Healthier Scotland

The Journal

March 2014

Socialist Health Association Scotland

SHA Scotland is a campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action. We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves.

SHA Scotland members meet three times a year at Glasgow City Council Chambers. The next meeting is on 15 May starting at 7pm. Membership of the Socialist Health Association costs £25 p.a. and details of how to join are on our website www.shascotland.org

Forthcoming events:

SHA Scotland & UNISON Scotland fringe meeting at Scottish Labour conference

Time to Care

Friday 21 March 2014 at Royal George Hotel, Perth starting at 5:30pm

Chair: **Gordon McKay** – Chair UNISON Labour Link Scotland
Neil Findlay MSP – Shadow Cabinet Secretary for Health
Stephen Smellie – UNISON Scotland Deputy Convenor and Chair of Social Work Group

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Healthier Scotland – The Journal

Contents: March 2014

Welcome

to the March 2014 edition of ***Healthier Scotland – The Journal.***

The Socialist Health Association was founded in 1930 to campaign for a National Health Service. While we will take pride in celebrating the achievements of the NHS, our main focus is looking forward. We campaign for improvements not only in health services but in health – and particularly in tackling inequalities in health service access and in health outcomes.

Healthier Scotland: the Journal is part of our attempt to take the health debate in Scotland forward. We welcome the level of political consensus in Scotland around health that means we avoid the ideological dogma that is undermining the NHS in England. However, we have huge health challenges to address and that requires new thinking on how to address them.

In this edition we start with SHA Scotland's first priority, health inequalities. The Shadow Health Secretary has established a Commission, not to churn out another set of depressing statistics, but rather recommendations for action. Neil Findlay MSP also emphasises the importance of this in his overview.

With the independence referendum now only months away, the arguments for, against are examined. Health is fully devolved but there are wider powers that impact on health that are not. So we also await the report of Scottish Labour's Devolution Commission with interest. Richard Bourne reminds us why we should be grateful for devolution with his description of the mess that is NHS England.

Minimum pricing for alcohol is bogged down in the courts, but Sheffield University are producing useful evidence to inform policy makers on this issue. Scott Nicholson tackles market failure in relation to sexually transmitted disease and Matt McLaughlin gives a front line view of NHS Scotland's current tribulations.

We hope you find this edition of *Healthier Scotland* interesting and we are grateful to the contributors for their time and effort. To keep the discussion going we would welcome feedback and views. Please go to our website or blog.

Dr David Conway – Chair

Dave Watson – Secretary & Editor

Health Inequalities

Dr David Conway, Chair of Scottish Labour's Health Inequalities Commission says its time for action

We are all shamed by Scotland's poor health record, but we are even more shamed by the wide socioeconomic inequalities in health. Inequalities that see the poorest, most disadvantaged bearing the greatest burden and suffering the most. Health inequalities are the unjust differences in life expectancy (how long we live) that are observed across our communities, cities, and country – differences determined by socioeconomic position or circumstances, determined by the unfair distribution of income, wealth, and power. In the Socialist Health Association Scotland, we believe that tackling inequality that plays out in health and disease, in life and death is the greatest challenge we face as a society.

The time for action on health inequalities is now. And we are delighted to announce that Neil Findlay MSP, Shadow Cabinet Secretary for Health and Wellbeing and the Scottish Labour Party have grasped this thistle and have commissioned the health inequalities policy review.

Our launch meeting, in the Scottish Parliament in February 2014, brought together a diverse "Reference Group" with representatives from community groups, activists, the voluntary sector, councils, health professionals, academia, Unions, the Labour Party, and the Socialist Health Association, and included a priority setting workshop.

The Reference Group agreed an overarching vision of the commission – to make tackling health inequalities a top priority and to propose a suite of policies for action. The Commission will have the following aims:

1. To understand the scale and depth of health inequalities; thoroughly clarifying both the manifestations of health inequalities and the social, political and economic determinants of health inequalities.
2. Across health and other public services to examine ways to tackle the Inverse Care Law and ensure resources are allocated proportionate to need.
3. To consider short, medium and long term policies needed to tackle health inequalities (incognisance of current and potential future constitutional arrangements).
4. To propose and cost specific policies that would help tackle health inequalities. This should take into account current spending realities, but could also consider what could/should be done with reallocating and reprioritising resources or under a financial situation that is different that differs from the current arrangement; this should look at both more generous settlements than those in place presently.
5. To consider how and where cross-portfolio work could/should take place to tackle health inequalities.

We are planning to undertake a process of community engagement in the policy development process.

We have set a call for written evidence on the following questions:

- What is the character of health inequalities? What do they mean for communities and families?
- What role can health and other public services play in tackling health inequalities?
- Are there any specific policies, initiatives or research evidence from Scotland, UK or internationally that you would propose to tackle health inequalities?

Other specific questions:

- What can be done within current devolved arrangements to tackle health inequalities?
- What further devolving of powers would enable health inequalities to be tackled?
- What mechanisms can be deployed to better join up policy and public services to tackle health inequalities?
- What can be done to tackle the Inverse Care Law in health and other public services?
- Is democratisation of health services important in tackling health inequalities?
- How would community development efforts be better supported to tackle health inequalities?
- How could resource allocation (geographic and in other budget planning terms) to health and public services be re-allocated to tackle health inequalities?

To respond to this call, please submit written evidence email tommy.kane@scottish.parliament.uk by end of May 2014.

Dr David Conway is Chair of the Socialist Health Association in Scotland

A national debate about NHS Scotland

Shadow Health Minister, Neil Findlay MSP makes the case for a review of NHS Scotland

As the debate around Scotland's future moves into the final six months of its long campaign timeline, other issues are being drowned out by the noise of the constitutional drum-banging. But one issue that will not go away is the future of the NHS in Scotland.

In Scotland there is a cross-party consensus that the NHS in Scotland will not go down the privatisation route being imposed by the Westminster coalition government. Even the Tories in Scotland accept that. But this does not mean that all is well in the NHS north of the border.

The reality is that the NHS in Scotland is under pressure like never before with budget pressures leading to auditor-general of Scotland Caroline Gardiner putting the NHS on an amber warning. We see fewer staff - 1,000 nurses lost since 2009 - being asked to do more for less with increased work pressures at a time of pay cuts and increasing pension contributions. The use of the private sector and bank and agency staff are all significantly up – evidence of a system under huge pressure.

Social care is being driven down to the lowest common denominator with falling standards, reduced training and poverty pay - all of this resulting in bed-blocking and waiting times increasing. In Glasgow 20% of care home places are out of commission because of concerns over standards (15% in Edinburgh and Highland).

Across the NHS cases of bullying and the use of gagging clauses to silence staff is up, junior doctors are being left to look after up to 100 beds and working up to 100 hours a week while stories emerge of patients left on trollies and sometimes being treated in cupboards.
And all the time Scotland's shame - health inequality - is increasing, unsurprising given the £1 billion of cuts to anti-poverty initiatives made by the SNP government.

In the summer I called for a full-scale review of the NHS in Scotland. This call followed wide-ranging discussions I have had with support staff, doctors, consultants, nurses, patients, trade unions and a range of stakeholders from across the NHS. The evidence they presented convinced me that we need to look at the whole system to ensure that the NHS in Scotland is fit to meet the needs and demands of the 21st century.

We need such a review to examine how we sustainably finance and resource the NHS, how we ensure that we have the right people in the right places and the right time to meet the growing demands and expectations on health services and we how we address the opportunities and challenges of an ageing population and the advances in personalised medicine and treatments. This weekend the Patients Association in Scotland joined the growing band of organisations and health professionals who have now supported the call for a review.

We need to start a national debate about the future of the NHS in Scotland and how we equip our greatest public service to meet the needs of the 21st century. Sticking our heads in the sands is a betrayal of our greatest public service.

Minimum Pricing for Alcohol

Dr John Holmes on reducing health inequalities without penalising responsible drinkers

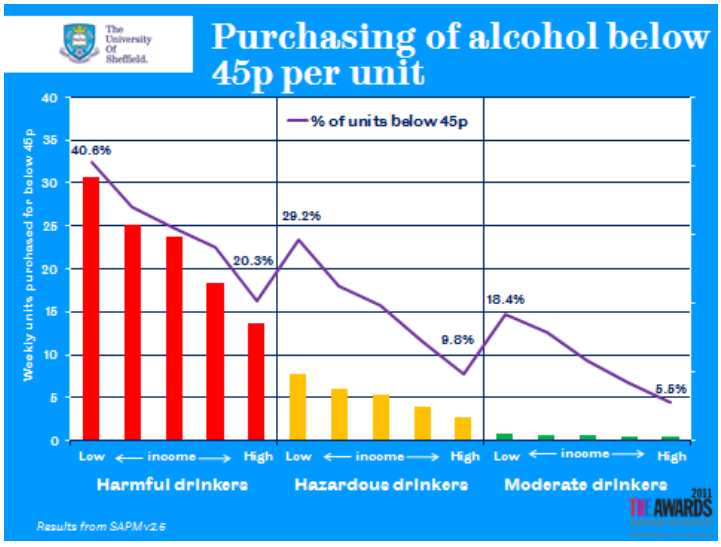
When the UK Government abandoned its proposal to introduce minimum unit pricing for alcohol in July 2013, it argued there was a lack of concrete evidence that the policy would reduce the harm caused by alcohol without penalising responsible drinkers. In research published in the Lancet, the Sheffield Alcohol Research Group show minimum unit pricing avoids penalising moderate drinkers on low incomes and would contribute to the reduction of health inequalities.

Minimum unit pricing (MUP) sets a threshold below which a unit of alcohol cannot be sold to consumers. Under a 45p MUP a pint of beer containing two units would need to cost at least 90p and a bottle of wine containing 9 units at least £4.05. Since heavier drinkers typically pay less per unit for their alcohol than moderate drinkers, and of course buy more units in the first place, this means that heavier drinkers would be affected the most by MUP.

The impact of MUP on the poor

In our new research, we explore the impact of MUP on those with low incomes who may be more likely to buy cheap alcohol. In particular we were interested in claims the policy could be particularly regressive by targeting drinks bought by the poor. To investigate this, we constructed a model of the relationship between MUP, people's alcohol spending and consumption and the health risks associated with that consumption.

We separated the population into moderate, hazardous and harmful drinkers and found moderate drinkers in the lowest income group bought very little alcohol for less than 45p per unit – less than one unit per week on average. When we estimated how much their consumption would reduce under a 45p MUP, we found it would drop by just 4 units per year – approximately 2 pints of beer. As this income group was the least likely to drink and most likely drink at moderate levels if they did so, this suggests the overwhelming majority of those on low incomes would not be substantially affected by MUP.



Among heavier drinkers the picture was different. For harmful drinkers, a 45p MUP was estimated to have a large effect which varied substantially by income. For the lowest income group consumption would fall by 300 units per year among the 5% who are harmful drinkers, compared to 34 units in the highest income group of whom 8% are harmful drinkers.

Reducing health inequalities

Even though harmful drinkers with lower incomes are the group likely to be affected most by MUP, this does not necessarily mean the policy is regressive. To understand its full implications we need to look at its success in achieving MUP's primary aim – reducing alcohol-related harm.

For reasons which are unclear, those with lower incomes appear to suffer greater risks of harm from their drinking than those with higher incomes. The combined effect of the bigger risks and bigger consumption reductions means low income groups would be by far the biggest beneficiaries of the policy in terms of health improvements. A 45p MUP is estimated to lead to 860 fewer deaths and 29,900 fewer hospital admissions due to alcohol per year and routine or manual worker households would account for over 80% of these. On this measure, the policy can be argued to be strongly progressive.

Model-based estimates of policy effects are, of course, subject to uncertainty and we take account of this by using different assumptions and inputting alternative data to see what the range of plausible effects might be. Although the size of the effects varied under these scenarios, the key findings remained the same and give us greater confidence in our conclusions.

Effectiveness and fairness

We consistently find, across a wide range of plausible scenarios, no support for the UK Government's concerns that minimum unit pricing would penalise responsible drinkers. This is because the estimated effects on this group are negligible, even in the lowest income groups. Instead, the policy targets those at greatest risk of harm – heavier drinkers on low incomes. As such, the benefits of the policy are also concentrated on this group.

The reduction of health inequalities, including those generated by alcohol consumption, is an explicit aim of the Government's public health policy. Our research shows minimum unit pricing would make an effective contribution to reducing such inequalities by particularly reducing the harm caused by alcohol in lower socioeconomic groups. It also challenges perceptions about levels of drinking among the poorest in our society and raises important questions about how we judge the fairness of public health policies.

Dr John Holmes, Sheffield Alcohol Research Group

This BMA info graphic is based on the lowest proposed unit price of 40p. The BMA believes the minimum price should be no less than 50p per unit.

Scotland – It's Time to Care

Dave Watson describes the shocking state of social care in Scotland and what we should be doing to improve it.

The care of older people in Scotland is a national disgrace. Fairly paid, well-trained staff on proper contracts with time to care is the very least older people in our communities have a right to expect.

Like others in the sector I have written reports highlighting staffing levels, budgets, structures and care strategies. Words have been written and numbers crunched – but that doesn't tell the whole story. I participated in a couple of focus groups made up of care workers last year and the messages from the workers who provide care were deeply disturbing. They painted a picture of care in Scotland that nobody would want for their elderly relatives, including my own.

I summarised a key impact of poor employment standards when giving evidence to a Scottish Parliament Committee considering the Procurement Bill:

"*The other day, I was doing a focus group with a group of care workers and I said to those who were on zero-hours or nominal-hours contracts, "Would you raise health and safety issues with your employer?" They said, "We're on these contracts. If we raise health and safety issues, we will not be asked back." That is exactly the position that colleagues were in with blacklisting. Sadly, when I then asked them, "What if you saw care abuse?", they said, "We'd be pretty reluctant to raise that as well, to be honest, for the same reason." People on zero-hours or nominal-hours contracts who raise difficult questions do not get asked back, and people are concerned about that.*"

Having experienced those messages first hand I decided we would ask a much larger group of care workers and the outcome of that work is in UNISON's ***'Scotland – It's Time to Care'*** report. This report gives staff at the front line of care delivery the chance to tell their story about care in Scotland and it doesn't make comfortable reading.

The majority of workers believe the service is not sufficient to meet the needs of the elderly and vulnerable people they care for – both from the time they can spend and the quality of care they can provide. Almost half of carers (44%) said they were limited to specific times to spend with their clients. One in two workers are not reimbursed for travelling between client visits, while three in four said they expected the situation to get worse over the coming year. They also revealed that one in ten are on zero hours contracts.

Time to do more than just deliver a few manual tasks was important to staff and the people they care for. As one worker put it, "*By doing the best that we can with the time given. I'll admit I sometimes miss out a job so that I can sit for two minutes with the person receiving care. That*

*means more to them than the dishes needing dried."*Adequate training is another concern, particularly for newly appointed younger staff. One said: *"Staff are not receiving the training they need to carry out their roles, only the training which is low cost or has been identified as core."*

The isolating impact of personalisation was often mentioned and the threat of losing contracts if they make a fuss. One worker said: *"Stop threatening charities indirectly that you will take the SDS contracts away from them and move to another provider if workers challenge decisions...Being told by management this is the case and we all must be quiet even though the workers sole concern is for the service user they care for and want the best for them."*

All of this adds up to staff stress and higher turnover that results in limited continuity of care. As another worker put it: *"I feel the staff in our organisation are paid pretty poorly for the standard of work they are expected to provide. This means we often have difficulty in recruitment and cannot attract a quantity and more importantly a 'quality' of staff. It can be hard to keep experienced, well trained staff as staff shortages and low wages lead to overwork, stress and dissatisfaction to a point were employees resign."*

These are the stories of front line workers that illustrate, all too clearly, what we guessed from the hard evidence. This report should be a wake-up call for the Scottish Government and commissioning bodies to take action to end the race to the bottom in care provision.

Procurement action should include a requirement that all care provision should mandate:

- The Scottish Living Wage: this will help the recruitment and retention of staff and support continuity of care;
- Improved training: to ensure that care is delivered by properly qualified staff;
- Proper employment standards: ending the abuse of zero and nominal hour contracts;
- Adequate time to care in every care visit.

This year's Scottish Labour Party conference will consider a motion from SHA Scotland on this issue. Shadow health minister Neil Findlay MSP has established a Quality Care Commission to look at the longer term policy aims and is promoting a campaign on the state of the care sector. The Leader of Labour led Renfrewshire Council has just this week committed his support for UNISON's Ethical care Charter. This all demonstrates that Scottish Labour is showing real leadership on this issue.

Scotland's older people and others, who rely on our care services, deserve nothing less.

Dave Watson is the Secretary of SHA Scotland and the Head of Bargaining and Campaigns at UNISON Scotland

Sexually Transmitted Infections

Scott Nicholson makes the case for state funded research

Sexually transmitted infections (STIs) have a significant impact on the health of Scotland. STIs cause mortality via human immunodeficiency virus and human papilloma virus; pelvic inflammatory disease and reproductive complications via gonorrhoea and chlamydia yet also infect the unborn foetus by syphilis and herpes.

Figures released by the Information Services Division of National Services Scotland (part of NHS Scotland) in January 2014, highlight that across all age groups, there has been a 43 per cent increase in STIs since 2003.[1] The figures, covering chlamydia, herpes and gonorrhea, show a rise over this period from 15,601 to 22,306.[1] Most interesting to me, was that the number of Scots diagnosed with gonorrhea rose by 133 per cent from 808 in 2003 to 1884 in 2012.[1]

Antimicrobial resistance is a serious issue in gonorrhoea treatment and has caused the last-line drugs (ceftriaxone combined with azithromycin) to become the standard therapy in the UK. [2,3] There is no reserve drug available if ceftriaxone resistance – already found in France, Spain and Japan – spreads across Scotland. [4,5] Without dependable therapy, many Scottish women with gonorrhoea will remained untreated and develop the associated pelvic inflammatory disease, ectopic pregnancy, infertility and even disseminated infections in synovial joints.

Between 1929 and the 1970s, pharmaceutical companies developed more than twenty novel classes of antimicrobials.[6,7] Since the 1970s, only two new categories of antimicrobials have arrived.[8,9] This has caused Gregory Daniel to write about market failure in antibiotic development. [10]

Market failure is an issue as, when used appropriately, a single £100 course of antibiotics could treat an infectious disease like gonorrhoea. However, being clinically effective after short-term use has the unfortunate consequence of making antimicrobials significantly less profitable than the drugs used in – for example - cancer therapy, which can cost £20,000 per year.

In September 2013 the Department of Health published its UK Five Year Antimicrobial Resistance Strategy.[11] The strategy called for "work to reform and harmonise regulatory regimes relating to the licensing and approval of antibiotics", better collaboration "encouraging greater public-private investment in the discovery and development of a sustainable supply of effective new antimicrobials" and states that "Industry has a corporate and social responsibility to contribute to work to tackle antimicrobial resistance."

As socialists, I think that we should have three major objections to these statements. One, managers in the pharmaceutical industry have no responsibility to contribute to work tackling antimicrobial resistance. They have a responsibility to make profit for shareholders or be replaced. It is the state that has the responsibility for the protection and wellbeing of its citizens.

Secondly, following last years' horsemeat scandal we, as socialists, should object to companies cutting corners in attempt to increase profits. This leads on to the final objection, that in

promoting public-private collaboration all the state is doing, is subsidising share holder profits by reducing their financial risk.

Mariana Mazzucato in her 2013 book, THE ENTREPRENEURIAL STATE, discusses how the state can lead innovation and criticises the risk and reward relationships in current public-private partnerships.12 I feel that significant advances in the prevention, diagnosis and treatment of STIs could be made by undertaking basic scientific research and we in Scotland should campaign for state funded researchers working within the public sector.

These scientists could study the mechanisms of antimicrobial entry into bacterial cells or screen natural antibiotic compounds to develop novel antimicrobials but also develop technologies such as point-of-care diagnostic devices that allow healthcare professionals to prescribe the most effective therapies. Point-of-care diagnostic devices like these would also help to tackle the development of antibiotic resistance in diseases like gonorrhoea by preventing the use of inappropriate antibiotics in patients who do not require them.

In addition to these, scientists could also develop vaccines. The human papilloma virus vaccine shows the great potential of this field and there is no reason why this approach could not be adopted for gonorrhoea but also additional STIs like chlamydia and syphilis. With regard to other STIs, our current therapy options for human immunodeficiency virus are very expensive and drug resistance is a continual threat. Development of a vaccine would reduce cost to the NHS and mortality in Scotland but also allow the UK to provide greater assistance with international development.

The state could choose to build laboratories researching STIs in areas of Scotland with high unemployment and that have been neglected by private sector investment, to help promote regional recovery. Even more radically, if novel antibiotics are produced for their social good rather than the financial return from the volume sold, they can be reserved indefinitely - as a last-line drug - until a time of crisis.

Finally, with regard to democracy, patients and the general public in Scotland could have a greater say as to which STIs are researched and it would help us shift away from our reliance on the market to provide what society needs. As we all know the market responds, not to what Scotland needs, but to what will create the most profit.

Scott Nicholson is a PhD Student, University of the West of Scotland

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Health and Independence

Dr David Conway sets out why he is not convinced that independence will deliver justice on health inequalities

The independence referendum takes place on 18th September 2014. But it is the days that follow which are more important. It is what Scotland does with its existing, or future further devolved, or independent powers which matters most - not simply where the constitutional border is drawn. The argument is not therefore primarily about the constitutional power, but about what we do with them.

The NHS in Scotland is THE case for Devolution – choosing public over private health services, and mitigating against the whims of Westminster ideology. However, it is public health policies and legislation including smoke-free public places and minimum unit pricing which mark the key achievements of the Scottish Parliament and of devolution. Successes which have also become central to the Scottish Government' s case for independence in their White Paper – *Scotland's Future*. Nevertheless, both the preservation of the values and quality of the NHS in Scotland and the pioneering of public health legislation are key achievements of devolution.

Both devolution of more powers or independence could bring further opportunities for progressive public health action. The White Paper states an independent Scotland would "use the full range of levers to promote good health," but there is little detail on specific policy, nor is the future of public health or health services given much attention. Under current devolution arrangements, health is one of the largest budgets and highest profile policy areas controlled by the Scottish Government. But, the questions need to be asked: if Scotland were to become independent, would the attention given to public health be substantially less when the focus will inevitably be drawn to fiscal, foreign and defence powers, as well as the substantial efforts needed to disentangle the country from the rest of the UK and establish the independent state bureaucracy? And, how radical could public health policy be in terms of taking on big business, for example, the alcohol, tobacco, or food industry on advertising regulation or taxation policies? when at the same time the independence white paper sets out a business friendly low corporation tax priority that undermines the determination that would be needed to take on big business in these areas.

However, it is on health inequalities that the recent Audit Scotland report was damming on health policy. Despite the investment from successive devolved administrations, inequalities in health have just not budged. It is well recognised that health inequalities are the result of the unfair distribution of income and power and to a degree they are also associated with the inverse care law of wider public (as well as health) services – where those who need them the most are least likely to have access to them. So, on this count, it could be that our failure on health inequalities is because we do not yet have enough fiscal or economic levers. However, it could also be that we have not yet fully utilised the powers we currently have at our disposal including our lack of will or action to meaningfully reallocate resources (in our current gift) towards those who need it most. Couple this to the proposed low corporation business friendly taxation system proposed in an independent Scotland and it does not bode well for demonstrating that an egalitarian society will emerge and deliver us justice on health inequalities. First independence then equality? A leap of faith is needed here, because the case is not convincing.

Dr David Conway is Chair of the Socialist Health Association Scotland and author of the health chapter in the Red Book on Scotland 2014

‘Scotland’s Future’ – Health

The Scottish Government’s White Paper sets out the health case for independence

This Scottish Government plans to continue with current arrangements for the management of the NHS in Scotland, focussing on sustainable quality and for the integration of adult health and social care services. Services will be accessed in the same way as under the devolution settlement.

Despite efforts to address the challenge of health inequalities in Scotland over recent years, health inequalities persist and demonstrate that the "fundamental causes" of health inequalities - the socio-economic inequalities in society - are the most important. Recent research shows the strong correlation between poor health and poverty. It suggests that the reason for Britain's high health inequalities is the failure of successive Westminster governments to choose to reduce inequality.

Independence will also allow us to do more to tackle major causes of ill-health, which disproportionately affect poorer communities. In March 2006, Scotland was the first country in the UK to enact a ban on smoking in public places. This has resulted in a dramatic reduction in smoking related diseases. We have also led the way in developing ambitious proposals to tackle harmful drinking by legislating for a minimum unit price for alcohol.

We have maintained our commitment to strong action to tackle smoking and alcohol misuse with all the powers available to us. In contrast, the Westminster Government has chosen to put on hold proposals for plain packaging for cigarettes, and abandon plans for minimum pricing for alcohol. With independence, we will have greater scope and clearer powers to regulate alcohol and tobacco, including through taxation - reducing the opportunities for legal challenge which have held up several of our initiatives to date.

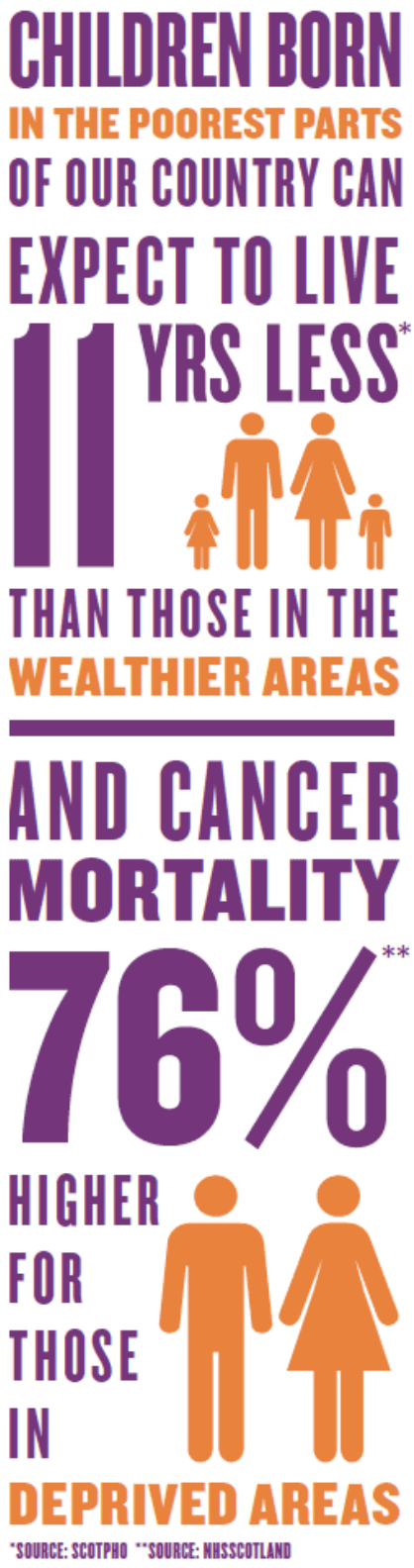
We are already taking a distinctive approach to food standards. Independence will allow this to be linked to tax policy and advertising regulation - allowing a coherent and concerted approach to issues of obesity and poor diet, which disproportionately affect poorer communities.

A major advantage of independence for health and wellbeing in Scotland is therefore to have the ability to use the full range of levers to promote good health. It is matched by the opportunity to grow Scotland's economy for the benefit of all and address inequalities in Scottish society that have not been, and will not be, addressed under Westminster.

After independence, Scotland will maintain a very strong relationship with the other countries of the UK. Scotland will continue to work with other parts of the UK to provide services where this provides access to the highest quality of care and delivers the best outcomes. There are already effective cross-border working arrangements in place, which will provide a strong foundation for continued co-operation, just as there is with Ireland. Partnership arrangements are also in place with a number of European countries, including, for example, Sweden.

Services provided for patients outwith Scotland include highly specialised care for people with rare diseases or conditions, and certain types of transplantation. The rare cases of transplants being conducted outwith Scotland are for lung, small bowel and paediatric transplants. Because

there is a relatively small number of these procedures, contracting these services from clinical specialists offers the best health outcomes for Scotland's patients. These arrangements will continue exactly as they are at present after independence.



On independence, Scotland will continue the current arrangements for organ donation across the UK, maintaining one donor register and sharing donated organs. This will ensure that all organs are placed with the best matched patient. The Irish Health Service Executive also co-operates on organ transplantation with NHS Blood and Transplant (NHSBT), who co-ordinate transplant services across the UK. This reflects international best practice in transplantation where groups of countries work together, for example Eurotransplant in mainland Europe (Austria, Belgium, Croatia, Germany, Luxembourg, Netherlands and Slovenia), and Scandiatransplant in the Scandinavian countries (Denmark, Finland, Iceland, Norway and Sweden).

Arrangements for reviewing NHS pay are already devolved but NHS Scotland currently operates within UK structures and modifies UK agreements to reflect Scottish circumstances where necessary. With independence, we will review the machinery for pay determination in partnership, including the potential for improvement across the wider Scottish public sector. The Scottish Government has developed a Scottish GP contract in partnership with the BMA, and with independence we will continue to work with them, and all relevant partners, to ensure that GP contracts are developed to meet the needs and circumstances of the people of Scotland. Similarly, for hospital based doctors and dentists, the Scottish Government will work with all relevant partners in Scotland, and seek to co-operate with Westminster where appropriate, to negotiate pay, terms and conditions.

Scotland is already responsible for the regulation of some health professions - those who came to be regulated after the establishment of the Scottish Parliament. After independence, we will become responsible for all regulation. We will seek to co-operate with Westminster, and the devolved administrations, to ensure that health professional regulation is maintained in the best interests of patient safety and the consistent treatment of healthcare professionals. We will also maintain the existing professional healthcare regulatory bodies, which are funded by fees from registrants, and will continue to operate in Scotland after independence.

With independence, we can build on the gains of devolution for our health and social care services to enhance the health and wellbeing of people across society.

Vote 'Yes' to tackle the causes of ill-health

Cailean Gallagher argues that a Yes vote will bring the powers Scotland needs to eradicate the causes of ill-health in our society.

The Scottish Parliament has proved itself in areas of health. Certainly there are disagreements and differences in administration and priorities. But whereas the English NHS is undergoing privatisation with clear for-profit motives, the cross-party consensus in Scotland is to deliver health service in the public interest, to keep the health service well-funded and in public hands.

Yet chronic health problems remain almost as severe as before devolution, and powers to change this lie beyond health policy. The great opportunity of a Yes vote is to bring to Scotland the deeper powers – over areas like the economy, jobs, incomes, welfare and other social security – which can begin to alter not the symptoms but the causes of an unhealthy nation.

Despite being one of the richest countries in the world, the unequal division of wealth and economic security in Scotland explains the shocking differences in healthy life expectancy between the richest and poorest parts of the country. Other inequalities matter too, like gender and ethnicity – but often these are linked to material deprivation or social discrimination, creating or exacerbating ill health.

Consider the health of the up to 100,000 children in Scotland who will be plunged into poverty by 2020. Take the Westminster welfare changes, not only certain policies like the bedroom tax, but the overall approach that leaves those with the least facing the greatest impact of austerity. Many thousands have to choose between heating and eating and are frozen out of even a basic living standard by falling wages and too few working hours. Under this government the Red Cross has started handing out food for the first time since World War Two. These are the symptoms of a profoundly unhealthy society, and ill health follows as a sad matter of course.

Preventative care mitigates the impact of social injustice, but poor health is not a disease isolated from deeper conditions of life, or something people are endowed with – like an asset or a liability. To properly address health challenges, we need to integrate powers over health with the powers to rebuild the economy and share the wealth we produce more broadly. The integration of social and economic policies to tackle the injustice in society is a significantly different approach from our Westminster system, which looks unlikely to invest in the social change we need, even if Labour wins in 2015.

We need powers over welfare, work and wages, held by a government willing not just to attend to the effects of social inequalities, but to work against the divisions in society. It will be up to socialists in Scottish Labour and beyond to champion social justice, and work for an independent government in 2016 that tackles the causes of ill-health in society: creating the work that gives people the security and living we all deserve; and ensuring that social security means more than sanctioned welfare, but is genuine support for all to attain a healthy living standard. A Yes vote is a means to this end, bringing to Scotland the powers we need to eradicate the causes of ill-health in our society.

Cailean Gallagher is a researcher for Yes Scotland, and a member of the Campaign for Socialism

Reflections on the NHS in England

Richard Bourne tells the unhappy story of the NHS in England

The NHS in England is under threat from the pro market lobbyists and under great strain due to financial pressures. It's not a happy story.

Shortly after the 2010 election rumours began about a monster Health Bill – 400 clauses and designed for change over 2 terms. Despite lies in the coalition agreement about no reorganisation of the NHS by 2012 we had the Act.

The Lansley blueprint to bring in a regulated market for healthcare, like the utilities, began with a white paper promising things which fooled many who should have known better, into vague support. The SHA was in the forefront of opposition pointing out the dark side, but only the leading health unions and Labour were openly opposed. The pretence that somehow the Tory proposals were some kind of continuation of existing policies was rapidly refuted. This was making competition and markets the strategy for healthcare not about the occasional and managed use of competition if appropriate.

The Bill was shorter than expected but was obviously about moving to a market. Labour fought the Bill line by line in Commons and Lords to no avail. Many amendments were made, making the result virtually unworkable, but the essence of the market was fixed into Part 3. By the time the Bill became an Act the opposition was virtually unanimous. It was too late.

The disaster might have been prevented had the GPs collectively signalled they would not accept the changes they had to be involved with or if the Royal Colleges had collectively signalled their opposition. It didn't happen. The LibDems ensured the Act was passed although they never got the payback they were promised in terms of constitutional changes.

The Act set up the structures and mechanisms by which healthcare moves to a market. It reinforced the commissioner/provider split with Clinical Commissioning Groups (led by GPs) and set out the architecture for greater competition amongst providers. It removed some of the political levers and downgraded the role of the Secretary of State; and it removed the idea of any local strategic leadership – not necessary in a market. Monitor was set up to be the economic regulator, fixing the prices and stamping out any anti-competitive behaviour.

The Act included, as an afterthought, Health and Wellbeing Boards to be vehicles for local integration of care services, and Health Watch as some king of body to facilitate public and patient involvement.

The greatest threat came from the pressure on commissioners to use competitive tendering . This was a one way process as it meant NHS providers could only diminish in terms of their share of the "market". There is no doubt that the Act opens up greater opportunities for private providers to have access to NHS provision.

The Act fundamentally changed the NHS and paved the way for the end of the NHS as provider, for co-payments, top up fees and even the possibility of an insurance based system.
Which is bad enough, but this massive and expensive reorganisation took place against the background of severe cuts in funding levels forcing the NHS to try to find savings on a scale never achieved before, anywhere. Cuts in budgets for social care have magnified the problems. Tory controlled communications attacked the NHS at every opportunity, distorting and exaggerating know issues.

Implementation of the changes has been patchy as it becomes clear that the original Lansley model has been quietly dropped and some pragmatism is coming into play. You would struggle to find any open supporters of the market, competition, privatisation model. There is already talk of amending some of the worst (unintended?) aspects. It is still early to judge the true impact of the Act but the negative impact of the combination of structural changes and funding cuts is becoming clearer as many NHS providers are now either officially or just obviously in financial difficulty. They are threatened with various forms of intervention and "failure regimes" which are likely to involve offering private providers and the leading private sector management consultancies rich pickings.

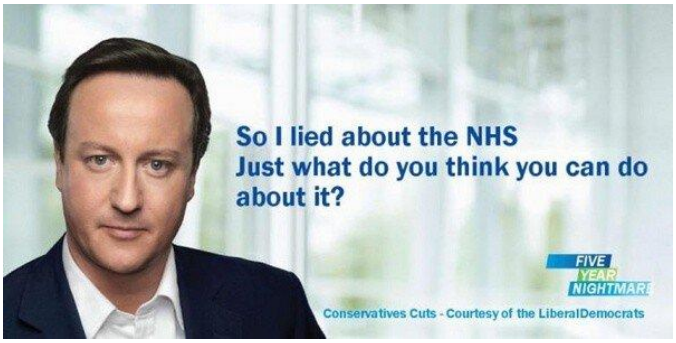
Some of the provisions in the Act around public and patient involvement have some positive aspects but there is little sign yet of activists engaging in the new structures.

Some CCGs are virtually ignoring the regulations and are not planning to competitively tender everything. Some CCGs got involved in tendering and make a mess of it! In a number of places local groups and trade unions are actively opposing tendering activity – with some success.
For the SHA in England the position has always been total opposition to the Act and to the whole idea of a market of any kind for healthcare. We have strongly lobbied the Labour Party and believe that our policy is quite well aligned to that being advocated by Andy Burnham and the Labour Team.

If the Tories get a majority at the next election in 2015 they can complete their plan to dismantle our NHS, everything is in place to do it.

If Labour wins then they are committed to repeal of the Act. They will remove all the market structures (in Part 3 of the Act) and restore the political and legal accountability of the Secretary of State. They will do this in a way which does not trigger yet another wasteful and destabilising set of structural changes. The SHA is working to find the best ways to bring this about as we need workable answers not just slogans and rhetoric.

Richard Bourne is the immediate past Chair of the UK Socialist Health Association



What's to gain from Separation?

Dr Richard Simpson MSP argues that we have all the powers we need to progress an NHS which is world leading

Scotland has had full responsibility through devolution for our Health Service since 1999. The result has been that the NHS here now looks substantially different from that in England, our approach being one of collaboration, cooperation and minimal use of the private sector. It has many unique features.

Some, such as the staff partnership, have been recognised by commentators like the King's Fund as world leading. Others, like our managed care networks, could only develop effectively in a collaborative system and are beginning to deliver results. Our patient safety strategy is also world leading.
The challenge for the Yes Campaign is to explain what possible advantages there are to patients through independence? The Union provides many advantages which will be put at risk with independence and will over time I believe degrade our Union advantage.

The biggest challenge to Scotland's current preeminence in health will come about indirectly. We have five medical schools. This is far more than would be required for an independent Scotland. Students from England pay tuition fees and it is very unlikely that this will be allowed under EU rules. The loss of income to Scottish Universities of fees has been estimated at £140 million. Over time the Crerar Report's prediction that we would half our medical student intake could happen. This would mean two fewer medical schools.

The current situation within the UK is that Scotland punches substantially above its weight in medical research. In competitive research applications we win around 14% of the UK Medical Research Council's (MRC) funding compared to a population-based share which would be 8.3%. The position is similar for UK medical charities like Welcome, the National Institute for Health Research (NIHR)and the 13 other research councils. Indeed it is uncertain that we would be eligible for any NIHR funding. Any delay in EU membership could interrupt Horizon 20/20 funding as well.

Of course the Nationalists will promise to match the research funding. But it is the competitive winning against the whole of the UK that is equally important in maintaining quality. The MRC stopped funding research in Eire three years after they gained independence.

Scotland has evolved already its own world-leading approach to medicines. But currently the larger UK Union has 'clout' in negotiations with the pharmaceutical industry. A smaller Scottish budget, whilst still significant, would inevitably have less influence.

There are also savings through size from the regulation of health professionals. Scotland has no guarantee that it would be able to retain the UK General Medical Council, the General Dental Council, the Nursing and Midwifery Council and the Health Professional Council. Costs are likely to increase from having to set up our own bodies in Scotland. On becoming independent, we would need our own regulatory body for medical devices (MRHA), Vaccines Advisory Committee and regulation of substances. This parallels concerns generally about setting up separate different and costly regulation.

There are also seventy UK wide disease registers which with their size is of great benefit in monitoring patient outcomes.

We already have our own separate institutions where these are useful like the Scottish Medicines Consortium and the Mental Welfare Commission

What has all this to do with patients? These underlying and unnecessary structural disruptions will lead to a parochialism and diminution of an integrated system which has built up over three hundred years of the most successful Union in the world with Scotland's contribution to that union in medicine exceeding almost every other region.
We could lose medical schools. Our research base will certainly not get better and we could lose funding. We are likely to pay more for our medicines. We would pay more for registration and regulation of health professionals. We would still be able to access the NHS in England but it is very likely that the favourable terms arising from being part of the UK would not continue.

Scottish Health Boards would be charged full price for the 24,000 patients treated annually in England.

So why risk our preeminence within the UK? Scotland under devolution has all the powers we need to progress an NHS which is world leading. What would we gain from separation?

Dr Richard Simpson MSP is Scottish Labour's Public Health spokesman.

Another NHS Review?

Matt McLaughlin questions the need for another NHS review, but sets out what could be done

Any observer of our NHS quickly concludes that it is littered with positive language and 'right on' strategic policies. Whether it's 'releasing time to care', 'staff governance', 'patient safety networks', clinical governance', 'mandatory workforce planning tools' or 'cash releasing efficiency savings' at a strategic level at least, the NHS in Scotland is able to tick lots and lots and lots of boxes.

However closer examination of staff surveys, sickness absence, critical incidents, trade union surveys and internal reporting mechanisms starts to suggest that the perceived wisdoms are not necessarily representative of the reality at the coal face. These factors and others, including the outcome of the Rapid Review Into Patient Safety at NHS Lanarkshire recently led Labour's, Neil Findlay MSP, to call for a system wide review.

Whilst some organisation backed the call, UNISON did not. Having been at the centre of the political maelstrom since 1999 (and before) Scotland's NHS actually needs a period of stability, not another restructure. That's not to say that we wouldn't benefit from a discussion and hopefully a consensus on the model of care and direction of travel, but a system wide review won't bring anything new to the table and is unlikely to deal with the chronic short staffing/ under resourcing which seems to be at the centre of much of the service's bad press.

There are however two or three simple steps that could be taken now and would make the world of difference.

At a strategic level NHS Boards should be made to set agreed 'establishment' figures for all grades and job families with local and national reporting required to ensure that at all levels the Board is as near fully staffed as it can be.

We already know that the nursing population is aging – fast. We also know that there is a sizable cohort of staff aged 55+ who could leave the service now. Whilst planning is underway to try and meet the future demand, the uncertainly of staff working longer added to the removal (rightly) of the mandatory retirement age, makes even the simplest form of workforce planning no more than an educated guess.

Government and Heath Boards should be actively working to make it attractive for older staff to stay on in the workplace. That might be lighter duties, shorter days and or shorter working weeks. We may need to review some of the pension rules to make coming back to work attractive, but the positives will far out weight the negatives in terms of service delivery and retention of experience.

The same approach could be applied to staff with young families (experience suggests that some areas are very resistant to nurses working 'short shifts' – even if refusal forces experienced and well regarded staff to leave the service, whilst their children are in infancy).

Setting to one side the general view that NHS Boards are 'managing vacancies' to meet budget pressures (Incidentally we'd welcome some hard commitments on this too), the NHS is painfully slow at filling vacancies once approval is given. For an organisation that relies so heavily on people, it has to be unacceptable that at best it can take 12 weeks to fill even a basic entry level post. We recently saw an example where it had taken so long to make the formal offer; the applicant had found another job!

No one believes that the NHS is safe from or managing to avoid public sector spending cuts, now is the time to be honest in that regard. At the same time a root and branch review will do nothing other than further de stabilise an already tired and demoralised workforce. The challenge for politicians is to set aside the spin and rhetoric and instead work with staff, unions and Boards to invest in their greatest asset.

Matt McLaughlin is the Secretary of UNISON Scotland's Nursing Sector Committee

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