NHS at 75: facing its greatest danger

The National Health Service will reach its 75th birthday on July 5. It remains a precious lifeline for the population as a whole, largely thanks to the increasingly valiant efforts of its 1.26 million staff, who have defied the odds to keep services going despite government policies. But with just a couple of weeks to go to the anniversary, the revelation of a record 7.42 million on the waiting list is a stark reminder of how far its performance has fallen.

When David Cameron’s Tory-led coalition took office in 2010 the NHS was reaching a peak of performance, with record low waiting times for elective and emergency care, and record high levels of performance and public satisfaction. These are now a distant memory.

The target for 95 percent of people in A&E to wait no more than 4 hours has not been met since 2015: the 92 percent target for patients to wait no more than 18 weeks was last achieved in 2016. Cancer services have been missing targets since 2015.

All of these services were in decline well before the Covid pandemic: by December 2019, when Boris Johnson won a landslide majority (with empty promises of increased NHS spending and 40 new hospitals) the waiting list was double the 2010 level, at 4.5 million. 13 hard years of austerity and cuts in public health and prevention have undermined the health of communities, while real terms cuts in staffing and in growing danger of collapse. The five hospitals are Airedale in West Yorkshire, Queen Elizabeth King’s Lynn in Norfolk, Hinchingbrooke in Cambridgeshire, Mid Cheshire Leighton in Cheshire and Frimley Park in Surrey. NHS England states: “This is on top of two of the worst affected hospitals - West Suffolk Hospital in Bury St Edmunds and James Paget Hospital

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Prime Minister Rishi Sunak – focused on maximising NHS use of private hospitals

The greatest danger to the NHS means we need the boldest answers if we are to rescue it.

- NHS plight in numbers – page 2
- Private sector can’t solve waiting list crisis – see inside page 6

Affiliate your organisation to HCT – AND to KONP, one fee! https://healthcampaignstogether.com/joinus.php
Plight of today's NHS in numbers

Waiting lists

7.42m
April 2023 total of patients waiting for elective NHS treatment in England

371,111
patients waiting more than 52 weeks,

11,477
patients waiting more than 78 weeks (18 months)

92%
of patients should be treated within 18 weeks

58.3%
ACTUAL proportion of people waiting less than 18 weeks

13.8 weeks
average waiting time, almost DOUBLE 7.2 weeks in April 2019

Emergencies: fewer Type 1 admissions than before pandemic, but vastly more delays

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Health spending per head

Country | Spend per capita $ | % UK
---|---|---
Germany | 7383 | +37
Switzerland | 7179 | +31
Netherlands | 6753 | +25
Sweden | 6262 | +16
France | 6115 | +13
UK | 5387 |

Latest comparative figures from OECD (NB 2021 or latest available, so all figures rather distorted and inflated by Covid spending)

Annual changes in health spending

UK health spending under Conservative, Labour, and Tory-Lib Dem coalition governments

NHS 75
ANNIVERSARY RALLY
ONLINE WEDNESDAY 5 JULY 6:30PM

We need a fully public NHS – because this is how we protect staff pay, conditions and it’s also how we protect services for patients too. It’s the only way the NHS will survive.

This isn’t time to reform or retreat, it’s time to return to founding principles. However, it is vital we mark the 75th Anniversary and use the spotlight under which the NHS will fall this year to make our demands and organise to save our NHS.

Speakers include:

Tony O’ Sullivan – Co-chair – Keep Our NHS Public
Holly Turner – Nurse – NHS Workers Say No
Harry Eccles – Nurse – NHS Workers Say No
Ellen Clifford – DPAC activist and author
Onay Kasab – National Officer – Unite the Union
Chantelle Lunt – Merseyside BLM Alliance
Claudia Webbe MP – Independent

Contact: konpsdsec@btinternet.com

Happy 75th Birthday

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23% FEWER Learning Disability nurses
25% FEWER school nurses
2000 FEWER GPs than 2015
7% INCREASE in population
12% DECREASE in real terms funding for GP services
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31 million GP appointments March 2023
70% of them face to face

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NO new hospitals being built... and there's no capital to build them

By Roger Steer
From The Lowdown
MAY 27, 2023

No one can be surprised that the Secretary of State for Health and Social Care has eventually had to recognise a bit of reality in delaying and reprioritising the New Hospitals Building Programme.

Schemes that Boris the Builder gleefully announced as “ready to go” in 2019 to be put back until after 2030.

Steve Barclay has ‘reprioritised’ his programme to direct funding to the most urgent hospitals facing the risk of falling down. However Barclay apparently took some persuading, if the account in the Guardian is to be believed.

Perhaps he noticed that all the constituencies in which the hospitals requiring “urgent” attention were in Conservative held seats.

But many of those now effectively bumped off the priority list are also in Tory areas. Like so many Jonson plans, requiring “urgent” attention were in constituencies in which the hospitals are falling down. However Barclayapparently took some persuading, if the account in the Guardian is to be believed.

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From the perspective of the ‘winners’ in the original struggle to push the capital programme. But this raises the question of what happens in the run up to the election if the Treasury say no to a “promised” new hospital. Will Jeremy Hunt step in?

From NHS England’s perspective it represents a recognition that problems which properly lie at ministerial level/Treasury level are finally being addressed. But something is obviously going wrong if no one has noticed hospitals are falling down before now, and nobody thinks it is their job to do something about it.

From the point of view of those looking to build new capital projects over the next ten years, including new technology, new equipment, new productivity boosting measures (for example in pathology services, scanners etc.) it surely means further delays – and more pressure on NHS managers to prioritise and subcontract services.

Already health chiefs in North West London looking to replace St Mary’s hospital are crying foul as they find their plans are now postponed beyond 2030. From the Labour Party point of view, it should be time to present their own coherent plans for a capital renewal programme. We need plans which aren’t based around self-imposed fiscal limits but instead are based on meeting long-term needs most economically and automatically funding self-financing business cases from an Infrastructure Bank.

For those who think its unaffordable read Marc Robinson “Bigger Government,” which concluded extra spending on health and social care was inevitable, affordable and desirable in the future to meet a more elder population’s need.

Plainly councillors, trade unionists and campaigners involved in scrutiny will want to make sure that legal duties are being fulfilled. Questions about strategic plans, business cases, procurement processes and contracts will need detailed scrutiny.

This is the relevant piece of legislation, – https://www.legislation.gov.uk/uk规/2013/218/regulation/21/ma2
Bevan's founding principles of the NHS have stood the test of time.

John Lister
When it was launched by then Minister of Health, Aneurin Bevan, on July 5 1948, the NHS was based on three core principles:

- that it should be comprehensive – meet the needs of everyone;
- that it should be universal – free to all at the point of delivery to access GP consultations or hospital treatment;
- and that it be based on clinical need, not ability to pay.

And although Bevan did not make a further explicit principle out of public ownership, the nationalisation of the hospitals was also central to the 1946 Act which established the NHS.

Bevan was convinced it would have been impossible to ensure that the chaotic mix of under-resourced and in many cases near-bankrupt voluntary, private and municipal hospitals would work together if they remained in separate hands.

Some Tories (not least Jeremy Hunt) have tried to argue that the NHS would have been set up whichever party had been in office. But the 1944 White Paper from Tory minister Henry Willink would have left the responsibility for the NHS in the hands of local government, and the scattered network of voluntary hospitals largely unchanged, with fees still in place.

Bevan insisted he had not felt any consensus behind him as he fought to get the Act passed and implemented: only Labour’s landslide 1945 majority ensured repeated Tory attempts to defeat the Act (and – as late as spring 1948 – block the launch of the NHS) were beaten back.

Public ownership and control, with public funding raised by central government through general taxation, rather than dependent on local council decisions or local taxes, was essential to ensure services would be equitably funded and available to all.

So most hospitals were nationalised, brought into a single system for the first time, and administered on a regional basis, although some public health, community health and ambulance services remained initially with local government.

**Insurance model rejected**

And with the call for hypothecated taxes or insurance based systems still doing the rounds in the right wing news media, it’s useful to note Bevan’s argument that by raising the necessary funding through taxation rather than insurance, the NHS also worked as a mechanism for redistribution of wealth and addressing inequalities.

... we rejected the principle of insurance and decided that the best way to finance the scheme, the fairest and most equitable way, would be to obtain the finance from the Exchequer funds by general taxation, and those who had the most would pay the most.

*It is a very good principle. What more pleasure can a millionaire have than to know that his taxes will help the sick? ... The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutic.*

The principles of the new NHS immediately proved so popular with voters that for almost four decades it enjoyed immediate proved so popular with voters that for almost four decades it enjoyed its popularity and those who had the most would pay the most. The same 1990 Act included similar plans for what we now call social care, implementing proposals from Sainsbury boss Sir Roy Griffiths in 1988. The new policies, implemented from 1993, transferred responsibility for ‘community care’ – most notably for long term care of older people – to local government social services.

This made these services subject for the first time to means tested charges. It deepened the divide between care for vulnerable people inside and outside hospital.

**Specialist beds axed**

As a result, most NHS specialist beds for older people were closed down, while government restrictions on councils’ use of funding for community care forced a growing level of privatisation of domiciliary services and long-term care.

To make matters worse, tightening ‘eligibility criteria’ imposed by councils from the mid 1990s, driven by growing constraints on local government budgets, ended any possibility of proactive and preventive care that might keep potentially vulnerable patients out of hospital.

Despite Tony Blair’s repeated empty promises up to 1997 to end the ‘costly and wasteful’ internal market, the fragmentation of the NHS was deepened from 2000 by even more far-reaching competitive market measures which included for the first time tendering out contracts for clinical care under New Labour’s NHS Plan, as well as the use of private capital to finance new hospitals and other projects under the Private Finance Initiative.

Unlike Bevan, who had been forced to compromise and permit private beds for consultants and independent contractor services in order to establish a new publicly owned system, New Labour actively pursued policies to privatise what had been core NHS services.

They signed a Concordat for NHS patients to be treated in private hospitals, and established Independent Sector Treaty Providers to contract out services funded by the NHS, as well as for-profit ‘Diagnostic and Treatment Centres’ – all at higher cost than NHS provision.

Even primary care was opened up to private corporations. Meanwhile substantial annual real terms increases in spending in the 2000s ensured that NHS performance indices were less than promising, with waiting times drastically reduced.

**Austerity since 2010**

But in 2010 David Cameron’s Tory-led coalition slammed on the financial brakes, ending a decade of NHS funding increases. Within weeks of that election Health Secretary Andrew Lansley also unveiled wide-ranging and complex proposals – none of which had been put to the electorate – to further entrench the competitive market within the NHS and close off new opportunities for the private sector.

Lansley’s hugely controversial 2012 Health & Social Care Act brought a wholesale top-down reorganisation of the NHS and compelled commissioners to put an ever-widening range of clinical services out to tender, while encouraging private capital to finance new hospitals and GP services.

NHS managers have been diverted down costly cul-de-sacs of ‘new public management,’ ‘business-style’ organisation, competition and privatisation, often urged on by unhelpful advice from expensive management consultants.

The huge historic achievement of the NHS in 1948 was always more than simply the first universal health care system to be funded from taxation and free from charges. It was a decisive reassertion, which made it possible to supersede the previous “mixed economy” of health care, in which voluntary, private and municipal hospitals and GP services had functioned in parallel, with no co-ordination between them, while patchy insurance cover left a majority of the population unable to afford to access a full range of services.
A new role for primary care

A specific arrangement was eventually agreed with General Practitioners, who had remained diehard opponents until the very eve of the launch of the NHS on July 5 1948. They would not accept Benvan’s plan to make them salaried employees, and were only eventually drawn to work with the NHS as independent contractors.

Nonetheless the rapid enrolment of so many families in the new NHS meant almost all GPs immediately found themselves dependent on NHS contracts.

Tories voted against it

From the mid-1960s as more, younger GPs embraced this link with the NHS, new policies increasingly focused on the development of a specific role for primary care as the first point of engagement and gatekeeper controlling referrals to specialist services and elective treatment.

The early NHS, funded almost entirely from general taxation, but launched in a period of generalised rationing and austerity, nevertheless provided all services free of charge at point of use – including prescriptions, eye-tests and spectacles, and dental checks and treatment.

Even overseas visitors living in Britain were covered. This removed any of the deterrents that might prevent poorer families from accessing the full range of treatment.

However this principle came under attack from the beginning, and there were soon discussions about imposing charges for prescriptions and for dental treatment, which has persisted.

Dr Naqvi also makes the important point about the impact on other aspects of British life – particularly culture and compassion:

‘Today’s NHS even more reliant on migrant workers than in 1948.

There is a long road still to be travelled in terms of equity and inclusion, even though all governments since the birth of the NHS have had to recruit overseas to solve workforce problems. The Royal College of Nursing at its 2023 Congress discussed the Windrush legacy, focusing on the unjust treatment of the Windrush generation and the need to recruit ethically from abroad and treat ‘migrants with respect and compassion’.

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Balancing act

The peoples’ history of the NHS describes the continuing balancing act between the need for workers from abroad – both skilled and unskilled – and the desire to keep immigrants out of the UK, as illustrated by racist legislation and government actions over the past 75 years.

A very revealing blog written by Dr Habib Naqvi, on the NHSE website, written in June 2020, describes Windrush as ‘still on a journey’ with a crucial stage being the effect of and on ethnic minorities in terms of their contribution and their terrible sacrifices during the worse of the Covid pandemic.

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**First year of crisis leaves ICBS seeking huge "efficiency savings"**

From *The Lowdown*

According to the latest NHS England overview, 16 of the 42 Integrated Care Boards (ICBs) failed to achieve their financial plan in last financial year, most of them failing by less than 1 per cent of total allocations. Of course a number of them had planned from the outset to run a deficit, or been obliged to admit during the year that they were not going to be able to balance the books.

NHS Finance chief Julian Kelly explained away the issues, arguing: “This variance is largely caused by operational pressures, in particular higher levels of COVID and sickness absence, and also the ongoing impact of inflation.”

However he also admits that a third of the ICBs (14/42) are projecting deficits totalling £60m for this financial year, despite the immense top-down pressure on Boards to reduce the shortfall from an initial £6 billion in March, and £3bn at the end of April.

NHS bosses have known that the financial pressures are growing ever-tightener: England’s NHS is expected to deliver £12 billion in “efficiency savings” over the next two years, while reducing waiting times and waiting lists.

Lowdown articles have explored the situation in 32 of the ICBs in London, East of England, and the North East, North West, South East and South West, underlining the many challenges facing the Boards as they seek to both balance the finances and expand the services. The latest information on the ten Midlands ICBs fits the same general pattern.

Underlying all of these local financial pressures are a number of common problems seen in most all ICBs:

- overspending above the arbitrary NHS England “cap” on use of agency staff costing £16.85 per hour compared with £16.85 agenda for change rate.
- Herefordshire & Worcestershire ICB trusts have overspent the cap by 38%, 60% and 79%, Northamptonshire system exceeded the cap by 58%.
- pressure on acute beds – especially given continued burden of Covid patients (703 in Midlands beds on May 17) and medically fit for discharge patients who cannot be discharged for lack of community health services or social care.
- inflation running far above the official forecasts, and showing little signs of falling as predicted, leaving providers carrying much higher than funded costs.
- under-funding of pay awards, leaving providers stuck with the extra cost.
- failure of NHS providers to meet tough targets for “efficiency savings” in 2022/23, (or sometimes imaginary assumptions or unassigned savings).
- and almost universal over-reliance on one-off “non-recurrent” measures and budgetary fiddles, which leave an underlying deficit rolling in to an even tougher 2023/24.

*The Lowdown* is being published in print and online every Saturday for the next 10 weeks, with each刊登 three times. The project is being funded by a grant from the National Lottery’s “What’s in it for you” fund.

The project is being run by Health Campaigns Together as an independent media initiative to help keep the public informed about the impact of cuts on the NHS.
The Lowdown

May 26, 2023

From The Lowdown

Privatisation/outourcing

Private sector can’t solve NHS waiting list crisis

Labour leader Keir Starmer: cross-party line or crossed wires?

been sceptical, asking why they should be expected to shop around when they just want a good local hospital?

A recent Health Foundation report has also warned that use of the private sector can only have a “limited impact” on tackling things like NHS backlog, and cannot solve other issues such as the spate of different workforce-related challenges and general underfunding.

Nor of course is the private sector any help to NHS trusts dealing with continued delays in treating the most serious emergency cases. The Health Foundation report, focused on private sector provision of NHS-funded ophthalmic and orthopaedic care, notes that the overall number of NHS-funded treatments has only just recovered to pre-pandemic levels.

Cataract operations

Independent Sector Providers’ (ISPs) deliveries 8.7% of these treatments – a 1% increase from before COVID-19. But the private sector share of ophthalmic care procedures almost doubled to nearly 4 in 10 in February 2022 compared with 23% before the pandemic. The report explains: “This suggests the delivery of cataract procedures is both highly amenable to scaling, and attractive to ISPs – which isn’t true of other procedures…”

The report also notes the increased share of orthopaedic operations carried out in the private sector to almost a third of inpatient orthopaedic care in February 2022, up from around a quarter before the pandemic.

However even the Times report notes that “the private sector performs about 140,000 procedures a month paid for by the NHS out a total of 1.5 million (i.e. 9.3%). There are

questions about how far this can be scaled up. This is especially true given the limited size of private hospitals (average size 40 beds) and their limited facilities, which mean they cannot take on more work than the NHS can, all of whom wind up waiting for the limited number of available NHS beds.

Same pool

The NHS Confederation in December noted that both the NHS and private sector “are recruiting from the same pool” of qualified staff, so any growth of the private sector inevitably undermines the NHS. It went on: “the independent sector will not have the capabilities, workforce or capital to take on the cases which are more complex in nature and acuity. The NHS will likely be left with the more complex and costly procedures due to the expertise and infrastructure needed.”

People on waiting lists, many of whom have been waiting several months, have deteriorated in their health and will need more complex care than they did when they first joined the waiting list.

“Due to this, these patients will not have the choice to use the independent sector, and this further complexity of care means health inequalities worsen.”

NHS Providers also warned: “private sector provision is not uniform across the country and therefore access to the independent sector isn’t always available. […] reliance on the independent sector could further widen health inequalities as independent sector provision is more likely to be present in affluent areas.”

Only low risk patients

“The role of the independent sector is limited. Independent sector provision largely covers high volume, low complexity cases as most independent sector providers do not have intensive care capacity. Therefore, independent sector provision can only really accommodate low risk patients.”

Money paid to the private sector cannot be used to develop NHS resources, and flows out of the NHS, often lining pockets of shareholders here and overseas.

Only recently the Health Service Journal reported private sector bosses calling for an increase in the rates they are paid for treating NHS patients, and threatening to “turo away” from NHS work if they don’t get a big enough increase – which

would destroy the argument that private provision costs the NHS no extra money.

The Health Foundation warns: “ISP activity is ultimately funded from an NHS budget already stretched by high inflation and other cost pressures.”

“Against a backdrop of an imperative for [CCHCS] to cut costs and deliver financial balance, it may be challenging for the NHS to fund a substantial increase in ISP activity even where genuinely additional capacity to treat more patients is present.”

The Public Accounts Committee itself has also questioned “the extent to which these initiatives (purchasing care from private providers) have so far generated genuinely additional activity, rather than simply displacing activity elsewhere in the NHS.”

Private beds may indeed be expensive, but with many NHS trusts carrying eight-figure deficits from last year, and Integrated Care Boards seek end-less “savings,” it’s not likely that many NHS bosses will be too keen to funnel more cash into the greedy hands of the not-so-independent sector.

Harsh lessons from Alberta:

Privatisation of surgery brings reduced services

May 26, 2023

An important new report has exposed the sorry failure of policy in Alberta in Canada, where the right-wing provincial government in 2020 announced it would spend $400 million outsourcing surgical services to for-profit facilities. It committed to doubling the number of outsourced surgeries over three years, from 15 per cent to 30 per cent of total surgical province-wide. This seems to closely resemble the “cross party consensus” policy proposed in England … but goes far further than New Labour’s experiments in 2005-2010.

“Three years later the report has found that Alberta has among the worst performance in reducing surgical wait times in Canada.

“The province has prioritised for-profit surgical delivery rather than system improvement, leaving nearly 30 per cent of public sector operating room capacity unused.”

Far from increasing provincial surgical capacity, data suggest that the expansion of the private sector’s ‘chartered surgical facilities’ (CSFs) has diverted resources away from public hospitals and, in turn, reduced provincial surgical volumes. Investor-owned surgical facilities have been expanding through substantial contracts with the government.

Public sector cut

Between 2018-2019 and 2021-2022, surgical volumes in chartered surgical facilities increased by 48 per cent while surgical activity in public hospitals declined by 12 per cent.

Surgical outsourcing has come at the expense of public hospitals and undermined efforts to reduce surgical wait times over the long term, especially for patients requiring complex surgeries only performed in the public system.

The report, Failing to Deliver, also shows the disproportionate private sector focus on quick and simple cataract surgery, leading to an improved province-wide performance under the Alberta Surgical Initiative, while performance has fallen back for more complex hip and knee replacement surgery, and the province’s total surgical activity declined in the first three years of the scheme. And it highlights more generalised problems with contracting out surgical services: in a period of growing staffing shortage the private sector is able to offer incentives such as reduced workloads, less complex patients, and higher pay to attract workers from the public system.

As a result, surgical activity in public hospitals has declined while for-profit facilities focus on lower-complexity procedures, destabilising the public hospital system.

“Over time, entrenched for-profit providers also reduces the public system’s ability to negotiate prices with private providers.” And, as British researchers have pointed out, evidence shows that private, for-profit health-care delivery is generally less safe and provides lower-quality care than public sector care where the profit motive is excluded.

www.healthcampaignstogether.com • healthcampaignstogether@gmail.com • @healthcampaigns
**Mental health: still treated as the poor relation**

Not one of almost 50 mental health projects for new hospitals submitted in response to the government inviting bids for an additional eight “new hospital” plans was successful, according to a recent HSJ report.

The so-called ‘New Hospitals Programme’ may not be delivering any new hospitals, but it is proving itself very much a reassertion of the dominant NHS England focus on acute hospitals and services that already command the lion’s share of NHS revenue and capital spending.

Some time ago the Royal College of Psychiatrists called for an extra £3bn capital, and £58m in additional recovery revenue over 3 years to equip mental health services to cope with the increased demands since the pandemic and expand services for adults and children. Their warnings like those of other medical specialists were ignored.

**Emergency funding**

But they have been included in the SOS NHS call for an emergency injection of £20 billion to help kick start the revival and repair of an NHS battered by a cruel decade of austerity before the pandemic.

Meanwhile there are other worrying signs that ministers are refusing to treat mental health services seriously, not least by misrepresenting statistics on the IAPT “talking therapy” services for some of the most common and least serious mental health problems such as depression and anxiety.

Therapists have pointed out via politicshome.com that although NHS figures show 1.81 million people were referred to IAPT in 2021/22, only 1.24 million entered treatment, with only 688,000 finishing a course of treatment.

Therefore only 38 per cent of those referred actually completed treatment, (which is defined as attending two or more treatment care contacts between referral and end of treatment.) And in the aftermath of the spring budget announcement of expansion of the individual placement and support (IPS) scheme – which supports people with severe mental health difficulties into employment – there are concerns that mental health services are not equipped to cope.

Royal College of Psychiatrists president, Dr Adrian James, said: “Last year, mental health referrals reached record levels of 4.6 million (but) there are just simply not enough psychiatrists to deal with this surge in demand if the government is serious about improving productivity, it needs to publish the workforce plan – backed by adequate investment – as a matter of urgency.”

**Vacant posts**

Recent NHS workforce statistics show a shortage of mental health nurses, with more than 1000 fewer employed in hospitals, community and mental health services in England than there were in 2010, and almost 13,000 vacant posts in March 2023.

And that’s hardly stop the press’ news – almost a year ago Baroness Watkins of Tavistock, chair of a review by Health Education England warned that, if steps were not taken immediately, “There is a risk that this profession will be lost.”

How long will it be before a government is willing to listen and act?

**Our vision for the NHS**

The NHS has served the people well for most of the last 75 years but it has been undermined by damaging underfunding and the private sector, within the body of the NHS.

There is an orchestrated chorus claiming that the NHS model and principles have failed. Not it is this Government that has failed the NHS over the last 13 years, taking it from best in the world into a dangerously deteriorating state.

**Principles**

We demand that the NHS is built back and built stronger, based on the principles that made it an unparalleled success:

* Universal care – no gatekeeping through insurance or means tests – ensuring equity of access for all and to comprehensive, high-quality healthcare required throughout life, publicly provided without private interest, and publicly funded through taxation, guaranteeing a service free at the point of delivery and offered according to need, not the ability to pay.

* People are dying because of political choices.

  * Austerity is responsible for 335,000 excess deaths 2012-2019.
  * A degraded and underfunded NHS that meant the NHS could not cope during Covid and is now the cause of up to 500 deaths per week from delays in emergency care alone.

  * An ideologically based support for private interests undermined the pandemic response in the UK, and over 220,000 have died with Covid.

  * This policy continues now as £1 billions are poured into private hospitals, at the expense of the NHS.

**Unions, campaign now join us!**

Health Campaigns Together is a broad campaigning coalition of trade unions and health campaigners, established in 2016. All three major health unions (UNISON, Unite and GMB) are part of HCT, and we support them in their fight to win a fair pay deal for staff. We also have great support from non-health unions.

Last year HCT and KONP played a key role in the establishment of the broad SOS NHS coalition launched in January 2022. This coalition now has the support of 55 organisations including 18 trade unions. The immediate demands of SOS NHS are: Emergency funding to save a struggling NHS; investment in a fully publicly owned NHS; and to pay staff properly - without fair pay, staffing shortages will cost lives.

SOS NHS gathered over 345,000 signatures on a petition early last year demanding emergency funding for the NHS. It held a successful conference in November with speakers from several trade unions. And we held a national demonstration on March 11th.

We hope your branch or regional committee will wish to affiliate for 2023. Health Campaigns Together merged with Keep Our NHS Public in 2022 and continues to play a vital role within KONP in broadening the alliance and strengthening the work of KONP and HCT with trade unions. Your affiliation to HCT will also bring with it the option of a complimentary affiliation to KONP.

**ANNUAL SUBSCRIPTION RATES ARE AS FOLLOWS:**

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Please affiliate (or reaffiliate) for 2023 – if possible ONLINE at https://healthcampaignstogether.com/joinus.php, which gives details on how to pay.

Make sure to send us your contact details.

**ANNUAL SUBSCRIPTION RATES ARE AS FOLLOWS:**

1. A commitment to fund the NHS and care services without which we cannot have a caring, successful society and healthy economy;

2. An end to feeding the private parasite eating away at the heart of the NHS; reclaim that wasted funding and reinvest it into rebuilding public services and safe staffing;

3. A commitment and respect for public servants: to provide the staff needed, to pay staff well and to repay their loyalty and service to a fully public NHS.

These commitments, if fulfilled, will guarantee the future of the NHS.

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