

Campaigning around the NHS: Taking Stock

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Introduction

I am a member of Keep Our NHS Public Leicester, Leicestershire and Rutland. The views I give here are my own.

The moral character of the NHS

The National Health Service has never been merely a system for meeting health care needs. It has never been merely a technical approach to combatting disease or promoting health. The NHS has always been a profoundly moral institution because it has always embodied a view of how human affairs should be ordered. It was founded on the principle of equity or fairness: that we should all contribute to its funding on the basis of our ability to pay; that we should all have access to its services on the basis of need alone. And it was founded on the principle of solidarity: the pooling of funding; the pooling of risk; acting collectively to meet one another's needs.

Despite its shortcomings, because it has never been a perfect service, this fundamental fact of the NHS - its intrinsically moral character - has not escaped political observers. Health policy Professor Rudolph Klein described the NHS as the 'only service organised around an ethical imperative'¹ and the historian Professor Peter Hennessy claims the NHS 'is the nearest Britain has ever come to institutionalising altruism'².

The NHS is a contradiction of our age. It is not about 'I want this' but about 'wait your turn'; it is not about profit, but about service; it is not about 'this belongs to me' but about 'all of this belongs to all of us and to future generations'.

¹ R Klein (1983) *The Politics of the National Health Service*, Longman p1

² P Hennessy (1993) *Never Again: Britain 1945 b- 1951*, Vintage p132

The NHS, with its focus upon care and service rather than profit and consumerism, is a contradiction of our age. And it is a contradiction that the New Labour leadership are no longer prepared to tolerate.

It is because of this contradiction - this exemplification of the right ordering of human affairs - that we now face the threats we do.

Threats to the NHS

I see broadly three different kinds of threats.

Privatisation

First, there is the threat of privatisation - not the selling off of the whole service after floating it on the stock exchange, but the piecemeal, gradual transfer of services, activities, assets, resources and staff to the private commercial sector. I'm not going to go through the full range of developments because they are very effectively discussed in the Patchwork Privatisation Report launched by KONP³ today but to put it bluntly the service is being restructured in a way which offers entry points to capital. Government ministers tell us that it doesn't matter who provides the service so long as it remains free at the point of use. Nye Bevan had a different view. Bevan⁴ was convinced that where you had commercial gain and private acquisitiveness, you would have conflict with public service.

There are several problems with the involvement of private companies in health care but one of the most important is that their material or financial interests are fundamentally different from those of the local NHS or the wider NHS. Their interests lie with maximised profit and maximised share value - they are required by law to prioritise the interests of their shareholders, not the interests of patients or the interests of the NHS as a whole. The management of the company looks for guidance, validation and future direction not to the local NHS, but to its HQ, whether that is in Minneapolis, Chicago, Johannesburg or Stockholm. As a result of this, I believe these companies

³ Keep Our NHS Public (2007) *The 'Patchwork Privatisation' of Our Health Service: A Users' Guide*, London: Keep Our NHS Public

⁴ See, for example, A Bevan (1952) *In Place of Fear*. MacGibbon and Kee ch5

lack an ethical commitment to provide the best possible health care to NHS patients and do not fit into the NHS on either a moral or rational basis.

Access

Another threat to our access to health care is the way in which particular services and procedures, services and procedures which conferred implicit entitlements, are being undermined. This includes the withdrawal of local services through downgrading local hospitals and the 'reconfiguration' of services. The Chief Executive of the NHS, Sir David Nicholson, and the Secretary of State for Health and their allies are trying to persuade us we don't really need a lot of services at our District General Hospitals, that some of these services are better concentrated into fewer hospitals; that others are better relocated to the community. They are trying to make us loosen our grip on our hospitals and to let them go.

But there are other ways in which our access to health is being threatened. Traditionally, if a GP referred a patient to a consultant, the patient went to see the consultant. Now if a GP refers a patient to a consultant, the referral is likely to be intercepted by referral management people who monitor all the referrals and where possible head them off to other, typically cheaper, services. There may indeed be instances where access to alternatives is preferable but I'm worried that these interceptions are finance-driven and that the principle that the patient has a right to access a specialist when deemed by the expert gatekeeper, the GP, to need a specialist is a right that we are in the process of losing.

Democratic Accountability

And a third kind of threat is the threat to democratic accountability. This has been traditionally weak in the NHS but significantly strengthened by the creation of Community Health Councils in the 1970s. The abolition of CHCs in 2001 and now the abolition of the much weaker Patient and Public Involvement Forums which came after them plus some of the proposals currently going through Parliament weaken further what little purchase we, as citizens, have over the service.

In many respects, these threats mean that what we are mounting is essentially a conservative campaign, conservative as in conserving and protecting. We are defending services, we are defending rights and entitlements through marches, protests, rallies, letter-writing campaigns, lobbying of decision-makers, participating in consultation exercises, asking awkward questions at public meetings and so forth.

Rebutting claims made by the other side

One aspect of this is rebutting proposals and analyses which come from the other side. This can be done through staff side responses to workplace consultations; through written submissions in community consultation exercises; and in other ways.

The importance of rebutting misleading claims has been highlighted for me and a fellow campaigner recently following the publication of the IPPR's report, *The Future Hospital*⁵, in January 2007. The IPPR is a think-tank which claims to produce academically sound analyses of policy issues. It claimed to make the case for hospital reconfiguration, especially for the concentration of some services (such as care for those suffering heart attacks) into fewer hospitals and the transfer of others services (such as diagnostics and some treatments and some routine surgery) out of DGHs to the local or community level.

What has preoccupied us⁶ is the way in which the IPPR uses - or doesn't use - the evidence. For example, it leaves out two major systematic reviews⁷ of the evidence. A systematic review is an analysis of all the relevant high quality research on the topic in question - in this instance, whether there is a link between high volumes of cases (which you can get by concentrating services

⁵ J Farrington-Douglas with R Brooks (2007) *The Future Hospital: The Progressive Case for Change*, Institute for Public Policy Research

⁶ D Byrne and S Ruane (2007) *The Future Hospital - the IPPR as Cheerleaders for Privatization - or 'He who Pays the Piper Calls the Tune'*, available from dave.byrne@durham.ac.uk

⁷ Fergusson et al (1997) *Concentration and Choice in the Provision of Hospital Services*, 8th Report of the NHS Centre for Reviews and Dissemination, University of York; E Halm, C Lee and M Chassin

into fewer hospitals) and the quality of care or better outcomes. These important systematic reviews were omitted from the IPPR report but in fact both of these reviews concluded that we do not know whether it is better to concentrate services because the evidence is not clear. And one of the reasons the evidence is not clear is because the research methodology which produced the evidence in the first place is often not of a high enough quality.

I am perplexed by these omissions and what this has signalled to me is that the IPPR's report cannot be taken as a reliable guide to the desirability of relocating services.

Going onto the offensive

This kind of arguing back and rebuttal of what we perceive as misleading or unsubstantiated claims is an example of defensive campaigning. But we need to go onto the *offensive* as well. For example, I think we should make funding part of our agenda. Bevan wanted a system of funding which broke the relationship between ability to pay and entitlement, one of the flaws of an insurance approach, and he wanted a system in which there was progressive redistribution. General taxation, with just a small proportion of funding coming from National Insurance, was the solution for him because in the 1940s and '50s, we had a progressive tax system - that is to say, the better off paid a higher proportion of their income in tax than the less well off.

The same, unfortunately, cannot be said today. If we look at the figures available on the Office of National Statistics website⁸, with some simple statistical analysis we can find out what proportion of household income is taken in tax. The graph⁹ given here shows UK households, ranked in ten deciles (or groups of equal size) by size of equivalised disposable household income. It show what percentage of gross household income (i.e. original

(2002) 'Is volume related to outcome in health care? A Systematic Review and Methodological Critique of the Literature', *Annals of Internal Medicine*, 137, 511-520

⁸ See the ONS reports entitled 'The effects of taxes and benefits on household income'. These reports are produced annually and cover the New Labour period between fiscal years 1997/98 and 2004/05.

income from such items as wages, self-employed earnings and investments plus cash benefits) is taken in total tax, including direct and indirect taxes. The graph shows the average percentages for the whole New Labour period until 2004/05.

There are two key points about this graph. First, it is clearly wrong that the households in the poorest income decile should be paying out a greater proportion of their gross income in tax than every other decile and it is clearly wrong that those in the highest income decile should be paying out a lower proportion of their gross income in tax than every single other decile save the second and the third.

The second point is that the brunt of the tax burden is clearly being borne by these middle deciles - in other words, by middle England. Now, Tony Blair is always saying how important it is to appeal to middle England: in fact, middle England seem to have done particularly badly under New Labour. Not only are they bearing this tax burden but they now find themselves also paying for long term care for older relatives, for the children when they go to University.

We should be going onto the offensive and exposing this injustice, demanding that the tax system be made progressive so that the NHS is fairly funded, demanding that long term care be funded through general taxation.

How we need to make our campaign more effective

Disseminating ideas

The examples I've given above about rebutting false claims and creating our own agenda are examples of getting our ideas into circulation. I think we cannot underestimate the importance of ideas. When you look at the generation of ideas about the NHS by think-tanks over the past few years, you find that most of these ideas - for markets, for breaking the NHS up into mutuals, for creating so-called public interest companies, for changing the funding basis of the NHS - most of these new ideas and blue skies thinking

⁹ D Byrne and S Ruane (2007) *Proportionate Tax Take from Gross Household Income: The Rich Pay Less*; available from dave.byrne@durham.ac.uk

are ideas which a few years ago would have been considered the exclusive province of a right-wing fringe. There is *almost* no, (not quite none because the Democratic Health Network¹⁰, for instance, has been doing some very interesting work), but almost no creative new ideas about how to develop the NHS coming from those who support the founding principles of the NHS. So during New Labour's period in office, the dominant ideas in circulation are ideas which are inimical to the essential NHS. We need to get our alternative ideas into circulation.

Coherent organisational form

We also need a more coherent organisational form - I don't think we should get bogged down in our own organisation and processes but I think we are at a point where we need to develop the way we operate in relation to each other. What I'm thinking of here is the need to address how KONP nationally relates to local affiliated campaigning groups and how these groups can relate to each other.

We need to think through our structures and processes a bit more - what kind of structure will enable local groups to participate in and help shape a developing national strategy and action?

Do we need or want some kind of federated structure whereby local groups come together on a regional basis - perhaps in a regional structure which mirrors the NHS' reconfigured Strategic Health Authorities - and the regional body then nominates/elects an individual to the national steering or co-ordinating committee? Do we need more communication between the national and local bodies - more dialogue, sharing of information?

Do we need a more formal structure to enable local groups to support each other more directly - the People United Saving Hospitals initiative in late 2006 was trying to address this.

Of course, there is little point in making this an academic exercise - this isn't about the perfect organisational form. I'm thinking, if we keep firmly in our

¹⁰ DHN (2003) *People Power and Health: A Green Paper on Democratising the NHS*, Democratic Health Network (www.dhn.org.uk)

minds the realistic constraints of finances, geography, time and energy, what kind of structures can we make work for our practical purposes.

I think there is some sense that we need clearer political direction nationally but this needs to be developed in a way which reflects/takes into consideration/relates to local concerns and views. I think we have definitely reached a point where, given the growth in the numbers of local campaigning groups over the past year and the diversity of actions they are involved in, we need to put our structures and processes onto a more democratic and effective footing. What kind of structure will make us - at a local and national level - more effective? This of course includes openness to working with local campaigning groups which aren't affiliated to Keep Our NHS Public but do want effective and constructive collaboration. I'm hoping that the discussions today lead us to a clearer position on these questions.

The trade unions

And in relation to the question of working with others, we should mention especially the trade unions. There is a lot of effort being put into developing strong working relationships between campaigning groups and trade unions at both a local and a national level.

I would like to see the unions:

- publicly declare their support for KONP and demonstrate that support with financial backing;
- withdraw support from New Labour, disaffiliating if relevant, and stop paying for these policies which are destroying the NHS and their own members' interests, instead backing political candidates for office who declare on an explicitly pro-public platform;
- encourage and support their members in the upholding of professionalism. Professionalism ought to be a safeguard of the service through protecting standards for patients but, particularly where cuts in services are savage, professionalism is jeopardised. I would like to see professionalism used more explicitly as a defence for the service. It is up to the representative

bodies of health professionals to enable individuals and groups of staff to fulfil their professional duties and aspirations.

And I would like to see greater encouragement to rank and file members to resist the implementation of damaging policies. And I think this conference should send a message of solidarity to the 90% plus of staff in Manchester's community mental health teams – nurses, occupational therapists, senior support workers and admin workers – who have voted to take strike action in defence of the services they work in.

Concluding remarks

However, realistically we have to acknowledge that, in a context of deindustrialisation and the shift of the New Labour leadership away from labour and towards capital, the labour movement is fairly weak. It is difficult for workers to take a stand in isolation.

It may be that it is a mistake to think that the greatest power lies in the hands of the workers. We may well be in a situation here where the greater power lies in the hands of users through their ability, *when organised*, to threaten the job security and political careers of their elected representatives, especially given the fragility of many Labour MPs' majorities.

It is local campaigning groups, groups whose composition and character vary across the country but which are able to mobilise local people, it is these local campaigns which seem to have startled the government into a propaganda onslaught to justify reconfigurations. Local battles over reconfigurations have the potential to build up the pressure.

We are right to focus so much of our attention on organising and building capacity at the local level. It is when people are angry, when they get organised and try to understand what is happening to them, this is when they start to become powerful.

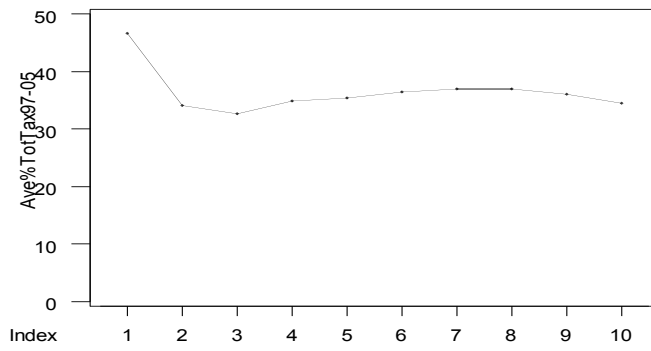
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1997-2005 % of Gross Income Taken in Tax by Decile



For Deciles One is lowest