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New Faces at the AGM

Spring 2006



Huw Davies, our new Honorary Secretary, has been a Councillor in Hammersmith and Fulham since 1994. He was a member of the local Community Health Council until its abolition and subsequently a member of the Health and Social Services Scrutiny Panel. He has been Chair of the Environment Scrutiny Panel for the past four years and is a member of the London Labour Party Regional Board.

Patrick Vernon, one of our new Vice Chairs, is also Vice Chair of Hackney Local Government Committee. He is running as a candidate in Hackney for the local government elections in May 2006. He worked as a Strategic Adviser at the Department of Health and Local Government Association and a senior NHS manager for Brent Primary Care Trust as the director responsible for the Brent Health Action Zone. He launched the



Editorial

This is a critical time in the history of the NHS, for the SHA and its role in informing and influencing health policy. Following the decision at our AGM to affiliate to the Keep Our NHS Public Campaign we may also have a part to play in helping that organisation to focus on the issues that matter, and to make practical alternative proposals. In this issue we provide information and discussion

on topics which have arisen this year, not least the Dental Contract (the editor has been told by his dental practice that after 45 years of NHS treatment he can only continue with them by subscribing to a private scheme at over £200 per annum). For reasons of space some topics will be held over to the next edition.

THE POWER OF PLACEBO - PUTTING ALTERNATIVE THERAPIES INTO THE EQUATION

Paul Walker, Chair

For most of my medical career the word placebo meant merely a technical aspect of drug trials. Volunteer participants were divided into two groups, experimental and control. The experimental group received the drug under trial and the control group received a pill that they thought was the drug under trial, otherwise known as the placebo. And that was all there was to it, or so I thought. Then, some ten years ago I read a piece that



changed my attitude completely. Its powerful opening gambit stated quite baldly that approximately 75% of the impact of medical/health care interventions was attributable to a combi-

nation of the placebo and the Hawthorne effects leaving only 25% attributable to specific effects of the medical / healthcare treatment given. In case you don't know, the Hawthorne effect is the heightened morale and performance that occurs when people are the subject of someone else's attention.

At first glance this seemed absurd and unbelievable. This was not what I had been taught, which was that medical treatment involved either a drug or some other modality such as X rays, which had a specific physiological effect; or surgery which had a specific anatomical effect. And that was the beginning and end of it.

One of the most remarkable illustrations of the power of the placebo/Hawthorne effect was engineered in the United States where patients with osteoarthritis of the knee were divided into two groups. One received the traditional endoscopic surgical treatment and the other received sham surgery ie they were anaesthetised and awoke with their knees bandaged as if they had had surgery but in fact had received no surgery at all. The ethics of this study are highly questionable but that's another story! Three months after the "surgery" both groups of patients were assessed in terms of state of pain and mobility in their affected knee. Not only did both groups report significant improvements but the degree of improvement was identical in both. Such is the power of belief; and it appears that a confident belief on the part of the doctor or therapist that the treatment will do good is transmitted to the patient and magnifies the effect.

Which brings me on to the role of alternative therapies. Whereas some of these like acupuncture do appear to depend on a specific effect of the intervention, in the main they rely for their undoubted effectiveness on that magic combination of the placebo and Hawthorne effects. So why should these not be available on the NHS free of charge? Of course the various therapies would have to be appropriately regulated but the concept of Integrated Healthcare involving both orthodox medical/healthcare interventions and alternative therapies where appropriate seems a sensible one that acknowledges the power of belief and confidence in the treatment process to its success.

SMOKE FREE LEGISLATION - Letter from ASH

Donald Reid

I am writing as the Chair of the Board of Action on Smoking and Health to express our thanks and appreciation for the work of the Socialist Health Association on smoke-free legislation.

As you know, ASH has been working to restrict smoking in workplaces and public places for many years, and this legislation has been our priority campaign for the last three years at least. Although I am a natural optimist, I never expected it to be crowned with such complete success in such a relatively short time. We would like to thank you for your support for the Smoke-free Action Coalition and for

the campaigning work you undertook on its behalf.

If the Government's Regulatory Impact Assessment is to be believed, more than 600,000 people will quit smoking across England when this legislation comes into effect. And of course millions of people who do not smoke will be able to work and visit leisure venues without the threat to their health from other people's smoking. This is truly the most important step forward for public health for many decades.

The campaign required the development of an active coalition of national health or-

ganisations, trade unions, local authorities, public and environmental health organisations and many individuals and groups at a local and regional level. Your organization was part of the most successful public health campaign of the last half-century, something of which you can be justly proud.

We look forward very much to continuing to work with you in the future and in particular to making sure that smokefree legislation is introduced on time and is a triumphant success.

*Action on Smoking & Health,
102 Clifton Street, London
EC2A 4HW*

NHS TO PLAY ITS PART IN REGENERATING COMMUNITIES

NHS Press Release

Organisations in the National Health Service are to be told they must play their part in regenerating local communities. The Health Secretary, Patricia Hewitt, said NHS bodies could be a powerful force for good and she is insisting that they take account of tackling deprivation when making decisions about providing local services.

Current guidance to the Health Service and to Overview and Scrutiny Committees on reconfiguration of services already advises them to consider the impact of changes on the wider community but Patricia Hewitt has told public health experts that the NHS should seek to make a real difference to the local economy and local community in its decisions about the shape of health and so-

cial care services.

Speaking at the UK Public Health Association's annual forum, she said that people on low incomes were more likely to have worse health and to die younger. "Too often, our most deprived communities with the greatest health needs have the worst services," she said.

The move towards a service focused on prevention not cure and the shift from hospital care to more community-based services meant the NHS had an historic opportunity to become an agent for regeneration and renewal. In many areas it was already the major employer and a big customer for suppliers. The decisions taken in the NHS about the location of buildings, equipment and ser-

vices could be a major contributor to regeneration in deprived areas.

"I will be insisting that from now on the NHS takes account of the impact of reconfiguration of services on the local economy and local communities. We will be reviewing our guidance to the NHS to ensure that when a new hospital or health centre is proposed, a key factor in the decision making process will be the benefit to the local community in terms of creating employment, buying goods from local suppliers, designing new buildings that save energy and are pleasant places to work and visit, as well as and providing sustainable transport policies," she said.

Reform of the NHS : Effect on Inequality in Health

Lilias Gillies reports from a recent SHA Seminar

Are current reforms in the NHS helping to reduce inequality?

This was the subject of an SHA seminar on 6 March in London, the sixth in a series of seminars across the country studying the impact of present trends.

Martin Rathfelder opened the meeting by summarising some of the points made in previous seminars. Life expectancy is going up and, by the end of the day's seminar, will have gone up by an hour and a half. This is mainly caused by engineering, clean water and sewage principally, and not from healthcare. There are huge differences in this, between urban and rural, between rich and poor and between those who are well-educated and those less so. Yet rich people complain more about their health and their disabilities. They usually get better

“the middle classes have always had choice. We want to extend that to the rest of you”

care. There are great differences in the provision of healthcare between prosperous and deprived areas. There are fewer preventive health consultations in poor areas and more GPs in wealthy areas. It is not surprising that GPs as small business owners choose, if they can, to practise in a prosperous area where conditions are pleasanter and their businesses will increase more in value.

Patricia Hewitt once said that every health authority should have a duty to reduce inequity in health. Are the reforms she is leading bringing that about?

Current changes are all about choice but choice is more about where you go for an operation. There is no choice for chronic conditions, maternity, mental health care, geriatric care.

Informed consent is a prime condition of medical treatment. Is present choice well-informed? There are huge information asymmetries and not all have the capacity or desire to choose. In many areas choice will be limited by reality, geography and the availability of services.

Patricia Hewitt has said recently "the middle classes have always had choice. We want to extend that to the rest of you". Previous speakers have emphasised the need for good information, and this is not just about a few leaflets. People need to talk through the options. Advice, information and advocacy must be good.

In discussion speakers felt that hospitals will continue to dominate the health service. Politicians are very sensitive to the loud voices around hospital closure. There are not many votes in mental health or elderly care. The loss of CHCs and the very minimal support given to, and publicity generated by, PPIFs was regretted.

Sharon Holder, Senior Policy Officer for GMB, said her union represented a variety of NHS staff, ambulance, domestic, car park attendants and NHS managers and had been involved in many campaigns for public services. It was in favour of choice and thought the White Paper was on the whole good but with some reservations. The GMB was particularly concerned about the

creation of foundation trusts which would be autonomous. Technically they would be part of the NHS but would be independent of it and would not be accountable through the ballot box. They would not be bound by national agreements on pay and training, except for doctors. Foundation trusts will employ 1.6 million staff, who are worried.

The private sector is being introduced to primary health care. GPs are reluctant to practice in poor areas and the same might

NHS reform:
Patient Choice
Payment-by-results
Foundation Trusts
New providers
Independent Sector Treatment Centres
Practice-based Commissioning
Direct payments in social care

become true of community nursing under the proposals. PFI is costing a great deal of money and yet deals are still being sought. GMB members are often in a position where patients talk more freely to them and they hear more than would be said to doctors or nurses. Patients often do not have the confidence to ask questions of doctors. Sharon knows how much difference it makes when she accompanies her mother and father to the doctor. She feels the goodwill of staff will go if they are no longer employed in the NHS. The GMB is not against voluntary sector providers but against big business which is only interested in making money for their shareholders.

Jo Ellins of the Picker Institute

described some of the results the Institute had found in surveys of patients around choice. Patients want choice but mostly they want a good local service. They want choice on kinds of treatment and they want to have the information to exercise that choice but that is not on offer.

Health literacy is what is needed and that is not in the White Paper. It seems to be of greater importance in health policy in US and Canada. It is estimated that half of the population of USA has low health literacy. This is defined as the capacity to access, understand and act of health information. Those without it need help in understanding.

Patients want choice about things like car parking, food, visiting times. These are not the most important matters for their treatment. They may choose a hospital for treatment for, say, diabetes

Can more choice mean more equity?

and then find there are a number of other clinics they may need which are not available there. Information about which doctors make more successful diagnoses and treatments would be useful but is not available. Informed choice is only going to be available to some.

What is required? Good health literature. Patient information of good usability. Support and advice framework such as patient care advisors. Self-help groups are good but it is important that GPs know about them and recommend them. Health education should be in the school curriculum and should be available in adult education. It has to be a programme which engages peo-

ple and particularly those who are most disadvantaged. Newspapers and magazines should be encouraged to give credible and accurate information. Cleaners should be educated so that they can give good information. But we do not want doctors and nurses to be absolved of responsibility to communicate adequately with their patients.

Sharon Holder commented in discussion that communication skills should be rewarded and perhaps doctors and nurses would bother more. She also reminded the meeting that many domestic staff were migrant workers.

Ruth Thorlby of Kings Fund Institute described the results of a study she had done with HIV/AIDS patients for whom choice of hospital had always been available. In general choice is a good thing. The government is introducing choice as a means of levering up quality but will it make for better equity. The main inequity is low intervention eg the percent of CABG in the lower socio-economic classes is much less than in the highest.

The movement of patients away through choice is supposed to be a signal to providers to improve. Did it work in HIV/AIDS services? Ruth spoke to 5 staff and 5 patients on 5 units. These were qualitative interviews: eg why did the patient move? with what information? and what was the effect on providers? It was a minority who moved, mostly white gay men, in search of anonymity but also quality of care. Sometimes they moved to a hospital at considerable distance. For information they used the internet and written information but mostly word of mouth though peer groups and support groups both of which were

trusted most.

There was no data kept by trusts on patient moves but senior staff did take note, certainly at first. They worked on improving waiting rooms, polite staff and extra services so that the HIV/AIDS areas looked much better than the ordinary sexual health clinic often adjacent. There did not seem to be much effect on clinical quality.

HIV is probably a special case, for resources and autonomy of units as well as in patient choice. The research was carried out in the late 90s when survival had increased due to antivirals. By 2000 the rates of diagnosis were increasing dramatically.

The units concerned were two big units where patients came from all over the country, two small units with predominantly African and local patients and one with a patient group which would probably be similar to most general hospitals. There seemed no difference in quality and statistics on mortality and length of illness were not different. Complementary therapies were widely available. Confidentiality was not an issue.

Can more choice mean more equity? The current policies will have little impact on the big inequities. There is a need for good information but will it be used by the most disadvantaged. Word of mouth is most important and peer groups are good. Advocacy is expensive. Ruth fears there will be skewed investment in peripherals. HIV units were freer to make decisions than other units. It is difficult to generalise from such small numbers in a qualitative study. More research is needed to show the effect of current changes.

The New Dental Contract

John Lipetz, London Branch SHA

On 1st April 2006 the new dental contract for England and Wales came into play. It replaced the General Dental Contract applied nationally by locally negotiated contracts between each dental practice and the PCT based on practice NHS activity between October 2004 and September 2005. The national items of service arrangements with separate payments by patients for each activity are replaced by three bands of patient charges for courses of treatment:

Band 1 £15.50 (£12.00 in Wales) - exams, x-rays, diagnosis, scale & polish. Also urgent out of hours work

Band 2 £42.40 (£39.00 in Wales) - fillings, extractions, root canal work

Band 3 £189.00 (£177.00 in Wales) - crowns, bridges, dentures.

Personal Dental Services schemes remain for specialist dental activity, particularly orthodontics. There have been discussions with the British Dental Association - who represent private as well as NHS dentists - but no agreement. It is understood that there has been some extra investment by government but this is not expected to continue.

Government objectives

It seems that these are broadly;

1. To simplify the dental contract;
2. To ensure dental money is spent sensibly;
3. To delegate dental contracts to PCT level;
4. To control costs through cash limited budgets capped at PCT level;
5. Perhaps, longer term, to deploy NHS dentistry to where needed.

Effects on dentists

The contract will affect GDPs in the following ways:

- (a) Each practice is required to negotiate the terms of the contract with the local PCT. The funds available are tied to previous activity. This introduces a considerable element of administration, although less detailed work on patient charges.
- (b) The amount of NHS work is to be controlled by the local PCT, not the dental practice. A practice that wishes to bring in a new associate for NHS work cannot do so unless the PCT makes funds available. Some NHS associates may lose their contracts because of the cap on contracts.
- (c) Dentists are limited within the year to NHS activity fixed to the earnings cap in the contract. Dentists will therefore have to balance the activity throughout the year or patients may have to wait until the new contract year for treatment.

Effects on patients

The contract will have the following likely effects on patients:

- (a) There will probably be no change for children and adults on benefits, neither of whom pay charges.
- (b) Access to NHS dentistry might be inhibiting for those whose teeth are in good condition and simply need a check-up, particularly to those on low incomes.
- (c) People who are poor but are above the exempt level will find the new contract a disincentive if they need a lot

of work done. Once in a band they cannot cut out a procedure to avoid extra cost. On the other hand, the limits on the amount to pay are likely to benefit patients needing extensive treatment. Patient access could be limited by a dental practice not being able to take on new patients because the yearly contract is capped.

- (d) As a result of payment by courses of treatment rather than items of activity there is a risk of under-prescribing for some patients.



Comment

Judgments on the effectiveness of the new dental contracts should concentrate on whether or not they will provide better dental care to patients and better oral health for the population as a whole.

The number of NHS dentists available to meet need varies across the country. Over many years there has been a continuing loss of dentists from the NHS. Some move over to private work; the majority mix NHS and private practice; and many of the latter increase the proportion of private work over time. The government claims to have introduced an extra 1000 dentists but it is not known how many full time equivalents (FTEs) have been lost to private

practice. A significant number may move to more private practice as a result of the new contract or increase their private work. A few are likely to refuse to sign up to the new contract and so be lost to the NHS but their NHS funding will return to the PCT so that the trust can make available that money to alternative dentists in the area.

The ability of PCTs to balance these effects by providing money for NHS growth depends on the availability of funds from the cash limited budget and local dentists being able and willing to take on more work on the NHS. The funding provided to PCTs for these contracts has been ring-fenced for three years based on historical expenditure in each practice. There is no sign that the funding will go to those areas where NHS dental provision is weakest. The most deprived areas have the poorest oral health.

Financial monitoring will be based on Units of Dental Activity. Work in Band 1 accounts for 1 unit; for Band 2, 3 units; and for Band 3, 12 units. Payments to dentists are based on these units irrespective of how much work is carried out in the band ie the same payment is made for 1 filling in Band 2 as for 12; and for 1 crown as for 3 plus 1 bridge in Band 3. Monitoring will be based on these bands and therefore not on the actual amount of individual treatments provided ie it will concentrate on the finances rather than dental health. There will be a lack of detailed information on actual treatments such as how many fillings are done or crowns put in. Patients with high dental needs, usually those who are poor, require more work within the bands. There is a disincentive for dentists to treat such patients. There will be a high risk of under-prescribing for such patients. Access to NHS could be made more difficult for poor patients and the

assurance of effective treatment put at risk.

The profiles of the work carried out by each NHS dentist will now be held by the PCT. Likewise, the Dental Reference Service will need to alter its system of working. Expertise within PCTs will need to be considerably enhanced if effective use is to be made of the practice profile information now to be available at local level. Some PCTs are already concerned that patient charge revenue that forms part of dentists' remuneration will be less than under the previous system and will not be made up by the payments for the units of dental activity they make to dentists. As a result, dentists could be obliged not to treat any more exempt patients than they do now. The Dental Practice Board is to become part of the wider Business Services Authority. Clearly there will be much less work there as a result of the change from detailed items of services to the broader courses of treatment. How its role adapts will be a relevant factor. Will the support to PCTs be adequate?

The new dental contract omits any indicators that measure the oral health of individual patients or for a patient population as a whole. NHS dentists have no incentive built in to improve the oral health of their patient populations. Indeed, the lack of information on treatments militates against examining oral health outcomes. This is the key weakness in the new arrangements. This is the most critical area that requires investigation.

Recommendation

When the contract has been in being for a period it will be necessary to revisit the contract to assess how it has affected patient care and the oral health of the population.

CAMPAIGN TO RAISE AWARENESS OF ABUSE OF ELDERLY PEOPLE

A survey shows that only two per cent of people see abuse of elderly people as a priority, in spite of evidence that suggests it affects as many as 1 in 8 older people. The results are published by Help The Aged as it launches a campaign to raise awareness of the problem of elderly people being abused through violence, neglect and financial exploitation.

These findings, from research conducted for the charity by Andrew Irving Associates, show that tackling child abuse, cancer and cruelty to animals top a list of issues cited by the public as causes they would most readily support. The researchers found, though, that prevailing taboos could be lifted with respondents being far more willing to identify abuse of older people as a priority once they were prompted.

The campaign challenges people to sign up to the pledge "I will" to show their determination to help stop the abuse. It is being run in partnership with the charity Action on Elder Abuse, and aims to address current low awareness of various kinds of abuse, ranging from financial exploitation, emotional bullying and neglect to violence committed against older people by their friends and family or by professional carers.

People most commonly assume that professional carers are most likely to be the perpetrators of abuse and old people in care homes are most identified as being at the highest risk. In fact the evidence suggests that most people responsible for abuse are related to those on the receiving end. A quarter of cases involve sons and daughters.

More than half of those questioned were adamant that no abuse of any kind happened within their own families. By contrast as many as two thirds accepted that serious abuse incidents happened in their town. Help the Aged fears such ignorance means abuse of dependent and vulnerable older people goes undetected and unreported.

Refugee Doctors

Dr Tom Fitzgerald

According to the British Medical Association there are over 1070 refugee doctors registered in the UK (with over 800 in London). The true number is likely to be many times more, as many are frightened to go on the database.

I think the BMA underestimate the numbers involved and massively overstate their role and the enthusiasm of the medical establishment to help. However their international team are very helpful and are a good source of information on this subject. Mention is made of funding for projects, but in my experience this is drying up fast. Many projects may fold imminently because of the cash crisis.

There is no umbrella organisation/body responsible & there are lots of piecemeal efforts to help by various agencies. Efforts to help do need to be centralised and better co-ordinated. It's crazy that at a time when the UK does not have enough specialists efforts are not being made to harness these doctors' knowledge, skills and experience. A lot of this boils down to racism, Islamophobia and xenophobia in the medical establishment. The same applies to nursing and other health professions. The voluntary sector are

achieving far more than the statutory agencies which are supposed to help.

I have become involved in mentoring and a PLAB group. They say you have to walk a mile in another man's shoes to understand his journey. I have witnessed many of the obstacles these people face. Without refugee status, asylum seekers cannot commence training, so they have to wait for their case to be processed. Immigration processes are designed to pander to Daily Mail readers rather than to help genuine refugees. People live in poverty, and sources of help like the RMBF are only available to GMC registered medics - a Catch 22! These doctors and their families cannot work or train, so they are dependent on benefits and they become deskilled.

The GMC only waive the fees for the PLAB exams if full refugee status is granted. Doctors from mainland Europe do not have to pass the PLAB exam to work in the UK, so why should non-European doctors be subjected to this unfair hurdle? This is a sneaky exam and lots of people fail. These doctors face a huge amount of stress - they risk having to return to their homeland where they and their families

face imprisonment, harassment and torture. Deaneries, PCTs, StHAs and the BMA make a lot of noise about the help they make available to asylum-seeker health professionals, but this is just hot air - the majority of people who help out are retired or volunteers. When I volunteered to be a mentor, I was told that I was the first medic to actually volunteer and I was asked to write a piece in *BMJ Careers*.

Even when asylum seekers pass the exams they have problems with the GMC. If a doctor flees his homeland because he has stood up and spoken out about injustice and human rights abuses, he is unlikely to get a Certificate of Good Standing from the medical regulator in his homeland. They often get convicted on trumped up charges - well, try explaining that to the GMC! There are asylum seekers with appalling keloid scars from the torture they received in their homeland, but the GMC take the view "no documentation - you must be a rogue doctor". Convictions for treason (in their homeland) or pinching some bread from ASDA (for their hungry kids) makes these people "unsuitable" to practice medicine in the eyes of the GMC. From the comfort of my home in Ful-

ham, I am a prolific letter-writer for Amnesty, but I do not think I would have the gallantry to risk my career, liberty and life to defend the rights of others if I actually lived in a totalitarian dictatorship.

The next hurdle is finding a clinical attachment, which can be very difficult



although it simply involves acting as an observer in the NHS. Many unscrupulous Trusts in London try to charge refugees for this, even though they are not supposed to; others simply refuse to help.

People who have been specialists cannot find jobs in the UK. Potential employers tell them that they are over qualified for training posts, yet the royal colleges refuse to recognise non-EU qualifications and experience so they cannot get consultant jobs. The GMC would automatically recognise an EU doctor's qualifications and put them on their specialist register with as little as 3 years experience in anaesthetics, yet an African doctor with over 30 years experience

would not be recognised. These regulators trot out the patient safety justification, but they are playing the race card. Not surprisingly, many give up and turn their backs on medicine.

That is a loss to medicine - but it's an even bigger loss to the NHS. We learnt from the Bristol Scandal that the NHS needs doctors who have the courage of their conviction rather than the usual clone that UK medical schools produce. These people have demonstrated that they have probity and integrity. You really need to meet these incredible people and their families to discover what's so special about them!

The situation with health professionals who are not doctors is even worse. Nobody knows the extent of the problem - or to turn around - the magnitude of the opportunity. These health workers desperately want to work in the NHS, and given the recruitment/retention crisis we definitely need them.

The medical establishment take the view that "unfortunately they are all from the wrong two continents". That's racist. I'd be happy for any of the refugees that I've had the privilege of meeting to treat me or my family. I always look for the best in others and there is a lot of good to be found in these people. The people we are

trying to help are all exceptional people, they could be making a real contribution to their community, but instead they are left to get up to mischief.

The plight of refugee health professionals would be a great issue for the SHA to champion. We could press for "joined up" efforts, we could promote the mentorship schemes and we could press government to devote more money to this cause. Money should go to the voluntary sector rather than to StHAs and Deaneries who have a dreadful track record of wasting money on eye-catching initiatives and gimmicks. In anaesthetics, there are currently 5,800 consultants in the NHS, but it's estimated that we need 8,500. For the NHS to train UK graduates to reach this target, it would only be achievable by 2019 and only then at the expense of the other Cinderella specialities. NHS operations are routinely cancelled because there is no anaesthetist. Refugee and asylum seeker health professionals are not economic migrants - we are not poaching them from developing nations, they are fleeing persecution. It makes perfect sense to welcome them and support them back into practice in the NHS. There can be no reason not to harness the skills and talents of these extraordinary people.

FREE PERSONAL CARE HAS 'MARGINAL IMPACT ON PUBLIC SPENDING' IN SCOTLAND

*From a press release dated
1 February 2006*

Scotland's policy of providing free personal care for older people has led to a fairer system without any undue extra public spending, according to an independent assessment carried out for the Joseph Rowntree Foundation and published in February. The Scottish Parliament decided in 2001 that elderly people could have free care at home and in residential and nursing homes.

Researchers from the University of Stirling say that people who use care services in Scotland and their families feel that the arrangements are more equitable and are an improvement on the past. The view is shared by social care managers in Scottish local authorities and by care home providers. The study also finds that the system has not only reduced means-testing and money worries but it has not led to a reduction in informal support provided by relatives and friends as some people feared it might. An economic analysis in the report shows the policy has cost more than expected. In 2002-03, for example, the actual bill was £127 million compared with a planned figure of £107 million. The report says, though, that the current annual cost of £140 million accounts for

0.6 per cent of the Scottish Executive's total budget and so has only a marginal impact on other areas of public spending.

The study concludes that differences in the public costs of personal and nursing care between Scotland and the rest of the United Kingdom are smaller than has been suggested because care home residents in Scotland are no longer paid Attendance Allowance and because payments for nursing care are more generous in the rest of the UK. The report anticipates that a big rise in the number of people aged 85 and over might lead to a tripling of the public costs of personal care by 2053 but a further shift towards providing more care services at home and policies to promote healthier living could reduce the projected bill.

The researchers, David Bell and Alison Bowes, found that free care had particularly benefited older people with degenerative conditions but that there were still misunderstandings among older people and carers about the extent of free personal care. They also identified concern among local authorities as well as older people and carers about the interaction between care charging policies and other parts of the welfare system, especially benefits.

"The Patients' Agenda for Safety & Justice", 9th May 2006, London

10.30 am – 4.00 pm

I am pleased to invite you to this important new style conference which is organised by Action against Medical Accidents (AvMA) in association with the Medical Harm Self-Help Network – a network of patients' organisations interested in patient safety and justice. Places are FREE for individual members of patients' groups.

The event sees the agenda and presentations being set and delivered by patients/ patients' organisations for a change. Representatives of the key statutory agencies will be in the audience mainly to listen and feedback to their organisations. The event will also see the launch of the "Patients for Patient Safety" project which AvMA is managing in partnership with the National Patient Safety Agency (NPSA). This initiative will create a network for lay people involved in patient safety/clinical governance work to share experiences and good practice, as well as training to help lay people gain the confidence, knowledge and skills to help the NHS improve safety.

Please complete and return a booking form to reserve your place

Yours sincerely

Peter Walsh

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Future Services Network



The Future Services Network is an alliance between the Confederation of British Industry, the National Consumer Council and the Association of Chief Executives of Voluntary Organisations.

“The Future Services Network is for organisations and individuals who want to see public services which are genuinely driven by citizens and consumers. The principles below are our "call my bluff" challenge for public service reform”

1. The public needs a voice in public services

Individuals and local communities should be given a real voice over key decisions about public services. Both at a neighbourhood level and at a government level, the citizen's voice should be heard, whether through consumer boards, user group representation, direct consultation, citizens' juries or other means. There should also be regular feedback so that citizens can find out how their participation has changed services for the better.

2. We need flexible public services that respond to people's needs

The service element of public services also needs to be much better developed so that consumers get a more personalised and responsive service. This means a greater emphasis on customer service, with friendlier, more accessible services with 24 hour and internet access.

3. Many services could be delivered in new ways, such as by voluntary organisations or private companies

In future public services will need to be delivered by a range of different providers from the public sector, private sector and the voluntary, or third, sector. Only a proper mixed economy of provision can ensure that providers are kept on their toes. This means that there should be a genuine level playing field between different providers so that the choice can be made about who can give the most appropriate and best value service. The third sector – voluntary sector and social enterprise organisations – can be used much more to deliver services where the consumer will be much better served by their grassroots experience and closeness to local communities.

4. People need more of a choice in public services

Choice is a major way in which citizens and consumers can have their say and decide what they want from public services. Choice should be extended wherever it can practically be applied in public services in a fair way, whether this is about the particular service people want, the way it should be delivered, or how it can be accessed.

5 Public services need to focus on customer satisfaction

There should be a rigorous and consistent measure of cus-

tom satisfaction so that the public can clearly see how services compare over time and providers can gauge customer satisfaction. This creates a virtuous circle where the feedback is used to ensure continuous, customer-focused improvement. It should also be made clear who is responsible for each element of service delivery, so that public service consumers know who to hold to account for what. This should extend to service providers: where services are not up to scratch, local communities should have the power to review service provision.

6. Motivated staff make for better public services

Responsive, well run public services require confident, respected and fairly paid public service workers. There should be less bureaucracy holding staff back from showing initiative and innovation in service delivery and proper provision should be made for decent training and career progression.

Earlier in the year I asked all members for views on the Central Council's approach to the marketisation of the NHS as set out in our paper on the topic; and for views on whether SHA should affiliate to the Keep Our NHS Public (KONP) campaign. The response was small – only about 10% of members replied – but it was, by a substantial majority, in favour both of our stance on marketisation and of affiliating with the campaign.

This was reported to our AGM when the decision was taken to affiliate for a year with the clear intention of being very active on the Campaign's Steering Committee and of influencing how the campaign develops.

Most members attending our AGM had reservations about some aspects of the campaign. For example, we do not see it as a vehicle for criticising everything that happens in the NHS or for trying to belittle the many achievements of this Labour government. On the other hand we do strongly support its worries about the effect of increasing commercialisation and we would like to see this concern channelled into some positive suggestions for an alternative future direction of travel for the NHS that remains true to its founding principles, is not in conflict with our socialist ideals, which builds on rather than undermines the commitment of its staff and which seriously addresses the core issue of reducing inequalities in health in this country.

I will endeavour to keep you informed on what we are able to achieve through affiliation to the KONP Campaign, and would be grateful if you could bring to our attention any relevant issues in your area.

Paul Walker

Chair.

Barrett v United Health at Creswell

From Dr Elizabeth Barrett MB, BCh,
MRCGP 62, High Street, Warsop, Notts.
NG20 0BZ

This is an edited version of Dr Barrett's letter. The full version is on our website, and Dr Barrett is speaking at our conference in Sheffield (see back page)

Background: Concerns about the service in Langwith

I have been a GP in Shirebrook for nearly twenty years. For quite some time, concerns have been expressed about the primary care service in Langwith village, which is on the edge of our catchment area. Langwith is in the historically anomalous position of being a branch surgery for Creswell, three miles away. The transport links between Langwith and Creswell are not good, and there is no natural social relationship between the two villages. Langwith patients felt that they were getting a second class service, and this view was supported by statements from various involved professionals and representatives of the public. Langwith and Shirebrook contain six of the ten poorest wards in the PCT. It is a big challenge to provide services for a cluster of deprivation like this.

Our involvement

In March of last year, I approached Martin McShane, the Chief Executive of North East Derbyshire PCT, and told him that I would like to form a multi-disciplinary clinical team to look after the patients in Langwith. I would leave my existing practice and involve myself, totally, in this project. The team comprised myself, a prescribing pharmacist a part-time practice manager and a part-time nurse. My semi-retired husband was going to take on the role of a flexible 'spare driver'. Among our team, we had lengthy local experience: three of our team are school governors for local primary schools; Frank (my husband) has served on a variety of local community regeneration

projects, including the Meden Valley Partnership; I am GP advisor to the local Village Companies Care Co-operative. In other words, we are firmly rooted in the community. As well as this, we have academic credibility. I am a GP trainer for the Chesterfield Vocational Training Scheme. I am also a GP appraiser for the PCT. Our pharmacist is one of the first three pharmacist prescribers in Derbyshire and has close links with Sheffield University.

Involving local people

Scarcliffe Parish Council did a door-to-door survey which supported the idea of a separate, small surgery for Langwith. We were prepared to borrow money to build a new surgery, as the small three-roomed building is not fit for purpose in the modern health climate. We took the view that our small team could offer simplicity of access and holistic care. We could develop clear pathways and clear delineation of roles. We had a flat-structured team that could communicate meaningfully, and continuously with its local community. We felt that we could re-engage this community back into its health care. We would bring the highly successful 'exercise on prescription' to the local Community Centre, and we would try and optimize health promotion activities. We would optimize performance because of commitment to the ideals of the NHS, professional enthusiasm and professional development. We would involve patients, right from the start. We didn't just know what we had to do: we knew, and had the confidence of, the individuals who would be involved.

Dealing with risks

This project presented some risks to the team. However, we felt that we could capitalize on our quality, improved access and the desire that patients have for continuity, and that we could build up our list and provide an element of competition that would encourage everyone to 'up

Page 13 their act'. It is worth pointing out that the two smallest practices in the PCT consistently score highest in patient satisfaction surveys. They seem to provide what patients want.

The process of our bid

At the beginning of October, when the PCT decided not to extend the contract for the existing Creswell PCC, the advertisement was placed in national papers. The PCT were prepared to offer Creswell PCC as a whole practice (Creswell and Langwith together) or as separate surgeries, because of our interest in Langwith on its own. However, concerns were expressed about the size of the proposed practice, and I was in no doubt that we were going against the trend for ever larger practices and 'consortia'. Nevertheless, I was also in no doubt that we were hitting all the buttons on the NHS new agenda; the bid was patient orientated and was, clearly, what the public wanted; it was local and accessible: it would give the patients an opportunity to exercise choice, and would improve their access to health care: it would do much to reverse the 'Inverse Care Law', which states that patients who are most in need of health care are least likely to get it.

When we filled the application form, there were eleven criteria, against which we had to evidence our experience and our achievements. We could satisfy them all. . We were aware that our bid could not be the cheapest because of the experience of our team. Nevertheless, we felt that our team would provide good value for money.

The decision

On 23rd of December, in a press release entitled 'Good News for Creswell', the PCT told us that UnitedHealth Europe was their 'preferred provider' (a misuse of an American HMO term). No-one in the area had ever heard of UHE. We were told that this was a 'young British company'. A basic search on the Internet revealed that this was, in fact, the largest private health corporation in the US. There had been no public discussion about the implications of

this decision, either locally or nationally. This seemed to be a major change in NHS direction, and many people were disturbed when they checked on the details. Bear in mind that it was at least five weeks before the pending White Paper and, although the enabling legislation had been put in place for Alternative Providers of Medical Services (eg private providers) there had been no public or parliamentary debate. The concept of bringing a global player into the NHS took everyone by surprise.

Finding out

Under FOIA, one of my colleagues obtained the interview marks. Six bidders had been short-listed: five of these were private companies, and one was an NHS practice in Eckington (Moss Valley). We discovered that UHE had scored the highest marks in 'record of engagement with public and patients'. It was not clear how they could have evidenced that score. UHE scored the highest marks on the criterion of 'proven track record of providing medical services' on the basis that they have one part-time GP on their management team (a GP in Kingston-upon-Thames); apart from this one GP in Kingston, there was no clinical team and UHE had yet to advertise. UHE, as an organisation, had no actual clinical team and no record of practice in UK Primary Care. It would appear that UHE was negotiating as a management company. Enquiries were directed to their media office in London.

Concerns about consultation

Patricia Hewitt has made it clear that she wants patients to 'be in control... patients will be in the driving seat'. She wants services that are accessible and close to people's homes.

To make choices, people need information, and they need time to consider the given options. There was no consultation with patients in Langwith, or with Scarcliffe Parish Council. The first they heard of the decision was their Parish Council meeting on 17th of January. The lack of consultation process with patients is currently the subject of a legal challenge.

Far from consulting and enabling the local community, the process of appointing UHE as 'preferred' bidder has been clandestine and surreptitious. There are issues which are of enormous importance to the public and to all health

professionals, not just the ones that are in the immediate vicinity. A change of this nature is unprecedented within the NHS.

Concerns about presentation.

Private status of GPs. Economical with the truth?

Since the public announcement of the choice of UHE, there has been a consistent attempt to portray NHS General Practitioners as being 'private' and 'profit-making'. General Practitioners are, indeed, small businesses. Their private contractor status was conferred, at the inception of the NHS, as a way of allowing doctors to work within the NHS but remain, simultaneously, a self-regulating profession. Our profits, however, are our wages, and are roughly commensurate with what the Government intends us to have, although remuneration varies from practice to practice. GPs use profits to pay themselves and their staff, and to invest in buildings and services. GPs do not have share-holders; their first responsibility is to patients.

Proponents of privatisation, however, repeatedly focus on the 'private' status of GPs, presumably so that the shift to UHE will be seen as conferring no great change. This is disingenuous. The status of UHE, as a private, profit-making company, is remarkably different from that of GPs. The first responsibility of share-holding companies is to their share-holders. Their financial affairs will be protected by commercial secrecy.

Criteria:

Applications were assessed against eleven criteria. We have the final marks of the applicants who were shortlisted, but we do not yet have the marks given in the shortlisting process. Neither do we, as yet, have any insight into how these marks were reached. I have already drawn attention to the fact that UHE scored highest on two criteria where it would seem difficult that it could score anything (public involvement and record of providing good medical services). When asked, at a recent meeting, what was the key 'edge' that made UHE stand out from the other applicants, Martin McShane replied that it was their strategic vision. It might seem that UHE were picked for its knowledge of the future White Paper

and its alignment with the future plans for the NHS. This is an advantage that NHS practices don't have. If this situation continues to pertain, it is probable that the private sector will take over vacant practices one by one. UHE has expressed its intention to do precisely this.

Why does a company the size of UHE want a practice the size of Creswell/Langwith?

It is difficult to accept UHE's argument that its dream is to provide high quality care in deprived areas. Critics argue that UHE needs a foothold into practices in order to get a hold of the lucrative commissioning budget in the NHS, worth billions of pounds. Commissioning, in the NHS, accounts for 80% of the NHS budget. The potential to manipulate this budget is huge. American corporations are unlikely to be in this business to provide our deprived areas with tender, loving care. One doesn't have to be a cynic to realize that lower wages and 'rationalisation' of services will be needed to service shareholders' profits. What will the British public feel when they see their precious NHS budget going to multi-national shareholders instead of being re-invested in patient care?

Conclusion

Those responsible for the current decisions about the NHS have become used to the idea of involving profit-making multinationals directly in the NHS. Ordinary people, however, still have an instinctive dislike of treating patients, and health care, as commodities to be traded. Those in positions of power are denying this reality. This could be described as 'ethics creep'; it no longer seems strange; they can justify it to themselves. Driven by ideology, they don't want to see the risks. In the arrogance of power, they see no need to explain anything, or seek consent.

Even if there were no ethics involved, we must think of the future and imagine the NHS, ten years from now, unable to re-invest in, and direct, its own health and social care.

The international trade story underlying NHS privatisations

Linda Kaucher

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Behind the various forms of privatisations being imposed on the NHS, there is a little-known internationalised dimension with huge domestic implications.

NHS privatisations are in a variety of forms - Private Finance Initiatives (PFI), private provision contracts within a tax funded, universal provision service, and privately offered services associated with the NHS. Whatever form the privatisations take, they are simultaneously being 'liberalised', although not named as such. 'Liberalising' means the investment opportunities of privatisations being offered to international investors.

This year, the current Round of negotiations for the World Trade Organisation's General Agreement on Trade in Services (GATS) is due to be finalised. The only previous GATS Round was modest and unnoticed, but this one is intended to significantly progress international corporate control. The GATS gives rights to international investors while reducing states' rights to regulate.

It is the liberalisations, such as those that have been, and will be, brought into the NHS, which will be entered into the GATS, as part of the EU's liberalisation offer. Once in the trade agreement, the liberalisations will become effectively permanent. But this also means that the privatisations on which the liberalisations are based will become effectively permanent, too.

So, however badly privatised contracts perform, however much more expensive private provision proves to be, however much of its funding the core service is forced to spend on the administration of private contracts, and however dirty hospital wards are, it will not be possible to take back the provision into the public system. The legal prioritising of shareholders' rights to feed off the NHS, over the quality of the service, will be set in stone.

The GATS came into being as a result of lobbying by the biggest international investment corporations, such as Citicorp and American Express (according to the UNDP), and behind the façade of negotiations and state-to-state trade-offs, all service liberalisations under GATS are primarily in the interests of transnational investors. And access to large scale public purse spending, such as the NHS, fixed irreversibly into the legalised rules of an international trade agreement, is the glittering prize.

The lack of discussion or recognition of something so significant may seem strange, but structures work to maintain this silence. Trade agreements appear complicated, and faceless Department of Trade and Industry bureaucrats provide the UK input, offshore, to the negotiating position of the European Commission. The UK Parliament doesn't discuss trade agreements and if they are mentioned, it is in 'development' terms, not in relation to

domestic effects.

Within the Parliamentary Committee system, again, the Overseas Development Committee looks at international trade agreements but the heavyweight Trade and Industry Committee doesn't, and the main civil society critical trade interest is again from development organisations, which emphasise the development perspective. The GATS, like all the multilateral trade agreements, does indeed have implications for developing countries, many of which are resisting GATS, realising that they can liberalise services without the permanent commitment of the GATS.

In the EU, though, transnational investors lobby hard. A main lobbying mechanism is the 'European Services Forum', led by Christopher Roberts, ex DTI, also heading the City of London's 500 foreign banks, under the International Financial Services London umbrella, and also a senior consultant with a major US law firm, lobbying, similarly, in relation to US trade policy.

What the EU, subject to this sort of corporate lobbying, is offering to liberalise on our behalf, was tabled at the WTO last June, without publicity, and is even hard to find on the web. The offer does not of course just apply to health. GATS covers Business, Communications, Construction and Engineering, Distribution (includes food) Educational, Environmental (includes water, energy, toxic and nuclear waste), Financial, Health and Social Services, Tourism and Travel Related, Recreational, Cultural and Sporting, Transport - plus Other!

The EU offer is not only comprehensive on service liberalisations but also includes an offer for temporary migrant service workers from all 150 countries of the WTO member states, to work in the EU, with no rights beyond the basic wage. Most jobs in health are service work. It appears that there is no mechanism in the EU offer to spread that influx across the EU, as this question was asked of the Department of Trade and Industry, with no response.

This part of the EU offer is called Mode 4, the movement of people. Mode 4 to the EU was requested by India, but under WTO rules, offers must be made equally to all members. The International Confederation of Free Trade Unions is calling for Mode 4 to be removed from the GATS, but the Mode 4 offer remains in the EU offer. Despite the implications for working conditions and pensions, this aspect of the EU offer has not been discussed in the UK Parliament.

Because of the urgency and the effects on the NHS, Parliamentarians must be urged to become informed on, and to take responsibility for, the implications of the GATS.

Future Events

An announcement on the future of Patient and Public Participation in England is expected early in June. Patient Forums as we know them may be abolished. CPPIH is for the chop. Local Authority Scrutiny Committees may be given a wider roles. The NHS is in the middle of a traumatic reorganisation.

Harry Cayton, the Patients Involvement

Tsar said, on the World at One:
Money being spent on CPPIH at the moment will go to the front line, so that Forums can have their own workers, offices and local presence to make them stronger.

Our next Conferences are designed to help you make sense of these developments if you are concerned about how the patient's voice can be heard in a system where individual choice is given more importance.

Involving Patients in Commissioning

Quaker Meeting House
10 St James Street, Sheffield, S1 2EW
Saturday 27th May 2006 10 am to 4 pm
Dr Elizabeth Barrett, GP, Creswell
James Munro Patient Opinion
Celia Dossett, Foundation Trust Network
Tina Funnell, Patient and Public Involvement
lead, Yorkshire Strategic Health Authority
Peter Johns, Director, Board of CHCs in
Wales
Jill Knight, Chair Scarborough Whitby and
Ryedale PPI Forum

Toynbee Hall
28 Commercial Street, London E1 6LS
Wednesday 21st June 2006 10 am to 4
pm
Patrick Hall MP. Chair of the Parliamentary
all Party group on Patient and Public In-
volvement
Dr Brian Fisher, Lewisham PCT, Patient
and Public Involvement Lead, NHS Alliance
Speaker from the PPI National Centre of
Excellence (to be confirmed)

Public Involvement in Developing Mental Health Services

Birmingham & Midlands Institute
Monday 12th June 2006 10 am to 4 pm
Lindsey Dyer, Director, Service Users and Carers Mersey Care
Susie Green, formerly Associate Director at South Staffs Healthcare NHS Trust

Regulating Healthcare Professionals London Wednesday 12th July 2006
With Sarah Thewlis, Chief Executive Nursing & Midwifery Council

Costs for each of the events above:

£12 SHA members. Some free places for people on means tested benefits.

We provide lunch and cater for vegetarians. If you have any other special needs please let us know.
To book a place please ring 0870 013 0065 or email admin@sochealth.co.uk.

Labour Party Conference Manchester 24th to 28th September

The SHA will be running a symposium on Inequality on Monday 25th September at the Friends Meeting House just outside the conference.

Main speakers so far confirmed include:

Sheena Asthana, Professor of Health Policy University of Plymouth,
Danny Dorling, Professor of Human Geography in the University of Sheffield
Richard Wilkinson Professor of Social Epidemiology, University of Nottingham

Articles, Letters, Announcements and Comments should be sent to Gavin Ross, 21 Connaught Road, Harpenden, Herts AL5 4TW, Tel/Fax 01582-715399 or by e-mail to gavros.ross@btopenworld.com