socialist HEALTH association

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These are the key issues we will be putting to the Labour Party National Policy Forum at the end of July. Thanks to all members who contributed their ideas. We will let you know how we get on, and will be asking for your help in getting some of them through Party Conference in September.

www.sochealth.co.uk

Our programme for the Labour Party:

* Free compulsory school meals
* Bring health considerations into planning law
* Increased benefits for pregnant women - from early in pregnancy
* Proper information for consumers about the contents of food and drink - including alcohol and take away food
* Universal health impact assessment of government policy
* Free nicotine replacement products as long as you want
* Proper programmes for prevention of mental ill health
* Abolition of charges for examination of teeth and eyes
* Abandon health charges for failed asylum seekers and the policy of forcing people into destitution
* Universal occupational health services
* Move Public Health out of NHS and into local authorities
* Duty on PCTs to provide proper information about services in their area
* Proper consultation before commissioning new services & measures to ensure commercial providers are not given unfair advantages in tendering processes
* All contracts to be made public
* Real local accountability in the NHS
* Recognition of the limits on choice for most patients
* Increase in Carers Allowance and abolition of rules which prevent people claiming it
* Introduction of a minimum standard of income below which nobody will be forced to live in court proceedings
* statutory targets for reduction in urban traffic
* integrated ticketing throughout the UK to make public transport more attractive
* Proper advice and advocacy services for disadvantaged people
* In the tax and benefit system abolish the principle that there is one law for the rich and another law for the poor
* Central ambition to create a fairer and more equal society where the benefits of prosperity are shared by all.

Reaching Agreement Between GPs and Govt. on Polyclinics

Dr Steve Bick. PPC for West Dorset

Lord Darzi has announced extra investment in primary care, in the creation on 150 new 'polyclinics'. Initially we were told that these clinics were being sited in the inner cities, where the standard of primary care was perhaps not as good as the rest of the country. They would there be helpful to various deprived and marginal groups. Also to commuters who were often away working in the day and therefore had difficulty getting to see their GP.

The Dept of Health has said that we have to have one of these clinics in every PCT- whether we want /need one or not. Also there was supposed to be 'consultation with local GPs'- but this hasn't really been happening. PCTs should have the option of whether to have one or not- according to local need.

The new clinics are generously funded. - operating costs of up to one million pounds per annum. Also the clinic hours are not in line with existing GP practices (the new hours being 8-8 7 days a week). There is concern that PCTs are favouring private providers from companies such as Boots, Tesco, United Healthcare and BUPA. Currently most primary care is provided by local GPs who work in practices that are committed to the NHS (although have independent contractor status).The GPs who are effectively local small businesses are concerned about these larger commercial companies moving in on the healthcare sector.

This policy area is going to open up into a widening rift between the Govt and our GPs. And open the door further to the private sector. However there are a lot of benefits that can be had from these new clinics. The main benefit is to provide a 'walk in' service to people who have difficulty accessing their GP ,and this could benefit the GP practices who often have difficulty offering appointments to everyone due to high demand.

The main change that I would suggest is that these new clinics do not actually sign on new patients. All are welcome to attend as is their preference but their registration would remain at their local family GP. If they are allowed to register they would be deducted from the GP list, with loss of income to the GP. Currently registration is just an option at the polyclinic. You do not have to be registered to be seen. By making this change Polyclinics would not be detrimental to GPs.

PCTs should be advised to work with willing local GPs as a priority, but could seek other providers if no local GP interest.
I would also like to see the end to any restrictive practices. To allow patients free choice as to which surgery they would like to belong to. There are certain qualifications on this. They need to live in the practice area. Also some Surgeries have been declared 'full' and are not able to take any more. Also some patients have previously been excluded for unacceptable behaviour. Sometimes there are local agreements to cover certain residential homes, provided that has been agreed with the PCT.

The GPs would aim to provide 'same day triage' (if required) offering same day appointment with GP, Nurse or allied health professional, or a telephone assessment to assess need and urgency while maintaining pre-bookable appointments for the patients' convenience. In many areas Demand exceeds Capacity, so extra resources may well be required. Blood tests should be done at the GP practices not at outpatients. Sessions should be provided with 'same day' slots.

Many GP surgeries do not have enough space. We need to expand the programme of replacement and expansion of surgery premises, so that more surgeries meet modern standards. Modern GP premises need enough space for the other members of the Primary healthcare team (District nurses, Midwives, Chiropodists, Counsellors, etc). New GP premises also give an opportunity to work along with other community organisations where there can be some joint benefit.
The Governments proposals for polyclinics need amendment and more careful thought along with other developments to improve primary care and help create a more effective NHS.

How Labour can win on health

Dr Neil Goulbourne

The disappearance of Labour's impressive and long-unassailable poll lead on health is frustrating for the Government. It would prefer that voters focused on the extra £50bn a year investment, on the 100,000 more staff, on Britain's biggest ever hospital building programme, on the dramatic fall in waiting times for treatment and improvements in performance across the country.

But instead the public sees the closure of local hospitals and what the media is calling 'cuts'. Rather than crediting Labour with securing the future of a valuable public service, many recall the introduction of the private sector, through the private finance initiative, and stand-alone, profit-making treatment centres. And the targets that have transformed performance in many areas of the NHS are regarded as unwarranted interference with the decisions of trusted nurses and doctors.

So Labour has a problem. And it is increasingly clear that the solution to it must lie with NHS staff themselves and in successfully reconfiguring the health service so that it works to prevent illness as much as to treat it.

Cuts, privatisation and the undermining of professionals – the public's view of the NHS under Labour couldn't be further from its own. It sounds worryingly like the Tories' record of the mid 1990s. Yet today's Conservatives, having successfully divorced themselves from their record in government, are now making a convincing bid to become the party of the NHS. Having promised to match Labour's spending plans, they have neutralised the issue of funding that formed the main dividing line between the parties for years. Furthermore, rather than picking a fight with health workers as Labour has tended to (the spat with GPs over opening hours being the most recent example) the Tories have promised to hand back power to staff. Although sharply at odds with their record in power, this message appeals both to clinicians who are tired of relentless change and to a public that still trusts health professionals above politicians.

If Labour now finds itself wondering how to recapture the initiative and regain health as an electoral asset, the solution may be close at hand. The focus of the NHS needs to shift if it is to meet the challenges of the years ahead. The crippled health service of the 1990s struggled (and often failed) to treat the sick. Having largely dragged its performance into the 21st century, a system designed to deal with illness must face the growing challenge of preventing it.

Not only is prevention of illness more powerful than treatment after onset, it is also the most effective way of reducing the growing inequalities in health that shame the UK. Inherent in the notion of an NHS focused on wellness is the need to intervene in people's choices, to reduce smoking, obesity and physical inactivity. The two-pronged attack formed by the recent ban on smoking in public and major investment in services that help people to stop smoking are examples of the way ahead. But to move this agenda further the NHS must treat patients as individuals – not as statistics. Only then will they give it license to step into the territory of prevention. For the NHS to become this type of 'wellness service', it needs to value quality of care over quantity alone.

Crucially, making that shift – to prevention not just cure, and to quality as well as quantity – means developing a fresh approach to NHS staff. The Government needs to find ways to show that it doesn't just see staff as barriers to reform – but instead sees them as valued resources, and partners with whom it can develop the new NHS.

There are some hopeful signs. GPs can now commission new services themselves and more targets are being set locally rather than in Whitehall. But the political message has not been clear enough. Without a sharper political focus on supporting and empowering staff, the Government will fail to convince staff or public that anything has changed.

At a time when the Right is once more finding an audience for the message that the State should stop meddling in society, Labour must recreate a coalition with the public sector to effect progressive change and to ensure that it presents a united and successful public face.

Labour can still regain its position as the party of the NHS and win the praise it deserves for saving it, but it will only do so if it can first recommit itself to be the party of the NHS's staff. If we cannot convince those working in the NHS that only Labour embodies their ideals, we will struggle to convince the wider public. We not only need the electoral support of that vast phalanx of NHS staff, we also need them to act as ambassadors for Labour's achievements, rather than the disgruntled critics they presently tend to be.

Scotland's health - 1 year under the SNP

David Conway – Chair Socialist Health Association in Scotland

As we approach the celebration of the 60th anniversary of the NHS in July – one of Labour's greatest achievements, we also have just passed the 1st anniversary in May of one of Labour's lowest points – the defeat at the polls to the SNP in the Scottish Parliamentary elections.

First let us echo the celebration of our NHS – Happy 60th Diamond Anniversary – and what a marriage it has been – still together: the public, the patients, the dedicated healthcare workers, and the politicians – now from across the political spectrum.

When we look around the world we can be rightly proud. And in a Scotland in particular where we are good at finding fault and problems – the 60th anniversary reminds us that there is much we should praise, preserve, and celebrate about our NHS.

In 1948, at the launch of the NHS, a leaflet was delivered to every home – the cover of which read:

> "*Your new National Health Service begins on 5th July. What is it? How do you get it?*
>
> *It will provide you with all medical, dental, and nursing care. Everyone – rich or poor, man, woman, or child can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness."*

This perfectly captures what the NHS meant then and still means today. So 60 years of quality health care – 3 simple principles – free at the point of access; free for all; and based on need. Brought to us by a Labour government at Nye Bevan's insistence that:

> "*It will be a great contribution to the wellbeing of the common people of Britain"*

Nicola Sturgeon, the SNP Cabinet Secretary for Health and Wellbeing, regularly invokes the memory of Nye Bevan as she sets out health policy – most notably on the occasion of the announcement of their flagship health policy of free prescription charges – ironically the issue Nye Bevan resigned over in 1951.

Not content with stealing the election from the Labour Party – the SNP are taking Labour's clothes too…

In addition to **free prescription charges**, not quite free yet – but they promise to be by 2011, let us look at some of the other big headline health policies / issues of the past year in Scotland; and let us examine the general SNP health policy direction – set out in the *Better Health, Better Care* document.

Reversal of the previous decision to close A&E Departments at Ayr and Monklands Hospitals.

Perhaps these were the decisions, which lost Labour power in Scotland. Decisions, which were taken in good faith, and with support of local health boards and professionals – and in keeping with the move to keep services as local as possible, but as specialist and central as necessary. However, and crucially, the patients and public of the local communities were not brought along with these decisions. Not that they were not consulted, but consultation is not participation, and participation is not partnership, and partnership is not devolving and sharing decision-making. Thus, these decisions were somewhat removed for the people. Of course this decision was aided by an Independent Scrutiny Panel to review the evidence – although the panel was somewhat redundant as the reversal was never in doubt.

This reluctance to devolve power to communities was perhaps further exemplified by Labour's refusal, when in office, to consider introducing elected health board members – another policy adopted earlier by the SNP and now being introduced albeit cautiously with pilots.

These reversal decisions of the SNP administration are not without their knock on effects, and the cost of these decisions. Further, have the SNP made a rod for their back?. Future, similar decisions are round the corner.

The end of Private Finance Initiative PFI
The promise to end the expensive PFI and replace it with the SNP's Futures Trust on the face looks like a good move. However, such a move does not completely remove the hand of the private sector in financing NHS infrastructural investments. They also did not stop new PFI contracts, which were just at the planning stage.

Privatisation of GP Practises/ Independent Treatment Centres
The last Labour/Liberal Democrat Administration "slipped" a clause into unrelated legislation allowing companies to bid for vacant GP practises. The one serious tender at Harthill by SERCO was fought off. The Cabinet Secretary for Health has stated that the SNP will seek to rescind this legislation as early as possible. She has also indicated that public funding for Scotland's only ITC at Strathcaro is likely to cease next year.

The introduction of free-school meals
This is – or rather should have been – a Labour policy, but is one it didn't like. Mainly, it seems, because it was the mantra of the Scottish Socialist Party's Tommy Sheridan. The SNP have no difficulty with adopting this policy. However, yet again the SNP have not quite fully implemented their policy – so far only a cautious pilot scheme has begun.

Anticipatory care – is an extension of the previous Labour administration's *Kerr Report,* which had already set out a vision for a Scottish NHS, which moved in a very different direction from the market ethos of the NHS in England. The SNP government shares Labour's vision of shifting the balance of care from a national sickness to service – to a truly health service.

A mutual NHS – The SNP have proposed the concept of a mutual NHS – an ethos one could fail to disagree with. This will be only be meaningful if it is based on the true, original, principles of mutualism – where everyone has an equal share, and everyone has an equal say. This must extend to the whole NHS workforce, the whole population and patients. Things within the NHS workforce are, at present, not quite so equal. Polly Toynbee's account of her series of jobs on the minimum wage is a timely reminder – she observed first hand how the poorest in our society are increasingly being left behind despite the average wealth increasing. But it was in her descriptions of the conditions of jobs she takes, particularly as a cleaner in the NHS which make the most uncomfortable and shameful reading.

Quality services – The SNP have adopted the US Institute of Medicine's definition of quality – patient-centred, timely, efficient, effective, equitable, safe services. All principles can easily be welcomed. However, while the patient safety agenda is receiving a lot of attention, the issue of equity has not had the same priority to date.

Worryingly, the new resource allocation formula for health boards has also significantly reduced the previous emphasis on deprivation and rural and remote services. Both are key components of equity.

Health inequalities – Finally, the SNP have accepted the challenge of health inequalities facing us in Scotland – best defined with the example set out in the recent World Health Organisation report – "In the Scottish City of Glasgow, life expectancy of men in one of the most deprived areas was 54 years, compared with 82 years in the most affluent. This means that the poorest men in Glasgow have lower life expectancy than the average in India". This statistically is equally astonishing and disgraceful.

Tackling health inequalities has received some attention – with the establishment of a Ministerial Taskforce. The report is expected this summer, however, it will be interesting to see just:

- how far it really goes in considering the wider social and economic injustice issues which are the fundamental causes of health inequalities.
- how far it will go in tackling the inequalities across society and not just from a health service bubble perspective.
- and how far it will go to reach out to communities to work with rather

Scotland's health - 1 year under the SNP

than work on to address this major challenge.

Thus, the SNP have asserted their intention to tackle health inequalities with renewed vigour – this is at least the rhetoric. But will they walk the walk? Firstly – they are keen on responsibilities of individuals. Will the burden of responsibilities shift to individuals at the expense of collective and community approaches and at the expense of recognising and addressing structural social and economic drivers of inequalities?

There is little need to remind this readership that lifestyle behaviours such as a healthy diet are not simply individual choices, rather it is about food access, affordability, cultural, cooking skills, as well as choice. Thus the focus should not just be on blaming individuals but the focus should be further upstream.

Finally, the SNP are still big on health targets – but not necessarily on targets that are about reducing inequalities. This is one area of English health policy which would be worthwhile adopting – as there are regular independent reviews on progress against reducing inequalities ensuring regular attention is paid to inequalities.

To close, the Socialist Health Agenda is all about fulfilling the original (and Bevan's) vision of the NHS: free at the point of access; free for all; and based on need.

The SNP have made some steps in the right direction. But they are still only steps, not strides. A review of whether their wider (non-health) policies fit with values from the left or right is for another day – but may be their undoing in terms of inequalities.

Words, plans, and strategies need to be converted to action – primarily to tackle inequalities and inequities in health and in access to healthcare. Inequalities which are not just the health service's responsibility – but all of ours collectively.

New Labour failed to be radical enough in Scotland. It failed in Scotland at the last election because it failed to put "clear red water" between Holyrood and Westminster – as Rhodri Morgan did in Cardiff.

If Labour is to shape the health agenda and to reclaim power again – it needs to start to argue for a truly radical agenda – one that takes a strong social justice perspective to health and health care – one that will allow us to have a meaningful NHS for the next 60 years.

Dr David Conway is Chairman of the Socialist Health Association Scotland and a Lecturer in Dental Public Health.

FRENCH HOSPITALS IN FINANCIAL CRISIS

NHS funding often gets compared unfavourably with levels of funding in mainland Europe. But in France too the health service faces a financial crisis.

According to Le Monde (13th May) **Hospices Civils de Lyon** (HCL) had a deficit of 36.5 million euros (just under £30 million) – in 2007 alone! HCL covers 17 different hospitals and clinics in France's third largest city, where, with 20 000 employees, it is the biggest employer.

Lyons is far from being an isolated case. 29 out of 31 teaching hospital centres in France – with the exceptions of Limoges and Poitiers – are in deficit. Between 2005 and 2007 the combined deficit of all these centres rose from 24 million euros to 367 million (approx. £286 million).

How has it happened? Since 2004 hospitals no longer receive grants from the state but are paid by results ('tarification par activité'). Most hospitals back then were anticipating an increase in activity but this did not materialise. Receipts have been below forecast levels. In Lyons activity has been stagnant and in general surgery has even declined. Why? 'Competition from private clinics'!

HCL are in the middle of a restructure and modernisation programme and cannot finance the investments needed. The Socialist mayor of of Lyons, Gerard Collomb, who also chairs the hospital board, has asked for a meeting with the Health Minister to 'find a solution while preserving quality of care'.

Privatisation is a global trend and nowhere is safe from its ravages. A case of 'Plus ça change???'

Paul Gerrard

Can health care reduce inequalities in health?

Dr Alex Scott-Samuel, EQUAL (Equity in Health R&D Unit, University of Liverpool)

I'm a public health physician with over 30 years experience of research and policy development relating to health inequalities in both NHS and academic settings.

Many people were surprised when the first Tackling Health Inequalities 'status report' (shamefully denied publicity by the Government when published in the August 2005 parliamentary recess) revealed that between 1997 and 2003, trends in both of the Government's headline inequalities indicators (which measure the socioeconomic gaps in life expectancy and in infant mortality) showed that health inequalities had increased in New Labour's first six years. Three further status reports since then show precisely the same picture. I didn't find this very surprising.

My opinion has long been that the only way to effectively address fundamental inequalities like these is to tackle their root causes. On the other hand, more superficial health inequalities, like those directly created by public institutions (eg inequalities in access to NHS care) are clearly more amenable to actions like those of New Labour on waiting lists. Inequalities in individual diseases are also more straightforward: investing in say, smoking cessation or cervical cytology services in poorer areas will not only reduce overall cancer prevalence but will also reduce inequalities in those diseases.

It has to be stressed however that the overall impact on health inequalities of such measures is much more limited - the reason for this being the effects of what epidemiologists call 'competing risks of death'. Competing risks, in this context, essentially means that if you just deal with 'downstream' risks and diseases rather than their 'upstream' sociopolitical causes, other risks will simply take their place. Thus, eliminating smoking would mean that the poor would continue to die (slightly less) prematurely, but from other causes, which would increase in relative importance. Upstream and downstream, by the way, refer to the metaphor of healthcare being like people who are constantly improving their skills at pulling drowning people from a river, rather than looking upstream to see who's pushing them in and trying to prevent them from doing so.

In addition to Labour's failure to address upstream causes of inequality – of which more below – there are two further causes of its policy failure: its exclusive focus on selective or targeted, rather than universalist health and welfare policies, and the well-known 'differential diffusion of innovation' whereby the middle classes take up healthy behaviours first.

What is to be done? Taking the above diagnoses in reverse order, there is more to 'equitable diffusion of innovation' than middle class prescriptions for health literacy. No-one chooses poor health: people suffering economic, cultural and educational deprivation need all of these addressing if their lives are to change. Universalist policies are clearly about Gordon Brown finally getting the message that Labour must begin to recreate the welfare state his predecessor helped the Tories dismantle. And the upstream issues are the most difficult of all, because they are about 'government as if people mattered' – about challenging and reversing John Hutton's recent adulation of mega-salaries and income inequalities, about acknowledging and acting on the knowledge that the tough, competitive, unemotional model of manhood that dominates our society creates in turn tough, competitive, unemotional public policies that are the root cause of health inequalities.

Finally, how can the NHS contribute to 'government as if people mattered'? Here's my starter for ten: by providing welfare rights advice in all primary and secondary care clinics; by abolishing all NHS charges so that healthcare – including of course prescriptions, dental and optical care – really is free at the point of use; by providing cheap public telephones for in-patients in all hospitals; and by making a commitment to return to the public provision of all clinical services at the earliest opportunity.

The NHS in 2008   Tom Smith

The Socialist Health Association is immensely proud of what the NHS has achieved in its first sixty years. Its growth has been supported by a social agreement that individuals collaborate to their mutual benefit when pooling their resources to provide a comprehensive health system for the whole of society – this is what we mean by socialism.

There are claims on all sides that the NHS is under threat and may not last another 60 years. Yet it is a system other countries are moving to – France, the system ranked as best in the last World Health Organisation rankings, for example, and even some US States are looking to pooling resources. The NHS faces challenges, but so do systems all over the world. The NHS has constantly evolved through its lifetime. To be effective, it has to adapt to changing conditions. The current review of co-payments for cancer drugs is an example of this. What is important is that the NHS is for the whole of Society.

The first sixty years has taught us many important lessons, especially the difficulty of managing precious resources. We know more about the causes of ill-health and are learning, slowly, that efforts to prevent ill health, rather than purely treat illness and disease, not only save money further down the line, but much more importantly improve an individual's quality of life.

The Next Steps Review, the report by health minister, Lord Darzi has been described by Alan Johnson as the most important development since the NHS was established. To live up to this billing the NHS has to steadfastly focus on four things:

support the emphasis on localism by supporting local innovation, not disseminating detailed models. Clinicians can and will innovate and collaborate in a variety of fashions if supported;

incentivise integrated care, bringing together professionals to forge pathways of care;

replace central steering with local accountability, focusing the NHS on the community it serves rather than the Department of Health;

the Department of Health should focus on national level strategy the reduction of inequalities between social groups and geographical areas – it should decide funding for services.

The major barrier to reform in the NHS is the often poor relationship between NHS management and staff. The vast majority of staff do not think that quality is important to their managers. While clinicians are often presented as barriers to reform, they are the means by which it will be achieved.

The one step that will revolutionise the culture of the NHS, would be to face managers towards patients and the community. At present they are so distracted by having to look up to the demands of the centre that they cannot reach out to their communities and patients, or within their organisation, to support clinical teams to develop services. The health service should be run for the benefit of society and of patients and not driven by either central targets or professional interests. The big gap in the government's reform plans is a lack of clarity on how services can be held to account and influenced locally. While supporting local innovation, the Department of Health would best support new approaches to ensuring local accountability.

Patients want to see integrated services. Not all services managed by a single board – this has not achieved integration in the past. But integrated services achieve better quality and value for money, such as the Kaiser Permanente system in California. The NHS has never fulfilled its potential to deliver integrated care, around common pathways. At present, GPs and hospital consultants have no opportunities to meet, making it difficult to bridge the gap between care sectors. To improve the quality of care, incentives should exist for collaboration between professionals. Integration will be achieved by strengthening relationships between clinicians rather than changing structures.

The Department of Health should ensure arrangements are in place to hold the local NHS to account. Current policy tends to emphasise information and choice as the way accountability can be achieved, and this will help support greater patient knowledge. Yet it is important to allow patients not only to respond to provision but also to influence commissioning and services that are planned. Groups of GP commissioners should be thinking though ways of involving patients in their decision-making processes.

Local professionals are better placed to construct new care pathways and relationships with patients than central government. Central government should stop designing models of how services should be delivered. It should instead have an unstinting focus on public health and on health inequalities in particular. This includes ensuring the NHS promotes as well as treats health. Despite the success of the NHS, the famous district line journey that demonstrates rapid falls in life expectancy as you journey east is a reminder that we cannot be complacent. Just as we can now be proud of the rising life-expectancy in recent decades, let us in the future celebrate plummeting levels of the inequalities that exist in our society as a result of poor health.

SHA Draft Health Inequalities Policy

Neil Goulbourne

Amongst the key objectives of the SHA, as expressed in our mission statement, is the eradication of inequalities in health. To achieve this end we must increase our impact as a campaigning organization. To do so requires the development of clear and digestible policies that can be readily understood by experts and lay-people alike. We believe that the breadth of our membership, coupled with the depth of their knowledge and experience place the SHA in a strong position to inform, influence and lead the wider Labour movement and the public debate.

Health inequality in Britain today

It is an off-quoted statistic that, with each mile traveled along London Underground's Jubilee line east from wealthy Westminster to deprived Canning Town, the population loses one year of life expectancy. Indeed, the gap in life expectancy between richest and poorest stands at a decade and grew by around 2% from 1999-2006. Infant mortality (often taken as a marker of the quality of a nation's healthcare) amongst the poorest is double that of the richest babies.

Why health inequality matters

Our first task must be to articulate why society should concern itself with health inequality. For many, successful health policy is defined by increased average life expectancy for the country as a whole. For others, such as Tony Blair's former policy advisor Julian Le Grand, increasing life expectancy for the poorest is a sufficient goal, even if the gap between them and the wealthiest grows. There are three key arguments in favour of a more ambitious approach to inequality itself.

The technical argument - we can do better

The poorest experience health outcomes significantly worse than those that are possible in the UK today. If the purpose of healthcare is to reduce illness and increase wellbeing, we fail to do so adequately for millions of Britons. Improvements in outcomes alone will never provide everyone with the best possible health at any given time unless the poorest catch up with the richest.

The centrist argument – the immorality of inequality

Inequality in something as fundamental to our lives as health is unacceptable. It is also contradictory to the founding principle pf the NHS, to which all major parties are signed up. The purpose of providing healthcare free to all at the point of use was to reduce (indeed eradicate) the burden of ill-health suffered most by the poorest, not just to equalize the provision of healthcare itself.

The growing Left consensus – the good society is the equal society

Everyone's health is improved by creating a society with more equal outcomes. In every society, there exists a gradient of health from the healthy rich to the unhealthy poor. However, it is not only those at the extremes of the income scale who experience inequality. Even those in the middle have poorer outcomes than their richer neighbours. Indeed wherever you are on the income scale, those above you will be healthier.

The difference between more and less equal societies is the steepness of the income (and therefore health) gradient. In more equal nations, although wealth still buys health, both decline less steeply across the population. As a result, not only is the health of the poorest improved, so too is that of the vast majority.

Health inequality is therefore far from being a marginal issue. It is central to how to create a healthier country. Moreover, there appears to be a growing consensus on the Left in favour of defining the good society as one that has equality of outcome, not just equity of access, at its core.

Our policy position

Despite its best intentions, New Labour has failed to couple increased wealth with reducing inequalities. It has sought to do so by targeting resources at the poorest (child and pensioner poverty, homelessness etc.) and seeking to foster meritocracy whilst tolerating rising income inequality. In health, Alan Johnson recently an-

nounced £34 million of additional funding for a range of targeted interventions in areas with the greatest health needs. This investment comes hot on the tail of a range of other targeted initiatives such as Health Action Zones. This approach – targeting the poorest, whilst tolerating growing income inequality – has proved to be unsuccessful. The following four overarching points focus on a few key political arguments that stem from the above analysis.

1. **Income inequality is the key**

A wealth of evidence points to a correlation between income inequality on the one hand, and health inequality, drug addiction, crime, family breakdown, lack of trust on the other. Without making our post-tax, post-benefits incomes more even, we cannot reduce the stigma associated with being less successful than our neighbours and thereby mitigate the psycho-social pathways that lead to falling health outcomes down the income scale.
Thus, interventions targeted at the poorest, whilst helpful, cannot be the key focus of public policy. Indeed they could be viewed as a distraction from the main imperative to equalize incomes.

- Universal, well-funded services are the best mechanism of redistribution
-

Earnest attempts have been made to redistribute income by Labour over the last decade. Tax credits, the best known of these measures, have undoubtedly slowed what would have been a rapid rise in income inequality. Nevertheless, income inequality has continued to grow under Labour, with the top 20% of earners in particular enjoying a disproportionate chunk of the nation's wealth. Moreover, tax credits, by tying millions into means-testing, have perpetuated the very stigma of inequality that redistribution is designed to mitigate. Finally, direct, means-tested benefits of this kind are fragile in political terms, because they provide nothing for the most powerful segment of society (the richest); at times of economic hardship, they will be the first to go.

Redistribution is best achieved through universal benefits (e.g. child benefit) and, in particular, benefits in kind, in other words, free public services. In this way, wealth is spread from the richest to the rest of society according to need, without generating stigma and is an articulation of the principle of Progressive Universalism.

- Equality not just equity

In the public and political debates on health inequality, much is made of the unequal access to medical services which Julian Tudor Hart described as 'the inverse care law'. It is best exemplified by the distribution of general practices in the UK, which are more concentrated in areas of wealth than in those of need. Whilst this inequitable distribution of resources exacerbates health inequalities, it is crucial that we do not allow it to be conflated with or to override the fundamental issue of unequal outcomes. We should focus on the means of healthcare only inasmuch as they affect our ends, namely achieving greater health equality.

Policies

- The prescription charge should apply just once per prescription, regardless of how many items are included.
- Free school meals for all, to promote healthy eating and ethical consumerism. Meals would not be obligatory but would be encouraged an important part of a child's education.
- Increase the minimum wage over time to a living wage.
- Raise taxes on the top 20% of earners.
- Raise child benefit.

2. **Public health on a national scale**

Inequality in income and status drives inequality in health. It does so through factors such as unemployment, poor housing, and limited educational attainment. In turn, such factors lead to illness (mental illness in particular) and lifestyles that cause illness - poor diet, smoking, inactivity.
The health service and government intervention more generally should attempt to tackle these 'downstream' consequences as well as their underlying causes. Indeed, as there will always be inequality, doing so will always be necessary.

Policies

- Introduce a ban on the marketing of foods high in salt, sugar and fat, targeted at children
- Introduce compulsory, front-of-pack, "traffic-light" information for consumers about the health of food they buy. This should be extended over time to food and drink which is provided for imme-

diate consumption. Consider imposing VAT on the most unhealthy food.

- Raise the legal age for purchasing tobacco from 18 to 21 and work to increase the price of tobacco across Europe to reduce smuggling.
- The number of units of alcohol contained within a container should be displayed on the front, in order to promote a more healthy consumption of alcohol.
- Tax on alcoholic drinks should be proportional to the quantity of alcohol the contain.
- Initiate measures to raise the price of alcohol across Europe in order to reduce smuggling.
- Ban alcohol sponsorship and advertising for sporting events and consider wider restrictions on advertising.
- Increasing the proportion of journeys made on foot is our central transport target and will require a substantial change in the way in which we approach the design and use of roads and streets.
- Measures should be implemented to reduce the number of children travelling to school by car when they could walk.

3. Community Health Centres at the heart of the NHS

So, what can healthcare do to mitigate the health inequalities that arise from wider social inequalities? Dealing with inequality downstream requires a focus on the community. For the NHS that means general practice, health visiting, community midwifery and community nursing, in collaboration with public health. Our vision is of an integrated service provided through health centres, along the lines of the Peckham Health Centre. The main purpose of community services would thus become the mitigation of inequality and the promotion of health, rather than the treatment of illness.

Where inequities in access exist, they should of course be eradicated. In particular, the perverse distribution of GPs that favours the rich must be reversed, not just through ad hoc measures (as recently announced in the Darzi next stage review) but as a permanent tenet of the NHS.

Policies

- Polyclinics and the 'GP-led health centres' proposed in the Government's Darzi review should do more than widen access to treatment for ailments. Whilst equitable access is necessary to achieve equality of outcome, it is far from sufficient. Instead, these new clinics should provide a range of community services, from sexual health to employment advice. Their primary purpose should be the reduction of inequality in health through prevention.
- Roughly 10% of the NHS budget should be allocated to prevention
- A well-trained, well-funded universal health visitor service should be available and accessible to support all parents of children under five with specialist help for the most vulnerable families.
- Occupational health services should be available to everyone through the NHS.

4. The NHS as exemplar

As Europe's largest employer, the NHS could be a powerful example of responsible employment.

Policies

- Introduce a boosted, in-house minimum wage
- World-leading occupational health
- In-kind benefits, such as subsidised sporting facilities
- A procurement policy that favours other responsible employers

Summary

Addressing health inequality is central to improving the health of the nation. It affects everyone in society, not just the least well off, and contributes to the social tension and decay that are a growing part of today's Britain. Therefore, rather than focusing on the least well off, policy should be progressively universal. The main driver of health inequality is income and status inequality. These must therefore be our central priority. However, prevention of the downstream consequences of inequality can be effected through both national initiatives and more consorted action through community health centres. Finally, the NHS itself, often the largest employer in a local economy, must show leadership in ethical, enlightened employment practice.

Future Events

Preserving Dignity: Can we protect elderly and vulnerable people from insult?

Monica Dennis Dignified Revolution

Ken Jarrold CBE Dearden Consulting

London 5th November

What is the best way to organise Urgent Care?

Liz Kendall Ambulance Service Network Director

Rick Stern NHS Alliance

Dr Ronan O'Leary

London 21st October

Will Topping Up Payments lead to the end of the National Health Service?

Joe Farrington-Douglas Senior Research Fellow - Public Services Institute for Public Policy Research

Dr Jacky Davis Keep Our NHS Public

London 2nd October

Is Information Technology the Key to Empowering Patients?

With Dr Brian Fisher NHS Alliance

Dr James Munro Patient Opinion

David Sellers Bolton PCT

Bolton 25th September

Costs for the events above vary but are reduced for SHA members (and delegates from affiliated organisations, such as Unite and Unison).
Further details will be on our website www.sochealth.co.uk or available from the office.

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