



Doctors In Unite: Our Vision for the NHS



About Us

Doctors in Unite (the Medical Practitioners' Union), a section of Unite the Union, is the only TUC-affiliated union formally party to the representative machinery of the British Medical Association (BMA), (by virtue of an agreement with the BMA in 1950), a progressive voice within the BMA, and a medical policy think tank for health as a social goal.

We played a major part in the development of the concept of clinical commissioning, by advocating neighbourhood health committees in our evidence to the Short Committee in 1978, by persuading the Labour Party in 1992 to adopt locality commissioning as its policy for the replacement of fundholding, and by persuading the BMA of that same policy in the mid-1990s.

This is a working document with which we intend to stimulate debate and distil our vision. It represents the launch of a renewed process of campaigning to save our NHS and developing detailed responses to current problems.

We are clear and unambiguous in our support of the NHS and not daunted by current circumstances.

... we may not succeed in our goals, but if we reach for the roof, we'll only get to the roof – if we reach for the stars, we may get to the moon!

We believe in a society that promotes good health.

To achieve this we believe in:

- An NHS which is publicly funded through general taxation. It should be publicly provided, publicly accountable, free at the point of delivery and comprehensive in its scope.
- It should be a mechanism by which society pursues health as a social goal, addressing the determinants of health as well as providing treatment and care.
- Action to eradicate the social determinants of health. Growing inequality, homelessness and poor housing, obesity, poor quality work and poor air quality add to the burden of sickness the NHS has to deal with. There has been an abject failure to make public investment in housing, public transport, and active transport such as walking and cycling, education, parks and leisure facilities whilst cutting enforcement of regulations on the environment and health and safety at work.
- Proper investment in social care, general practice and community health services. The crisis in these services directly causes the crisis in the hospitals. Cutting spending on these areas is yet again ill considered.

... cutting spending on prevention is like 'stripping the lead off the roof to make buckets to catch the rain'.

- Healthy ageing is essential to contain health and social care demand. The cost of a dependent older population arises from the difference between healthy life expectancy and life expectancy, not from age structure alone. As this gap is greatest in deprived areas, it compensates the wrong areas if we allocate resources according to age structure without taking this factor into account.
- Welcoming migrants, who, despite the propaganda, are a net benefit to the economy, and without whom the NHS and other public services would not survive. Migrants pay the taxes for the services they use, and the problem is that the money is not then passed on to fund those services.
- Democratic control of the NHS by neighbourhood health committees, to which people are elected and which feed up to larger regional and national committees, for over arching planning, to which people are also elected.

We believe that the NHS is sustainable. We are a rich country and our health service is the most cost-effective in the developed world (ref Commonwealth Fund Report - <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>). Our vision will require greater investment but the UK can afford this, and the cost-benefits from people being in better overall health that our vision would deliver, cannot be ignored. We were able to afford a decent NHS, a welfare state and proper local services when our country was not as rich as it is today. There is therefore no reason why we cannot afford them now.

We believe that if Government values the good health of society then they will be prepared to pay for the public services that promote health.

We believe that industries that provide the basics of life, the natural monopolies, such as health, water, clean air, housing, education and transport should be owned and run by those working in them, and by the communities they serve. These are public services and not for private profit.

We wish to explore views on a completely salaried GP service. We accept in the present climate, that the likely employers in such a service would be large private health care providers, and we would oppose this. However in the publicly funded, publicly provided health service that we aspire to, GPs would be employed by the National Health Service, and subject to national terms and conditions in a similar way to their hospital colleagues. A salaried GP service would remove the bureaucratic burdens such as HR, premises and recruitment, from doctors to administrators, and would enable the doctors to focus on their patients.

We believe in good working conditions for staff, with optimal work/life balance. Good morale amongst staff delivers better care for patients. Workforce planning should inform the number of training places necessary for health workers. Tuition fees should be abolished and training grants and bursaries should be re-introduced. Health workers should not have to pay for their own training courses and exams.

We believe in continuity of care, and that the patient should be seen holistically as part of society. We reject the fragmentation that has led to itemised patient "events" with many different care givers, hence poorer patient and staff satisfaction, and a greater strain on the hospital emergency departments. (BMJ Ref to article.)

We believe that primary care facilities should not just be places where traditional health care is delivered, but that they should be at the heart of the community. Places where people can gather for exercise and leisure activities, and places that house community cafes and libraries. Places that build communities and include the lonely and more vulnerable. Places where joint work can occur with the voluntary sector. Failure to address the wider determinants of health is socially irresponsible and financially imprudent, given the burden it imposes on the NHS.

We believe that there should be an end to outsourcing, which has caused fragmentation and deterioration of services. Cleaners and catering staff should be directly employed by the hospitals they work in, and care workers should be directly employed by the local authorities.

We believe that people with complex needs can only be looked after satisfactorily if all of the people involved in their care meet up regularly. Care workers are a vital cog in this wheel. Privatisation, which has a desire for profitability imposes time pressures on care workers, and excludes them from the review process.

We believe that the pharmaceutical and medical supplies industries should be publicly owned. (Cross reference with existing Unite policy which agrees with this). Ten per cent of the NHS budget is paid to the drug companies, which operate for profit and not for the health needs of the population.

We believe that everyone in the UK, whether ordinarily resident or not, should be entitled to health care, and that the UK Government should negotiate similar arrangements for British citizens in other countries.

We believe that public health should be at the core of primary care. Before 1974 the health service included environmental and public health, and health and social care were integrated.

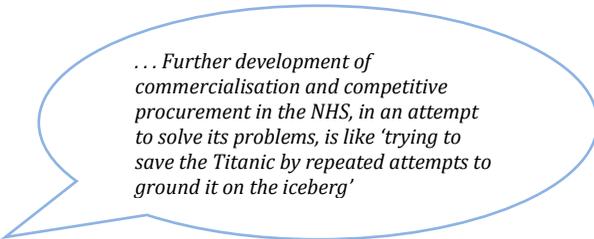
We believe that management can be a force for good if data are used appropriately for planning purposes, but we oppose those forms of management which disempower health professionals and local communities.

We support the NHS Reinstatement Bill but our vision goes further than the measures contained therein.

We reject the government policy of austerity. Investing in public services brings a net gain to the economy as people who are well are more likely to be employed, pay taxes and spend their wages. (need simple explanation of fiscal multipliers and good graphic – see below) Fiscal multipliers prove this and show that the Government's intention with austerity is not to stabilise the economy, but to transfer public services to the private sector. Indeed, there is now considerable evidence that the Keynesian multiplier for health and social care spending is well over the figure of 2.5, the figure at which increased health and social care spending will be fiscally self-financing (indeed more than self-financing) and economically beneficial.

We reject the market in health care. Markets are an inefficient way of distributing health resources.

The clinical commissioning which we pioneered in the 1990s has become distorted by commercialisation, underfunding and privatisation, undermining its original goals of local



... Further development of commercialisation and competitive procurement in the NHS, in an attempt to solve its problems, is like 'trying to save the Titanic by repeated attempts to ground it on the iceberg'

The NHS needs significantly more money for demographic reasons and because of the epidemics of obesity and alcohol. It is not, however, the bottomless pit that is being portrayed by its enemies. This money will be most efficiently raised and spent through general taxation and a publicly owned and planned NHS. It would be unfortunate if a less efficient system were adopted out of antipathy to taxation, or an ideological commitment to a smaller state. Investment in public health and social care is an important part of that need and would reduce, but not eliminate, the need for NHS investment

June 2017

Explanation of fiscal multiplier effect

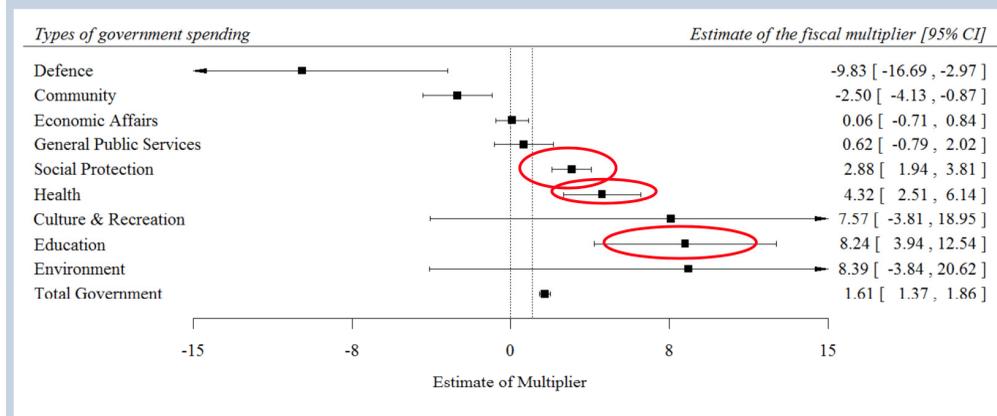
Calculating the fiscal multiplication value of an area of government spending is simply a method of measuring the returns on government investment. It recognises the growth in the economy which occurs when governments spend money and when people who are provided with an income, for example by being employed on useful work, spend the money they earn.

A form of government spending with a high fiscal multiplication value of 2.5, would return £2.50 to the economy for every £1 of investment, whilst a form of government spending with a low fiscal multiplication value of 0.3 would only return 30p to the economy for every £1 of investment.

The use of fiscal multiplication estimates is absolutely essential for any responsible government concerned with ensuring taxpayers get good value for their money.

If it can be shown that a government service creates a strong fiscal multiplication effect, the government should consider increasing their investment in that sector to boost the economy, confident that the resulting economic growth will generate the taxes to pay for the spending. On the other hand, if an area of public policy creates extremely low fiscal returns, this is where governments must prioritise spending within the limits of affordability, or introduce reforms

Protect health, education, and social protection spending



Reeves A, Basu S, McKee M, Meissner C, Stuckler D. Does investment in the health sector promote or inhibit economic growth? *Globalization Health*. 2013; **9**(43).