socialist HEALTH association

Socialism and Health

The journal of the Socialist Health Association

Winter 2005/6

Editorial

This edition contains an invitation to members to contribute to the debate on whether the SHA should formally subscribe to the "Keep Our NHS Public" Campaign. Following disagreements within Central Council as to the wisdom of a formal link with the campaign, it was agreed to consult the wider membership before a final decision is made in April. The SHA is also organising a series of meetings at which these issues will be raised, and details will be found on the back page.

We also discuss the apparent change of conservative policy following the election of David Cameron as leader. Using sound-bites that sound strangely familiar to SHA members he appears to jettison much of what his party has always stood for. Is he merely attempting to regain the centre ground and appeal to voters, or will he be able to reconcile the obvious inconsistencies in his position?

Following the decision to hold meetings of Central Council quarterly rather than every two months, the AGM has been brought forward to take place in April, and details, including requests for nominations and resolutions, will be found in this issue.

Gavin Ross, Hon Editor

THE MARKETISATION DEBATE – WHAT SHOULD THE SHA POSITION BE?

And should we join the Keep Our NHS Public Campaign?

BACKGROUND

The SHA was invited during the Summer to sign up to the " Keep Our NHS Public" campaign by one of its founding organisations, the NHS Consultants Association of which our Chair, among other SHA members, is a member. Details of the campaign are reproduced below.

It is clear that three recent government actions have been the immediate stimulus for the campaign namely, the requirement that at least 15% of revenue should be expended in the independent sector, the stripping of the provider role from PCT's and the setting of a clear timetable for all NHS Trusts to become Foundation Trusts. This invitation was considered by Central Council at its September meeting and in the light of the limited information then available about the campaign it was decided not to support it.

It is fair to say that there was some unhappiness among members that Central Council has been rushed into this decision and in the light of this a paper was presented to the November meeting of Central Council proposing a policy for SHA on the whole issue of marketisation and pointing out that the decision not to join the Keep Our NHS Public campaign could be reconsidered at any time in the light of a such a policy.

Central Council decided that the SHA position on Marketisation was of such importance that it should be determined by the whole membership as also should the decision about joining the Keep Our NHS Public campaign. And that a paper, amended in the light of discussion at Central Council, should be sent to all members with 1) an invitation for them to comment on it and 2) to give their views on whether the SHA should support the Keep Our

NHS Public campaign
The paper was distributed at the New Year to members with e-mail, but by the middle of January only 17 members had responded, probably because it was not made clear that a response was needed from as many members as possible.

So please help us make these two important decisions by sending your responses to the chair, Paul Walker, preferably by e-mail at paul@crawfordwalker.freeserve.co.uk; or by post to 8 Church Avenue, Bristol BS9 1LD, BY 28th FEBRUARY 2006 AT THE LATEST so that central council can make a final decision at its meeting in April.

THE PROPOSED SHA POSITION ON MARKETISATION OF THE NHS

What should the SHA position be; and on what foundations should this be built?
Central Council agreed just such foundations at its meeting in September comprising a statement of mission, values and priorities for action. This is reproduced in full below. The elements which are considered to be most relevant to the marketisation issue are shown in red :

1.OUR MISSION - OR WHAT ARE WE FOR?

To promote health and wellbeing, social justice, and the eradication of inequalities through the application of socialist principles to society and government.

This clearly includes the three original aims of the SHA as set out in 1930. The new ingredient which dominates public health and socialist thinking at the beginning of the third millennium is the reduction and ultimate eradication of inequalities.
To achieve this MISSION we believe that we need to be an actively campaigning organisation as well as one that supports critical debate about the wide range of issues that comprise health and wellbeing in the third millennium. We want to make a difference by having influence at the highest level, that is on the government and on the Labour Party as well as on other bodies that influence them such as trade unions and on other socialist societies.

2.OUR CORE VALUES

Underpinning our Mission are three core values :

DEMOCRACY – informed participation with election not selection
EQUALITY – of opportunity and respect supported by affirmative action

UNIVERSAL HEALTHCARE – meeting the prevention, treatment, rehabilitation and care needs of all, publicly provided, free at the point of use and funded by general taxation.

Underpinning these core values are seven guidelines for action :

PREVENTION AS WELL AS TREATMENT - investment in prevention of disease as well as on treatment
WIDER DETERMINANTS AS WELL AS HEALTHCARE - recognition that the wider determinants such as income, education and employment are as important in promoting the nation's health as healthcare
INTERNATIONALISM - recognition of the UK's international obligations to developing nations in respect of trade agreements and the importation of scarce healthcare personnel
SOLIDARITY – working in close collaboration with other like minded bodies such as trade unions and the other socialist societies

LOCALISM – decision making as near as possible to where it will have impact and at community level wherever practicable
AN INTEGRATED, WHOLE SYSTEMS APPROACH – health, social care and wellbeing services provided through partnership working as integrated packages tailored to the needs of user, not the convenience of providers

COOPERATIVE ENDEAVOUR – a cooperative approach to the running of public, voluntary and private sector services with worker and user participation

3.OUR PRIORITY AIMS

It is not possible to espouse every good cause. So we will concentrate our efforts on those issues which we consider to be central to the attainment of our mission :
Reducing inequalities in health particularly for disadvantaged groups such as the mentally ill; and for vulnerable groups particularly children
Local democratic control of the NHS including giving patients a voice at local and national levels
Defending and extending the NHS including securing adequate public funding, and removing all costs to users such as prescription charges and travel costs
Promoting healthy lifestyles through the provision of easy to understand and quality assured information to empower the public and through countering the influence of anti-health forces and any other factors which undermine this empowerment.

4. MAKING IT HAPPEN

To achieve these aims we will actively campaign both in our own right and, where appropriate, in collaboration with other like-minded organisations.

So, our key planks for evaluating marketisation policy are fivefold :

- Impact on inequalities
- Integrated care
- Impact on user charges
- Impact on level of "publicly provided" services
- Impact on total funding available to the NHS

with impact on inequalities being the most important.

Taking the five planks in order:

Impact on health inequalities. At the outset it has to be said that an economy based on free market principles is bound to create health inequalities. And the same would apply to a health economy based on such principles. But what about the impact of such an economy on its users, ie patients?

In theory there is no reason why a marketised NHS should increase disparities in access to healthcare as long as it is adequately regulated. This is necessary to curb the innate tendency for commercial providers to maximise profits by, for example, seeking economies of scale, providing only the most profitable types of service, and paring down the care package to the minimum. The key question is whether a workable system of regulation within the NHS could fully protect users who are in the main ignorant of the technical features of healthcare. The answer is almost certainly not; the task is just too great.

What evidence there is, mainly from the US, indicates that disparities in access to healthcare would indeed increase at least with the levels and methods of regulation prevailing there.

We believe that the most effective way to

reduce inequalities in health is via the public health/health-and-wellbeing agenda, rather than by means of the NHS. Supporting lifestyle change, improving literacy, providing full and fulfilling employment, and raising levels of income at the bottom end of the income range, are more important in the long term than finessing the structure or the provider pattern of the NHS.

Integrated care, that is integrated care packages involving primary and community care, including social care where necessary, plus, in some cases, secondary healthcare also, has been the Holy Grail since at least the 1974 reorganisation of the NHS. It has to be said that progress in this area has been slow although more rapid in the last 10 years. Such care is almost certainly most easily provided where a single organisation directly provides all the constituent parts. Though even in this case a comprehensive and managed care plan is crucial; and differences in approach and culture between the various professions involved can often obtrude. Where there are several organisations involved the difficulties are compounded especially where their cultures, languages and driving forces are different as with a mixture of public sector, charitable sector and private sector providers. And where several organisations become many organisations as is quite possible with a mixed healthcare economy these problems are just that much greater. And the person who suffers most is the patient rather than the provider.

So, it is our view that integrated care, which has never been so important as the number of patients/clients with chronic diseases continues to rise, would inevitably suffer with a multiplicity and mixed economy of providers. And, at a more strategic level, partnership working would become that much more difficult, again to the ultimate detriment of patient care.

On user charges these are currently levied for dental and optical care, prescriptions, wigs and various other items and we are committed to their total elimination where clinical need for and effectiveness of the interventions are established. The question is would further marketisation give rise to an increase in user charges? There is a view that the government has it in mind to increase the scope of user charges and co-payments and that recent increases in user charges are part of a plan to get patients used to paying for things which they once got free. We would of course be totally against this.

Impact on publicly provided services. Clearly, encouraging independent sector penetration of the NHS will have a negative impact on the overall quantum of service that is publicly provided. But does this really matter? What are the benefits of public provision of healthcare services? Two immediately spring to mind. Firstly, the safeguarding of income levels of lower paid staff on the basis that in order to generate profits commercial independent sector providers will seek to depress the wages of staff, particularly ancillary workers and lesser skilled carers. This will have a predictable impact on the health of such workers and on health inequalities

The second factor is the retention of the public service ethos in the delivery of care. This comprises several elements including a pride in the quality of one’s work and a sense that public service staff give more to their work than they are paid for.

The government has sought to undermine the importance of the public service ethos which is strongly supported by the healthcare professions and the healthcare unions alike by labelling the latter as “ provider interests” only interested in maintaining the status quo and thus resistant to further marketisation

For our part we strongly favour the provision of NHS services by NHS employed staff.

We accept, however, that for many years services have been delivered quite satisfactorily by charities and some specialist private not for profit providers in

areas where NHS provision was poor, mostly for people with chronic conditions. There may even be scope for this approach to be expanded with, for example, further community services being provided by various types of social and community enterprise.
Then there is the related issue of patient choice. We are not opposed to patient choice, though we greatly prefer the route of empowering patients through giving them more voice. But whereas choice in the delivery of elective surgery is relatively unproblematic in our view choice in the delivery of care to people with chronic medical conditions is another matter. Such patients are in a position to have informed views about how their care should be delivered, and many of them see existing systems of care provision as insensitive and autocratic. Generally speaking, experience tends to suggest that systems with more choice favour the upper and middle classes. Unless strenuous and determined efforts are made to ensure that independent advice and information are provided to those who are disadvantaged the extension of patient choice will have the effect of further increasing health inequalities.

Impact on total funding available to NHS.
The marketisation premium, ie the extra payments currently made to independent sector providers to encourage them into the market, is a real issue because its inevitable result is less overall funding available to the NHS. So clearly an argument against marketisation but is it certain that the premium will continue? One might imagine that when the marketisation process has gone further the independent sector will have sufficient confidence in its future to be willing to participate on a level playing field with NHS providers although the economics will be challenging especially to achieve a profit for shareholders at NHS prices. Even if this does happen at some time in the future the opportunity cost for the NHS will have been considerable.

There is in addition the separate privatisation premium relating to capital investment and PFI where large amounts of the future NHS revenue stream have already been committed to paying private contractors for “risking” the investment in the first place. The separate opportunity costs to the NHS of these repayments are already highly significant resulting in bed closures and service reductions.

Akin to this transfer of funds from the directly provided NHS to the private sector is the separate transfer of capacity and funding to management consultants necessitated by the run down of the Department of Health’s own in house capacity to commission, plan or develop health policy.

So, in summary, applying our own mission, values and priorities for action framework we cannot support the further marketisation of the NHS for which there is persuasive evidence that the government is committed to.

Paul Walker and Julian Tudor Hart on behalf of Central Council
December 2005.

What is the Keep Our NHS Public campaign?

The initial publicity leaflet of the campaign asks supporters to
1) Help organise a campaign to prevent further NHS cuts and closures across the country
2) Stop our NHS from being privatised and handed over to transnational health care corporations
3) Help stop the disruption and privatisation of primary and community health services.

Subsequent press releases have dealt mainly with local issues, in particular the problems of NHS Trusts in deficit, and the uncertainties posed by the amalgamation of Primary Care Trusts.

Further information may be obtained at www.keepournhspublic.com

Letter to the Editor.

From Gordon Will, Birmingham.

The editorial in the Autumn 2005 edition does not make it clear that the Central Council of the SHA refused to support the "*Keep the NHS Public*" campaign. I only gleaned this from John Lipetz's letter in the same edition.

This lack of support is incomprehensible in the light of the 'Mission, Values and Aims' of the SHA. In particular the section on Universal Healthcare which refers specifically to "publicly provided" healthcare (my emphasis). Government policy since 2002 has been for creeping (now galloping) privatisation, of education and probation services, for example, in addition to health. Health examples include the 15% compulsory private sector element in acute procedures whether wanted or needed or not locally, and the hiving off of provider functions from PCTs. These are purely ideologically based. They emanate not from patients, the great majority of whom know nothing of them, but from Tony Blair and his coterie of unelected advisors. It is hardly surprising that patients do not comprehend the Government's privatisation plans since they are obfuscated by a new and alien language, including 'independent' (instead of private) provision, 'plurality of provision', 'choice or 'range' of providers, and 'contestability'. George Orwell should be alive now to do justice to these efforts.

Is pointless for the SHA to think that it can treat with Government Health Ministers around the margins of such policies. The ministers are under a privatisation mandate from Blair who seems to have embarked on a scorched earth policy prior to his departure.

I am a former member and Chair of a CHC. I have never heard patients in Birmingham call for privatisation, choice, ranges of providers or contestability. In general they wanted high quality, publicly provided health services delivered at primary, community and hospital level locally, and specialist services at NHS centres of excellence.

The SHA Central Council should reverse its refusal to back "Keep the NHS Public", tell government ministers just that, and throw its weight behind the UNISON Composite 6, passed at the 2005 Labour Conference.

Incidentally a Labour leadership election to test whether Blair's privatisation policies have the support of the Party might be the best way to stop irreversible damage to the NHS.

Yours sincerely
Gordon Will

The editor replies: "The SHA in July had had no formal approach from the campaign organisers, apart from the initial statement of aims. Central Council required more information as to who was behind the organisation, what its real objectives were, and whether the wider membership agreed with its statements. Criticism of detailed aspects of government health policy had already been voiced by many organisations and individuals, tempered by praise of many real benefits to patients and staff, and increases in funding.

In the last edition of Socialism and Health we reported from Annual Conference that we had supported the Unison composite motion, which was better argued than the statement of the "Keep the NHS Public" campaign. Central Council then agreed to a consultation process which would include a series of regional meetings in early 2006 and a decision in April taking into account the views of members who respond on this issue." ***Gavin Ross***

VIEW FROM THE CHAIR

Reflections upon retirement; 40 years of working in and around the NHS

In December I achieved my super-majority on celebrating my 65th birthday. So I am now in receipt of my state pension and am probably regarded as a second class citizen. But I am also in a position to look back on 40 years of

working in and around the NHS and to identify the three greatest disasters that have happened to health and healthcare during my professional lifetime.

First, and perhaps foremost, was the great public health extinction of 1974. In that year the public health function was removed from local government where it had always resided and transferred into an alien land, the NHS. The sole reasons for this were to allow public health doctors to flaunt the coveted status of consultant and to give some among their senior ranks the opportunity of stuffing their mouths with golden merit awards. The result was that the discipline of public health has languished in obscurity ever since and local authorities have lost sight of their key public health role. Tragedies of the highest order.

Then there was the demise of consensus management in the wake of the infamous Griffiths Report of 1983. One of the only two good things that came out of the 1974 “unification” of the NHS was the notion that doctors and nurses should be party to all major management decisions of the new health authorities with the power to exercise a veto on any decisions which they conceived as inimical to the interests of patients. Only decisions where there was a consensus among all members of the management team including particularly the clinical members, were valid. To the then Tory government this gave the clinical professions far too much power; and to Sir Roy Griffiths it did not accord with how profitable supermarkets were run! So it was jettisoned in 1984 and has vanished without trace. It is as if it never existed. From my own experience it was a challenging but entirely workable management system that kept the needs of patients rather than balancing the books at the heart of NHS governance.

And lastly was the separation of the commissioner and provider functions within the NHS in 1990. At first glance this seemed to offer real advantages in putting commissioning, informed by a public health led health needs analysis, in control. But in practice the public health discipline has rarely responded to this challenge, commissioning has never really taken off because it is so difficult and of course this separation of functions has paved the way for the introduction of first an internal market and now an external market for healthcare in England with all that this now entails and portends.

Which begs the obvious question of what the health and public health scene would have looked like had these monumental mistakes – and many others along the way – not been perpetrated. But that’s another story.

Paul Walker

DAVID CAMERON AND THE NHS

The following information was downloaded from the web.
We think that readers should be aware of what the Tories are now saying.

David Cameron has committed the Conservatives to improving the NHS for all patients.

While pledging to retain the principle of free treatment within a publicly funded health service - marking a shift in party policy away from so-called 'patients passports' - the Tory leader also hinted at a radical extension of the role of the private sector in the NHS.

Cameron was addressing the King's Fund think tank after spending the morning with an ambulance crew in central London.

In a bid to benefit all patients, rather than just the better off, he has dropped the party's policy of offering to pay for half the cost of private operations. The policy was strongly attacked by Labour during the general election for taking money out of the health service and only benefiting those who could afford to go private.

Cameron said it had contributed to a sense that the Conservatives did not believe in the NHS or wanted to leave it as a safety net for the poor.

"The fact that we have in this country a health service that takes care of everyone, whatever their needs, whatever their background, whatever their circumstances, is one of the greatest gifts we enjoy as British citizens," he said.

"We should never forget it, and never take it for granted. The NHS does not belong to one political party. Conservative governments since the war have built it up, as have Labour ones. But there still seems to be a question mark over the Conservative Party's commitment to the NHS."

He said health policy was crucial to changing voters' perceptions of the party. "So as we embark on this process of change, becoming a modern, compassionate Conservative Party, in tune with the aspirations of the British people, want us to leave no-one in any doubt whatsoever about how we feel about the NHS today," Cameron argued. "We believe in it. We want to improve it. We want to improve it for everyone in this country."

The Tory leader agreed with the government that the NHS required more and sustained funding, as well as reform. "We are now at the European average of health spending," he said. "But we are not at the European average for health outcomes."

However he rejected a social insurance model of funding. "Some people think that we Conservatives want to change the NHS into something that it isn't," he claimed. "Well, they're right. We do. We want to change the NHS into a more efficient, more effective and more patient-centred service. We want to change it into something of which we can be even more proud.

"Other people - some of them in my own party - urge me to go much further. They want me to promise that under the Conservatives, the NHS will be transformed beyond recognition into a system based on medical insurance. I will never go down that route. Under a Conservative government, the NHS will remain free at the point of need and available to everyone, regardless of how much money they have in the bank."

Cameron called for more trust to be placed in staff, as well as the public taking more responsibility for their own health. He said the NHS had suffered from "an overdose of ideology" in the past. "The NHS should be neither a state monopoly, as the left have sometimes believed," he said. "Nor is it something charitable or demeaning - so we should not use taxpayers' money to encourage the better-off to opt out."

The Conservatives want private providers to be able to compete for all NHS contracts.

Ahead of the unveiling a review of party policy on the public services shadow health secretary Andrew Lansley said that Labour has failed to get value for money from investment in the NHS by holding back private provision. The government has indicated it has a 15 per cent limit on the level of NHS services to be provided by the independent sector, a cap which the Conservatives say they would scrap.

"They now agree that a National Health Service does not have to mean a nationalised health service, but they haven't gone far enough in giving a wide range of health providers the right to supply services to the NHS," Cameron said. "Labour now agree with the devolution of power and control to the local level, but their foundation hospitals are not truly autonomous, and even under Labour's new plans, GPs ill still not be in the driving seat. In fact, in every area where Labour are moving in our direction, whether giving patients more choice or cutting bureaucracy, we think they could and should go further."

Co-payments and charges in the NHS

SHA Submission to Health Select Committee, December 2005

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. This submission is made on behalf of the Association.

We believe the NHS should be organized in such a way as to minimize disparities in quality of service between the socially excluded and the most advantaged sections of society. Ideally it should be organized in such a way that all such disparities disappear.

We have campaigned for many years for a free health service without any charges. We are very willing to give oral evidence to the committee.

1. Whether charges for treatments, including prescriptions, dentistry and optical services; and hospital services (such as telephone and TV use and car parking) are equitable and appropriate?

As Aneurin Bevan said in the debate about the introduction of prescription charges in December 1949: "The proposal to have a charge up to 1s. creates no administrative difficulty at all. The administrative difficulties arise out of the necessity of exemption." It is apparent from the debate at that time that charges were imposed primarily as a method to restrict demand. It is not clear to us why it is still thought necessary to restrict demand specifically for medication prescribed outside hospital, wigs and trusses, dentistry and spectacles, but only for poorer people of working age. Since we established the National Institute for Clinical Excellence there are criteria for the prescription of medication and other treatments. It is difficult to see what positive role these charges play.

"What evidence is there that user charges, known to health economists as co-payments, have the selective effects on consultation rates required to restrain over-use, even if that were a real problem? Obviously user charges discourage use, but economists have good evidence that consulting behaviour has little elasticity. Poor people will give higher spending priority to consulting a doctor than to food, if they believe medical advice is needed.[1] The effect of user charges is simply to reduce all consultations across the board, regardless of the nature of the problems that prompt them. The effect is selective only for those with lowest incomes, least able to afford them, but most likely to be sick. [2] In the early years of the African AIDS pandemic, user charges were imposed at state-funded Sexually Transmitted Disease (STD) clinics in Kenya on advice from the World Bank and as a precondition for international aid. Consultation rates fell by 60%. [3] Public care systems have collapsed throughout Africa: no money, no treatment.[4]

User charges are advocated not to promote more rational behaviour, but to shift public behaviour "corrupted" by experience of a free public service back to a "normal" commercial pattern."[5]"

2. What is the optimal level of charges?

In our view zero is a proper level of charge for treatment or services which are clinically required. If a treatment or service is not clinically required then we would not consider that it should be within the scope of the NHS and charges might properly be made.

3. Whether the system of charges is sufficiently transparent?

The Director of the SHA worked for ten years as a Welfare Rights Officer in a large teaching hospital giving advice to patients and their families. He can give evidence that the Hospital Travel Costs Scheme in particular is not understood by those who are intended to benefit from it or those who administer it. In many hospitals determined efforts are made to prevent patients from claiming the help with fares to which they are entitled. The offices concerned are hidden away in obscure parts of the hospital, there is no publicity given to the scheme and the offices are often closed at times when patients would reasonably want to access them[6]. Although the research upon this work was based is now dated we have reason to believe that little has changed.

There are particular problems with the cost of taxi fares. Many hospitals refuse to pay for taxis. The official guidance on this point states:
"In a few cases, where there is no alternative (for example, in cases where patients have restricted mobility, or public transport is not available for all
or part of the journey), patients may have to use a taxi or volunteer car service for the whole or part of their journey."[7] This does not

1 Creese A. User fees. *British Medical Journal* 1997;315:202-3.
2 Evans RG, Barer ML. The American predicament. OECD Policy Studies No.7 *Health care systems in transition*. Paris: OECD 1990. pp.80-5.
3 Moses S, Manji F, Bradley JE. Impact of user fees on attendance at a referral centre for sexually transmitted diseases in Kenya. *Lancet* 1992;340:463-6, and Editorial. Charging for health services in the third world. *Lancet* 1992;340:458-9

4 de Sardan JPO. Africa: no money, no treatment. *Le Monde Diplomatique* June 2004:15.
5 Dr Julian Tudor Hart - *The Political Economy of Health Care (in press)*
6 Hospital Travel Costs Scheme - Current Practice and Best Practice Guide, Manchester Health Authority 1997
7 **The hospital travel costs scheme - update May 2005**

correspond with the law, which states:
"The amount of any NHS travel expenses to which a person is entitled under these Regulations -

(a) must be calculated by reference to the cost of travelling by the cheapest means of transport which is reasonable having regard to the person's age, medical condition and any other relevant circumstances;"[8]

It seems to us perfectly reasonable that patients should attend hospital using a taxi, and indeed that they should be encouraged to use taxis, which are a form of public transport, rather than use their own vehicles for which car parking provision should be (but rarely is) made.

4. What criteria should determine who should pay and who should be exempt?

"The present system of NHS charges is a dog's dinner lacking any basis in fairness or logic" Lord Lipsey, Social Market Foundation. In reply to this comment, made in the SMF's report in 2003 the Department of Health said it regularly reviewed its prescription policy. It is difficult, however, to discern any evidence of such reviews having any influence on the real world. The list of conditions which give exemption from prescription charges appears to have been laid down in 1950, on the basis that these were conditions where medication was then permanently required. We are not aware that there has been any subsequent change. As stated above we feel that the fairest and most efficient system would be to abolish charges altogether. We defy the Department to produce a fair and acceptable system of charges to replace the present embarrassing mess.

5. How should relevant patients be made more aware of their eligibility for exemption from charges?

If there are no charges we will not have to worry about this matter. If there were a fair and comprehensible system of charges and exemptions it would be much easier to explain. The lack of awareness of exemptions, particularly in respect of Hospital Travel Costs, acts in practice as a system of rationing by ignorance which is perhaps the most indefensible of all rationing systems.

6. Whether charges should be abolished?

A long series of reports have established that charges on patients are the worst possible method of financing a health service. These include both the NHS Plan, [9] and the Wanless Report[10]. The National Consumer Council in 2003 pointed out that around 750,000 people in England and Wales fail to get their prescription dispensed because of the cost and how little clarity there is on the purpose of NHS charges.[11] The National Association of Citizens Advice Bureaux in 2001 described how the "fundamental contradiction at the heart of the National Health Service is the existence of charges for essential items such as prescriptions, dental and optical treatment, within a service which claims to provide health care free at the point of delivery"[12].

Further reports have described in detail the inequitable consequences of the present system for cancer patients, [13] and the importance of tackling travel costs effectively.[14] In our view the development of a more complex system of healthcare provision such as is now proposed, requires this problem to be tackled now. Many of our members and many NHS staff have formed the view that this government intends to privatise the NHS. If the government wants to prove wrong those critics who assert that the widespread introduction of charging is next on the agenda then it would do well to sort out this mess.

"The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed

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8 The National Health Service (Travel Expenses and Remission of Charges) Regulations 2003 Reg 3(5)

9 The NHS Plan: a plan for investment, a plan for reform 2000
10 Securing Our Future Health: Taking a Long-Term View 2002
11 Creeping charges by Saranjit K Sihota
12 Unhealthy Charges 2001
13 Free at the Point of Delivery Macmillan Cancer Relief 2005
14 Making the Connections: Final Report on Transport and Social Exclusion Social Exclusion Unit 2003

to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."[15]

We do not accept that it is desirable to deter the population, particularly the poorer members of it, from seeking medical attention: "The myth that consultations for retrospectively diagnosed "non-illness" represent over-use or abuse is refuted by evidence, but this has not deterred advocates of NHS "reform" from using it as a weapon in argument. Bosanquet and Pollard confirmed its grip on public opinion in their survey noted on p.5. Apparently unconcerned about whether it was true, they identified it as their best entry point for eroding persistent public support for an inclusive NHS funded through social solidarity:

> ".... almost two-thirds say that people visit their GP when there is no real need, simply because the service is free at point of use ... it is the public's readiness to concede over-use ... that points the way forward. ... With 64% saying that there is over-use, there is a strong moral as well as practical case for a charge ..."[16]

There is no way that any care system can function without the number of people consulting about worries greatly exceeding the number whose worries eventually prove justified. For example, rectal bleeding is an important signal of possible bowel cancer, for which early surgery is life-saving, but it still commonly presents too late. About 20% of adults have some rectal bleeding each year, but less than 1% of them consult a GP, and the proportion referred to a hospital specialist for further investigation is ten times less even than this.[17] For this example alone, and there are many others, there is overwhelming evidence that patients use the NHS too little rather than too much.........."[18]

We urge the Government to take a bold step by abolishing charges. If it is felt necessary to restrict demand for NHS services then let us devise a rational way of doing so which does not discriminate on the basis of personal wealth.

"The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged."[19]

5th December 2005

Annual General Meeting

You are hereby invited to the AGM of the Association, which is to take place at noon on Saturday 8th April at Wesleys Chapel, City Road London. Please note that, unless there is a need for a ballot, you will not receive further notification of this important meeting.

A copy of the constitution and the minutes of the last AGM can be found on our website, www.sochealth.co.uk. An Agenda of business to be transacted at the AGM, the Annual Report and the other documents will be put on the website when they are ready. If you would like paper copies of any of these documents to be sent to you before the meeting please let me know. If a ballot is required you will be sent a ballot paper not less than two weeks before the date of the AGM. **According to our constitution you will not be sent paper copies of the documents unless you let us know you want them.**

You, or your organisation, are entitled to propose up to four resolutions at the AGM. Resolutions moved or made by individual members require seconding by another member. Emergency resolutions may be accepted with the agreement of the AGM.

You are also invited to nominate Honorary Officers:
Chair, 2 Vice-Chairs,
Honorary Treasurer and Honorary Secretary
Up to 20 members of the Central Council, 2

15 The Lancet: Saturday 27 February 1971 The Inverse Care Law, Julian Tudor Hart
16 Bosanquet N, Pollard S. Ready for Treatment: popular expectations and the future of health care. London: Social Market Foundation, 1997:98-103.
17 Fijten GH, Muris JWM, Starmans R et al. The incidence and outcome of rectal bleeding in general practice. Family Practice 1993;10:283-7.
18 Dr Julian Tudor Hart - *The Political Economy of Health Care (in press)*
19 Nye Bevan In Place of Fear 1952

Auditors, Delegate to Labour Party Conference: Socialist Societies Executives
Nomination to Labour Party NEC, Delegates to

ent to the editor Gavin Ross, 21 Connaught Road, Harpenden, Herts AL5 4TW, Tel/Fax 01582-715399 or by e-mail to

FORTHCOMING EVENTS

Reform of the NHS: Choice, Markets, Competition in the NHS – What does this mean for health inequality?

York Friday 17th February 1pm to 5pm The Bar Convent

Chair: Hugh Bayley MP
Main speakers: Prof Alan Maynard
Prof Paul Corrigan, health adviser to Tony Blair
Emily Sparks, Experian Mosaic UK
Tina Funnell, General Secretary of the SHA

Tuesday 28th February 10am to 4pm Toynbee Hall 28 Commercial Street, London E1 6LS

Main speakers:
Anna Coote, Head of Patient & Public Engagement Healthcare Commission
Frances Blunden, Principal Policy Adviser Which?
Jessica Allen, IPPR - joint author of Equitable Choices for Health
Prof Chris Drinkwater, President and Public Health Lead for the NHS Alliance
Jon Trickett MP, Secretary of the Parliamentary Labour Party Health Committee
Prof Wendy Savage

Information advice and advocacy for patients The needs of disadvantaged patients in a more market based system.

Monday 6th March 10am to 4pm Friends House Euston Road London NW1 2BJ

Chair, Neal Lawson, Chair of Compass

Main speakers:
Dr Jo Ellins, Picker Institute
Ruth Thorlby, Health Policy Researcher, King's Fund
Sharon Holder, GMB
Mark Duman, Chair, Patient Information Forum

Annual General Meeting of the Association,

Noon on Saturday 8th April at Wesleys Chapel, City Road London

Contact the SHA

Do you have a point of view? The pages of *Socialism & Health* are open to everyone. All letters and articles will be considered for publication. And the SHA welcomes any other expertise or help you can offer to ensure that the SHA remains a dynamic and respected campaigning pressure group in the 21st Century.
The views expressed in this journal are not necessarily those of the SHA

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