

Health and politics in harder times

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It is now clear that there will be significantly less money for healthcare for the next few years, and the chances of a Labour Government after May 2010 don't look good either.

So what should we be arguing for now?

1. Real prevention. There is plenty of evidence of effectiveness of simple public health measures – increasing activity, reducing smoking and alcohol intake, eating fruit and vegetables. Of course there is a long payback time for these measures, but that doesn't seem to be a problem in the provision of education or defence.
2. Real reductions in inequality. Abandoning the idea that more or better health care can compensate for the underlying economic inequalities. The problem is the assumption among many politicians that increasing inequality will drive economic growth.
3. Real choice. Most patients don't much want a choice of where they are treated. They want more choices about how they are treated.
4. Real involvement. The repeated reorganisation of public involvement mechanisms has increased cynicism and it will take some years to repair. In the wake of events in Stafford we are promised stronger mechanisms of involvement, but there hasn't been any obvious improvement yet..
5. Real integration. Move away from the present system which is called payment by results but is actually payment by episode. Link payment to outcomes. That might protect the quality of care from pressure to meet targets

Taken together these measures could be a charter for higher standards of life for the whole population.

Healthy School Meals and Educational Outcomes

Michèle Belot and Jonathan James published a very useful study in January. The celebrity chef Jamie Oliver started the campaign “Feed me Better” in 2004, drawing the attention of the media to the poor quality of meals offered in schools. His campaign was documented in a TV programme which was broadcast in prime time in February 2005 on Channel 4) The program featured mainly Kidbrooke secondary school in Greenwich, which then served as a pilot for the Jamie Oliver “experiment”.

In many developed countries, children's diet has deteriorated tremendously over the last decades; resulting in significant increases in child obesity, but also in important deficiencies in those nutrients playing an essential role in cognitive development. This paper uses the unique features of the “Jamie Oliver Feed Me Better” campaign to study the effects of healthy school meals on educational achievements of children in primary school. The Jamie Oliver campaign introduced drastic changes in the meals offered in the schools of Greenwich, shifting from low-budget processed meals, high in saturated fat, salt, and sugar towards healthier options.

The Jamie Oliver team hired nutritionists to analyse the meals before the changes and found that the meals contained no vitamin C at all and contained between 1/3 to a 1/2 of iron of what is typically recommended in a meal. There is a large body of evidence in the medical literature showing the importance of vitamin C for immunity from the common cold, to lung function, and on the absorption of iron. Iron has been found to influence cognition and concentration. Numerous studies have found that there is a link between diet on the ability of children to think and concentrate.

Since school meals were changed in one Local Education Area only at first, they can use a difference in differences approach to identify the *causal* effect of healthy meals on educational performance.

As part of the experiment the council increased the investment into school meals: an initial increase in the school food budget by £628,850 was agreed in the February 2005 budget going to cover the cost

of the extra staff hours that were needed in preparation of the meal, equipment costs and promotion to the parents. By September 2007 a total £1.2 million had been invested in school meals³.

Using pupil and school-level data from the National Pupil Database (NPD) and from the School census, they compare Key stage 2 test scores results before and after the campaign, using neighbouring local education areas as a control group.

They identify positive effects of the “Feed me Better” campaign on Key Stage 2 test scores in English and Sciences. The effects are quite substantial: their estimates show that the campaign increased the percentage of pupils reaching level 4 by 3 to 6 percentage points in English, and the percentage of pupils reaching level 5 by 3 to 8 percentage points in Science. Moreover, they find a substantial decrease in absenteeism in Greenwich schools after the campaign, in particular in “authorised absences”, which are more likely to be due to sickness (and therefore health). The rate of absenteeism falls by about .80 percentage points, which is about 15% of the average absenteeism rate in the sample, thus a notable effect.

These effects are particularly noteworthy because they measure direct and immediate effects of improvement in children's diet on educational achievements only. There could be additional benefits (in particular in terms of health), beyond the improvements in educational achievements, which they were unable to measure because of lack of data. Nevertheless, even if only these short-term benefits are taken into account, they find that the campaign was very cost-effective, with costs and benefits similar to other policies (such as the “literacy hour”) implemented in the UK in the nineties.

Inequality and the recession

Breaking the boundaries between primary and secondary care

"Wilkinson and Pickett's book indeed makes sweeping statements and I have arguments with it on the levels of data, analysis and interpretation. But first, I would like to hear their view on what they expect to be the results when data on the various social sectors for 2008-2009-2010 appears. I expect that, because many more people will fall into real poverty (measured however), inequalities in all of the social indicators will widen with one very important exception - income inequality. The latter will narrow because, although very many people will become poorer, income inequality has been dominated statistically for the last 10-15-20 years by the very rich and some of the poor things (floods of tears you notice) are losing a few billions. But Wilkinson and Pickett should of course argue that if income inequalities narrow then inequalities in the other social dimensions should narrow. I'm not saying that it makes the current depression fascinating but i'd love to see their reply!"

Roy Carr-Hill

Centre for Health Economics
University of York

About the Roy Carr-Hill point: As I've often said - in the book and in your presence - there is a background rate of improvement in life expectancy which no one has ever explained - the population gains 2-3years life expectancy for every ten years that passes and it has been doing so for over a century. Changes to inequality merely make that background rate of change (which affect most countries - rich countries regardless of economic growth), a little bit faster or slower.

There are two other complicating factors affecting the impact of the recession. First is that relative deprivation seems to affect health not only as measured in relation to others, but also in relation to what you are used to. So getting poorer seems harmful and I think would be so even if everyone got poorer - deprivation in relation to what you are used to. In some studies it looks as if the effects of middle class people loosing income are particularly strong. The other factor is lag periods. There are of course cultural and biological lags and they will probably be different lengths for every cause of death. IT is even possible that the death rates of old people are affected by inequality in early life as well as accumulated affects throughout life.

So, hold everything else constant, wait long enough, and I would predict that any lasting effects of the recession on inequality would eventually become apparent. Roughly as I expect you and anyone else who thought about it would expect..

Richard Wilkinson Emeritus Professor of Social
Epidemiology, University of Nottingham.

The second wave of Integrated Care Pilots should be developed among existing promising commissioners and providers to encourage a complete restructuring of the way primary and secondary work together.

The current pilots, which were suggested by the NHS Alliance at the beginning of last year, have not been able to comprehensively redefine the boundaries between primary and secondary care in a way that allows for a significant redesign of out-of-hospital services.

Dr Michael Dixon, chairman, NHS Alliance, said: ***"Integrated Care Pilots are an excellent idea, but instead of choosing from a list of applicants, we should work closely with a few committed commissioners and providers to help them further develop services that really break the boundaries between primary and secondary care by creating a truly integrated provision."***

The NHS Alliance is also calling for some of the second wave pilots to be based within practice-based commissioning consortia. This will enable them to develop services in partnership with secondary care clinicians, where any overarching structure might be not-for-profit and run by the community and its primary and secondary care clinicians and managers.

Dr Dixon added: ***"Only then we can test the concept of a geographically- based health maintenance organisation whose arrangements for integrated services and initiatives are actually provided by a local group, who is also responsible for commissioning."***

The NHS Alliance believes that such an organisation would work closely with social services, third sector, private sector and other agencies, but its initial focus should be on fully integrated primary and secondary care to realise the potential of out-of-hospital care. An independent steering group of experts, including academics, managers and clinicians, appointed by the Department of Health, should also be set up to choose the relevant candidates and help them develop and implement their projects.

NHS Alliance

Cooperative Commissioning and the NHS – A Smoother Solution

Brian Fisher

Patients still find the NHS to be too disjointed: there are many examples of poor internal communication, poor information transmission, poor links between parts of the system. More needs to be done to ensure that the patient journey is smooth and efficient and that care is both effective and holistic.

What Issues Should a Cooperative Care organisation tackle?

1. The gap between primary and secondary care aggravated by the consequences of financial reforms.

Care pathways are not always smooth. There can be a lack of mutual understanding and, in the past, there has been a lack of funding. But the main impediment to integration is the contradictory incentives that make cooperation across this divide increasingly difficult. Payment by Results, of course, is actually payment by activity.

As a recent NHS Alliance document explains:

“...there are many examples where even the best networks and pathways have failed, not because of lack of clinical commitment but because of unintended consequences of system reform, particularly those concerned with commissioning and Payment by Results.

The current Payment by Results (PBR) system based on a nationally set tariff ensures that patient activity in hospital based care remains the dominant mechanism for financial reward in NHS secondary care..... Rather than providing incentives for Acute and Foundation Trusts to collaborate with PCTs PBR mechanisms discourage co-operation and can even result in inappropriate competition (or at least adversarialism) across the health care system. “

We need to rearrange incentives to ensure that they encourage NHS organisations to cooperate and that they reward both quality and efficiency.

2. The gap between Primary care and Social Care and Health.

There are clear differences in culture between these two groups. The most basic is that Social Care has means-tested charges as central to their

function while primary care sees itself as a free service, though prescriptions are charged on a means-tested basis and practices directly charge patients for some services.

PCTs and Local Authorities plan jointly through various processes, but primary care has little involvement. The issues tackled by these planning techniques are very relevant to primary care and more involvement would be useful.

Another cultural gap is that of democracy and involvement. The Local Authority is underpinned by democratic accountability – there is no equivalent in the NHS. The Secretary of State is the only elected authority in the NHS. There is much that the PCT and Practice Based Commissioning can learn from the Local Authority experience. Expanding community development and enhancing accountability may be two possibilities. Some Local Authority's are working with PCTs to share commissioning roles and pool parts of their budgets.

3. The gap between voluntary agencies and health care.

Voluntary agencies should be involved in both planning and provision far more and should increasingly influence the approach to care taken by the NHS. Many mental health organisations offer excellent examples of integration here, as do Local Authorities. Practice Based Commissioning could find this liaison particularly helpful.

Principles Of An Integrated Care Organisation

- Align finances where needed to incentivise quality, efficiency and cooperation.
- Plan together: Practice Based Commissioning, PCT, Local Authority, specialists, local people
- Use Long Term Care pathways as the basis for integration
- Incorporate local people's involvement
- Create new structures only when needed
- Consider new roles where needed
- Integrated shared information systems between patients and professionals
- Appropriate training and support to be available

Aligning Finances – Cooperative Commissioning

There is one feature of the current marketised NHS which must be retained, namely, inbuilt incentives to improve care. The existing incentives of Payment by Results and Practice Based Commissioning, however, are divisive and wasteful.

Primary care has the capability to do more outside hospital. Prior to the introduction of PbR, hospitals were generally happy to cooperate in order to reduce their workload, even if there were other forces that militated against cooperation, such as empire-building. In the new climate, however, it is no longer in a hospital's interest to enable fewer referrals, or reduce emergency attendances and admissions. Service re-design often depends upon action within secondary care, but that action may lead to reduced income through PbR for the secondary care provider. For example:

GPs need open access to diagnostics if they are to avoid unnecessary hospital care. Hospitals may have to commit some more resources, or rearrange existing resources, to make this possible. But, if the desired result is achieved, demand for hospital care will decrease, reducing their income.

A PCT may wish to reduce demand on hospital emergency care by placing nurses in A+E to triage and organise community care to reduce admissions. There is no incentive for hospitals to do this because it reduces their income.

Cooperative commissioning as one solution.

Firstly joint (not pooled) budgets are allocated virtually across primary and secondary care, along care pathways, based on a programme budget approach. The task of Practice Based Commissioning groups, PCTs, local people and hospitals then becomes to manage that joint budget so that it maximises efficiencies and patient care. The incentive for everyone is that savings can be reinvested in the pathway, or elsewhere, as agreed.

Pooling budgets has huge opportunity and transaction costs and may not deliver results. Joint budgets are more likely to enable agreement and functional outcomes without the complexities of

more formal merger.

For instance, in cardiology: the spend on heart disease would be seen as belonging to both Practice Based Commissioning and local hospitals. If savings were made through more efficient care pathway design, then the savings would be shared. If fewer patients came through the hospital's doors, the hospital would still gain if savings were being made. It would become a joint task to ensure patients received treatment in the most cost-effective way. For many long term conditions there are evidence-based interventions that reduce hospital attendance, including information-provision for self-care management and prevention. There would now be an incentive for hospitals to invest in these as well as primary care. There may be more enthusiasm for cooperation in A+E, as savings there would mean more joint benefit.

In this way, incentives for efficient care are retained, but the planning and investment becomes a shared enterprise. We predict that NHS staff will leap at this chance to work together again in a shared enterprise. This, in a different context, is one of the ways in which Kaiser Permanente in the US achieves such excellent cost-effective outcomes.

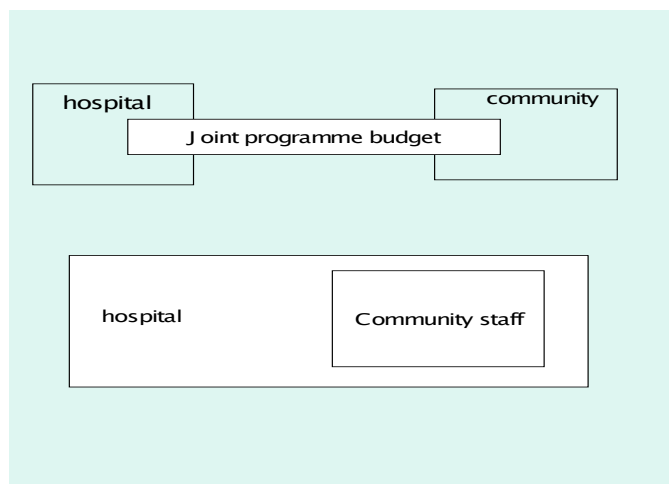
The NHS Confederation, in its discussion paper in June 2009 "Commissioning in a cold climate" suggested that "A system based on payment for discrete units of activity will never create the right incentives for providers to help make care pathways (or the sum of multiple pathways) more efficient and less costly." They also recommended that the system be redesigned to "encourage efficiency along whole care pathways rather than cost-shifting and encouraging supplier-induced demand."

Vertical integration is likely to become more common in the next couple of years. Here the Acute Trust takes over community services whose workers become employees of the Trust. This results in total integration, but it will be essential that PCTs or Practice Based Commissioning groups protect against:

- Community services losing identity and becoming offshoots of the hospital with an acute care focus

- Community services operating as merely

support services for the hospital
Funds being sucked out of community services
to support the hospital when financial
times are hard.



Integrated Information Systems and Patient Record Access

As the NHS IT systems remain behind schedule, the most efficient way of enabling smooth transfer of clinical information is through patient record access. This is available for 60% of practices now and allows patients to share their record with whomever they choose – all that is needed is a web-browser which could be on a mobile phone. This could include NHS or other professionals or members of the family. As a result, there could be record sharing between all parts of the system with the patient as the key:

- GP to GP
- Social Worker to GP/hospital
- GP to consultant
- A+E and primary care

So, an essential prerequisite for an integration is patient record access. The PCT would need to support practices to enable record access. This would require some financial and personal support initially.

Record access is also a portal for patient-centred information that supports self-care. The evidence is good that offering patients appropriate understandable information with the personal support of clinicians or others can reduce use health service use and improve outcomes. An integrated information system must supply that.

Incorporate Local Involvement

Local Authorities have a long tradition of involvement from which the PCT and Practice Based Commissioning could learn. An Integrated Care Organisation would need to integrate local intelligence into planning, monitoring and provision.

The Local Authority approach includes a focus on community development and concrete democratic systems. If most planning took place along care pathways, then the population who would need to be involved would be fairly easy to establish. Care planning groups would include Local Authority or community development reps to aid shared decision-making. The Local Authority might become the route by which public involvement is delivered.

Integration with the third sector

This can be complex. Close working between voluntary agencies and the statutory sector can bleed the third sector of ideas and independence. In addition, the NHS can assume that the voluntary sector speaks for the populations they serve, thus reducing more grass-roots involvement by local people.

This is not an argument for excluding the thirds sector – quite the opposite – but an argument for ensuring that involvement is fair, just and effective.

Joint Planning

The Local Authority will need to be a real presence at all major decision-making: at PEC, Board and Practice Based Commissioning levels. To ensure redesign is effective, the Local Authority needs to be integrated into planning. Not only for current Local Authority targets but also for design of illness pathways – we need to ensure that transport links match redesigns, that sexual health and education are aligned, that libraries support self-care and bibliotherapy.

Joint commissioning could spread – it is a common arrangement in mental health. There is no reason why this could not be achieved in a more general fashion. It would certainly be preferable for commissioning to be carried out by Local Authorities than private companies who have no local knowledge.

Contemporary Issue for Labour Party Conference

Every affiliated organisation is entitled to raise a contemporary issue at Labour Party Conference - in 10 words, with 250 supporting words.

We propose to raise the issue of protection for whistleblowers, and invite any organisation affiliated to the Party to do the same. There have been a number of cases in the NHS recently where either nobody blew a whistle even though they must have known things were going wrong or the person who blew the whistle was sacked or struck off. We think there may be a connection here.

The supporting statement we plan to lodge is as follows, but if anyone wants to make different points in their submission that would be very welcome. 250 words is a bit restrictive.

1. There should be a statutory right to raise concerns about wrongdoing without fear of retaliation.
2. Employers are encouraged by the legislation to have whistleblowing/confidential reporting procedures. Parliament should impose a statutory duty to establish internal procedures and train staff in their use.
3. Statutory protection is dependent on the worker acting in good faith. This may inhibit some important disclosures. Reasonable suspicion should be all that is needed. The test should be that the discloser has an honest belief on reasonable grounds that there is, has been, or will be wrongdoing. The burden of proof should be on employers to show that this was not so.
4. Whistleblowers should have a right to disclose to external recipients like trade unions and MP's.
5. Recipients of concerns should be obliged to formally record that a disclosure was made and how it was handled. They should have a duty to assess and act on a disclosure where appropriate and to keep the whistleblower informed.
6. An agency should be given responsibility for overseeing the legislation, set standards, conduct investigations, advise employers and employees, legal aid, report to Parliament etc.
7. Disclosures and investigations should be kept confidential as far as possible.
8. Whistleblowers should be protected against criminal and civil liability and other detriments imposed by professional bodies.
9. Employers should be required to assess the risk of a whistleblower suffering detriment and take remedial action if it occurs.

The effect of economic recession on population health

Stephen Bezruchka

Economic recessions have paradoxical effects on the mortality trends of populations in rich countries.

Contrary to what might have been expected, economic downturns during the 20th century were associated with declines in mortality rates. In terms of business cycles, mortality is procyclical, meaning it goes up with economic expansions and down with contractions, and not countercyclical (the opposite), as expected. So while most nations enjoyed sustained declines in mortality during the last century, the pace of the decline has been slower during economic booms and greater during so-called busts. The first rigorous studies demonstrating this trend have appeared only in the past 9 years, although the concept is not new. In contrast, for poor countries, shared economic growth appears to improve health by providing the means to meet essential needs such as food, clean water and shelter, as well access to basic health care services. But after a country reaches \$5000 to \$10 000 gross national product (GNP) per capita (or gross domestic product or gross national income per capita, all of which are similar for our purposes here), few health benefits arise from further economic growth.

Health gradients exist in every society, those lower down the socioeconomic ladder having worse health than those above. Poorer people will always do worse in any given economic situation, whether it be boom or bust and whether they are employed or not.

If we recognize that economic growth may not good for our health, then we can consider means of reining in the excess wealth (which has been justified by its production of growth) and of redistributing national resources through social spending for the common good.

The full article is at
<http://www.cmaj.ca/cgi/reprint/181/5/281>

New report reveals that like banking before it the danger signs are there for the pharmaceutical industry

Jon Cruddas MP and Zoe Gannon, Compass Research Coordinator, in a report published this month argue that like finance before it the pharmaceutical industry has been left to run too free for too long and is nearing crisis point.

The report *A Bitter Pill to Swallow: Drugs for people not just for profit* offers an in-depth analysis of the UK pharmaceutical industry and finds that while profits and pay are up productivity is down.

- **Since 1991 the NHS drugs bill has grown by over £7.5 billion – faster than GDP**
- **While the Department of Health invests nearly £4.95 million in postgraduate education for doctors, the pharmaceutical industry spend over 300 times as much: £1.65 billion influencing doctors.**
- **Innovation is declining - During the late 1980s, nearly 60 new molecular entities were released onto the market each year this had halved to a mere 27 by 2007**
- **Between 1993 and 2003 only 152 of the 321 drugs licensed, less than half, offered potential clinical improvements on already existing drugs.**

Just like the banks, the pharmaceutical companies are too important to let fail.

Effective regulation must now be a priority. This report supports five priority policy proposals.

- **Policy 1:** Reform the pricing system and ring fence the savings to invest in publicly funded science.
- **Policy 2:** Make clinical trials open to public scrutiny
- **Policy 3:** Increase independent education available to doctors through public funding
- **Policy 4:** Review progress made since 2005 Health Select Committee report
- **Policy 5:** Control pay and bonuses – to ensure that they do not warp the market

Zoe Gannon, Compass Research Coordinator, says: “A day doesn’t go by without news on swine flu or the latest scientific breakthrough. If anything this tells us how important pharmaceuticals are to us, and to modern healthcare. But as this report shows all is not rosy in the pharmaceutical industry. Profits and pay are up – but productivity and innovation are down. The industry recognises this and has taken steps to ensure its survival, but this hasn’t led to greater therapeutic innovation. The argument in this report is that the pharmaceutical industry must be more effectively regulated, so that all stakeholders – the public as well as the private investors – get a better deal. Like housing, transport, gas, electricity and now financial services, some things are too important to be left to the whims of the market.

The report shows that the NHS risks bankruptcy from increasingly expensive, but often not more therapeutically effective, drug therapies. This is not just the case in the UK but also across Europe and in the US. It is increasingly apparent that action must be taken to ensure that the industry makes the drugs we need at prices we can afford. Furthermore the report highlights that if we hope to see innovative breakthroughs for drug therapies for diseases like Alzheimer’s and Cancer in the future we must now act to reform the industry.”

Jon Cruddas MP says: “We have learnt from the banking crisis that some things are too important to let fail – the pharmaceutical industry is one of them. The report shows that unless we take action now we are not going to get the life saving drugs we need in the future. Historically the pharmaceutical industry has played a key role in medicine and health-care, we must ensure that it can play an effective role in future.

The socio-economic contribution of the industry is significant and should not be ignored; however, neither should it be used to legitimise the declining levels of therapeutic innovation. Our analysis shows a decline in innovation and rising costs as the pharmaceutical companies try to squeeze more from less through increasingly dubious methods that bring little benefit to the patient or the taxpayer. We want to see effective regulation that would stop biased clinical trials and excessive influence over the medical profession. It is now essential that the government steps in, only through effective regulation can the pharmaceutical industry be saved from its own worst enemy – itself.”

Future Events

What Outcome Measures matter to patients?

James Munro, Patient Opinion
Carol Rawlings University Hospital Birmingham:
Birmingham
10.30 - 4pm Thursday 24th September

Is healthcare corrupted by market forces?

Dr Hamish Meldrum British Medical Association
Hilary Wainwright, Red Pepper
John Grogan MP chair of the Parliamentary Labour Party Health Committee
John Harris Compass
Professor Wendy Savage Keep Our NHS Public
Brighton

12.30 - 2pm Tuesday 29th September

Lessons from Mid Staffordshire

Dr David Colin-Thome, Department of Health
Frances Blunden, NHS Confederation
Peter Walsh Action Against Medical Accidents
Malcolm Alexander, National Association of Links Members
Cathy James, Public Concern at Work
London

11am - 4pm Tuesday 6th October

Does the Benefit System Improve Your Health?

Dr Clare Bamba Department of Geography Durham University
Leeds

10.30—4pm Thursday 22nd October

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

Articles, Letters, Announcements and Comments should be sent to the editor Gavin Ross, 21 Connaught Road, Harpenden, Herts AL5 4TW.

The deadline for contributions to the Winter 2009 edition is 1st December
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