Minister wants you to pay (again) for your NHS care!

Return of a zombie policy!

The newly-appointed Tory Minister for NHS Productivity, Lord Prior, has set up a fresh inquiry into the possibility of funding the NHS through user fees for treatment or be required to take out health insurance. Cameron’s previous explicit insistence that patients would not face charges for treatment or be required to take out health insurance.

We can expect an orchestrated campaign of such arguments to grow. Cameron’s previous explicit insistence that patients would not face charges for treatment or be required to take out health insurance.

Sir David Nicholson, the new chief executive of the NHS, will be the subject of a new inquiry into the possibility of funding the NHS through user fees for treatment or be required to take out health insurance.

This raises the possibility of the new government publicly flouting David Cameron’s previous explicit insistence that patients would not face charges for treatment or be required to take out health insurance.

But we are in a period in which a newly-elected Tory government feels free to ditch its pre-election promises and earlier commitments, and crack on with the policies which will appease the right wing backbenchers and the backwoods men and women who fund the Party. Of course charging for healthcare is not a way to balance the books of the NHS. The example of prescription charges underlines the problem. For adults in work, each item on a prescription is supposed to be charged at £8.20 per item, giving only pence change from £25 for anyone requiring three items.

But while the charge acts as a severe deterrent and often an insuperable obstacle to low-paid workers getting all of the drugs they need, it only raises peanuts towards the total costs of running the NHS. The latest Department of Health figures show that prescription charges totalled £504 million last year – less than 5% of the full cost of running the prescription service, and an infinitesimal part of the £110 billion NHS Budget for England. Exemptions mean that almost 90% of prescriptions are dispensed free. Many of those exempted (the elderly, children, people on benefits) would struggle to pay the prescription price, and would as a result receive only a part of the medication GPs believe they should have. In other words, more charges and bigger charges, almost certainly coupled with a reduction in numbers exempted, would inevitably mean more people on low incomes failing to get the access treatment they need – becoming more sick, and increasing the likelihood they will be expensive emergency cases when they finally do require treatment.

Germany recently scrapped charges to access GP services: the charges irritated the GPs who had to administer them, and were big enough to deter many of the patients who most needed regular treatment. A diehard right wing fringe of the Tory Party has always argued for charges to access NHS services. They never accepted the premise of Bevan’s NHS, which was to eliminate the cost barriers to health care for everybody – including more affluent middle class families who could be thrown into chaos by hefty hospital bills. The principle was that the NHS was funded on the basis of general taxation, not by charging the sick. But every so often – almost every year at the BMA’s annual conference, and periodically in the media – another attempt will be made to resurrect this zombie policy. The inescapable problem facing anyone wanting to turn the clock back in this way to the 1930s is that most health care is needed by those – the very young, very old, mentally ill, and the poor – who are least in a position to pay any significant price for it. And health care is not the sort of service which people who don’t really need it would access simply because it’s free.

Radiotherapy is free to cancer patients: there is no queue of punters wanting it because it’s free. The zombies are emerging again because we have a right wing Tory government determined to use its 5-year term to slash public spending and open up as much as they can of the NHS to the private sector. But the private sector will take care to ensure that any services they take over are publicly-funded, to guarantee numbers of patients and fat profits.
Large cuts have hit social care budgets every year since 2010, subjective to a 16% cut in real terms to services for older adults from 2009-2014, leaving 300,000 fewer people receiving care.

The scale of these cuts, with the prospect of more a deeper cuts to come in social care prompted leaders of the Local Government Association to join forces with the NHS Confederation and health professional bodies and jointly sign a letter to the Observer early in 2015 warning of the dangers to patients if more cuts continue in health and social care:

“Councils work incredibly hard with health partners to ease the growing strain on the NHS. But putting extra money into the NHS without easing the pressure on council budgets is not a solution.

Without adequate funding for care, the NHS will continue to be forced to pick up the pieces from a social care system that is not resourced to meet demands, which will be increasingly unable to keep people out of hospitals.

This would be a disaster for the health service and those left languishing in hospital beds instead of being cared for in their own homes and communities.”

Impact

The impact of the financial cuts on social care nationally in England – following 15 years of growth in budgets for Personal Social Services – are also spelled out in another report The Coali- tion's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015:

“Overall spending is projected to have fallen by 13.4 per cent over the Government’s five years in office. Already by 2013/14, 17.4 per cent less was being spent on services for older people. By contrast, the number of people aged 65 and over is projected to rise by 10.1 per cent over the same period, including an 8.6 per cent increase in the population aged 85 or over.”

The researchers showed that the shrinking budget at a time of growing population inevitably means care is be- ing given to fewer people who need it:

“The number of people receiving publicly-commissioned adult social care services fell by one quarter between 2009/10 and 2013/14 from 1.7 million to below 1.3 million.”

This is especially hitting those who according to many NHS plans for reconfiguring services should be supported to live at home, and avoid the need for hospital admissions:

“Care at home and other community- based services. Most of these services have been hit very hard, resulting in an average 8 per cent reduc- tion in the number of users each year.”

The Local Government Association has warned that spending on other council services in England would have to drop by 66 per cent in cash terms by the end of the decade, from £24.5 billion in 2010-11 to £8.4 billion in 2019/20 to accommodate the rising costs of adult care.

According to the latest HSCIC data there were 10,000 fewer jobs in adult social care services in England in September 2014 than the year before, and a reduction of over 18% from 159,400 in 2011.

Falling volumes of care

NAO analysis also shows that:

“Around three quarters of the reduc- tion in local authority spending has been through reducing the amount of service provided. Volumes of care have fallen across all types of care service.”

A consequence of this reduction and inadequate resources is, according to the NAO that: “In 2012-13 patients spent 833,000 days longer in hospital than necessary because of delayed discharge.

The average size of the weekly pay- ments to older people and adults in London vary enormously: 8 boroughs paid out an average of less than £200 per week, the lowest being Bexley, pay- ing £62 on average. The most gener- ous was Kingston, where 345 clients received an average of £492 per week. However the statistics in this spending offer no information on what these sums of money are spent on, and whether this represents value for money for the borough or for the client. Nor do they seek to explain why there have been so few payments, or what costs the smaller payments are expected to cover.

No meals services

Nationally one third of UK local au- thorities have ceased to provide “meals on wheels” for elderly and vulnerable people. This may put them at risk of malnutrition, and means that older people unable to cook for themselves are obliged in those areas to seek care elsewhere, increasing the numbers us- ing care homes and hospitals.

Age UK has estimated that of 2 mil- lion older people in England with care-related needs, almost 800,000 receive no support of any kind.

The new eligibility criteria in the government’s controversial Care Act only offer any support to those with the highest level of ‘substantial’ needs. An overview analysis by the As- sociation of Directors of Adult Social Services found that eligibility to social care for people assessed as having ‘low’ to ‘moderate’ needs had fallen from almost 30% of English councils providing support in 2010 to just over 10% in 2014/15.

Setting the minimum eligibility threshold at the level of those being assessed in the (phrasing of the Care Act) a signi- ficant risk to any aspect of the adult’s well-being clearly runs in contradiction to the new statutory requirement to offer “preventative services.”

The lack of preventative services to help people cope longer living at home makes a nonsense of the many NHS strategic plans which rely on this as a way to minimise use of hospital services.

The Department that claims to know nothing

The lack of any coherent or convincing plan to take account of the levels of need of older people and support them in their own homes has been highlighted by the highly critical report of the Commons Public Accounts Committee last July on Adult Social Care in England.

Having taken evidence from the Department of Health and the Department for Communities and Local Govern- ment, the all-party committee noted:

“The Department do not know wheth- er the care system can become more efficient and spend less while continuing to absorb the increasing need for care. […] Local authorities’ cost savings have been achieved by passing lower fees to provid- ers, which has led to very low pay for the care workforce, low skill levels within the workforce, and inevitably poorer levels of service to users. […]”

“We are concerned that the Depart- ments have not fully addressed the long-term sustainability of the adult social care system, and that its policies to drive change (the Care Act and the Better Care Fund) are not supported with new money or do not acknowledge the scale of the problem.”

The Departments acknowledge that they do not know whether the required efficiencies, but still believe the ambitious objec- tives of implementing the Care Act and integrating services are achievable.”

“The Department of Health acknowledges that it does not know whether some preventative services and lower level interventions are making a difference.”

“The Department for Communities and Local Government told us that they did not know how local authorities would be able to maintain spending on care for adults and improve outcomes in a situation where needs were increasing but overall public funding was falling.”

To complete the picture of central government ignorance and indifference to the wellbeing of adult social care services, the PAC found:

“The Department of Health recognised the scale of the problem in their own research in this area, and it acknowledged that the lack of evidence on what works and how changes should be implemented was a barrier to integration of health and social care.”

In other words at national level and in London a grand strategy for the development of a coherent health and social care, and the further integration of primary and community services – which run as an objective through almost all policy statements from NHS commission- ers – has been advocated and adopted as policy despite a lack of working examples and evidence, and alongside relentless cuts in resources to meet rising demand in health and social care.
Cameron’s plan for 7/7 working threatens NHS pay agreement

Immediately after the general election Tory Prime Minister David Cameron and his Health Minister Jeremy Hunt raised the urgent need for the NHS to move towards a 7-day service.

The hundreds of thousands of NHS workers who already provide a 24 hour, 7 day a week, 365 days a year service can be excused for wondering what are these people going on about, what are we working now?!

In reality the government wants to extend the core hours when all NHS services are open – but is not prepared to increase funding to employ the extra staff needed to do so.

To deliver this within same budget they need to find the money elsewhere and true to form it will be NHS workers who will be made to pay the bill. The existing staffing levels would be stretched thinner across longer hours.

In January the then coalition government instructed the NHS Pay Review Body (PRB) to “look at affordable out of hours working arrangements”.

According to government ministers, unsocial hours payments to compensate staff for sacrificing time other workers can spend at leisure are “archaic” and “a potential barrier” to other workers can spend at leisure are

The PRB has been given a number of options to consider all of which reduce some or all of the enhancements paid for change. If that’s the way ministers want scarce NHS money spent, the NHS is in for a rocky ride.

Challenging times for ‘challenge fund’

David Cameron’s ‘Challenge Fund’ for 7/7 working in primary care has two big problems: the GPs and staff don’t want to do it – and few patients apparently want to use it.

Many of the pilot schemes trialling 7-day GP access have cut back on extended evening access, and some have closed Sunday sessions completely after finding far lower than expected patient demand.

In one pilot area 60% of appointments went unused, despite efforts to publicise the service. But of course all this unused provision still has a cost and once the Challenge Fund money is exhausted the bill will land on the desk of the local CCG.

In Manchester, soon to be ‘devolved’ obsessive CCG chiefs are pressing ahead regardless, despite poor results so far, with 7-day access schemes costing £1.3m to save a claimed £425,000.

Just 65% of Manchester’s extra GP appointments had been taken up, and the extended service had reduced A&E attendance by a feeble 3% – all of them minor cases. The biggest saving was in “out of hours” GP services.

That’s the way ministers want scarce NHS money spent, the NHS is in for a rocky ride.

Cash crisis brings green light for unsafe staffing

Craig Pigott

Monitor, the NHS regulator, has written to cash-strapped trusts facing a massive £2 billion total of deficits this year, telling them in effect to disregard targets for waiting times, and tear up guidance on safe staffing levels. All financial penalties will be suspended, in a desperate effort to balance the books. Monitor has joined the chorus of people warning that there is simply not enough money to maintain NHS services as before – again proving that Cameron’s pre-election promises of an extra £8 billion for the NHS by 2020 is no guarantee that services will be slashed to ribbons and the choicest services privatised.

NHS England boss Simon Stevens suggested the £8 billion. It sounded like a lot when the consensus seemed to be for more austerity. But it does not add up to much each year if phased over five years. In fact England’s NHS budget, even frozen in real terms since 2010, has grown in cash terms by far more than £8 billion – from £98.5 billion in 2010 to £110.5 billion in 2014-15. And still we have the vast majority of NHS and foundation trusts predicting heavy deficits this year, with even worse to come.

Stevens also argued that the NHS could generate a staggering £22 billion more of ‘efficiency savings’ between now and 2019-20 to cover the increased cost pressures of a growing population and larger numbers of frail older patients. That seems nigh on impossible to achieve.

For Stevens, the cash squeeze – and the desperation flowing from it – is an additional lever to be used to force a brutal “reconfiguration” of hospital services, which have time and again run up against a solid wall of popular public opposition. But with waiting lists already at new record levels, and hospitals missing key performance targets, we can expect far worse to come.

Another 4 years of NHS pay cuts?

If anyone was in any doubt of the Tory view of NHS staff, the decision by George Osborne to impose yet another cap on public sector pay, with a 1% limit for the next four years, should make it quite clear.

The Tories want to reduce the NHS to a minimal back-up service, with as much of it as possible provided by private contractors. For NHS staff whose wages have already been cut by upwards of 16% in real terms since 2010, this throws down another challenge, especially if the threat to Agenda for Change and its provision for unsocial hours payments goes ahead in the drive for 7/7 working.

But the Tories are also inconsistent: one section of the private sector is now squabbling in protest, after Jeremy Hunt demanded a clampdown not only on the hourly pay of agency staff but also imposed strict limits on spending on agency staff by financially troubled trusts.

The agency employers complained that Hunt’s language was “outrageous”. The problem in the NHS is that years of frozen pay, followed by years of below inflation pay awards, coupled with stressful work are driving some towards agency work as a way to regain control over their workload.

Capping agency pay rates will just make it even harder to secure staff when they are desperately needed, while the new 1% pay limit for the next four years guarantees more staff will be driven out of the NHS.

Fight to defend unsocial hours pay

The NHS Staff Council is a negotiating body made up of the NHS Trade Unions and Employers representatives. UNISON and the other NHS trade unions have all opposed any moves to erode unsocial hours payments and the RCN has publicly stated that it will ballot for strike action for the first time in its history if unsocial hours payments are reduced.

UNISON’s Health conference in April this year also voted for a strike ballot so a summer/autumn of discontent in the NHS is becoming more and more likely.

If the government does go ahead with their attacks on enhancements staff will have no choice but to fight them.

Every protest and strike has confirmed that the general public believe health workers are better value for money than Jeremy Hunt and co!
The neoliberal propaganda factories continue to have the ear of many. But KONP is determined to fight on – and the way to do that is not alone.

Local groups

All of KONP’s local groups and affiliates share the same values. They all want an end to privatisation, bringing back government responsibility for the NHS, and returning the NHS to government ownership; to end compulsory competition and reject TTIP; increases in NHS funding to restore it to what it should be; and to stop cuts based on cost and the travesty of PFIs.

The key question is, how do you make this happen in a political landscape in which the Tories hold power at Westminster?

Parliamentary solutions, in the form of an NHS Bill that becomes law (see page 5), are denied the campaigns unless the government’s majority fails it at some point. That cannot be relied upon.

What can be done, though, is promising and plays to the strengths of the campaign movement – if it can avoid shaking itself to pieces with internecine squabbles.

Monitor CCGs

A key strength is the local groups. Here are where the careful monitoring of privateer-leaning CCGs is done, here are where the press campaigns can still be encouraging as the local press (where there still is one after years of savage cuts by corporate giants like TMG) remain more likely to listen, here are where the demonstrations happen a lot of the time.

But local groups face problems. It’s often only a small number of determined people acting in their ‘spare’ time, often without the information of similar battles won in other parts of the country to hand, nearly always facing corporations who have massively more resources to apply.

People burn out. They can easily feel disheartened, and righteous anger can all too often wither to exhausted despair.

Privatisation and cuts can happen through simple attrition – if we let them. This is where planning and coordination at a national level are the solution.

Groups and individuals have always talked to others they know of who have the experience to help, but it’s so much easier and encouraging when there is already a network and resources which put people in touch immediately, and continue to give the best possible information and advice.

They rely on the experience learned at a local level to inform and help others fighting their battle locally.

KONP has undertaken a major upgrade of its national website to achieve this better coordination, offering local groups a national presence, and will continue to produce resources nationally to help people locally.

Local battles

Of course the national media profile will continue to be important: but local efforts to win the local battles are where the victories now lie.

What is true within one group is an even greater truth amongst them. KONP, like several other NHS campaigns, has started to reach out to other groups and talk to them about joint planning, sharing of resources in a more coordinated way, advising and supporting people locally across the country in a way that so far has not been achieved nationally.

This newsletter is the first concrete example of that collaboration. There will be others – and their aim is simple. To unite us all against the common threat facing our NHS.

It will not be easy. There are genuine and deeply held differences of opinion which can destroy alliances just as easily as the Tories could shut down and sell off a hospital if unopposed.

The way forward is not to insist all the campaign groups sing the same song, and certainly not to impose rules or structures that rob any one group of autonomy or direction.

But if all of them can ensure all the words mean the same thing, the differences will not matter so much as making the only difference that counts: stopping the NHS from disappearing.

Health campaigns will be stronger together

Winning by joining

The neoliberal propaganda factories continue to have the ear of many. But KONP is determined to fight on – and the way to do that is not alone.
5-year freeze is taking its toll

NHS Trusts line up for billions in bail-outs

Despite David Cameron’s claims to have protected NHS spending, the prolonged austerity regime imposed by George Osborne in his quest to cut the share of GDP spent on health has taken a heavy toll.

Shocking figures from the Health Service Journal show that Department of Health bail-outs to prevent hospitals going bust in the run-up to the General Election add up to a massive £1.2 billion.

In all 56 struggling trusts were given extra money to cover wage costs, pay bills and finance new equipment or repairs. But there is no guarantee of further payments and many trusts are now staring into a financial abyss.

Prominent in the lists of the largest bail-out payments are hospitals built with funding from the ‘Private Finance Initiative’, which has left the trusts saddled with soaring and unaffordable payments for 20-30 years to come.

The HSJ also reveals that eleven of the bailouts have now been converted into loans – requiring trusts already struggling to balance their books to fork out extra payments each year until the loans are paid off.

With the cash squeeze tightening and the pitiful promise of an extra £8 billion over five years tied to demands for an impossible £22 billion in savings, and two thirds of trusts already predicting deficits this year, the situation is set to get much worse.

More telling figures from the HSJ reveal that Clinical Commissioning Groups which hold the purse strings for local health care are implementing or considering rationing services to restrict spending.

Many of these are looking to pull funding from a treatments claimed to have “limited clinical value” – one list of which was drawn up by management consultants McKinsey back in 2009, straight after the banks crashed. Patients denied these services from their local NHS would face a grim choice of going private or going without.

Now the Tories have been elected for another five years, the grim consequence of the squeeze and demands for “efficiency savings” can be expected to emerge in a fresh wave of hospital closures.

But this can be a point of leverage against a government with a majority of just 12 in the Commons.

The fight for the NHS is not just a campaign against outsourcing: we need to challenge each of these cuts, and put local politicians on the spot when any services are threatened on their patch, proving to them they could pay a heavy political price if they conspire at the destruction of local health care.

London’s NHS faces a ‘funding crisis’ that is impacting across the system as a whole, according to recent papers produced for a conference of finance directors.

Having got through last year by the “skin of their teeth” finance directors are facing further cash constrictions and complications. The figures give a glimpse of the crisis facing all areas of England.

The NHS in London alone faces a £4.76 billion ‘affordability gap’ by 2020, equivalent to £3.4 billion from London providers (trusts) – 25% of their turnover, equivalent to closing 1 in 4 hospitals – and £1.74 billion from Commissioners (who often seek to ‘save’ money by further cutting funds to providers).

These figures assume a best case scenario in which the promised increase of £8 billion in NHS funding (asked for by NHS England boss Simon Stevens) is delivered by 2020.

The London problem, as in many other areas is also worsened by the fact that the social care sector is also “experiencing a significant funding challenge that is projected to worsen over time”.

London local councils have seen cuts in core funding of 45% since 2010, and faces further cuts up to 2020 of 42% from the level they are now – leaving less than a quarter of the funding they had before the Tory-led coalition took power.

However the population is growing in London, with some boroughs set to increase by 15%. The combination of reduced funding and growing pressure is expected to bring a £3.4 billion funding gap for London’s local government.

There is a grim warning that “London may need to explore options for revenue-raising to meet the funding needs of the health and care system”.

The NHS problems are compounded by “complex duplicated regulation” and the conflict between commissioners and providers worsened by Andrew Lansley’s 2012 Health & Social Care Act.

And the financial pressures have led to “an unclear policy” on the “consolidation” of services onto fewer hospital sites, and the future of smaller hospitals.

The Trust Development Authority’s Business Director for London points to a massive £3.3 billion bill for temporary staff across the NHS as a whole last year, increased by a third since 2012, of which a disproportionate share is down to London’s trusts and foundation trusts.

The cost of agency nursing has doubled since 2012, while the rate of nurses leaving the profession has increased by a massive 29 percent, and – after cutbacks in 2010 – there are now fewer nurses than ever before.

NHS organisations also reveal that Clinical Commissioning Groups are implementing or considering rationing services to restrict spending.

Many of those are looking to pull funding from treatments claimed to have “limited clinical value” – one list of which was drawn up by management consultants McKinsey back in 2009, straight after the banks crashed.

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MANCHESTER - Tory Party Conference
National Demonstration: SUNDAY 4 OCTOBER
No to Austerity – Yes to Workers Rights
Assemble 12 noon, Oxford Road
Organised by the TUC & the People’s Assembly
“Laugh Them Out of Town” @ Manchester Academy
Line up includes: Frankie Boyle, Mark Steel, Francesca Martinez, Sara Pascoe, Jeremy Hardy, Robin Ince
Tickets: £10 / £20 / £30 (concession / standard / solidarity)
Tickets from https://manchesteracademy.ticketline.co.uk/order/tickets/13309295/
laugh-them-out-of-town-manchester-academy-2015-10-04-19-00-00
The NHS is already suffering as a result of racist changes to the rules governing non-EU staff, even as desperate NHS boxes scour Africa and Asia in the quest for staff to fill growing numbers of vacancies.

From next April, non-EU nursing and other staff earning less than £35,000 (i.e. most nurses) will have to leave the country. The government has persisted with this policy, despite warnings from NHS Employers.

Indeed the Migration Advisory Committee, specifically decided in February not to include nursing on the list of ‘shortage occupations’ that were allowed to recruit outside the EU.

The Health Service Journal’s Shaun Lintern reports one clinical director at a London hospital warning that non-EU staff are already leaving the NHS, seeking to get jobs paying above £35,000. “In London we rely on nurses on work permits to keep our services going,” he said.

The HSJ has previously reported that a staggering 85% of trusts have failed to meet their own planned nurse staffing levels.

But already staff are leaving, and expensively recruited new potential staff are unable to get work permits.

That’s Tory policy for you – appeasing the racist right at the expense of public services.

The other reactionary Tory policy targeting non-EU migrants is also creating more problems for the NHS – the imposition of a £200-a-year ‘health surcharge’ which migrants have to agree to pay as part of their visa application.

The initial tabling of the Bill March 11th – again regardless of their ability to pay.

The Bill’s shortlived progress will be eventually killed off by an amendment on the lines of the amendment proposed in the House of Lords, which was defeated.

The law the Bill would make the Health Secretary responsible for the NHS again, do away with FTs and centralise PFI-debt, integrate primary health services, introduce successors to community health councils as genuine local bodies to represent the public, scrap Monitor, stop TTP from wrecking the NHS’s future, and reinroduce the NHS’ own terms and conditions for NHS staff.

But with a Tory majority we can expect to see all of this noble and completely effective legislation failing to become law. If nothing else, the likes of Rees-Mogg will relish the chance to do this.

Then and now: the “nasty taste” of Tory calls for charges

Aneurin Bevan, the founder of the NHS, argued strongly against suggestions that the NHS should charge foreigners for using services:

“One of the consequences of the universalist of the British Health Service is the free treatment of foreign visitors.

... There are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain.

“...The whole agitation has a nasty taste. Instead of rejoicing at the opportunity to practise a civilised principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialised medicine.”

(Revealed in Place of Fear, 1952)

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In Place of Fear: The struggle to undo Lansley’s disastrous Act

Fighting on to reinstate the NHS

Many of our readers will have been sickened to hear of the peerage given to Andrew Lansley, the architect of the disastrous Health & Social Care Act 2012, which has so thoroughly fragmented the NHS and paved the way for much greater privatisation.

But reports of the death of the NHS were widely exaggerated. And the Bill to reverse the market-style reforms since 1990 is alive, and part of the new Parliament.

Though it is highly unlikely to ever reach the statute book, the presence alone of the NHS Bill holds out some hope; and stands for the determination of a lot of people.

As in the last Parliament, it was Green MP Caroline Lucas who took up the cause again. As before, she gained the support of a cross-party group of MPs so she could table the Bill as a Private Members’ Bill.

Her supporters included Jeremy Corbyn and Dr Philippa Whitford, the SNP health spokesperson. The House of Commons Clerk insisted it couldn’t contain the word ‘Repealment’ so it was registered as the National Health Service Bill 2015-16.

It was ‘laud before Parliament’ – counting as its first reading – on 1 July and its second reading is expected on 11 March 2016.

Straight after the election the Tory government announced plans to consult on extending these charges to emergency and primary care, which are currently free of any charges.

And to “incentivise” NHS Trusts to collect the money, short-term visitors from outside Europe – most of whom are working or studying here – will be charged 150% of the cost of treatment – again regardless of their ability to pay.

Trusts that fail to collect these charges face possible fines.

Ministers claim such charges could raise up to £500 million per year; but they have not addressed the question of how much it would cost to collect the money, or the extra bureaucracy required to do so in each Trust.

No money to pay

Nur have ministers explained how such charges could be raised from ref- erals and second opinions, but their reason do not have the means to pay.

In some fee-charging hospitals in West Africa, desperate hospital managers trying to secure payment for maternity services from destitute mothers have even resorted to keeping their babies hostage until the bills have been paid.

It’s not clear if this is the model that appeals to Tory ministers.

Of course denying migrants access to primary care or emergency treatment on the basis of their ability to pay will not only turn away undocumented migrants in need of emergency or maternity care – but are obliged to pursue them afterwards for payment.

While appeasing their right wing fringe Cameron’s government is eroding both the principles and the workforce that underpin the NHS.

It’s time both lines of policy were challenged.
Hospice boss speaks out against Staffordshire privatisation

Staffordshire anti-privatisation campaigner Gail Gregory of Cancer Not For Profit has echoed the fears voiced by the Chief Executive of Douglas Macmillan Hospice regarding the impact of CCGs tendering for a £353 million End of Life Care contract – for which five of the seven bids are from the private sector.

The campaigner says Douglas Macmillan Hospice fears that the End of Life project will damage the charity’s ability to provide care and confirm their fears that this ‘pioneering’ project is completely unworkable and should be scrapped.

Douglas Macmillan and its shareholders were offered their already lowly funding from the CCGs which amounts to just £2 million per year, leaving the charity to find an additional £10 million. So far they have managed this through fundraising, but there is a clear fear that a private ‘provider’ will channel funds away from Douglas Macmillan to provide profits to shareholders.

Cancer Not For Profit have also been warning that this contract is being priced at current spending levels, which equates to a real terms cut in funding over five years. So the need to pay shareholders would mean a further reduction in the money available for patient care in this 10 year deal.

Douglas Macmillan is one of the major End of Life Care providers in the county, but despite making a bid with St Giles hospice, they have been turned away by programme bosses without explanation.

However, the risk to Douglas Macmillan Hospice now is that the contract winner will continue to commission them to provide end of life care, but within the terms of the new contract’s financial restrictions, meaning less money to do more work.

If Douglas Macmillan can’t cope, they face becoming financially unviable and End of Life Care is commissioned from rival private sector care homes keen to cash in on dying patients in Staffordshire, and maybe even forcing them to travel much further afield to get the care they need.

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Douglas Macmillan say so, the Parliamentary Health Select Committee who visited the charity and interviewed the 64,000 people who signed our petition.

The question now is - will the CCG and Macmillan dismiss these concerns as they have all the others?

“The Douglas Macmillan is the most informed and experienced critic to date and their opinion must be taken seriously. Contact the campaign on Facebook: https://www.facebook.com/cancernotforprofit

Chaos in cancer care carve-up

In Staffordshire four CCGs have been carving up cancer care and end of life care into commercial contracts.

End of Life care seems certain to go to a private provider, although the CCGs have still not said which one.

But the even more controversial contract for cancer care is in chaos after University Hospitals North Midlands – the only Staffordshire trust in the only remaining consortium in the bidding process – pulled out of negotiations.

The Trust argued quite simply that there was not enough funding in the contract. They could not guarantee to treat a rising caseload with such limited funding on offer.

But they have been the main provider of cancer services – it’s not at all clear how services could cope without them.

Only the Royal Wolverhampton Hospitals Trust is hanging on. The Staffordshire CCGs that have been driving the process, shamefully engaged on and financed by cancer charity Macmillan, are now left with a lame ‘consortium’ led by support service provider Interserve, which has no clinical expertise, and now no prospect of being able to offer a viable or accessible service.

But with so much prestige now seen to be at stake for the CCGs, which have defied local opposition to press the scheme through so far, there seems little chance of them seeing sense and scrapping the whole farcical process to negotiate a fresh contract with the trusts – as they should have done in the first place.

Macmillan’s reputation at risk

While it is possible that the appointed Prime Provider will commission services from Macmillan, their primary role has been as sponsors of the procurement.

This includes donat- ing approximately £20m to meet project set-up costs. So for the initial two years ‘double-running period’ in which cancer services will be run in tandem between the Prime Provider and exist- ing providers.

Macmillan’s practical involve- ment with the Cancer and End of Life Outcomes has also drawn criticism, with the charity apparently wanting to go beyond their independent status in order to secure the future of the project.

The support pro- vided by Macmillan was assessed by the Parliamentary Health Committee, who asked project officers to clarify Macmillan’s role.

Barbara Keeley MP said “I have to say, as a person who did run a coffee morning for Macmillan a few weeks ago, that I think this is a risky thing for Macmillan’s reputation...

“This is seen as privatisation ‘As a charity, it seems to me that Macmillan is taking a lot of risk in mak- ing what sounds like very a substantial investment into a model which an aw- ful lot of people who might have been your supporters don’t agree with.”

The Doc will see your money now

Skype hype rip-off for the worried wealthy

As if cherry-picking the NHS wasn’t enough, there comes news today that private medicine has seized on video technology to offer people GP consultations purely via their tablets and computer screens.

And this bargain high-tech wonder will only cost you £259 (10 minutes only and the meter’s running – be quick)

A good example of this latest hit to undermine the NHS is Pushdoctor (www.pushdoctor.co.uk), proclaiming that it’s fast and easy to see a GP this way.

And that’s the point. All they do is see your image. They are then empowered to refer you to a consultation, issue a private prescription (by e-mail) or advice – yes, you guessed it, your own.

Kerching! Pushdoctor was founded by former Macmillan Hospice boss Ben Ogden to ‘save a gap in the market’ – and landed 1.5 million dollars of seed money.

The biggest worry is risk. The company offers medicolegal cover to the GPs signing up for it. Small comfort if they miss something out, but you would have walked in, to the way your breath would have smelled.

Would you bet your life on it? Then there is what this does to exist- ing health inequalities. Rural GPs are already struggling, and this new tech- nology of ‘tele-medicine’ is worthlook- ing at as part of a coordinated, national service, interwoven with and supporting other GP services.

There are moves being made by the NHS to do that. Some practices offer web-based contact and preliminary ad- vice options but are still geared to the GP-patient relationship. But it needs gentle, careful handling. Not like this.

An astonishing accomplishment even for this government: a THREE-tier service or from KOMP for £9 including our chat in other words a market where there should be a health care system.
The battle to stop TTIP

Campaigners have been waging an increasingly urgent battle against a number of treaties being negotiated behind closed doors by EU and other bureaucrats and rubber stamped by neoliberal governments like our own. The treaties aim to prevent lowering of standards concerning employment, social, environmental, privacy and consumer, and also seek the deregulation of public services (such as water) and cultural assets. Campaigners across Europe are calling on the institutions of the European Union and its member states to stop the negotiations with the USA on the Transatlantic Trade and Investment Partnership (TTIP) and not to ratify the Comprehensive Economic and Trade Agreement (CETA) with Canada.

A variety of organisations at national and international level are campaigning, with a proliferation of petitions, mobilisations and strategies. They especially want to prevent TTIP and CETA because these treaties include several critical provisions that pose a threat to democracy and the rule of law.

Exemptions

Not all the campaigns are the same. Some campaigns are specifically seeking to ensure (in the UK) that the NHS and key public services are excluded from the treaties, rather than being left open to potential intervention by US or other multinational companies.

Other international campaigns go further, and also express outright opposition to the Trade in Services Agreement (TISA), a trade agreement currently being negotiated by 25 members of the World Trade Organisation (WTO), including the EU.

Its professed aims are “opening up markets and improving rules in areas such as licensing, financial services, telecoms, e-commerce, maritime transport, and professionals moving abroad temporarily to provide services”.

Another similar agreement, the Trans-Pacific Partnership (TPP) is being negotiated by trade officials from 12 Pacific Rim nations.

The common thread in each of these treaties is the drive by US multinationals to impose a set of extreme foreign investor privileges and rights to be enforced through the notorious “investor-state” disputes system (ISDS).

Secret tribunals

This system allows foreign corporations to challenge national health, consumer safety, environmental, and other laws and regulations that apply to domestic and foreign firms alike, and to skirt national courts and directly challenge our governments before tribunals of private sector lawyers operating under UN and World Bank rules. In these secret kangaroo courts the corporations would be able to demand taxpayers pay compensation for domestic regulatory policies that investors believe diminish their “expected future profits.”

EU bureaucrats and Britain’s Tory government have repeatedly issued assurances that TTIP would not compel a UK government to privatise NHS services – but of course important parts of the NHS are already being privatised.

They also have issued assurances that there is nothing in TTIP that prevents member states of the EU managing their own health services (or public services) as they see fit.

In theory this is true – a future government would, for example, be free to reverse privatisation of the NHS if it wanted – at least in theory.

Irrevocable

However, TTIP currently involves an irreversible commitment to give transnational corporations ‘market access’ (meaning the right to enter the UK market and operate without limit on their activities) and ‘national treatment’ (which means the right to equal treatment with domestic companies with, for example, the same right to government subsidies).

This means that if TTIP were in force, bringing NHS services back into the public sector would be likely to lead to a massive claim for compensation under ISDS.

It is also thought that if this or a future British government introduces charges for NHS treatments (see front page), these charges will be locked in by TTIP and we may never be able to return to an NHS that is free at point of use.

Since the passing of the Health and Social Care Act (2012), the NHS has potentially been opened up to TTIP.

Simon Stevens

It’s worth noting that NHS England’s Chief Executive Simon Stevens, while working for the private health giant UnitedHealth in the USA, was a founder member of The Alliance for Healthcare Competitiveness, a US lobby group pushing for the inclusion of health in TTIP.

There is still a chance to stall TTIP if the campaign pressure is maintained. This is because it will most likely also have to be ratified by EU Member States. The parliaments of all EU Member States except Malta would need to give their consent and could therefore bring down TTIP and CETA.

In half of all EU Member States referenda would be possible. The UK Parliament can initiate a referendum: in other EU countries citizens themselves can initiate a referendum – Croatia, Lithuania, Slovakia, Hungary, and Netherlands.

This is why it’s so important to build public awareness of the TTIP threat.