

NHS



Keep our NHS Public

Unite to save health service

This paper has been produced by the London region of "Keep Our NHS Public" with the generous support of TGWU (Unite) Branch 1/524, Brent and Haringey TUCs, Kambiz Boomla & Anna Livingstone (Tower Hamlets KONP), Shirley Murgraff, Lorna Solomon & Bronwen Handyside (Hackney KONP), Janet Shapiro (Haringey KONP)

Across England NHS patients and local communities have been linking up with nurses, doctors and other health care workers to fight against further closures and cuts in local NHS services.

Beds, wards, Accident & Emergency departments and even whole hospitals are closing down. Thousands of health workers' jobs are being axed.

But along with the cuts, an unprecedented process of privatisation is under way: vital services and precious NHS resources are being handed over to the private sector, including companies run for profit for shareholders here and overseas.

The government and its advisors tell us they listen to the people, but Community Health Councils were replaced by Public and Patient Involvement Forums, now to be replaced by LINKS with no rights of inspecting health premises. At the

same time Strategic Health Authorities are quangos, a law unto themselves!

Keep Our NHS Public started in 2005 and has won the backing of hundreds of senior doctors, academics, health workers and trade union leaders, celebrities, MPs and local campaigners.

In 2006 health trade unions and professional organisations formed **NHS Together** which is calling the national march and rally on 3 November "to celebrate and defend the NHS".

They are asking "supporters of the NHS across the UK to turn out in force to celebrate the many successes of the NHS and call for a robust defence of its core values"; the TUC annual conference in September unanimously called on all trade unions to support this event.

So let's unite to save our health service!

MARCH AND RALLY

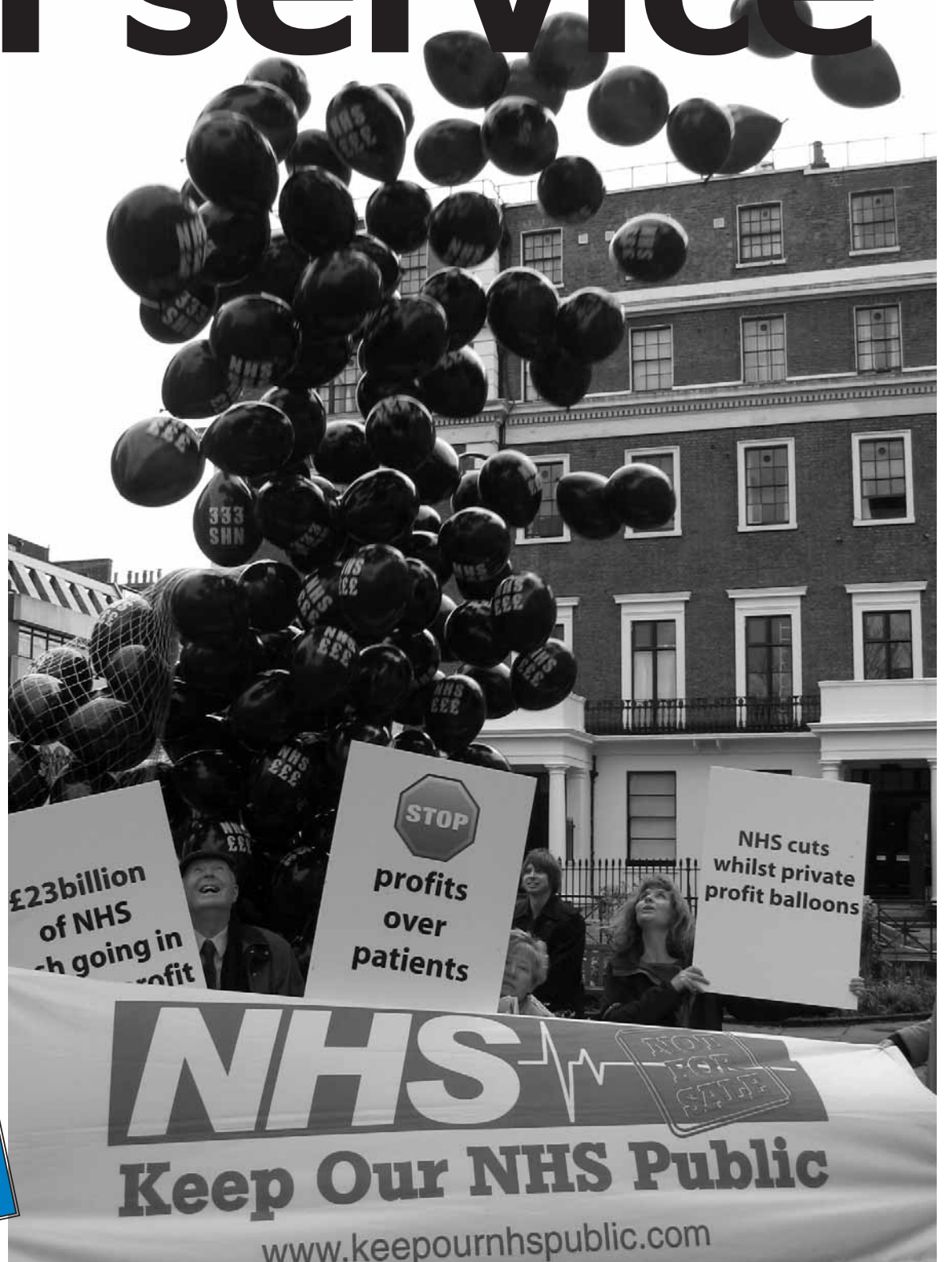
Keep our NHS Public

Assemble Temple tube at 11 am.

March to Trafalgar Square

for a joint rally.

**SATURDAY
3 NOVEMBER**



STOP PRIVATISATION, CUTS AND CLOSURES

Darzi report — a cover for NHS privatisation?

Background to Lord Darzi and his plans

Lord Darzi, a leading cancer surgeon, was appointed as health minister when Gordon Brown became prime minister in June. He was commissioned by the New Labour government to remodel the National Health Service to provide, according to the website which publicises his proposals "an NHS which will deliver effective, higher quality services that are safe, personalised to individual needs, and equally available to all".

This is the latest in a long series of major "reforms" and restructuring the NHS has undergone over the last three decades, since the Tory government of Margaret Thatcher.

Darzi has already produced a report on health services in London "Healthcare for London: A Framework for Action" (available at http://www.healthcareforlondon.nhs.uk/framework_for_action.asp) and will bring out reports in the spring on the future of the NHS in the nine English regions outside London.

His "interim" report "Our NHS, Our Future" on the whole NHS was launched on 4 October. (see a summary and the full report at <http://www.ournhs.nhs.uk/2007/10/lord-darzi-laun.html>)

The link between Darzi and government policy on NHS privatisation

Lord Darzi has made an array of recommendations said to be aimed at cooperation across the NHS and he advises "patient choice".

But we asked ourselves: is his report the smokescreen behind which the government will continue to privatise the NHS? The answer came the day after his report was released.

On 5 October Health Minister Alan Johnson's announced that the private sector would be involved in providing 150 new health centres and 100 new GP practices.

The Department of Health will also shortly announce the winners of a contract which means Primary Care Trusts (public health bodies

which provide local health services through contracts with GPs, dentists, pharmacists, opticians and others) can employ the private sector in "commissioning" (buying) health services.

The 14 contractors, bidding for these contracts, include four big US health insurers and care managers, Aetna, Humana, Health Dialog Services and UnitedHealth, as well as UK health specialists such as Bupa, Axa PPP and Tribal and the consulting firms KPMG and McKinsey.

This is a huge change for the NHS. Big private health companies with the power to commission health services on a massive scale will naturally turn towards the private sector (and especially those sections of their own companies which provide health services) because they are driven by profit, rather than a public service ethos.

Marketing violations by US commissioning bidders

Two of the big US health companies named by Alan Johnson (Humana and UnitedHealth) are among 11 which have been audited and fined by the American state-owned insurance company Medicare for "marketing violations and failure to provide timely notice to beneficiaries about changes in costs and benefits". Interestingly, the president of UnitedHealth's European subsidiary is Simon Stevens, formerly health advisor to Tony Blair.

According to the New York Times: "The audits document widespread violations of patients' rights and consumer protection standards. Some violations could directly affect the health of patients — for example, by delaying access to urgently needed medications." (6 October)

The health department is also advertising for more private suppliers of NHS operations and diagnostics before April 2008, when patients will be able to choose any approved

hospital in the country that will treat them at NHS prices.

What democracy, what consultation?

Health campaigners have raised in many arenas locally and nationally the New Labour government's forcing through of changes to NHS services (including privatisation cuts and closures) without consulting those who will be most affected.

Those with the deepest interest in health services, including patients, pensioners and public are finding that the government and health authorities are handpicking those it chooses to consult with — and designing the questions they ask to get the answers they want.

This became clear when former Health Minister, Patricia Hewitt launched her "listening exercise" and paid £125 each to 1,000 people chosen by a private consultancy at enormous cost to the taxpayers.

The latest of these revelations about what consultation means for example to NHS London (formerly the London Strategic Health Authority) is almost laughable, if it weren't so serious.

At their last board meeting on 26 September, health campaigners discovered that the implementation of Darzi's plan was to take place simultaneously with the consultation on his plan! This somewhat defeats the purpose of consultation — and suggests that NHS London has decided to bulldoze through Darzi's proposals in the face of any protests.

Alan Johnson's announcement of the government's plans for a huge surge in privatisation of NHS services has used the justification of Lord Darzi's plan — with its claim of wide consultation.

London Keep Our NHS Public campaigners, most of whom have been active on health issues for many years, know that none of us were consulted in the preparation of Darzi's London Plan — and we demand to know why.

Why do we need a public health service?

A publicly funded, publicly provided health service is the fairest and most efficient way of providing high quality health care to all. It must be based on rational planning to meet the specific needs of the people it serves.

These needs vary between communities and across the country, meaning the financial system must be fluid and integrated so that funds can be distributed easily. There must be cooperation between hospitals, between primary and secondary care, and between different forms of care. Account needs to be taken of public health and the prevention of illness, an area totally lost within the private sector.

In Britain we are lucky to have a health service that was designed

on precisely these lines. But it is being dismantled by stealth, cloaked by the rhetoric of 'patient choice'.

Instead of money flowing to where it is most needed, it is increasingly flowing to shareholders. Instead of cooperation, we have competition. In place of the invaluable public sector ethos that has sustained the NHS, we have the profit motive.

Unless this drive is resisted, a comprehensive and equal health service will be a memory. To resist we must first understand what is happening to our NHS.

From the KONP Pamphlet "The Patchwork Privatisation of Our Health Service: A User's Guide", available from www.keepournhspublic.com

What's wrong with privatisation?

It is far more expensive

Privatisation introduces a whole swathe of administration costs — for multiple contracts, tracking contracts, and billing and litigation over contracts. In the old NHS system, administration cost around 6 per cent of total budgets. Earlier market "reforms" in the system have already doubled that to 12 per cent.

Administration in the largely private American health system amounts to 21-22 per cent of total costs. The US spends over 16 per cent of its country's wealth on health, yet more than 45 million Americans have no health insurance. Britain spends half of that and covers everybody. (NB: American private health companies have been circling the NHS for some time, looking for fresh markets for new profits. Four of them are bidding to provide commissioning services for the NHS presently — see story "Background to Lord Darzi" left)

(rather than the NHS) for further services — for precisely that reason.

It means the "Cherry-picking" of easy and profitable services

"... the private sector takes on the lucrative work, leaving the rest to an NHS under increasing financial pressure. This can ultimately lead to services being cut. Already some services are being dropped and fees are creeping in. For example, the Queen Charlotte and Chelsea Hospital in London offers pregnant women a one-to-one midwife service (the recommended NHS standard) for £4,000 fee. It also results in the loss of training opportunities for junior doctors as ever larger shares of routine surgery are diverted away from the NHS."

Independent Sector Treatment Centres (ISTCs) are prime examples. They are private sector clinics specialising in simple treatments, such as cataract or hip operations. But, if anything goes wrong, the patient is sent back to the NHS to be looked after. NHS hospitals are not allowed to compete with the private sector for ISTC contracts, so private companies compete with each other for guaranteed profits. The government has also admitted that ISTCs are paid on average 11.2 per cent more than the NHS for each operation.

From "The Patchwork Privatisation of Our Health Service: A User's Guide", available from www.keepournhspublic.com

Less accountability

It is impossible to scrutinise public spending when the private sector is involved, because the fog of "commercial confidentiality" descends. Local health campaigners in the London Borough of Hackney were told by the Primary Care Trust at a Health Scrutiny Committee that they would never be able to find out what proportion of patients GPs at a local privatised surgery were sending on to their parent company



Young nurses march against cuts to London's Whipp's Cross hospital this year



Join/donate to
Keep Our NHS Public

We need members and donations!

- Annual membership fee is £10. Affiliation fees and information about how to join, and where your local group is located available from www.keepournhspublic.com
- Send donations to KONP, c/o NHS Support Federation Office, Community Base, 113 Queens Road, Brighton, BN1 3XG.
- Make cheques payable to: **Keep Our NHS Public**



Pensioners marched through London last year on a KONP march

Stop these attacks on London's health service

One in five of London's Primary Care Trusts are rated at high risk on their financial situation.

Many of these PCTs are now being driven to make cuts in hospital services as well as savage reductions in mental health and other forms of care.

Nine London Accident & Emergency (A&E) departments are threatened with closure, and the knock-on effect, given the pattern of local demand and the poor infrastructure of community and primary care services, is not addressed.

Some senior medics seem obsessed with the notion that those with the most serious life-threatening conditions would receive better specialist care in larger centres. But such cases make up just 3 per cent of the A&E caseload — while most of the remaining 97 per cent would face a drastic worsening of care, with longer delays, longer journeys for treatment and more complex discharge from hospitals many miles from where they live.

Ambulance services — already under the cosh, with some services facing job losses to save money — would be stretched to breaking point in many areas, facing ever-longer journeys to find emergency treatment, and delays in handing over patients as bed numbers prove inadequate.

Under the costly Private Finance Initiative (PFI — see back page for more information) even the newest hospitals are desperately short of beds and lack any spare capacity to treat patients from outside their existing catchment area.

In South West London an ambitious plan for a new £250 million PFI hospital and a network of smaller local hospitals has already effectively been ditched, and there is a real danger that Epsom and St Helier could close without replacement as they wrestle with a deficit of £41 million.

On the opposite end of the capital, in outer North East London, a new Treatment Centre will milk millions from local Trusts: it is on the site of King George's Hospital in Ilford, itself only completed in 1993, and now the hospital most at risk of losing its A&E and acute services.

The financially challenged Barking Havering and Redbridge

Trust (BHR) attempts to find the cash required to pay the sky-high unitary charge on the new PFI-financed Queen's Hospital in Romford.

This has just 939 beds and even as local MPs belatedly question whether it is large enough to cope with the health needs of an ageing population in its existing catchment area of Barking & Dagenham, Havering, and Brentwood, plans are being laid to divert even more patients to it as part of the Trust's "Fit for the Future" proposals for a population of 700,000.

The BHR Trust now picks up the bill for the £238m hospital in the form of annual index-linked payments of £36m for the next 30 years, despite a projected deficit of £16m for 2006-7.

Whipps Cross Hospital Trust forecasts a deficit of £13m and one proposal would reduce Whipps Cross — whose long-promised PFI-funded £300m rebuild has been dropped — to an "ambulatory only" hospital, but it seems that the favoured option is to downgrade King George's.

Since both existing A&E departments and hospitals are normally full, and Queen's is already struggling for lack of beds, the closure of King George's services could well mean a trip in to central London for heart attack victims.

Just around the North Circular to the west a tenacious fight is being waged to defend Enfield's Chase Farm Hospital against the loss of its emergency services to Barnet General Hospital, an awkward journey away across boroughs for anyone without a car.

The odds are stacked in Barnet General's favour by the substantial PFI investment already standing and operational, which will incur charges for the whole of the 30-year contract regardless of any subsequent changes in the NHS.

Over the river in South East London, a complex plan is being hatched up for a 4-way merger between four chronically indebted hospital Trusts — Lewisham, Bromley, Queen Elizabeth, Woolwich and Queen Mary's Sidcup. Three of the four were handed a massive windfall in the form of a refund of a large share of their deficit — leaving Queen Mary's exposed as the only Trust without a large PFI hospital but still shouldering a £5.6m deficit.

KONP looks at Darzi's plan

Keep Our NHS Public does not oppose change.

We seriously study each proposal and therefore look forward to taking part in a serious and wide consultation of Lord Darzi's report.

However, the NHS has passed through a succession of major reconstructions, the underlying purpose of which has been the creation of a market in the NHS, in which private companies can compete to make a profit out of providing health services.

Market competition is incompatible with NHS cooperation yet Darzi's report says "the current set of reforms to the NHS should be seen through to their conclusion", and his report makes no mention, let alone analysis, of the innovations introduced by the Blair governments.

Darzi's aim of achieving a local vision supported by national principles needs careful examination.

For how does he expect to accomplish his laudable aims when this whole series of reforms is forcing the NHS to compete against itself (and the private and voluntary sector) and when lack of funding and successive restructurings have plunged sections of the NHS into financial deficit, forcing them to make cuts?

The review is designed to assess the performance of the NHS and to indicate the way forward.

It states that an evidence base for the different aspects of healthcare is necessary and seeks practice related to this.

It is therefore looking at clinician engagement, improvements to patient care and better access. At the first of the consultation meetings Darzi said that quality of care is more important than simply measurement.

Eight clinical areas are to be reviewed: maternity and new born care, children's health, planned care, staying healthy, long-term conditions, acute care, mental health and end-of-life care.

The themes he suggests are quality, innovation, education/training/workforce, and constitution. On the latter he is looking at the NHS mission, what citizens want and expect, and public accountability.

Using the original planning of the NHS and developing the systems in place before "market reforms" the innovations he suggests would ensure that, unlike commissioners at one remove from the operational end of the business, the two groups of employees work together to

achieve a shared purpose and essential outcomes. It is only through managers and clinicians working effectively together that sound outcomes can be achieved. Darzi's approach requires just such cooperation between primary and secondary care, between different specialties and between hospitals.

However when he says "the current set of reforms to the NHS should be seen through to their conclusion" he expresses the very opposite of cooperation.

The purchaser (or commissioner)

patients they have contracted for. They will not accept patients who may suffer from other conditions and they return patients to NHS care should the procedure fail or complications arise.

Darzi does not explain the impact on health care when a trust is locked into paying back the money, plus interest, over periods of 20-30 years, to a Public Finance Initiative (PFI) consortium for building developments.

Does he agree that future projects for new build or other capital

Keep Our NHS Public campaign says "NHS market competition is incompatible with NHS cooperation".

and provider divide established to allow for market measures, and "payment by results" puts in question appropriate treatment according to clinical need.

Too many senior clinicians report difficulties with this system. Pressure to release beds when either diagnosis in complicated cases has not been completed or when a patient has not fully recovered from an operation occurs too readily causing danger to the patient and further cost on readmission.

Referrals to other specialities within a unit now often require reference back to the GP for re-referral causing wasted time for the patient and extra paper work, all to ensure more income for a given trust. This increases waiting times for treatment.

Darzi exposes very effectively the need to improve the present complicated arrangements for patient access to the health service but he also needs to examine with the same thoroughness and, we hope, objectivity the most effective routes for patients within the system.

For instance the setting up of private diagnostic centres risks undermining the key role of the GP taking decisions for referral in consultation with the patient to enable the appropriate treatment and care pathway. In addition the existence of Independent Sector Treatment Centres (ISTCs), private providers contracted for straightforward elective procedures, like cataract removals and hip replacements, impact on the capacity of the NHS to provide services.

Unlike the NHS they are not on a "payment by results" system but paid a guaranteed sum even if they do not treat the full number of

improvements should be funded and contracted for through the traditional direct funding system?

Does he agree that the government should discontinue these market mechanism reforms until it has carried out a thorough analysis of the effects of each of these measures and published the results?

Darzi plans to produce an interim report this autumn, linked with the government's comprehensive spending review, and a final report probably in June 2008.

But without an analysis of the effects of the "market reforms" the review will be ineffective.



Frank Dobson MP, former Minister for Health, signs a birthday card for the NHS's 59th birthday

NHS

NOT FOR SALE

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Brighton BN1 3XG

www.keepournhspublic.com

Darzi's plan for London

"With no credible route map for its implementation, there are real fears that the Darzi report may simply be a smokescreen to divert attention from unpopular policies which threaten to undermine local access to care and allocate an expanding role to private sector providers."

LORD Darzi has produced a detailed plan designed to address some long-standing inequalities and important weaknesses in health and healthcare in London. It deserves to be taken seriously in proposing some radical changes and seeking genuine modernisation to deliver improved health and social care in Greater London. Some of its proposals merit careful consideration; others much less so.

His proposal to develop 150 polyclinics to provide a mix of primary care, urgent care, ambulatory care and outpatient treatment may have some merits, but remains controversial even among Darzi's own team of advisors and NHS London.

There are serious doubts over the proposed size, cost-effectiveness and user-friendliness of such large catchment populations for primary care, while concerns that polyclinics may involve a further inroad by private sector providers have been underlined by recent statements by Health Secretary Alan Johnson stressing the increased role of private sector provision in primary care.

Above all the polyclinic model has been rejected by organisations representing most of London's GPs, and without their involvement the scheme is unworkable.

Darzi's call for the reconfiguration of hospitals, proclaiming the "end of the era of district general hospitals" also requires a lot of careful consideration and public debate to clarify what is being proposed.

This will be difficult while the debate remains locked at the level of general principles rather than discussing specific plans to allocate resources.

There would be little disagreement with the proposals for invest-

ment to enhance stroke and other highly specialist services at specialist centres: but the report has been published at a time when many hospitals and other units are facing controversial cash-driven cuts in services, and this raises understandable fears that the upgrading of a few acute centres would run alongside the downgrading of busy local hospitals.

These fears are amplified by the failure of NHS London to insist on a moratorium on hospital cuts and closures while the debate on Darzi takes place, and the fact that services in, for example, Enfield (Chase Farm), Redbridge (King George's Hospital) Brent (Central Middlesex Hospital) South West London (Epsom & St Helier) and South East London (Queen Mary's Hospital) are currently under threat, out to consultation, or being run down.

With no credible route map for its implementation, there are real fears that the Darzi report may simply be a smokescreen to divert attention from unpopular policies which threaten to undermine local access to care and allocate an expanding role to private sector providers.

No decisions to cut or close NHS services without a full public debate

KONP, recognising the financial pressure placed on PCTs and trusts, reiterates the call for NHS London to step in and ensure that no decisions to cut services or close facilities should be made until a full public debate on Darzi's strategic plan for London has taken place, and to guarantee that no London-wide roll-out of the policy will be attempted without first piloting its key proposals to test their effectiveness, popularity with patients, and affordability.



Unison members marching to defend the NHS in Hackney this year

PFI causing cash shortfalls for NHS

"There are more than 80 signed PFI contracts in England's NHS and charges to be paid over the 30-60 year contracts total £52bn. This is almost six times higher than the £8.5bn construction cost"

The annual cost of private finance initiatives to the NHS in England is set to increase five fold from £480m to £2.3bn over the next eight years, according to a report from the University of Edinburgh.

The study, by the University's Centre for International Public Policy, highlights how the cost of PFI contracts are already causing financial problems for the trusts involved, particularly those that have signed up to high value schemes.

The researchers draw attention to the significant shortfall that trusts face in making payments for capital costs, which include the "rent" paid to the private sector for use of PFI buildings combined with capital charges for publicly-owned

assets. Their report shows that trusts that have signed up to PFI schemes worth more than £50 million were, in 2005-2006, confronted with an average shortfall of at least 4.4 per cent of their income to meet these payments.

Mark Hellowell, lead author of the research, said: "Under PFI, trusts have capital costs that are much higher than average. Many NHS trusts therefore have a funding shortfall under the current financial regime.

"Despite cutting services and selling off assets, many NHS trusts have shortfalls in funding. As trusts struggle to attain financial balance, in line with government policy, further closures are being considered.

The impact will be felt not just among trusts with PFI contracts but across the wider health economy."

One example detailed in the paper is that of South East London, where the total deficit of two trusts with large PFI schemes, Bromley and Queen Elizabeth, was £151 million by the end of last financial year.

The research observes that planned cuts will focus on public, rather than PFI, assets.

There are more than 80 signed PFI contracts in England's NHS and charges to be paid over the 30-60 year contracts total £52 billion. This is almost six times higher than the £8.5 billion construction cost.

There will be 126 PFI schemes in operation, taking into account current planned projects, by 2013-2014. This will lead to a five fold increase in annual PFI charges from £470 million paid for 2005-2006 to £2.3 billion by 2013-2014.

Mark Hellowell said: "The payments to PFI consortia are an albatross for the NHS and are associated with service cuts.

As the PFI programme expands, the problems will become even more acute."

Make your own comments on the Darzi plan at www.healthcareforlondon.nhs.uk/have_your_say.asp

NHS London — run by a bunch of arch-privatisers and marketers

A hard-nosed team of top executives has been installed to drive forward the New Labour "modernisation" agenda through what is now called "NHS London". They are a unique mix of high-profile figures linked both to the most extreme market reforms and to the private sector.

Chair of NHS London is Mr. George Greener, formerly a top director from the tobacco, confectionery and pharmaceuticals industries while the Finance Director is

now a former Unilever finance chief.

Chief Executive Ruth Carnall was one of the management consultants who advised on setting up the new SHA shortly before she took its top job. She has also been involved with private medical companies, one of which runs treatment centres and provides GP services.

Also included in the team is Professor Paul Corrigan, husband of Hilary Armstrong (Tony Blair's chief whip) who despite the lack of any

hands-on experience in the NHS lands the plum post of "director of strategy and commissioning".

Corrigan was advisor to Health Secretaries Milburn and Reid, and to Tony Blair: he was an architect of the notion of Foundation Hospitals: he is a keen proponent of treatment centres and "patient choice".

Former Health Minister Lord Warner will pick up £30,000 for a part-time post as chair of the new "London Provider Agency" — which

has the task of forcing London's NHS Trusts into seeking Foundation Trust status. Another avid privatiser in the new London team is so-called "turn-around specialist" Anthony Sumara, who as chief executive of Hillingdon's cash-strapped Primary Care Trust stirred a wave of anger with his announcement that he planned to privatise virtually the whole of the PCT's services and operations, reducing staff numbers from 300 to just 30.

"I want to get rid of everything, outsource it — and we are distancing the PCT from its provider functions . . . It's commercialising, not privatising, and the public don't care," Sumara told a shocked Health Service Journal. Challenged to justify head-hunting such an ideological team, Carnall opted for straight denial, claiming that: "The notion that I have put in place a team with the aim of privatising the NHS in London is nonsense."