

Our Health Manifesto

- A system second to none in the world.
- Democratically accountable
- Where people matter.
- Where health is as important as illness.
- Where the recipients of care are key to defining the quality of that care.
- Where patients are respected and trusted to share decision-making where they want to and to look after themselves more consistently.
- And given the tools to do so by clinicians who see this as central to their work.
- Where vested interests are challenged

www.sochealth.co.uk

Editorial:

The coming General Election looks to be the first since 1992 where the result is in doubt. The Association is doing its best to assist local campaigners by providing information and support.

The divisions between Labour and Conservative over health policy are not as obvious as they have been in earlier elections. Cameron is keen to assure us of his devotion to the NHS and his personal experience makes this claim more credible. There are clearly some people in the Tory Party who would like to bring in a regime of private insurance, but it seems unlikely at present that they will have much influence.

The Conservatives, however, propose to go much further than Labour has in relying on choice, competition and markets to increase quality and efficiency. We could see a return to GP fundholding—on steroids. They will offer NHS cash to any willing provider of services. They plan to establish an independent NHS Board and to make the Secretary of State responsible for public health rather than the NHS.

This whole issue is devoted to the election manifesto we are working on with Compass. This concentrates on positive moves we want to see rather than attacks on the Opposition. As we do not expect the election until 6th May there is still time for members to make constructive suggestions to improve our manifesto.

“In health, perhaps more than other areas of the public sector, Labour can point to real advances, with patients being treated more quickly, services such as accident and emergency transformed, and improvements in survival among heart and cancer patients.”

Niall Dickson Chief Executive of the King's Fund July 2009

Compass/Socialist Health Association Manifesto for Health

The Labour Party and the Socialist Health Association can both be proud of the part they have played in the institution and development of the National Health Service. Labour has a good story to tell in health.

For the next election we need to build on these achievements.

Under Labour, spending on health care has about tripled since 1997. Life expectancy of the population in the UK increases by about 3 months every year. But measures of happiness and wellbeing, and of health inequality have hardly changed. The lives of people who are richer and better educated are longer and healthier. Although the lives of the poorest people in our society are a little longer, they are accompanied by long years of disability.

An individualised, lifestyle approach to public health enables those with most advantages to benefit substantially but it leaves the poorest and most disadvantaged behind. As both Richard Layard and Richard Wilkinson have demonstrated from different perspectives, in developed countries increased income does not produce more happiness or longer life. In fact if economic growth increases inequality, as it often does, it may have the reverse effect. Neither health nor happiness can be bought.

Health can be protected if patients are fully involved, individually and collectively, in the provision of healthcare. Where communities, by cooperation across government, are sustained through the development and maintenance of social networks that we know protect health, combat health inequalities and improve accountability. Communities and networks are the shock absorbers for society and for health. Healthcare providers need to be embedded in communities, and there for the long term. Initiatives that come and go are a waste of money.

NHS improvement over the last 10 years has mainly been due to targets, central planning and various consensual approaches such as the National Service Frameworks.

Jake Chapman has identified four problems with targets: first, people face the wrong way – the target not the citizen becomes the focus of all activity; second, the goal becomes achieving the target, not improving the quality of the service; third, data is manipulated to meet the target or gaming takes place (an example of which is being passed around the health system because no one wants you to mess up their figures); and finally, collecting data takes time and resources and detracts from the real job of care for patients.

Targets have perverse outcomes – but so do all incentives. When organised with sensitivity, targets can be life-enhancing. The response of the NHS to NSFs, for instance was inspiring – a huge amount of work was done and care improved.

Targets need to be intelligent. It helps if local communities can define their own, on the background of nationally agreed targets. Waiting times were picked as a target because they were the number one complaint by the people that used the NHS. Intelligent Targets should be clinically derived with strong patient and public involvement and an open and evidence-based approach applied to prioritisation of national strategies and targets, and involvement of local staff in this process.

We are committed to a planned and managed NHS with incentive to encourage efficiency, productivity and innovation. Commissioning is necessary to ensure a balanced planned approach. We support the commissioner-provider split as a useful mechanism for obtaining a reasonably objective view of the needs and wants of the local population.

Commissioning has to deal with the vested interests of various groups, of which doctors are the most powerful. A strong and committed investment in public involvement is the most effective counter. Transferring commissioning to Local Authorities will make it more likely that a democratic approach to commissioning would become the norm. Restructuring local government in England to create a universal pattern of unitary authorities would help. There should be maximum devolution of responsibility for healthcare to regional, area and neighbourhood levels, moving away from the single monolithic national blue print model but with retention of a core of national standards.

We recommend “cooperative commissioning”. That is, planning along pathways, where a budget is shared by primary and secondary care. Savings made in that pathway are re-invested.

There are thus incentives for:

- efficient use of resources,
- clinician, staff and patient involvement
- PCTs driving the process

Incentives to move upstream towards health promotion
This implies a rejection of payment by results

Accountability and Power sharing with Patients

We want an NHS responsive to its local populations, an NHS that is responsive to individual patients, offering shared decision-making in their own care, as well as collective responsiveness to local communities.

Collective accountability:

A **democratically accountable** NHS with both democratic as well as participatory accountability, using community development as a key approach. All NHS organizations should be required to demonstrate their responsiveness to their local populations. The details of contracts should be available to the public. Openness should be part of the price of doing business with the NHS.

At practice level:

- elected practice boards to work with the partners to run the practice should be offered as an option to practices
- patients are encouraged to work with staff to select new doctors and clinical staff
- every practice should be encouraged to have a patient participation group or panel.
- the CQC demanding evidence that the practice has changed in response to patients' views
- quality of care is in part defined by patients working with local community development workers to improve social networks, gather local intelligence and respond to it.

Commissioning

The PCT Board is accountable, but to the Secretary of State, not to the local community. We remain optimistic about LINKs but NHS commissioners will need to become responsive for the process to be effective. More power to overview and scrutiny committees would help that process. PCT Board members should be appointed for their interest and ability to ensure responsiveness of the organisation to the local population.

Community development should be formally adopted, as NICE has recommended, as a key approach to involving the local community in NHS planning and monitoring. It is a standard approach in local authorities and now needs to be applied systematically to health

Local Authorities to take over the full commissioning functions of PCTs. This process should

start by passing the responsibility for appointing non-executives to PCT Boards to local authorities. The Care Quality Commission should demand evidence that local commissioners and providers have taken on board patients' views in the following areas

- Needs assessment
- Choosing priorities for investment and disinvestment
- Monitoring quality
- Identifying problem areas and successful areas of service provision
- Determining the shape of service development
- Deciding on how to spend any savings

Every Professional Executive Committee of a PCT should have lay representation. Also, half the Board could be patient leads within Practice Based Commissioning clusters

Shared decision-making in the consultation

We need a systematic shift in the way the NHS does business:

- listening and understanding health beliefs,
- offering clear information, supporting people in making choices from a menu of options,
- offering decision aids
- continuing support for prevention and healthy choices.
- Training and support for clinicians to alter behaviour
- expansion and de-regulation of the Expert Patient Programme,
- access to the GP record electronically

One key aspect of this kind of involvement in care is patient access to their full GP record linked to information to explain what they mean— this is available now and is likely to transform care. What we need to do is to extend these approaches so they are available to everyone, especially those who don't have a computer

Responsiveness to staff

Social partnership developed within the NHS with active worker participation in the management and governance of the Service. Community services in particular could work very well if run as worker co-operatives.

Promote Social Justice and Public Health

The difference between left and right is that we see the intrinsic worth of an institution like the NHS because of its capacity to build and foster social citizenship and the egalitarian spirit that goes with it. It is the moral underpinning of the NHS that can re-enforce public commitment to it and so increase its instrumental performance. Our goal must be the creation of a virtuous cycle of experiential and emotional commitment to key public institutions like the NHS.

Shared risk – we are all in this together. The NHS is a system for sharing risk across the nation, with the bulk of the risk taken by the state. This approach to social justice should never be put at risk and needs to be extended as an underlying principle .

Health Inequalities which are resistant to change can be most effectively and morally reduced by a pan-UK policy that focuses on social justice:

- Responsive
 - Cooperative
 - Empowering staff and communities and individual patients
 - People-centred
- Reducing income inequality

•Salary range for all NHS employees of not more than ten-fold.

• Abolish extra merit awards for consultants and replace them with other forms of recognition. The very best clinicians could become dukes (but without a seat in the House of Lords), the lesser clinicians knights.

Give every child the best start in life

- To improve the health of mothers and babies.
- To improve support to parents.
- To build the resilience and well-being of young children.
- To improve access to quality early years care and education.
- To improve the early years workforce.

Give all the chance to develop skills and opportunities to control their life chances

- To improve skills across the gradient.
- To improve access to life-long learning across the gradient.
- To achieve greater integration between school and family policy and interventions.
- To ensure that schools promote the health and well-being of children.
- To improve the children's workforce for school aged children.

Create fair employment and decent work for all.

- To improve access to employment across the gradient.
- To promote equalities in the workplace.
- To improve the health of working age adults both in and out of work.

Ensure a healthy standard of living for all

- To improve standard of living across social gradient.
 - To eradicate child poverty.
 - To establish a minimum income for healthy living.
- A comprehensive occupational health service should be developed for all NHS staff and could also be offered to other employers. Social security benefits and the minimum wage to be geared to measured minimum needs such as the low cost but acceptable standards with regular updating

Create and build communities and places that give people control needed to live physically and mentally healthy lives.

- To improve access and quality of open spaces across the gradient.
- To improve community resilience across the social gradient.
- To improve housing quality.
- Community empowerment.

Strengthen the role and impact of prevention.

- To increase availability of long-term and sustainable funding in ill-health prevention.
- To improve prevention and early detection of diseases that contribute to the social gradient.
- To improve the evidence base for the effectiveness of ill-health prevention.
- Promotion of positive mental health should be a priority

Healthy public policy making with universal health impact assessment applied to both national and local policies

Liberate Communities Public Health

Social networks protect health, reduce inequalities and can improve the effectiveness of patient and public involvement across the NHS. People who use services are hidden resources, not drains on the system - no service that ignores this resource can be efficient.

Clients or patients provide the vital ingredients which allow public service professionals to be effective. They are the basic building blocks of our missing neighbourhood-level support systems – families and communities – which underpin economic activity as well as social development.

The NHS relies on this underpinning operating system that consists of family, neighbourhood, community and civil society. The economist Neva Goodwin called this operating system the ‘core economy’. The consequences of failing to recognise and support this core economy are all around us: isolation, time poverty, low levels of trust, engagement or social infrastructure.

Co-production is central to the process of growing the core economy. It goes well beyond the idea of ‘citizen engagement’ or ‘service user involvement’ to foster the principle of equal partnership. It offers to transform the dynamic between the public and public service workers, putting an end to ‘them’ and ‘us’. Instead, people pool different types of knowledge and skills, based on lived experience and

professional learning.

The NHS needs to transform its way of working to work with communities, to harness their energy and insights. In this way, we will be able to save money, obtain better outcomes and improve relationships.

Social connectedness and integration are good for health.

Social relationships protect people against both physical and mental problems. Those with strong social networks get ill less often and recover more quickly. This is also true of control over work.

Stronger social networks and control over your life and work show social gradients, with poorer people having fewer networks and less control.

Community development is a technique that can enhance social capital, social networks and improve a sense of control. In addition, it has been shown to improve the process of PPI. It is a standard approach in local authorities and now needs to be applied systematically to health. It would encourage a holistic approach to health at a local level and will enable closer working between PCTs and LAs.

We need to develop our ideas about public health further. It is interesting that the Conservatives are putting considerable stress on this area, although their approach is even more about life styles and personal responsibility than Labour has been.

In fact the Conservatives have produced a public health manifesto—possibly the first we have ever seen.

It seems sensible to elaborate our ideas in this area after the publication of Michael Marmot’s review of health inequalities in England which is about to be published. However there are a number of key areas which must be prioritised:

- Taxation of alcohol should relate to units of alcohol.
- Information about the fat salt and sugar content of food should be compulsorily displayed
- Increasing the physical activity of the population should become a central target for both central and local government

Contain Costs

Use insights from industry:

The key to innovation in health is to stop the poorest providers and support the best provider. That might mean campaigning to close hospitals or surgeries. Unless there is a genuine failure regime then neither choice, voice, planning nor markets will have much effect.

Mental health and wellness should be a key driver for services.

Capital funding for NHS should be provided from the public purse, possibly from publicly subscribed NHS Bonds

Abandon Payment By Results – it drives up costs

Reduce the use of management consultants

Begin proactive primary care. Ensure that primary care focuses on shared decision-making, supporting patients in understanding and managing their own diseases. In addition, investing in approaches that enable primary care to transform its approach to a proactive one, reaching out to patients with long-term conditions to prevent crises and increase self-care.

Shared decision-making with patients

There is good evidence that if patients are involved in decision making they tend to choose less expensive treatments than clinicians and get better outcomes.

A commitment to community capital and social networks. Establishment of local health partnerships for coordinating action on health with community sector taking the lead

Eco-friendly policies

Abandon marketisation – it drives up costs

The NHS exists in a market economy. The fact that patients generally do not pay for treatment does not mean that the NHS is outside the market. NHS organisations trade with the outside world. They compete for resources. They need to borrow money. The issue which needs to be addressed is the way in which markets impinge on health care.

There has always been private provision of services within the NHS. Many of the complaints about the effect of privatisation are actually the effects of the contractual arrangements between the private sector and the NHS. Private contractors do what they are paid for. That is how markets work.

What is marketisation? The treatment of health and health care as a commodity to be bought, traded and sold. Competition is a key driver here – the assumption is that competition will drive up standards and efficiency.

What is privatisation? The increasing provision of healthcare by private providers. Significantly, this extends to the provision of commissioning by private organisations such as BUPA or Humana.

It is important to recognise that GPs are, in many ways, private providers, as are (and have always been) most of the organisations that deal with key infrastructures of the NHS – its IT and the building of its hospitals, not to mention pharmacists, opticians etc.

What is Choice? The idea that, if patients have the information on differences in quality between providers such as hospitals, they will become drivers of change and competition across the NHS. The evidence is that patients actually want choice in the management of their own conditions rather than their healthcare providers.

Why marketisation is inappropriate for the NHS:

In public services budgets are more or less fixed. Pressure from buyers does not expand the market.

- Markets work well when buyers can easily choose between different offers. In most parts of the NHS

there are few buyers, few sellers and little opportunity to make a choice.

- Market forces in health might have beneficial effects if poor providers lost customers, but in reality this rarely happens. GPs form cartels to protect their weaker colleagues. Politicians are desperate to defend even the worst hospitals which are always dearly loved especially by people who don't use them. Even Stafford Hospital experienced very little loss of business during the long period when it was publicly accused of massacring patients. Markets work much better if the buyers know what they are buying. Few groups of patients have knowledge of the options available to them

Patients can choose which Out-patient Department to visit to get a diagnosis, but without a diagnosis they are going to find it difficult to make an informed choice. That first visit to outpatients may be the first of many. Even in elective surgery, a proportion of patients cannot really be offered choice because they need specialist treatment only available in a regional centre. Most old people, the majority of patients, are very unenthusiastic about travelling any farther to hospital than they have to. They are not keen on choice of provider.

Elective surgery, where a choice can easily be offered to patients, is quite a small part of NHS activity. Probably less than the 20% of activity where the only person who can make a choice is the ambulance driver.

Patients should not be in a position where they wonder if the treatment they are getting is in their interest or in the interest of the providing institution.

Where choice is not a viable mechanism – as in acute care (probably about 80% of hospital activity) – then we should be looking to harness a collective voice in a much more systematic way.

Why marketisation is dangerous to the NHS

- The interests of private companies are not those of the patients they serve
- Private provision is almost always likely to be more expensive
- They are less stable – they will exit the market if their interests change
- The transaction costs of a market in healthcare is prohibitive
- There is no spare capacity to make choice and competition effective drivers
- Competition is wasteful

Private involvement in commissioning is always unacceptable.

Some aspects of marketisation are useful

- Knowing where the money goes
- Being able to choose a private provider in the unusual circumstance when no NHS provider will do.

Drastically reduce private involvement in the NHS – but do not eliminate it.

Andy Burnham's recent formula –

that the NHS is the preferred provider and poor NHS providers should be given an opportunity to improve before services are put out to tender - seems to be a reasonable compromise. It may turn out to be more effective at closing down poor NHS provision than the earlier rhetoric of the free market, because it actually provides a procedure for the termination of poor services

Payment systems should be aligned, as far as possible, to real outcomes, and all providers of services which impinge upon that outcome should be paid out of the same pot. There should be no incentive to provide treatment of a kind which is more expensive than is necessary for the benefit of a provider.

But do we believe that it is possible to derive measurable outcomes for all services? Is the failure to do this in mental health a symptom of a greater problem – that they don't know what they are doing?

- Separation of private practice from the NHS and promotion of whole time NHS consultant contracts with no private practice allowed

- A determined attack on businesses that profit from damaging the health of the population. Regulation should be for the benefit of the consumers, not the providers.

- Promotion of the cooperative model of private, voluntary and public sectors.

Future Events

Foundation Trusts, Democracy and Public Ownership

Toynbee Hall 28 Commercial Street, London E1 6LS
Friday 5th March 11am - 4pm

Patricia Moberly : Is this democracy? Is it public ownership?
Malcolm Alexander National Association of Links Members
Jessica Asato Director of Progress

Hannah Jameson Research Manager Involvement and Participation Association
Sharon Carr-Brown Foundation Trust Governors' Association: Have Governors made a difference?

There is a charge for this event

Debate on Markets and Health

CIVITAS: Institute for the Study of Civil Society
55 Tufton Street London SW1P 3QL.
6.30pm - 9pm Wednesday 17th March

This house believes that a market will deliver quality and efficiency in healthcare better than central planning ever could

For the motion:

James Gubb Director - Civitas Health Unit
Steve Smith, Chief Executive of Imperial College Healthcare NHS Trust

Against the motion

Neal Lawson, Chair of Compass
Jonathon Tomlinson GP. Keep Our NHS Public

In the chair

Martin Rathfelder Director of the Socialist Health Association

with drinks reception after the debate

There is no charge for this event but you must book a place

Costs for the events above vary but are reduced for SHA members (and delegates from affiliated organisations, such as CSP, SoR, Unite, and Unison). Further details will be on our website www.sohealth.co.uk or 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 Summer 2010 edition is 30th July Tel/Fax 01582-715399 or by e-mail to gavros.ross@btopenworld.com

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