a significant provider of services in the poorest countries so must therefore be central to any scaling up strategy'.
2. 'The private sector can provide additional investment to cash starved public health systems'.
3. 'The private sector can achieve better results at lower costs'.
4. 'The private sector can help raise the quality and effectiveness of health services'.
5. 'The private health sector can help reduce health inequity and reach the poor'.
6. 'The private sector can improve accountability'.

No evidence was found to support any of these suppositions and the paper concluded that "the evidence available shows that making public health services work is the only proven route to achieving universal and equitable healthcare".

Even not for profits organisations such as Mission Hospitals, although doing very valuable work, could not be a substitute for public provision but worked best in collaboration with a state system. This report has been widely read and, according to Ms Marriott, has caused quite a stir in international circles such as the IMF.

A problem in many developing countries is the lack of any general healthcare programme, even though numerous disease specific programmes (52 in Congo, each with its own administrative structure) means that care is increasingly fragmented, while local doctors are attracted to work for these aid programmes which provide higher salaries and status than that of public health professionals. It was very sad to hear that the main route of AIDS transmission in Africa is by dirty needles, mainly in healthcare, with 8 billion 'dirty' injections given worldwide and whole villages in countries such as Congo often sharing a single needle. Pregnant women, we heard, are significantly more likely to be HIV positive than their husbands because they have had more contact with health care.

Jean-Pierre Unger from Belgium gave an interesting paper on healthcare in South America including the astonishing statistic of a 72% caesarean section rate in Brazil (because hospitals are paid more for caesarean sections). He compared the healthcare situation in Columbia (purchaser provider split, increasing private sector involvement and increasingly expensive insurance cover) with that in Costa Rica (with a similar GDP) where most healthcare provision is by the Government and there is a unified and integrated system with no internal market. In Colombia access to medical care is becoming increasingly expensive and a large part of the population is now excluded. In Costa Rica there is universal access to care and life expectancy and infant mortality are similar to that of the United States although at one 9th of the cost per head.

Rather closer to home, several speakers from different parts of Europe described the effects of increasing private sector involvement.. Pressure on Turkey to privatise health care to facilitate entry to the EU is opposed strongly by the Turkish Medical Association, but public healthcare centres have been replaced by private family doctors and co-payments are increasing rapidly. Greece has embraced PFI in spite of the greatly increased costs. We heard that public health services there are under-funded, while Greece has the highest private health expenditure in the EU. As in a Canadian study, mortality has been shown to be greater in Greek private for profit hospitals, and the costs higher. A speaker from Germany told us that the number of private for profit hospitals there has doubled in 16 years (Hamburg now has no public hospitals) and that this has resulted in lower staffing levels, reduced salaries and wages and increasing complaints. Clive Peedell (on BMA Council) ably summarised the changes which have occurred in the English NHS, while Julian Tudor Hart contrasted this with the more sensible policies in Wales where the purchaser

provider split and healthcare market have been abolished.

From across the Atlantic a speaker from 'Physicians for a National Health program' (www.pnhp.org, a most interesting website) outlined the Obama health plans and the misgivings of the PNHP campaign about these proposals. Although somewhat better than at present, the Obama plan would only achieve 1/7 of possible savings. The big health insurers would remain in place and only those who could not afford health insurance would be covered by the new public insurance. The PNHP 'single payer' policy would not include the insurers and this would greatly improve costs while providing the universal and comprehensive coverage which even so many insured Americans do not have. We heard that the current healthcare providers are investing huge sums in opposing the Obama and PNHP plans. Meanwhile, 62% of the 900,000 personal bankruptcies each year are now caused by medical costs even though 78% of those affected were insured. As those who have seen Michael Moore's 'Sicko' are aware, many billion dollars are spent each year to prevent insured patients obtaining the care they need.

It is obvious from this interesting conference that the intense pressure to privatise healthcare is worldwide and has very powerful backers. The evidence, however, is that it will prove both expensive and damaging for patient care as well as worsening employment conditions for staff. John Lister left us with the hope that the current financial problems will present a short window of opportunity to publicise the increased costs of private sector involvement. But how can the public be made aware of what is going on and what will happen if it continues? There are no easy answers.

ANDREA FRANKS
Chester

Colchester's Redevelopment Fudge

About ten years ago Colchester's hospital service made their third attempt in as many decades to address, firstly: their inadequate provision of emergency care and secondly: the fragmentation of service delivery caused by having to deliver these services from more than one site. This master-plan, which had to be achieved by using the Government's Private Finance Initiative (PFI), was abandoned in June 2006 after a relatively new hospital management executive decided

that the project was unaffordable. However, the new Chief Executive, did promise to give urgent priority to reinvigorating our emergency service and the transfer of cancer services from Essex County Hospital (ECH) to Colchester General Hospital (CGH).

Three years have passed but only the name of the hospital trust has changed - from Essex Rivers to Colchester Hospital University Foundation Trust

(CHUFT). Emergency services and cancer services remain gridlocked just as they were in 2006. You might have imagined that these three years would have been spent developing a detailed overarching plan to optimise the functionality of the CGH site and accommodate within it the services currently delivered from ECH (built 190 years ago). You will be disappointed to discover that, like the foolish virgins in the parable, management has sat around theorising on problem solving ideas instead of getting down to the nitty gritty.

In theory, after Essex Rivers Trust became a Foundation Hospital Trust just over a year ago, the force driving the quality of healthcare delivery would have been the Trust's public membership represented by their duly democratically elected Governors. Unfortunately when these Governors meet their agenda is not set by themselves but by CHUFT's Chairman and therefore active participation in the decision making processes which should be shaping future service delivery is virtually non-existent. What is the point of having gagged governors?

Colchester is not alone in its quest to deliver best practice to its local population but other Trusts appear to have had greater determination to deliver the goods and were quick to involve their local MPs to steer the process through the minefield of arbitrary politically divisive bureaucratic baggage that encumbers the NHS. Currently the ground rules of engagement for Foundation Trusts are set by a QUANGO called Monitor. This is a non-elected autocratic body that treats healthcare like a business where priority is not given to the needs of patients but to the purses of the moneylenders. It rules with an armamentarium of sticks and carrots but prefers and relishes the use of the stick.

About a month ago CHUFT announced a £114m building programme to be rolled out over the next 5 years. Jubilation temporarily swept aside the pessimistic grumblings of the workforce. The first detailed plans appeared soon afterwards. A brand new Paediatric Department and a new surgical ward to replace Great Bentley ward, one of the many temporary buildings littering the CGH site and which was given a sell by date of 18 months when it was erected more than ten years ago. However it sets a number of potential handicaps

on the future centralisation of services on this site. Furthermore, whilst the Paediatricians looked longingly at their brand new accommodation it was now even more remote from the Emergency Department and placing a children's ward next to the mortuary shows a certain lack of sensitivity. What was the driving force behind this sudden urgency to start an expensive building project on the CGH site? Essentially it was the chronic lack of appropriately located medical beds. Although this was not a new problem, apparently it came to a head in February 2009 when Monitor menacingly waved its big stick at the Management Executive because A&E waiting times had been excessively long. As a result the Chief Executive issued a threatening letter to all members of staff telling them to cooperate with management's contingency plans to alleviate the problem. Not long afterwards A&E waiting times miraculously improved but the cause for the problem had not gone away and, like a snake hiding in the grass, it would sooner or later reappear and bite them with a vengeance. Hence the urgency to get some minor construction projects under way to free up a little space for medical admissions and then embark on building this new block in 2010.

But doesn't this just sidestep the main issue, namely the chronic shortage of medical beds? The £20m to be spent on this new block would be better spent building a new state of the art Emergency Department containing improved accommodation for medical emergencies and forming the basis for future inpatient developments. Additional inpatient surgical capacity in the form of a state of the art surgical ward is a perverse decision except in so far as it might attract to the CGH surgical patients who can choose where they are treated. Planned surgical procedures form the most profitable activity of Hospital Trusts. On the other hand medical emergencies can choose neither where they are taken nor by whom they are treated and therefore improving their accommodation is not a sound financial investment. Compassion is not a necessary requirement for becoming a hospital administrator.

However, there is more to the provision of additional medical beds than sheer numbers. It is the appropriate location of these beds that is equally important so that medical and nursing

staff are always concentrated at the focus of acute clinical activity and not spread out over a wide disconnected area. Emergency medicine requires many different components working in unison and not in isolation. Herein lie three other factors which are also degrading the ability of the medical staff to deliver a focussed service to its medical emergencies.

The first of these factors is the European Working Time Directive (EWTD). In August 2009 Hospital Trusts failing to comply with the proscriptive EWTD will incur vindictive fines. CGH management were quick to address that issue and currently it is unlikely that we will fall foul of this draconian directive. However, in the process of devising rotas for the junior doctors which are EWTD compliant, continuity of care for medical patients has been virtually destroyed. Typically less than 30% of patients admitted as medical emergencies will have their hospital journey supervised by the same consultant. There is also the added handicap that junior doctors who only see a snapshot of the disease process as it affects individual patients will in the long-run be less well equipped to give holistic management advice. Devising junior doctor rotas which respect continuity of care whilst being EWTD compliant can be achieved without having to increase the numbers of junior staff. It would involve some remodelling of consultant activities in order to reinstate the team structure that existed more than ten years ago. Paradoxically the curious mechanism that calculates junior doctors' remuneration would award them a pay increase although the intensity and duplication of their work effort would actually be reduced!

The second factor which degrades the quality of care given to emergency admissions is the difficulty in providing same sex accommodation when unisex sleeping arrangements are not uncommon and unisex toileting facilities are commonplace. Modifying existing medical wards to meet dignity and privacy standards would reduce the number of beds available by 30%. That approach would merely compound our problems. Clearly money would be better spent building new medical ward accommodation and modifying the existing wards to give support staff, who are spread around

the site, a decent work environment close to the clinical staff to whom they give that support. The third factor is the poor connectivity of the laboratory services, and in particular the location of the biochemistry laboratory in a remote isolated building on the defunct Severalls Hospital site more than a mile from A&E. The laboratory has state of the art equipment but the method of conveying urgent blood samples to their staff is Dickensian. Having the Emergency Department connected by a robotic delivery system to the laboratory services is the best way to speed up clinical decision making. The Radiology Department, with their digital picture archiving system, have revolutionised the imaging process and facilitated early accurate diagnosis, but with other parts of the diagnostic support system lagging behind the overall speed of establishing the diagnosis and formulating a management plan is invariably set by the speed of its slowest component.

For decades hospital managers have claimed that they could predict future emergency workloads but their forecasts have proved far less reliable than weather forecasting. Recently the Norfolk and Norwich Hospital declared a serious bed shortage. This exposed the lie that moving from the old hospital site to their new flagship hospital would be sustained by a reduction in bed capacity. The Government's initiatives to improve the health of the nation will not confer immortality on its population. These measures will merely delay the appearance of that tidal wave which will ultimately inundate our emergency services. More than 60 years ago Nye Bevan entertained similar aspirations only for history to show that this was a pipedream. The sinking of the Titanic and the associated loss of life resulted from many poor decisions, driven by profitability, during its construction and subsequent operation. At the present time the management executive operating the CGH are like that fateful orchestra playing some baroque divertimento whilst sinking under the weight of arbitrary decisions, except that this orchestra will in all probability jump ship at the last moment leaving the passengers (patients) foundering in the maelstrom.

MARK AITKEN
General Physician, Colchester

Consultants' Conference 2009

The Conference started with the keynote speech of the chairman of the CCSC, Dr Jonathan Fielden, who was making his final speech as chairman to the annual conference as he retires as CCSC chairman in October. He will take up a Medical Director post in Reading in the near future.

This speech differed considerably from his previous two speeches to Conference as instead of conveying a neutral stance on the privatisation of the NHS, he actively condemned the private exploitation of the NHS. This has been BMA policy for some time but the change might have resulted from a new campaign which is now being actively led by the Chairman of Council, Hamish Meldrum.

Dr Fielden called for private management consultants "to be ditched from the NHS" and that public money should not to be diverted from patient care into "the pockets of shareholders." He emphasised that only clinicians can lead the NHS because for them a successful outcome was good patient care and "not money like MPs."

He believed that the economic crisis would result in the NHS facing a difficult future. "Everywhere around us we see the effects of the financial crisis, e. g. unemployment and staggering levels of public debt." The multi-billion bank bail-out and "quantitative easing" will mean debt repayment for the rest of our working lives or even longer. This spells the end of growth in NHS funding." He pointed out that David Nicholson had stated that £15B-£20B would need to be saved--- "small beer for a bank survival, but a massive cultural change for the NHS."

Clinicians in partnership with their patients will not be able to avoid making decisions in "what is kept and what is cut and what the NHS can afford." If they fail, those decisions will be made by "faceless bureaucrats, accountants and those out to fleece the tax payer. "

His proposals included:

- a) scrapping ISTCs to which £5.5B had been allotted and £3.5B had been spent. (He quoted Allyson Pollock's estimate of £900M wasted on cases not done)
- b) freeing NHS Trusts from the planning

blight of NHS IT program and letting them move forward independently. However he wished to retain "the national electronic superhighway" ----presumably "the electronic patient record"----- which has resulted in the greatest delay.

- c) ditch management consultants and instead use the talent of 40,000 consultants and 1.3M NHS employees which will save £350M
- d) cut the growing bureaucracy of revalidation and "save millions"
- e) guarantee safety by using quality and innovation and so save about £2M
- f) renegotiate the poorly negotiated appalling contracts of PFI, for, if the incompetent City can renegotiate contracts and make millions, so can we
- g) remove "unnecessary bureaucracy, unnecessary tiers of administration and unnecessary rafts of Department of Health bureaucrats."

It is the first occasion that I have heard Jonathan Fielden in polemic mood and it achieved its goal in inspiring his audience despite the weakness of some of his suggestions.

Earlier in his speech he had alluded to those patients who had been let down by the NHS at Stoke Mandeville and Maidstone and Tunbridge Wells and more recently at Mid Staffordshire where targets were put before quality and "aberrant corporate cultures" suppressed concerns and disregarded safety.

"To patients we pledge this:

We will never relent from our efforts to enhance the quality of care

We will not be suppressed by even the most belligerent political interference

We must condemn bullying from anyone, of anyone

We must develop cultures within our organisations

that encourage every member of the team, porter to consultant, scientist to nurse, manager to junior doctor to speak out to improve care. “

I have discussed this speech in detail because it is arguably the most striking part of the proceedings and seemed to your reporter to imply a considerable shift of position on the part of the chairman.

The speech was followed by debates on a series of motions about which there was little serious division of opinion. Some representatives felt that the motions had been selected by the agenda committee to limit controversy. There were few speakers in opposition.

These included:-

Motion 5

That this conference

- i) believes that the widespread use of centrally imposed and clinically inappropriate targets has many unintended consequences, distorts clinical priorities and harms patients
- ii) calls for NHS organisations to be driven by excellence in patient care and led by patients and doctors

Motion 27

That this conference believes that visible relevant senior clinical input should be a core component in any commissioning process

The few motions which were controversial were taken as references (for discussion by CCSC but not considered policy) at the request of the CCSC Chairman and included “that responsible officers should be independent of employers to ensure

that potential bias and conflict of interest issues are minimised (Motion 47 ii) and

“any move to resident consultant on call be subject to strict national criteria on remuneration, standards of resident accommodation, catering and leave entitlement.

The Conference concluded with a Discussion Forum led by Niall Dickson who became the BBC Health correspondent in 1981 and later (1995) the Social Affairs Editor for the BBC. He was made Chief Executive of the King’s Fund in 2004. Immediately after the Conference, it was announced that he had been appointed Chief Executive of the GMC.

He initially outlined the recent direction of health care policy and his vision of the way forward. This was followed by a bland discussion of future policy moderated by Mr Dickson who felt that a balance between the public and private sectors would be an optimal solution.

Many representatives expressed dissatisfaction with the forum, feeling that a more controversial figure should have led the discussion

Conclusion

This proved to be another conference engineered to limit controversy but lightened by the contribution of the Chairman who, for his concluding address to Conference, expressed support for the preservation of the NHS as a public body for the first time.

GEOFFREY LEWIS

The Essence of General Practice

On December 29th 2007 Lord Darzi, in an interview in the Guardian, gave an example of a patient with abdominal pain who required a scan for diagnosis and an operation for a cure.

The essential problem with the NHS, Darzi argues, is not a lack of funding or expertise, but the way different parts connect. Patients in search of treatment must navigate a maze - and may not end up at the door of those best equipped to treat them. “Take the example of a patient in London who develops abdominal pains in the evening,” he says. “They tolerate the pain overnight,

then they go to see their GP, who says they need to see a consultant...” What follows is a time-consuming and costly back-and-forth: to the consultant, to the hospital for an ultrasound scan, to the consultant to discuss the results, to the hospital for a surgery pre-assessment, to the hospital again for an operation, back to the GP with a wound problem. “I mean, if you did your shopping this way..... If Tesco provided you with that service, you wouldn’t go there. If you booked your flights that way you’d be all over the place.”

He then went on to explain that he was going to

change primary care services to reflect the needs of patients like this. I responded with a letter to the Guardian because it was immediately obvious to me as a GP that this wasn't remotely typical of general practice. I see several patients with abdominal pain every week, but in nine years only a tiny minority have needed a scan and even less an operation. None of these have had an unnecessary delay. Just as everything looks like a nail to a man with a hammer, only a surgeon would advocate the reorganization of primary care on the basis of patients that need operations. And yet it was with that in mind that his plans were born.

Far more typical of general practice was a 50yr old man who came to see me with abdominal pain 2 weeks ago.

He was accompanied by a friend who said she was there to help him because he never came to doctors and he was really anxious. He looked anxious; he was also very overweight, slightly tremulous and pale. His friend explained that he'd been worrying about stomach cancer ever since his father died from stomach cancer last year. He wanted a scan to see if he was alright. He confirmed that this was the case. I spent a few minutes talking to him and asking a few general questions about his health. Soon it was clear that he didn't have any symptoms suspicious of stomach cancer. I examined his stomach and checked his weight and blood pressure.

His blood pressure was 224/124, extremely high, though not altogether surprising.

I checked a urine sample which revealed glucose, (probable diabetes) and signs of kidney failure (associated with high blood pressure and diabetes)

I asked him about his smoking (40 a day for 30 years) and family history of heart disease (his father also had a heart attack) He'd been experiencing pain in his arm on walking upstairs for the last few months, but had put it down to sleeping awkwardly. It was more likely due to angina, pain due to poor coronary circulation.

He was beginning to relax because of the level of attention and concern he was getting, and because I hadn't yet broke the news about the significance of what I'd already discovered.

He asked his friend to leave and asked me if he could have some Viagra. Unsurprising really that someone with diabetes, hypertension and kidney disease should suffer from impotence.

He asked if he could also have some sleeping tablets.

Not really surprising then, that he also admitted that he was depressed since up to 50% of people with chronic illness are depressed and insomnia is a common symptom of depression.

Not surprising either when he admitted that he was drinking excessively.

Perhaps he might have something wrong with his stomach after all, an ulcer? Pancreatitis? Or even cancer.

One by one I talked through his problems with him.

What he **wanted** when he came in was a stomach scan, some Viagra and some sleeping tablets.

What he **needed** was looking after. He needed a doctor who was prepared to take responsibility for his care.

He needs a **vocationally trained GP**; that is, a doctor with specialist training who can recognise that a presenting complaint may not be a pressing need or even a primary concern.

He also needs **continuity**; a doctor who he could see regularly and develop a relationship of confidence, trust and understanding.

He also needs a **comprehensive service**. With so many associated problems he needs to be seen by a doctor willing and able to manage all his different conditions.

What the changes proposed for primary care offer is the opportunity for people to be seen by a number of different professionals including protocol-led advisors, healthcare assistants, nurses, paramedics and so on in a range of places other than their usual GP, including walk-in centres, urgent care centres, and GP led health centres. The opportunity cost is that this delays or removes the possibility that they will be seen by GP who is able to take responsibility for them and offer continuity.

Comprehensive care is threatened by the unbundling of primary care services. Instead of a GP who will provide comprehensive, holistic care in one place, patients will be forced to choose between providers competing with each other to offer care for each separate condition.

Over 80% of people who see their GP have chronic conditions and of these are over the age of 70 and yet the changes being forced upon primary care are designed to suit the needs of young people who occasionally get sick, whose wants are closely allied to their needs and for whom prompt convenient care is more important than continuity or comprehensive care.

People (especially elderly) always say to me after I've give this talk, 'this sounds wonderful, but my

GP's just not like that!' Younger people say, 'this sounds terribly paternalistic, you just want to wrap your patients in cotton wool, shouldn't they take more responsibility for their health?

To the elderly I would say, continuity of care and a comprehensive service is something we GPs should aspire to. We can't be available every day and every night and there are many things we are not trained to do. But we know that over 80% of our patients value a relationship with a doctor they know. We know that medicine is more satisfying, more effective, more efficient and safer when the doctor knows the patient. We know that travelling is difficult when people are sick and elderly and that people want to be cared for close to home or at home when they can no longer go outside.

I would agree with the argument that people need to be helped to take control of their own health, but this involves supporting them, not abandoning them. For all the exercise and dieting in the world won't change the need that the man described above will have for complex ongoing care.

JONATHAN TOMLINSON
General Practitioner, London.

Member of Steering Committee, KONP
Talk given at a meeting with MPs on 9/6/09

A Not So Tender Process

Of all the disciplines, the treatment of addiction sits closest to that interface between medicine and issues within society at large. It is thus peculiarly prone to the whim of local politicians as I found to my cost. After almost twenty years building a combined drug and alcohol community service, it was broken up and passed in stages into the non statutory sector. While this shift of NHS Addiction Services to the Non Statutory Sector is part of a national trend, in Cambridge peculiar factors were at work. This is my story of that tendering process.

My service was set up in a less salubrious

part of Cambridge which in time became gentrified. Even the chair of my NHS Trust now lives locally. One of the innovations of my service was the creation of its own pharmacy to dispense controlled drugs so enabling us to monitor our patients more closely, in particular their alcohol use. As a tourist city Cambridge has had a large number of homeless people, many with dual addictions to drugs and alcohol. However, disquiet was increasingly expressed at the visibility of these people when they attended the service. Indeed prior to local council elections both the police and ourselves would come under pressure to reduce the

presence of these homeless addicts. Our nemesis arrived when lead commissioning for addiction services moved from the PCT to the County Council who immediately put us out to tender.

In separating the alcohol from the drug service the PCT clawed back a large sum of money. Inevitably the drug service passed into the hands of a national non statutory agency. They promptly closed the pharmacy as promised but failed to open the six small clinics across the city to reduce the “concentration” of addicts. Property prices meant that moving the service was never a feasible option. A number of experienced nurses were replaced with drug workers without professional qualifications who thus earned lower salaries while medical input was cut considerably. As a result the frequency with which patients attend the service has dropped markedly, thus satisfying a local electoral priority.

The service specification stated that addicts dependent on alcohol should be given verbal advice and referred to the now independent alcohol service. This lacklustre policy has resulted in a rise of alcohol abuse among addicts and I think it is no coincidence that the local homeless hostel has erected a memorial to the large number of recent deaths in their community. The same specification omitted any provision for drug and alcohol dependent patients with comorbid severe mental illness. This vulnerable group benefited greatly from close monitoring and contact but many have since disappeared or are marooned on acute psychiatric wards. Partly in response to these changes in the community service, the Acute Hospital Trust in Cambridge has appointed its first Liaison Consultant Psychiatrist in Addictions to ensure adequate cover for its own inpatients.

The NHS staff who were “Tuped” across have borne the brunt of the burden. Unlike the NHS,

the infrastructure within the non statutory service is a virtual one. Indeed it has relied on these NHS nurses to reconstruct a service as it has no experience of clinical practice or governance issues. The naivety of the non statutory service was further demonstrated in their failure to realise that the County Council did not hand over the prescribing budget with the tender. This is a not inconsiderable sum in a methadone prescribing service. Perhaps the County Council was equally naive but they have refused to compromise resulting in ongoing litigation. One may ask what was the PCT doing during this tendering process and why did they not prioritise the health needs of this patient group. Rumour has it that a deal was struck, but whatever the reason, the PCT averted its gaze at that crucial moment.

It has been suggested in some quarters that greater local representation be brought into the NHS or even passing much of the NHS into the local government structure. The dangers of this policy are clear as it will open up health care to local partisan politics. Addicts have little leverage and what is happening to Addiction Services across the country may be a dummy run for other services. There has been little public awareness let alone dissent over the removal of addiction services from the NHS. The decline set in when Consultant Addiction Psychiatrists lost their influence over local or national strategy and commissioners excluded consultants from any meaningful debate. If this sounds familiar to Consultants in other disciplines then take heed! As for myself I have retired and I am now a patient rather than a clinician. I only hope that the medical unit I attend at my local Acute Hospital Trust remains where it is and that I am not one day met by a health worker with dubious qualifications working for an even more dubious organisation.

DR MERVYN LONDON
Consultant Psychiatrist

Payment by Results

Payment by results (PbR) is a central plank of the government's reforms of the NHS and provides 90% of hospital income. Providers receive a fixed payment (national tariff) for each type of patient treated. The policy rewards providers for volumes of work adjusted for differences in case mix. Case mix is defined by the Healthcare Resource Group (HRG) to which each patient is allocated.

The stated aim of PbR was to make funding transparent and to allow money to follow the patient. Hospitals are paid a set fee for each patient based on the procedure and the clinical state of the patient. The theory is that this should make hospitals more efficient and encourage a greater volume of patients. However a healthcare system is a complex and interdependent organism. What looks good on paper may not work so well in the real world and this has proved to be the case with PbR.

In the old system the NHS worked by pooling risk – it didn't matter whether you had a bunion or a brain tumour, the NHS would treat you. But PbR treats patients as financial units, and the use of a scheduled payment creates the concept of the profitable and the unprofitable patient. Broadly, profitable patients are those in good health and who require a one off intervention such as hip replacements or cataract surgery. Unprofitable patients are those who have long term or complex needs, the young and the old, those who have physical or learning disabilities. The commercial sector, which to date has been able to choose who it treats, cherry picks the cheap and easy procedures on fit patients as this is where profits are made. The public service is left with low volume, complex and expensive care for the unhealthy. This results in overdiagnosis and overtreatment of some and the neglect and undertreatment of others. There is already evidence of overtreatment of cataracts, one of the operations farmed out to the ISTCs.

Simple procedures help subsidize more complex ones. When hospitals lose them to the commercial clinics there is a danger that they can no longer fund their specialist services. In the early days of PbR four major children's hospitals said they were going to have to halt paediatric brain and heart

surgery as the new method of payment meant that these services were no longer financially viable.

So it is not only unprofitable patients who will find themselves neglected, but we now have the concept of unprofitable services. Since it is the duty of foundation trusts to make a profit, they may withdraw or reduce unprofitable services. We have already seen chronic pain services cut back. Prime Minister Tony Blair was rushed to hospital a few years ago for an emergency cardiac procedure which is no longer available at that hospital as the service was found to be 'unprofitable.'

And if all of a hospital's income is to be derived from individual procedures, then incentives are created for hospitals to 'game', a polite word for fraud – for example to make unnecessary internal referrals, or to admit patients when they could be sent home. Although A&E visits have only increased by 3% in the UK, admissions from A&E have gone up by 18% in those hospitals being funded by PbR. Professor Chris Ham stated in a recent paper (Health in a Cold Climate: developing intelligent response to the financial challenges facing the NHS), that 'The consequence of creating strong incentives for trusts to increase activity and income... has been to turn Acute Hospitals into profit centres, whose leaders are focussed on increasing income and surpluses.' Now who could have predicted that?

PbR is specifically intended to keep patients out of hospitals, where treatment is more expensive. This may often be appropriate, but patient trust may suffer when GPs have financial incentives not to refer to a specialist. We have already seen dermatology departments closed down as skin care is taken on by non specialists in the community in order to save money. The same thing is happening to rheumatology and diabetes. A recent letter in the BMJ described how a PCT tendered out its entire musculoskeletal service. The PCT stipulated charges that were less than tariff. The local hospital's lawyers advised that it could not tender below tariff and was thus excluded from applying to do its own work. The hospital naturally lost the work to a private

company. This cannot be in the best interest of patients.

Another unintended consequence of PbR is the loss of collaboration across health services, with poor outcomes for patients. With everyone competing for money it is increasingly common for hospitals to ban specialists from giving telephone advice to family physicians or from going out to work in the community. Specialists are not allowed to refer patients to each other within hospitals without the permission of their GP, thus slowing down patient care.

And where hospitals once joined together to share clinical knowledge they now jealously guard their profit making activities. As a radiologist I heard about a hospital that won't share its MRI scanning protocols for thalassaemia – because it makes money when those patients are referred from elsewhere.

PbR was always meant to increase patient throughput and that is desirable until financial considerations take priority over clinical judgement. But financial pressures mean that we now see managers acting like bailiffs for a ruthless landlord, eager to evict one set of patients in order to make room for another. There has been a rise in emergency readmissions over the last two years, reflecting the pressure to discharge patients too early in order to maximise turnover.

And finally PbR cannot work in a system with a fixed budget. It inevitably leads to the introduction of demand management, with government targets for cutting hospital referrals and GP referrals being diverted to referral management centres. GPs have even been offered financial incentives not to refer patients to hospital, a move condemned by the BMA.

And of course PbR brings a bureaucratic burden calculated at approx £200,000 per PCT or trust, recurrent.

A recent paper by the NHS Alliance (July 2009) states that PbR has 'inflated NHS costs and encouraged acute trusts to become 'profit centres''. It goes on to say that 'The fact that Payment by Results is not fit for purpose is

nothing new. It failed to deliver on both cost and quality'. However their remedy is not to abandon the purchaser provider split but to lower the tariff, making PbR not 'average cost' but 'maximum price'. Originally PbR was fixed so that service providers would concentrate on quality rather than undercutting each other. As the paper notes - 'by offering a fixed tariff for different hospital procedures, the unfulfilled PbR promise was that commissioners would be able to focus on quality rather than price'. Now inevitably it has moved to 'best value cost' which is government speak for 'cheapest'. Under the new proposals payment by results – which was never anything to do with results – will be about competition on price. The paper also expresses concerns that 'PCTs and practices will need to ensure that commissioners do not fall prey to market tactics such as loss leading or skimming'. They might as well hope that pigs will fly.

It has been repeatedly said that PbR is not fit for purpose, but instead of rejecting the policy this observation only leads to more elaborate attempts to make it work. Commissioning and PbR – the mechanisms of the purchaser provider split – lie at the heart of the market in health care. They have led to fragmentation of the service, over and under treatment and the loss of collaboration between primary and secondary care which is essential to the patient pathway.

Splitting provision from purchase is a fundamental mistake and it came as no surprise to read Prof Chris Ham's recent comments in the BMJ, the summary of which was that international evidence, "shows that integrated delivery systems perform better than systems where the roles of commissioner and providers are separated."

Why does England continue to buck the evidence? We need to find a better way of doing things, one that leads to collaboration between primary and secondary care and which stops treating patients as financial pawns. We might even emulate Scotland and Wales who have seen the light and turned their backs on the purchaser provider split, commissioning and PbR. Now there's an idea whose time has come.

JACKY DAVIS

In the June Newsletter we published our response to a consultation by the little publicised Cooperation and Competition Panel

There has now been a further consultation, which can be viewed on the Panel's website, to which we have responded.

NHS Consultants' Non-Contracted Hours

Possible recommendations

In response to this consultation by the Co-operation and Competition Panel the National Health Service Consultants' Association wishes to make the following points:-

1. Significant work for other NHS providers in non-contracted hours would in most cases require a consultant to make a voluntary opt out from the EWTD.

However, the total of medical work carried out would have to stay within the overall maximum allowed under the opt out arrangements.

It would remain the responsibility of the consultant to ensure that within these limits the total workload did not have an adverse effect on patient safety.

2. In a system where NHS providers are expected to compete with each other on a commercial basis, it is surely inevitable that managers would wish to ensure that their employees do not also work for rival organisations whose success might affect the financial status or even viability of the Trust they manage. Is this not in line with normal commercial practice?

It applies not only to strategic management roles, preparation of tenders and financial interests, for which you propose an exception (7c) but to general work for an organisation

which is in direct competition with the main employer for finite NHS funds. Any employee has some knowledge of their main employer's future plans, strategy, strengths and weaknesses which could be very useful to a competitor.

3. Could not prohibiting managers from safeguarding the interests of their organisations in this manner and thus allowing fair competition be seen in itself as anti-competitive?
4. If there are to be any such prohibitions, they should make a distinction between working for another NHS Trust and for a provider in the independent sector such as an ISTC.
5. In summary, it is difficult to see how under a commercially competitive system the rights of consultants to use their non-contracted time as they wish can be reconciled with those of managers to protect the interests of the organisation they manage, whose failure could have serious implications for the population served.
6. The problem would be resolved if competition were again based purely on reputation rather than on financial gain. This would allow NHS provision to be seen as a whole with the opportunity for full cooperation between units and freedom for staff to do NHS work in other settings during their non-contracted hours without conflict of interest.

8TH JULY 2009

Rationing, Charity and Private Support: How Much Longer can the UK Afford the NHS?

A symposium at the Royal College of Physicians of Edinburgh – 22 June 2009

It was brave of the RCPE to host a meeting with this rather puzzling title (should the first comma have been an “or”, or absent?), and the audience, although mixed, disappointingly small for such a potentially important -- even vital -- topic. The confusion in the title was, regrettably, reflected in a lack of focus in the topics addressed and in the discussion. The account that follows reflects my own memories and notes of the occasion.

Liz MacDonald of Cancer Focus Scotland proposed the obvious need to involve the public in decision making about resource allocation, but did not discuss the inherent (and, in some circles, unmentionable) difficulties in achieving this: the involvement of the sick versus the well public, the potentially counterproductive influence of single-interest groups and, above all, involving the public in deciding how much and how it wishes to pay for the NHS. Her thesis seemed to be that “patient-centered” care would reduce costs.

Fergus Macbeth (Director of NICE’s Center for Clinical Practice) explained the undoubted value of NICE, which will shortly double its overall activity and take over Quality Control. He touched only briefly on the methods by which NICE had set an acceptable cost per QALY, and how it had recently increased it for end-of-life medicines, and did not discuss the essential issue: how is it to be reset according to the available budget? He declined to answer why NICE was not allowed to negotiate the price of drugs in terms of their value.

Ken Paterson of the Scottish Medicines Consortium (the “Scottish NICE”) illustrated convincingly the advantages of the SMC’s earlier, speedier but non-consultative assessment of medicines (overall health interventions are not assessed), but claimed that SMC’s inclusion

of industry representatives did not subvert the consortium. He explained that SMC made no recommendation about funding or supply of the drugs it approved, but he did not attempt to resolve the 17% of decisions where NICE and SMC differ – NICE being slightly more liberal: a “postcode lottery”, or a better rationing decision?

Allyson Pollock’s contribution would have been familiar to readers of this Newsletter: she eloquently illustrated the adverse effects of the various NHS reforms since 1979 on child health and on life expectancy. She exposed the inevitable conflict of interests in the privatization of health service management, as well as provision, and explained some of the beneficial effects of the abandonment of PPS and PFI in Scotland. She reminded us how costs had been pushed out to the family carers, and to the self financed private sector, so that the claimed “efficiency savings” had been achieved only by ignoring in the total costs of care arising after a hospital stay. Finally, she urged managers not to “tighten their (!) belts” in the knowledge that they would be helping only PFI shareholders.

Audrey Birt, of Scotland Breakthrough Breast Cancer, discussed the current and future role of the voluntary sector in the NHS. She described the very wide role it already has in improving patients’ experiences, in assessments of the quality of care, and in research. She touched briefly on the role of a Citizens’ Jury in the consultation on co-payments, but did not address the (perhaps pointless) question of whether the voluntary sector could have any role in major healthcare provision or in rationing decisions.

Mike Richards, the “Cancer Czar” for England, explained the findings of his review of “exceptional case funding”, mostly for drugs which NICE has yet to consider, or for off-label use, rather than for drugs which have been declined by NICE. He described the wide variation in PCT approval rates in similar situations, but did not

explain how this might be resolved -- or how, indeed, "exceptional case funding" fitted in with the overall concept of rationing. He stated clearly that his review supported co-payments (whilst admitting the practical problems that this raised for in-patient care), the speeding of NICE deliberations, the coordination of PCT decisions and the consideration of international decisions of drug usage.

My memory of Alan Maynard's contribution (as Professor of Health Economics at York) is dominated by his statement "if only "my" (sic) doctors would [stop thinking?] and follow the guidelines, then there would be no problem". However, my notes record several more interesting arguments. Indeed, he made the point that focusing on guidelines or outcomes does not decrease expenditure (and we all know that guidelines, being conservatively drafted, can increase costs). He suggested that there had been no change in the efficiency of the NHS since 1976, and listed several well-known sources of inefficiency, including the continuing use of ineffective treatments, and medical error, but did not include in his list the many health service reforms since 1979. Despite this, he went on to argue in favour of abolishing PCTs, and of a general cut in pay. He argued strongly for the universal assessment of quality, and efficiency, of health care -- but admitted that such activities would cost money with no evidence that they would change behaviour or reduce overall costs.

Nicola Sturgeon (Cabinet Secretary for Health and Well-Being in the Scottish Government), by contrast, argued strongly that the greatest waste of money had not been in clinical practice itself, but in deviations from the founding principles of the NHS: PFI, PPS etc.. She committed her government to protecting these principles, and to focusing on cooperation rather than competition and proposed, in what was inevitably a rather aspirational polemic, a new Quality Strategy for the NHS led by clinicians and patients and based on self-management and on patient responsibility as well as rights. She also proposed direct elections to NHS Boards and, in response to a question, the involvement of patients, clinicians

and the SMC rather than politicians in long term rationing decisions - the Minister remaining responsible for justifying others' decisions.

David Price (Centre for International Public Health Policy, Edinburgh) gave perhaps the most interesting talk. He challenged the need for any change to the current system based on funding by taxation, provision by public servants, and area organization by cooperation: was there really any problem with this? He reminded us that the NHS was created when the UK was bankrupt, and has always been "unaffordable": waiting lists need not be seen as evidence of shortage. He pointed out that market-based (DRG driven) competitive systems do not limit expenditure because they have to allow for surplus and profit; whilst studies in the USA have shown that new technology does not necessarily increase cost. He reminded us that the PPPRS essentially means that NHS budgets support the export industry, and that the new GP contract has failed dramatically to evaluate efficiency or quality, but only cost -- where it has failed. Practicing, as I do, in the ivory towers of the Scottish Highlands I have to agree that the "problem" may arise largely from the English solution: the current recession may prove me wrong!

I think it is a pity that the College did not grasp the opportunity of fostering an academic examination of "the problem" and thereby, I suspect, of supporting the BMA's - or is it Hamish Meldrum's? - lone voice in finding a solution in the abolition of the reforms of NHS management. To which I would add a reconsideration of certain aspects of clinical practice - the continuing use of disproven (not unproven) drugs, surgical procedures, and screening and preventative programmes, and of activity at what would (should) be the end of life. What is still sadly lacking is an economic model of the "post-modern" NHS. I would have been tempted to title the meeting "NHS funding past and future" but this might have offered an irresistible temptation to the Hannans of the world to draw a false analogy with Scrooge!

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What's the point of a Constitution for the NHS?

Plans to draw up a constitution for the NHS are at best cynical and at worst a smokescreen to increase the commercialisation of the service.

Apart from legally guaranteeing patients a choice of GP practice or hospital, there is nothing new in this constitution – so why bother? It will do little to address the paradox of a health service that professes equity as a core value but implements policies that contribute to widening inequalities.

Nobody would disagree that NHS patients deserve a clearer idea of their rights and responsibilities and a worthwhile constitution could help achieve that. However, there are good grounds for concern that the constitution will do none of that while reinforcing the reforms that are increasing the privatisation and fragmentation of healthcare.

The biggest threat to the NHS today is the commercialisation of the service in the guise of competition, plurality of providers and the double-edged sword of “patient choice”. The new constitution makes no attempt to protect the service from the market onslaught it faces, and in fact the government has put commercial values squarely at the heart of the new NHS. As it stands, the constitution simply says that private companies should “take account” of the principles within it, but that will not be sufficient to preserve the values and ethos of the NHS when the big corporations start sniffing around.

This government has already introduced charges for healthcare (co-payments and top-ups), crossing the final Rubicon of NHS privatisation – its funding base.

The risk now is that with continuing patchwork privatisation and a cash squeeze, public support for the principles of the NHS could erode,

opening the way to charges, top-up fees and private insurance. Professor Allyson Pollock, head of Edinburgh University’s international health policy centre, calls it the “last piece in a jigsaw” that opens the door to a US-style health maintenance organisation model.

The hopes expressed in the document run contrary to the effects of the government’s own policies. For instance, because the constitution does nothing to protect the service from the effects of the private sector, its professions of hope for an integrated service are deeply hypocritical. The incursions of commercial interests serve only to fragment the service and interrupt the patient pathway.

Further evidence of hypocrisy is found in pious promises to “engage in full and transparent debate with the public, patients and staff”. Debate has been perfunctory or absent, and consultation has been on the government’s terms, with the questions written to produce the required outcome. Patient groups round the country are fighting local decisions made over their heads, while PCTs do the bidding of the politicians.

Elsewhere, the document is frankly dishonest. It states as one of its principles that “public funds will be devoted solely to the benefit of the people that the NHS serves”. It is difficult to equate this with the handing over of public money to private companies to run the service, particularly when the commercial sector still has not been shown to be better value or better quality than the NHS when it comes to delivering care. In fact, quite the reverse.

What’s more, the government’s proposals miss an opportunity to depoliticise the delivery of healthcare. The new NHS constitution falls well short of expectations. It is hypocritical and

