



Unite evidence to the All-Party Parliamentary Group on Primary Care and Public Health: *Were massive reforms necessary to save the NHS?*

This evidence is submitted by Unite the Union - the UK's largest trade union. The union's members work in a range of industries including manufacturing, transport, agriculture, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite represents approximately 250,000 members across the public sector and 100,000 of these are health sector workers, including members in seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA). Unite has members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services. Unite also represents a large range of members working in social care for local authorities, housing associations, health, disability, elderly and children's charities as well as other community and not for profit organisations.

Executive Summary

- The Government's arguments for reform are based on ideology not evidence.
- The NHS is currently experiencing its highest satisfaction levels and statistics show that it is one of the most efficient and cost effective health systems in the world.
- Cuts to funds and the Health and Social Care Bill are likely to lead to a decline in health standards, increased costs and worse public health outcomes.
- It is still unclear how Clinical Commissioning Groups will function, manage demand or be held accountable.

1. Unite case in detail

- 1.1 Unite welcomes the chance to respond to this consultation. The Government's health policy is extremely worrying and puts the future existence of the NHS, in all but name, into question.
- 1.2 The NHS is currently undergoing a series of severe austerity measures, through real term cuts in health spending and the requirement to make £20bn of efficiency savings by April 2015.
- 1.3 At the same time the Government is implementing the biggest restructure of the National Health Service (NHS) in its history. The Health and Social Care Bill is pushing an agenda of privatisation, fragmentation and market competition of health care provision supposedly to cut costs and improve the efficiency of the health service.
- 1.4 Unite is concerned that this policy is largely driven by ideology and lacks any coherence of argument or evidence base.

2. Justification

- 2.1 The justification for these actions is officially based on concerns about demographic changes and the increasing costs of health provision on the public purse. While these issues do pose potential challenges, they do not justify the radical ideological changes currently being carried out in the NHS.
- 2.2 The Government is cutting costs from the NHS as part of its austerity plans to reduce the sovereign debt liabilities. This has been a clever spin exercise to blame debt liabilities on so called “excessive” government spending on public services like the NHS, while deflecting attention from the real cause – the bailout of failed private banks. It is unacceptable that banks can run up huge unsustainable debts, plead for nationalisation of those debts and then downgrade government credit ratings due to unsustainable levels of “public” debt due to the nationalisation.
- 2.3 Unite also rejects the rationale that cuts to public spending will help reduce the deficit. The best way to reduce the deficit is to support job creation in the economy, to increase spending, and thus revenue to the exchequer. Even the IMF now argues that the Government’s austerity measures could lead us back into recession¹.
- 2.4 Secondly there is no evidence that the plans that the Government are bringing in will make health delivery more efficient. On the contrary what is likely is that we will pay more for a worse service. Several recent pieces of evidence have questioned the Government’s chosen reform strategy.

3. Current satisfaction levels and health outcomes

- 3.1 It is clear that the NHS had been substantially improving in the last few years. Leading health economist, Professor John Appleby, recently reported that satisfaction with the NHS was at an all time high. Quoting

¹ <http://www.guardian.co.uk/business/2011/sep/20/imf-uk-growth-forecast-cuts>

data from the latest annual British Social Attitudes Survey, he pointed out that 64% of people were either very or quite satisfied with the NHS. This is the highest level of satisfaction that the NHS has received since the survey began in 1983 and much higher than in 2001 when it received 39%².

- 3.2 Despite both the Health Secretary and Prime Minister misrepresenting outcome figures to claim that the NHS is failing, the evidence seems to be showing the contrary. Health statistics should never be quoted in isolation as they are affected by many factors, some of which are very long-term. Trend data on many key issues are showing marked improvements in the UK. For example mortality from cancer has fallen every year since 1995, and heart attack deaths have halved since 1997³.
- 3.3 Appleby has countered government claims that the UK rate of death from heart attacks (myocardial infarction) is double that in France at the same cost. Appleby argued that from 2006 figures in isolation the government is right, but the trajectory of improvement in the UK is so phenomenal that if the straight line continues – as it has done for 30 years – we will be better than France by 2012⁴.

4. Markets

- 4.1 Ben Goldache⁵ has illustrated that poor use of evidence is endemic in the Government health policy, particularly with regards to competition. He shows that research done into competition based on price are more likely to make things worse than better, whereas competition based on quality rather than price is hard to assess.

² <http://www.bbc.co.uk/news/health-12805586>
<http://www.bmj.com/content/342/bmj.d1836.full>

³ M. Whitehead, B. Hanratty, J. Popay *NHS reform: untried remedies for misdiagnosed problems?* The Lancet, Volume 376, Issue 9750, Pages 1373 - 1375, 23 October Published Online: 06 October 2010

⁴ <http://www.bmj.com/content/342/bmj.d566.full>

⁵ B. Goldache, *Landsley and his imaginary evidence*, <http://www.badsience.net/2011/02/andrew-lansley-and-his-imaginary-evidence/>

- 4.2 Goldache goes on to point out that over the years there have been 15 major reorganisations of the NHS in the last 30 years. These include GP fund holders, GP multifunds, primary care groups, primary care trusts, family practitioner committees, purchasing consortiums, and more. He argues that there has been very little assessment or study carried out into the outcomes of these and what evidence there is does not back the Government's agenda.
- 4.3 The Government's main justification for pushing market mechanisms are claims that competition raises standards in hospitals. The main evidence that has been presented to back this claim is an article on comparative fatalities produced by Cooper et al. at the LSE⁶. This evidence has been recently challenged by several leading health policy experts in the Lancet⁷.
- 4.4 They argue that the LSE paper is not scientifically coherent, concluding that:

“Cooper and colleagues have chosen to base causal conclusions on a fundamentally flawed analysis. The potential consequences of the Health and Social Care Bill are too serious for politicians to use such work as part of their justification for the legislation. Far from showing that competition saves lives, at best Cooper and colleagues' study shows that people who have an AMI and whose GPs are close to a hospital or who have many hospitals in their area might have better chances of survival.”

⁶ Z Cooper, S Gibbons, S Jones and A McGuire, *Does hospital competition save lives? Evidence from the English NHS patient choice reforms (Working paper No: 16/2010)*, LSE Health/The London School of Economics and Political Science, London (2010), <http://eprints.lse.ac.uk/28584/1/WP16.pdf> (accessed Sept 29, 2011).

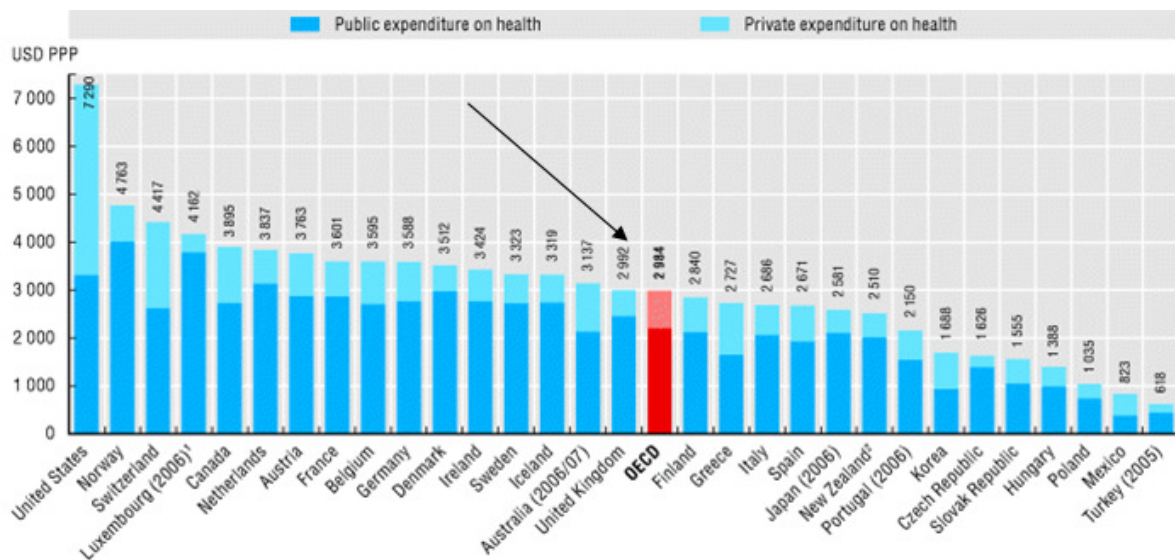
⁷ A Pollock, A. Macfarlane, G. Kirkwood, F. Majeed, I. Greener, C. Morelli, S. Boyle, H. Mellett, S. Godden, D. Price, P. Brhlikova, *No evidence that patient choice in the NHS saves lives*, The Lancet, Early Online Publication, 10 October 2011 Available at: http://www.allysonpollock.co.uk/administrator/components/com_article/attach/2011-10-10/Lancet_2011_Pollock_NoEvidence_Cooper.pdf

5. Comparing health spending as proportion of GDP

5.1 Health spending in Britain is significantly below the average of its peer group in the richest OECD economies. Government cuts will take it to below the OECD average as a whole. Figure 1 below is from the OECD's 'Health At A Glance' 2010. It shows the per capita health spending for the OECD countries in comparable US\$ Purchasing Power Parity terms.

5.2 The chart shows that in general, as the proportion of private spending on healthcare rises, so does the overall cost. The US has the highest proportion of private provision and its total healthcare costs are off the chart - even though 45 million Americans have no healthcare insurance - compared to the universal system for the NHS. For 2007 (latest OECD data) the US spent 16% of GDP on healthcare, whereas Britain spent 8.4% (OECD, 2009). Yet there is the same ratio of health workers in the workforce and life expectancy at birth is higher in Britain.

Figure 1: Per capita health spending for the OECD countries in comparable US\$ Purchasing Power Parity terms



Source: OECD's 'Health At A Glance' 2010

6. Health outcomes and efficiency of service

6.1 A recent paper in the Journal of the Royal Society of Medicine found that during the Labour government the NHS saw health spending rise to a record 9.3% of GDP. Interestingly this was still less than Germany with

10.7% or the US with 15%. This was based on the latest data from the World Health Organisation.

6.2 The paper goes on to show that, not only was the UK cheaper, it also saved more lives (see figure 2). The NHS reduced the number of adult deaths per million of the population by 3,951 a year – far better than the nearest comparable European countries. France managed 2,779 lives a year and Germany 2,395. This means that dramatic NHS improvements have led to a situation where there are now 162,000 fewer deaths every year compared with 1980.

6.3 Looking at elderly patients, the difference was even starker with the best performers – Ireland, the UK and New Zealand – having health systems that were three times more effective and efficient than the worst – Switzerland, Portugal and the US.

Figure 2: Efficiency of different health services

GDPHE: reduced death ratios 1980–2005 (ranked by greater GDPHE: 55–74 mortality rate ratio)				
Country and rank	Average 15–74 reduced deaths (rpm)	Average GDPHE: death ratio	55–74 Deaths reduced (rpm)	55–74 Deaths: GDPHE ratio
1 Ireland	4941	1:696	12,903	1:1817
2 UK	3951	1:557	10,576	1:1490
<i>Numbers saved</i>	<i>162,264</i>		<i>121,190</i>	
3 New Zealand	4076	1:566	10,449	1:1451
4 Austria	4460	1:551	11,194	1:1382
5 Australia	4328	1:521	10,903	1:1314
6 Italy	3579	1:436	9290	1:1133
7 Finland	2255	1:318	7183	1:1012
8 Japan	2600	1:380	6500	1:929
9 Spain	1586	1:233	6316	1:929
10 Sweden	3123	1:355	7919	1:900
11 Canada	2822	1:324	7321	1:841
12 Netherlands	2570	1:306	6633	1:790
13 France	2779	1:316	6849	1:778
14 Norway	2407	1:294	6230	1:766
15 Greece	2230	1:265	6423	1:765
16 Germany	2395	1:247	5916	1:610
17 USA	2498	1:205	6286	1:515
<i>Numbers saved</i>	<i>415,702</i>		<i>238,642</i>	
18 Portugal	1304	1:169	3344	1:434
19 Switzerland	1298	1:140	3229	1:347
UK 1979–1981 population (age bands) 41.069 m and 11.459 m USA 166.414 m and 37.964 m rpm = rates per million				

Source: Pritchard, Colin; Wallace, Mark S (2011), Comparing the USA, UK and 17 Western countries' efficiency and effectiveness in reducing mortality, J R Soc Med Sh Rep 2011;2:60. DOI 10.1258/shorts.2011.011076

6.4 In recent studies by the Commonwealth Fund, the NHS ranked first or second on many significant criteria. For example in a comparison of eleven countries, the NHS ranked first for patient confidence, equity and safety⁸, and in a comparison of seven countries, the NHS ranked first for effective care and efficiency⁹

7. Wider social context

7.1 These statistics have to be understood in a wider social context. Health systems are hard to compare because a countries health outcomes are not solely dependent on health spending and delivery. For example issues such as diet, access to employment, the quality of that employment, employers' duties to protect workers' health at work, housing, local environment, the strength of civil society, facilities for active recreation and both income level and income inequality. Statistics show that poverty and inequality play a crucial role in health inequalities and a person's health and wellbeing.

7.2 For example the integrated and universal nature of Scandinavian models of welfare provision is a major reason why these countries are regularly cited as having some of the most efficient and effective health outcomes.

7.3 Recent reports of growing unemployment¹⁰ and increases in poverty¹¹ due to government policy do not bode well for health outcomes in the UK.

8. Outcome of the reforms – CCGs, quality and accountability

8.1 Unite is, therefore, unconvinced that the massive "reforms" of the health service are either necessary or effective in improving the NHS. Rather

⁸ http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx?utm_source=NHS+Supporters&utm_campaign=78ee90a592-Still+a+dangerous+prescription&utm_medium=email

⁹ http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/Davismirror2010exhibitsFINAL%202%20pdf.pdf?utm_source=NHS+Supporters&utm_campaign=78ee90a592-Still+a+dangerous+prescription&utm_medium=email

¹⁰ <http://www.ft.com/cms/s/0/f0d36cf6-f4b0-11e0-a286-00144feab49a.html>

¹¹ <http://www.guardian.co.uk/society/2011/oct/11/children-poverty-institute-fiscal-studies>

than “saving” the NHS the reforms appear to be putting the NHS into greater danger and risk.

- 8.2 In this context Unite has no confidence that CCGs will be able to deliver a better NHS. In fact Unite can foresee several worrying outcomes of the new system.
- 8.3 Firstly the creation of CCG will lead to potential conflicts of interests for GPs who will act as both budget holders and rationers of services. This is made worse by proposed financial incentives (bonuses) for commissioners and GPs, which could lead to distortions in the patient/doctor relationship and cuts to services.
- 8.4 GPs are currently the most trusted part of the NHS¹² and these changes could severely damage the trust that local communities have for their doctors.
- 8.5 Similarly the opening of services to “any qualified provider” and EU competition law will mean that not only will GPs be subject to new commercial pressures from private sector providers bidding for contracts, but this will more than likely increase costs. GPs will need to grapple with complicated bureaucratic processes, like contract law, and face barriers to knowledge of service outcomes due to commercial confidentiality and lack of freedom of information duties for private contractors. Unite believes that the most likely outcome of this is that the contracting process will be outsourced to private sector consultancy firms, adding a further layer of cost and bureaucracy.
- 8.6 Unite is also concerned about the accountability measures proposed in the new NHS structure. In the current draft of the Health and Social Care Bill, CCGs will have a huge amount of autonomy from government control.

¹² <http://www.bbc.co.uk/news/health-12805586>
<http://www.bmj.com/content/342/bmj.d1836.full>

8.7 CCGs autonomy will mean the removal of duties from the Secretary of State, the removal of the duty to provide a comprehensive service and giving CCGs the right to decide what constitutes core health provision. CCGs will not face sufficient levels of public scrutiny as they are given the option to avoid public meetings if they are not considered in the “public interest.” Lastly accountability bodies, like HealthWatches and the Care Quality Commission, will have too few resources and power to effectively protect patient interests.

8.8 Unite believes that the outcome of all this will be added costs, a failure to achieve QIPP targets and potential perverse incentives for GPs and companies seeking to safeguard contracts and compete in the new markets. One often cited example of this is the “cherry picking” of profitable services and patients at the expense of universality and more difficult cases.

9. Conclusion

9.1 In short Unite is unconvinced that the NHS needed “saving” or required massive structural changes in order to make it more efficient and effective.

9.2 Even if it did, the policies currently being proposed will almost certainly make the service worse.

9.3 Government policy appears to be driven by a desire to remove responsibility from Government for health delivery and outsource austerity measures to less accountable actors. At the same time this will open the NHS up as a “cash cow” to private sector providers.

9.4 This is an ideological project, not justified by evidence and not being made in the interest of patients.

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