

NHS

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Keep our NHS Public

Price 20p

JOIN OUR CAMPAIGN - HELP SAVE THE NHS

This year Valentine's Day was not only a day to celebrate our nearest and dearest, but also our devotion to our publicly funded and publicly owned health service. Under the banner "We Love Our NHS" nation-wide Valentine's Day protests by 12 local Keep Our NHS Public groups called for an end to commercialisation and cuts in the health service.

Thanks to all who took part and made the day a special one, as well as a success.

The campaigning didn't stop there. A few weeks later Tower Hamlets KONP organised a public meeting on the theme "Unite to defend Jobs and Public Services" in March. Speakers included Jane Loftus, Vice President of the Communication Workers Union, Matt Wrack, General Secretary of the Fire Brigades Union, and John MacInally Vice President, Public and Commercial Services union.

Camden and Haringey KONP groups have continued to campaign very actively against the privatisation of GP services, with pub-

lic meetings, lobbies and demonstrations. Camden is calling for a local referendum on the issue.

Next, Sam Semoff of Merseyside KONP was granted permission to challenge Liverpool PCT and the Royal Liverpool Broadgreen University Hospital on their proposal to rebuild the Royal Hospital using the Private Finance Initiative (PFI).

Finally - Welwyn Hatfield has really pushed the boat out and is standing a candidate in the County Council elections on 4 June - on the platform "Support the Welfare State", which includes the demands of their three year long campaign to defend local NHS services.



Valentine's Day in London

We can only list a few of our local KONP groups' activities here. If you want to find out more, go to www.keepournhspublic.com

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NHS privatisation at "tipping point"

The government is pushing through two major projects as part of its privatisation agenda for the NHS - dressed up in the fancy phrase "world class commissioning". Both initiatives make it much easier for the private sector to muscle its way into providing health services.

Firstly Primary Care Trusts (which provide all health services except hospitals) must artificially separate themselves into "commissioning" (which pays for services) and "provider" (which provide services) arms. At present Primary Care Trusts simply provide these services, and use their budgets to pay the costs. The new

system means the parts of the PCT that provide services have to turn into strange organisations called "social enterprises" - private-sector organisations which generate surpluses from providing health care, but do not distribute profits to shareholders. The commissioning aspect of PCTs then have to commission services from these social enterprises, Foundation Trusts (hospitals that have taken on the nature of businesses), or the private sector.

Second is the so-called Cooperation and Competition Panel - which is all about encouraging competition and the

market within the NHS, and nothing to do with "cooperation" - as the Foundation Trusts Network has already pointed out.. Any private company which thinks it has been left out of tendering for Primary Care Trust services can now appeal to this panel.

All KONP groups and others who oppose NHS privatisation should go to their local Health Scrutiny Committee meetings (find details of these on your local council's website) and Primary Care Trust/Foundation Trust Board meetings to oppose the continued forcing of the market on the NHS.

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KONP AGM

Saturday 6 June 2009

Caxton House 129 St Johns Way, N19 3RQ
AGM 10 am - 12 pm **Public meeting** 2-4 pm
Malcom Alexander, Nat. Assn of LINKs Members
Mark Serwotka, General Secretary PCS
Dr Jonathan Tomlinson, GP services
Dr John Lister, Director of Health Emergency

NHS cash wasted on ISTCs?

the NHS may have overpaid the first wave private treatment Centres (ISTCs) up to £927m in England - see article www.bmj.com/cgi/content/full/338/apr30_2/b1421

STOP NHS PRIVATISATION, CUTS AND CLOSURES: Issue 5 Summer 2009

Keep Our NHS Public

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How big business dehumanises care

The view from a busy inner-city GP's surgery

GP Jonathan Tomlinson explains

I've written this because I'm afraid that the coorporatisation of healthcare is dehumanising. By this I mean that real, whole people living with their hopes and worries, ideas and expectations, are broken down by the process of coorporatisation into biological parts not for diagnosis and treatment but so that they can be measured, valued and converted into profits.

We are far more than the sum of our biological parts; we also have relationships with our past and future, our family and friends, our work and environment, our country and our home. We are irrational and passionate as well as calculating and objective, we need kindness, affection and understanding as well as treatments. And treatments themselves work better when they take this into account. Whilst the NHS can and will always need to be improved, the government's proposal to introduce competition and markets into the NHS risks seriously damaging it, not only because it has been shown to make it more expensive and less efficient (as in America) but because it dehumanises us all.

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The following items are edited extracts from a longer article (at www.keepournhspublic.com) by GP Dr Jonathan Tomlinson.

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They illustrate how commercialised health care damages patients. When big business carries out health care, the most important relationship is between the NHS's budget and the pockets of private share holders - not, as it should be, between the GP as a human being and the human beings who are his or her patients.

A patient-centred NHS understands and respects the complexity of human health and puts human relationships at the heart of healthcare. Corporate healthcare converts human health into commodities and commercialises human relationships, putting profits at the heart of healthcare.



NHS General Practice and corporate healthcare - differences

ITEM	NHS General Practice	Corporate healthcare
Interests	A traditional general practice has only one interest, the care of its patients	Corporations have a portfolio of interests
Responsibility	The partners are responsible to their stakeholders (their patients)	A corporation has limited liability and is responsible to shareholders.
Profits	The partners are allowed to do as they wish with their profits but are not obliged to put profit before any other consideration	A corporation is legally obliged to put profit before any other consideration
Commitment	Traditional general practice has an open-ended commitment to the care of its patients	A corporation has a limited tenure and may move on at the end of the tenure if the business is not profitable
Proximity	Partners are usually GPs and therefore are directly involved with the patients they are caring for	A corporation is a legal entity, it can have no involvement with patients

Medical research doesn't study "real" patients . . .

Science is a part of medicine though not the major part of it. It only studies carefully selected groups of patients.

They are selected so that they only have one disease, they are keen to take the treatment exactly as the doctor tells them, and they come back for regular check-ups. They are less likely to include ethnic minorities, very old, or mentally ill people, pregnant women or people in institutions (care homes etc). And yet most patients in a GP

surgery (where over 90 per cent of meetings between doctors and patients takes place) are very different.

Barely half take their medication as the doctor prescribes, many, especially those most likely to suffer illness, are mentally unwell and/or elderly. They live in inner-city areas, and come from ethnic minorities. And yet the results of this limited research ("evidence-based medicine") are applied to them.

Coping with bereavement

SA has come back from her appointment with the hospital cardiologist to say that she didn't understand what was said.

She was given the results of some investigations and told to change her medication. She hasn't started taking it yet because she wanted to check it was ok with her own doctor, "I know she's the specialist, but you're my doctor".

I've been looking after her for the last four years. After receiving her notes from her previous GP I called her in because her blood pressure had been very high. Unfortunately she has been

unable to tolerate at least half a dozen different anti-hypertensive medications, though the side effects she complained of only occasionally coincided with those listed in the literature. This prompted the cardiology referral.

I told her the name of the medication they suggested and she flatly, but politely refused, clearly recalling the ankle swelling she experienced when she took it before, a well recognised complication with these pills. She takes her medication infrequently because she doesn't like to take it when she's feeling unwell, which

she quite frequently does. Her hypertension started four years ago after her husband died. Since then, she freely admits, she has lost the will to live.

I think she comes to see me because she doesn't like to disappoint me in my vain attempt to treat her hypertension. The bereavement counsellor referred her to the psychiatrist who referred her to the psychologist who sees her frequently though her letters to me now simply say, "we have had our monthly supportive chat and things are much the same"

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Patient 2 - distressing childhood experiences

DS is a 38 year old Afro-Caribbean man who our practice nurse asked me to review because of his very poorly controlled diabetes. He is prescribed 21 tablets a day though his records indicate he isn't taking them regularly. He has refused insulin consistently for the last year.

His mother died when he was a child, following blindness and amputation of both her legs as a result of her poorly controlled diabetes. His father (also diabetic) died at 60 following a stroke and his older brother has diabetes. The nurse found him difficult to talk with and said he seemed suspicious. She has been trying to help him address his obesity and

unhealthy diet. I thought he seemed shy and reluctant to talk about his health or his family. After meeting him now for the third time he has indicated that his childhood was traumatic for reasons other than his mother's illness and death.

His records show that he has never remained under the care of a single doctor for long and he admits he doesn't trust people. I know that it will take a long time to develop a relationship with him so that I can help him deal with his past experiences, his present health and his future wellbeing and that there may be little or no improvement in his diabetes before then

High cost private healthcare

The United States has a system of private healthcare which is far more expensive than any other country - as a result of greater administration costs, unnecessary spending on health treatments because of a fear of being sued by unhappy patients,

more use of expensive "branded" drugs and over dependency on high-tech equipment and so on.

The costs will rise as new treatments become available and an aging population needs more health-care.

Patient 3 - and an unnecessary treatment

GF wants a referral to a neurologist. For the last two-three weeks she has had a sensation of unsteadiness and nausea caused by an illness called 'Acute vestibular neuronitis' which lasts in most cases for six weeks and then goes away of its own accord.

She accepts my explanation and has read the patient information leaflet, but she would nevertheless like to see a specialist. She has private health-care insurance. We joke that if I referred her to an NHS consultant the condition would

have spontaneously resolved by the time she got to see them. Two weeks later I receive a letter from the private neurologist, he agrees with my diagnosis, and notes that the medication I prescribed has improved her symptoms, but just to be on the safe side he arranged a MRI brain scan, which was normal.

Although everyone involved, including the patient, agreed that she did not need the MRI, it was arranged according to what the insurer would pay rather than clinical need.

Health, the new illness

Old and sick people don't make profits for private health care companies. They are expensive to look after, and they don't go to work - so can't afford expensive treatments.

Therefore to make more money private companies create anxiety about health in young, healthy, working people.

So a state of health is redefined as a state of impending illness and healthy people are encouraged to pay for screening and preventative treatments that they don't need and that haven't been shown to be effective.

In the past, for most people, health was to be enjoyed until it was interrupted by sickness, at which point they went to see the

doctor. Now people are worried into illness by an obsession with risk factors for illness rather than illness itself. Drug companies spend more money on advertising drugs to compete for their share of the market in wealthy countries, than on research into new drugs to treat serious infectious diseases such as TB and malaria in poor countries.

They also campaign so that drugs are prescribed for risk factors as well as disease such as milder forms of depression and anxiety, mildly raised blood pressure and cholesterol levels, and so on. For many patients, if a doctor gives them a prescription, especially if they are expected to take for the rest of their life; it means to them that they are sick.



Is it really 'Your health, your choice?'

The market says to people - you are responsible for your own health, you can't blame the circumstances under which you live.

Managers in the NHS who believe in the marketisation of NHS services show their belief in this through their motto "Your health, your choice". Fat or thin, sedentary or active, smoker or non-smoker, whole foods or junk-foods, in short, whether you are in control of your life or not, in their opinion it all comes down to a matter of choice. Differences in health due to social class and circumstances out of your control are blamed on individual lifestyle choices.

But in countries such as the UK, the lower your social class, the more illnesses you have, especially heart disease and most types of cancer. As the level of inequality in society increases, as it has done over the last 40 years, the health gap widens between rich and poor. This difference "cannot be attributed, in the main, to diet, smoking or other determinants of 'lifestyle'"

The government has failed to protect people's health by increasing their ability to fully participate in society through education, employment, and housing.

They have shifted the blame for bad health to patients who are expected to improve their lifestyles, and GPs who have to spend more and more time promoting healthy choices. Businesses are encouraged by the Government to sell people the promise of health by marketing their products - cholesterol-lowering spreads, gym membership etc.

The position that everyone is free to choose to be healthy assumes that society consists of equally free individuals making rational choices in their own best interests. But the freedom to choose in this way is not equally distributed; it's strongly associated with educational and financial empowerment so the most unhealthy are usually the least educated, and wealthy - and therefore least free.

Differences in health due to social class are blamed on individual lifestyle choices. But in countries such as the UK, the lower your social class, the more illnesses you have, especially heart disease and most types of cancer. As the level of inequality in society increases, as it has done over the last 40 years, the health gap widens between rich and poor.

Patient 6 - and smoking

I opened the window of my consulting room wide in the hope that the smell of cigarettes would fade before the evening clinic. I had just been to visit SD at her home which was always thick with smoke and the 1970s decor - memories of my own childhood, was stained yellow like an old pub.

For the last two years I'd been visiting her to check on her blood pressure and give her a general check up.

She was well aware of the risks of smoking and hypertension and had guessed rightly that she had suffered a stroke during the night, but wanted to see me before calling an ambulance.

She had started smoking 60 years ago as a 15 year old. Then she smoked Lucky Strike because that's what everyone was smoking, but for the last 20 years or so she's

smoked whatever was cheapest at the local store. That's what everyone smokes these days. You can even buy single cigarettes for 30 pence if you can't afford a packet.

Disabled by severe arthritis, she rarely goes out, but she's always cheerful and denies being lonely. She has tried giving up cigarettes on a few occasions, and managed for a couple of years before her husband died, but started again afterwards to help fill the gaps in the day.

She tried again after a chest infection shortly after we first met, but became depressed and rapidly returned to her cheerful self when she started smoking again.

She gestured to her flat and the estate around, "when you live somewhere like this, it's not like where you live doctor, we don't mind smoking here"

No freedom to make a choice

Even in the absence of market pressure, the assumption underlying choice is that ladies like SD and doctors like me are equally able to take control of our lives and define ourselves by our choices.

It assumes, wrongly, that providing information is enough to empower people to choose a healthy lifestyle.

Offering choice without addressing the conditions within which people live their lives, the experiences that affect their decisions, and aspirations which shape their vision of the future, widens inequality by empowering those ready to make those choices and alienates those people who have very different priorities.

Patient 7 - and obesity

RT has pain in her knees and ankles, she starts telling me about them as we walk from the waiting room to my consulting room. She is also morbidly obese and eats to cope with her emotions.

She finds herself overwhelmed by first comfort and then remorse as she cries throughout her eating binges. She has spent thousands of pounds on countless diets including one from a private clinic that injected her with amphetamines and resulted in a psychotic episode.

She has spent hundreds of

pounds on gym-memberships and bought dozens of self-help guides, none of which have had a lasting effect. Recently we discussed referral for gastric bypass surgery but the thought of the risks and future complications frightened her. She rarely goes out except to work or to collect her daughter from school. For a long while she stopped going to the doctor, because whatever she wanted to talk about, all they seemed interested in was her weight, "it was like they stopped seeing me as a person".