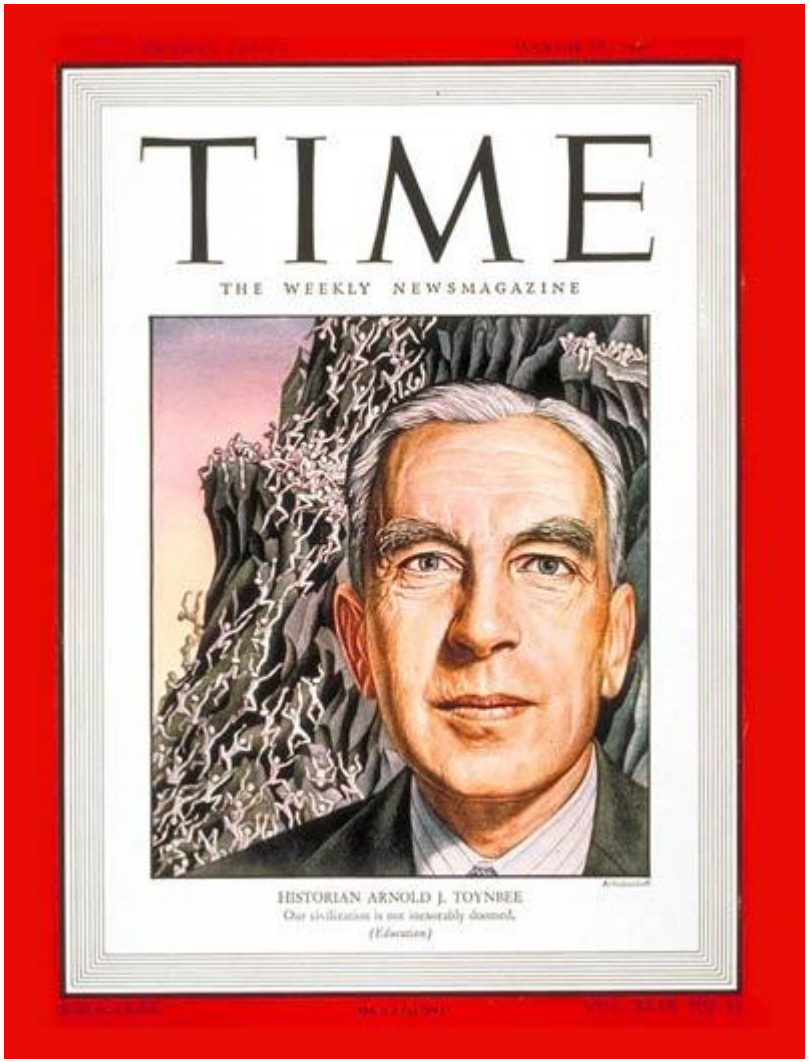
Nordic Supervision Conference
Tromsø, 25 – 27 May 2011

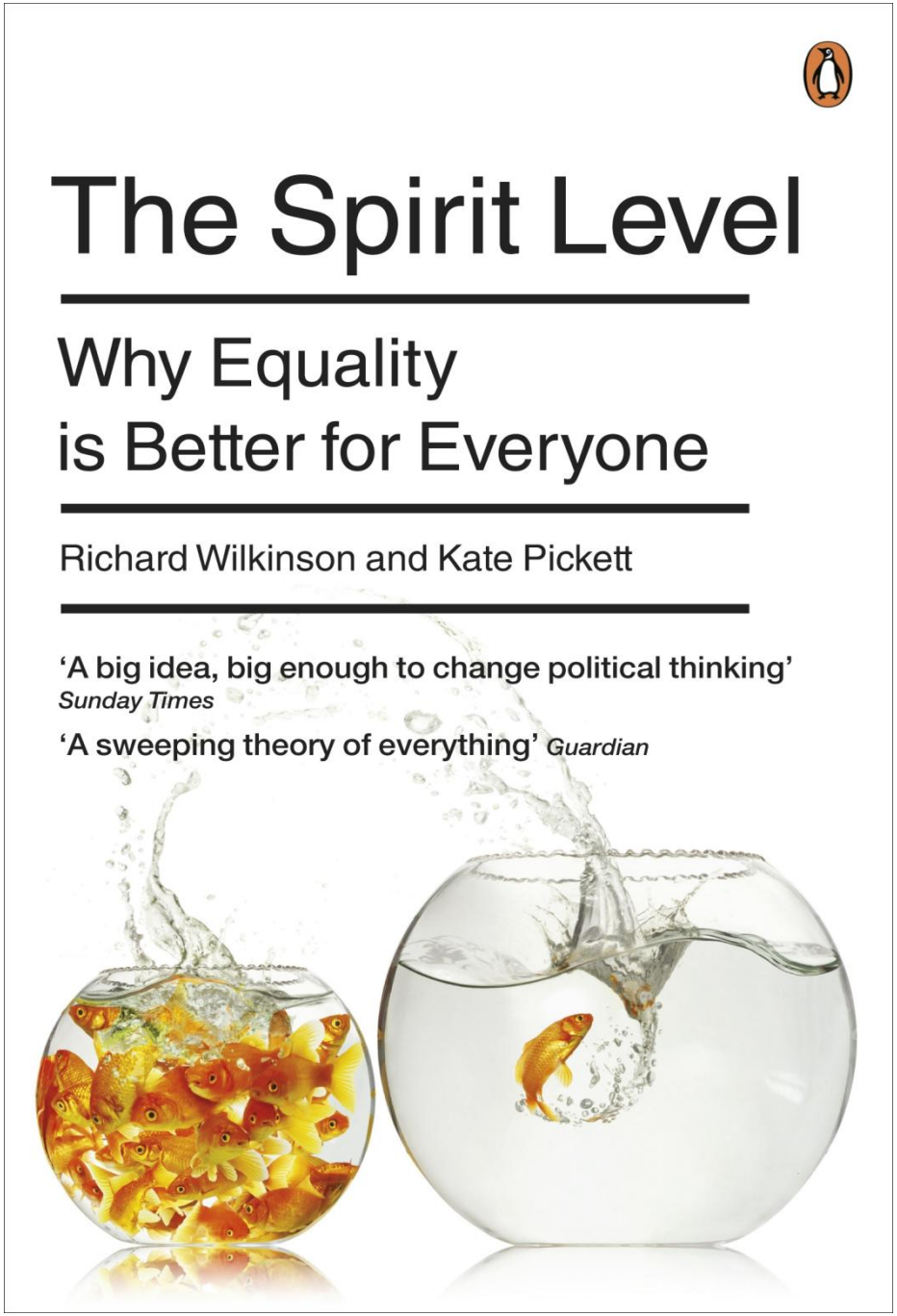
Welfare for all – or only for the needy? In defence of a decent society

Steinar Westin
General practitioner and professor of social medicine
Norwegian University of Science and Technology
Trondheim, Norway



Arnold J. Toynbee
(1899 - 1975):

"…Civilization is a movement and not a condition, a voyage and not a harbor"



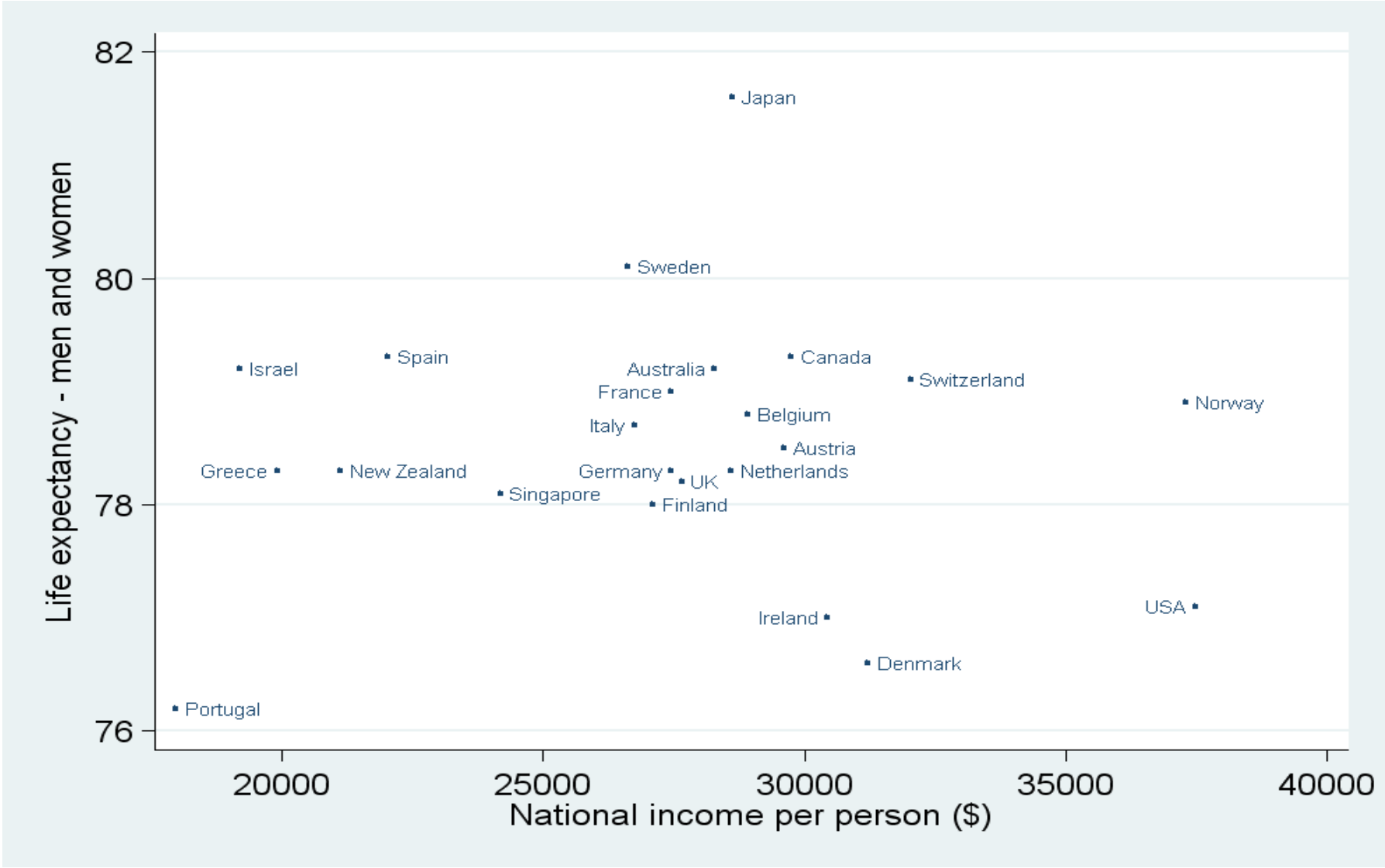
Richard Wilkinson
Emeritus Professor of
Social Epidemiology
University of Nottingham

&

Kate Pickett
Professor of Epidemiology
University of York

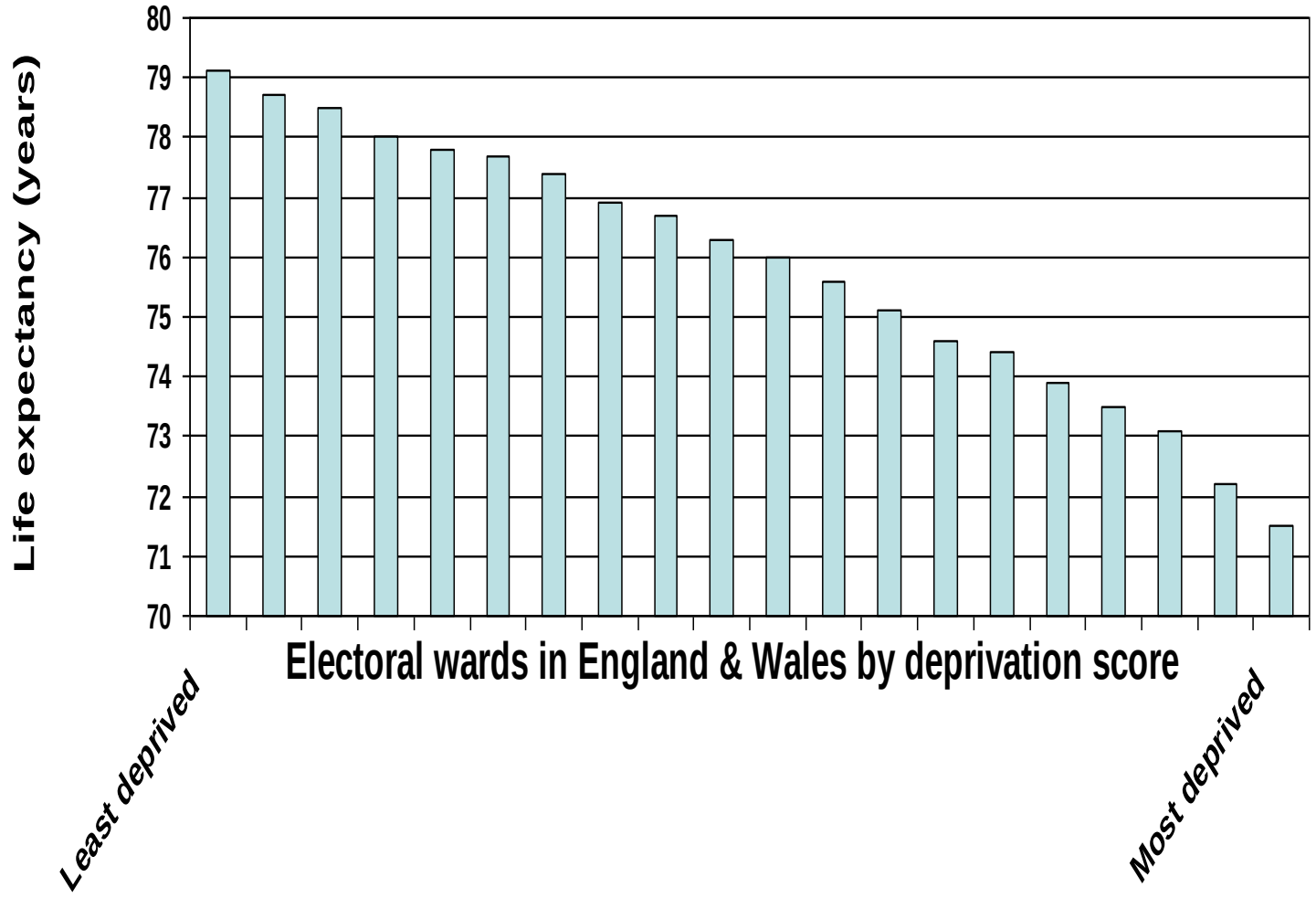
http://www.equalitytrust.org.uk

Among the rich countries life expectancy is not related to national differences in average income



Source: Wilkinson & Pickett, The Spirit Level (2009)

…but life expectancy is related to income differences *within* rich societies

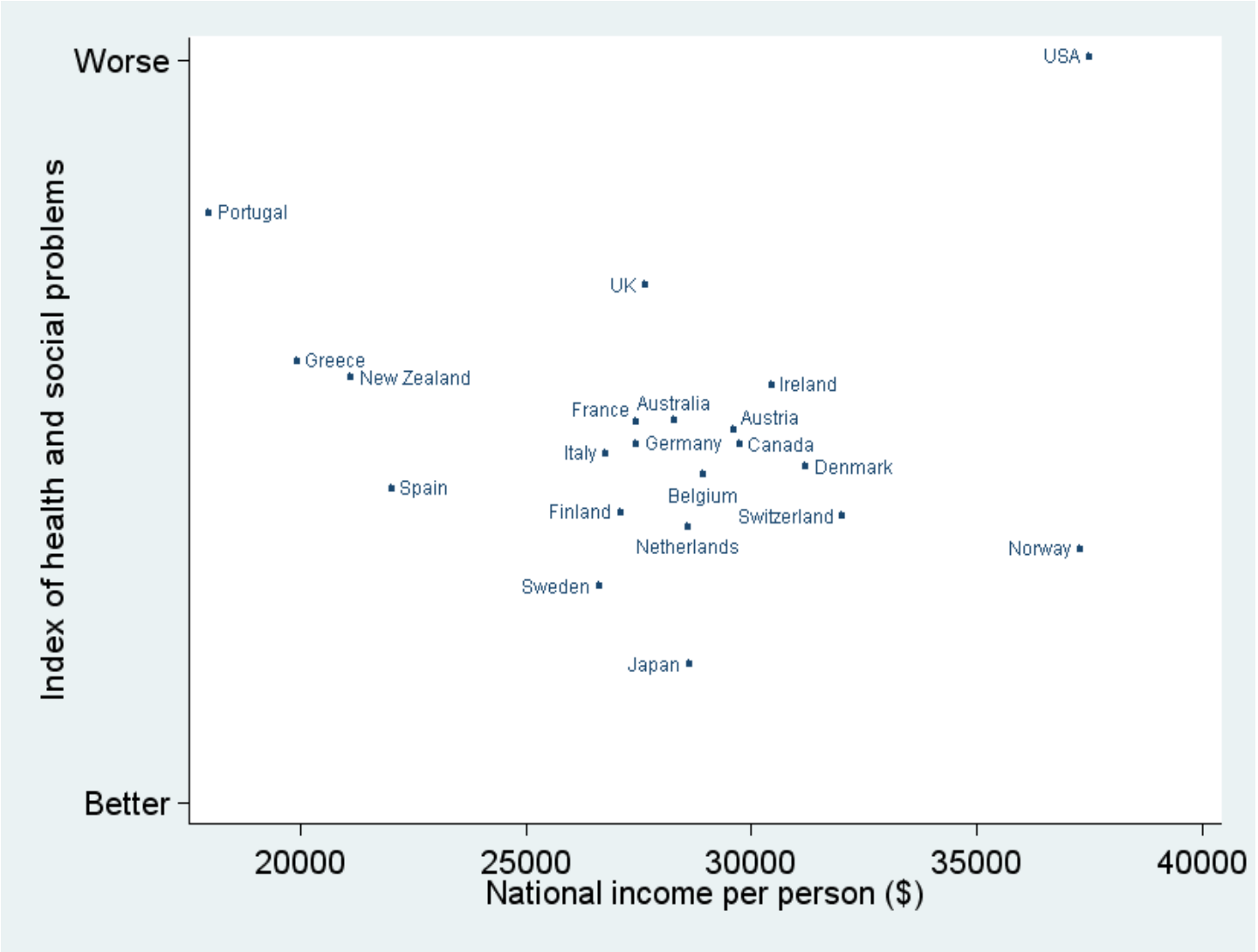


Source: Wilkinson & Pickett, The Spirit Level (2009)

Health and Social Problems are not Related to Average Income in Rich Countries

Index of:

- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility



Source: Wilkinson & Pickett, The Spirit Level (2009)

Health and Social Problems are Worse in More Unequal Countries

Index of:

- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
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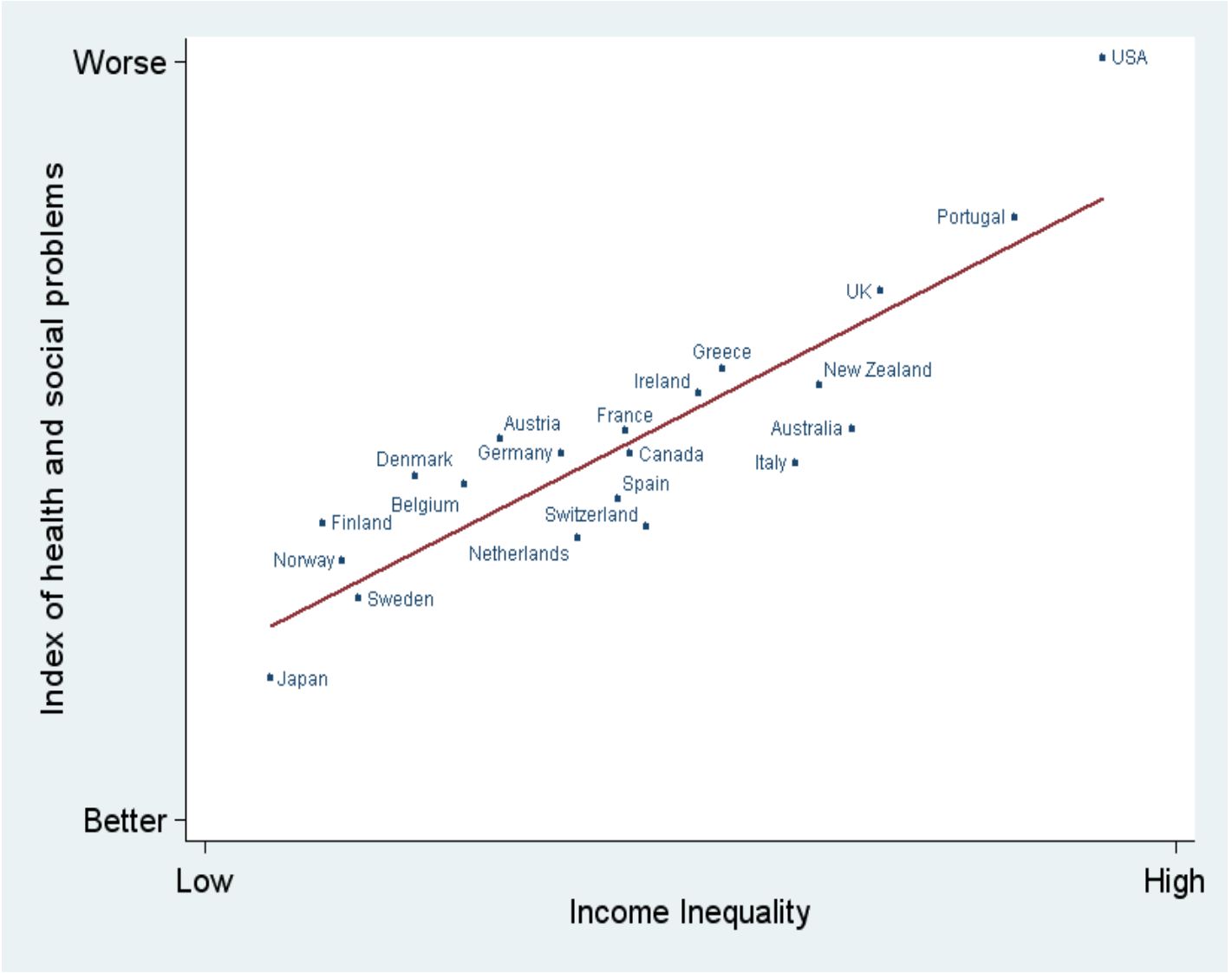
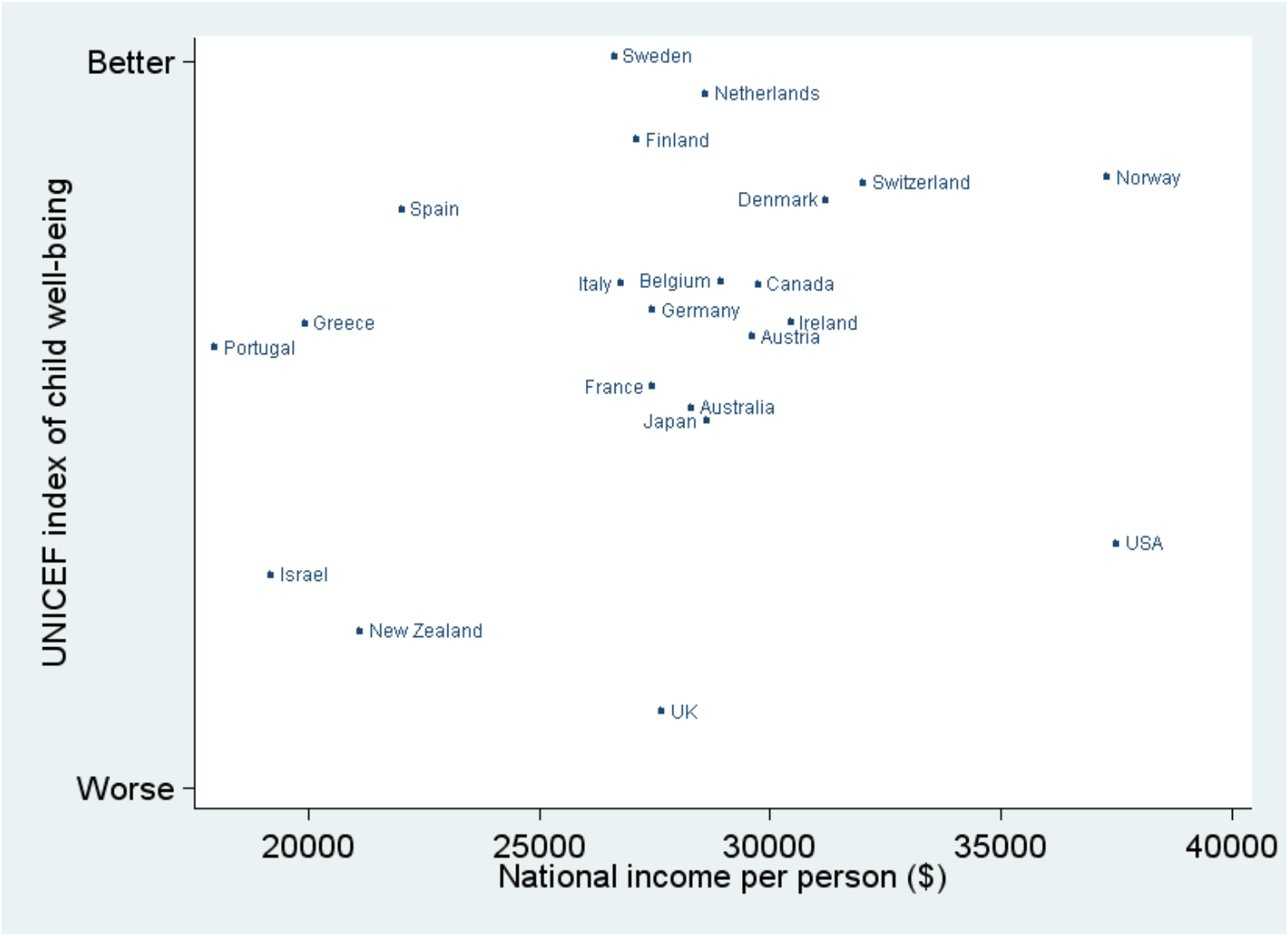


Source: Wilkinson & Pickett, The Spirit Level (2009)

Child-Wellbeing is Unrelated to Average Incomes in Rich Countries



Source: Wilkinson & Pickett, The Spirit Level (2009)

Child Well-being is Better in More Equal Rich Countries

Source: Wilkinson & Pickett, The Spirit Level (2009)

Levels of Trust are Higher in More Equal Rich Countries

Source: Wilkinson & Pickett, The Spirit Level (2009)

Almost everyone benefits from greater equality

Usually the benefits are greatest among the poor, but extend to the majority of the population

The “Wilkinson hypothesis…”

Is universal welfare good for equity and equality in health?

The Lancet 2009: Studies for the WHO Marmot Commission, Olle Lundberg et al

The role of welfare state principles and generosity in social policy programmes for public health: an international comparative study

*Olle Lundberg, Monica Åberg Yngwe, Maria Kölegård Stjärne, Jon Ivar Elstad, Tommy Ferrarini, Olli Kangas, Thor Norström, Joakim Palme, Johan Fritzell, for the NEWS Nordic Expert Group**

Summary

Background Many important social determinants of health are also the focus for social policies. Welfare states contribute to the resources available for their citizens through cash transfer programmes and subsidised services. Although all rich nations have welfare programmes, there are clear cross-national differences with respect to their design and generosity. These differences are evident in national variations in poverty rates, especially among children and elderly people. We investigated to what extent variations in family and pension policies are linked to infant mortality and old-age excess mortality.

Methods Infant mortality rates and old-age excess mortality rates were analysed in relation to social policy characteristics and generosity. We did pooled cross-sectional time-series analyses of 18 OECD (Organisation for Economic Co-operation and Development) countries during the period 1970–2000 for family policies and 1950–2000 for pension policies.

Findings Increased generosity in family policies that support dual-earner families is linked with lower infant mortality rates, whereas the generosity in family policies that support more traditional families with gainfully employed men and homemaking women is not. An increase by one percentage point in dual-earner support lowers infant mortality by 0·04 deaths per 1000 births. Generosity in basic security type of pensions is linked to lower old-age excess mortality, whereas the generosity of earnings-related income security pensions is not. An increase by one percentage point in basic security pensions is associated with a decrease in the old age excess mortality by 0·02 for men as well as for women.

Interpretation The ways in which social policies are designed, as well as their generosity, are important for health because of the increase in resources that social policies entail. Hence, social policies are of major importance for how we can tackle the social determinants of health.

Funding Swedish Ministry of Health and Social Affairs.

Lancet 2008; 372: 1633–40

See Editorial page 1607

See Comment page 1609

*Members listed at end of paper

Centre for Health Equity Studies (CHESS), Stockholm University/Karolinska Institutet, Stockholm, Sweden (Prof O Lundberg PhD, M Åberg Yngwe PhD, M Kölegård Stjärne PhD, Prof J Fritzell PhD); **NOVA, Oslo, Norway** (Prof J I Elstad PhD); **Swedish Institute for Social Research, Stockholm University, Stockholm, Sweden** (T Ferrarini PhD, T Prof Norström PhD, Prof J Palme PhD); **Social Insurance Institution of Finland, Finland** (Prof O Kangas PhD); **and Institute for Futures Studies, Stockholm, Sweden** (Prof J Palme, Prof J Fritzell)

Correspondence to:
Olle Lundberg, Centre for Health Equity Studies, Stockholm University/Karolinska Institutet SE-106 91, Stockholm, Sweden
olle.lundberg@chess.su.se

Introduction

When addressing the wide range of social determinants of health, an equally wide range of policies needs to be considered.[1] In a general sense, social determinants of health consist of resources through which the individual can control and direct their conditions of life.[2] Consequently, lack of such resources will increase the risks for poor health and premature mortality. Resources are generated within the family and in the market, but also through the welfare state. Although there is a range of resources that are important to health, economic resources are central since they can easily be transformed into other types of resources. Also, economic resources can be directly reallocated by the welfare state through social policies, including programmes such as unemployment insurance, sickness insurance, family support, and pensions, and also by means of subsidised or free services such as child care, health care, or elderly care.

There are large variations across welfare states in the guiding principles behind policy schemes as well as the ambition of these schemes. As a consequence, there are large variations in the proportion of the relevant population covered by specific programmes and in how generous these programmes are. In addition to the benefits provided, welfare state institutions and policies can improve people's ability to generate resources in the market, for example through active labour market policies or by implementing policies that enhance women's labour force participation. Thereby, different welfare state set-ups will have consequences in terms of the resources available to individuals, and especially the amount of resources available to those in low-income or middle-income groups.

The Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden) have developed a distinct type of welfare state. Some typical characteristics include universal social policy programmes, equality in opportunities and outcomes as explicit goals for social policies, a large public sector with extensive transfer programmes and services, high employment rates, and high taxes to finance these programmes. Some other

The Lancet 2009: On the advantages of universal coverage, Steinar Westin

Welfare for all—or only for the needy?

"Die Medicin ist eine sociale Wissenschaft und die Politik ist weiter nichts als Medicin im Grossen (Medicine is a social science and politics is nothing but medicine at a larger scale)"

Rudolf Virchow 1821–1902

Over a decade ago, an editorial in *The Lancet* voiced serious concern over the degree to which epidemiology had abandoned its traditional emphasis on issues of obvious importance to public health.[1] Journal papers were increasingly occupied with refining statistical methods to address individual risk factors on a biological and molecular level. Appealing as the potential of molecular epidemiology might be, the editorial argued, "the benefits have not been, and are unlikely to be, at the population level". The editorial called for a conscious effort to restore public health to epidemiology—by, for example, "reorienting its focus to global issues such as war, poverty, and environmental warming and to the social aspects of health and disease". Multidisciplinary cooperation and between-population studies were among a range of suggestions.

If this concern was a call for research with a broader scope and greater public-health relevance, the paper by Olle Lundberg and colleagues from the NEWS Nordic Expert Group in today's *Lancet* could be a long-awaited answer, although it comes not from epidemiologists but from social scientists.[2] Nonetheless, their extensive report[3] to WHO's Commission on Social Determinants of Health[4,5] borders on social epidemiology[6] and undoubtedly addresses a major public-health issue: is there any evidence to show that measures of health are related to welfare-state policies that are based on universal coverage, as in the Nordic countries? This question is not minor, because the alternative, targeted welfare for the needy, has been in vogue for some time, even on the Nordic scene. Lundberg analysed selected cross-national data from 18 countries of the Organisation for Economic Co-operation and Development (OECD) for infant and old-age mortality on an aggregate level to test the hypothesis that the design of welfare-state programmes and their level of generosity might affect these indices of population health.

The original NEWS report (The Nordic Experience: Welfare States and public health) is long, technically complicated, and might not attract a wide readership.[3] In the short version presented today, the authors have selected a few core questions, described their methods so that critical readers can challenge the results, and provided an interpretation which is bound to raise further debate: they show that universal coverage and increased generosity in family policies are associated with lower rates of infant mortality, and generosity in basic universal pensions is associated with lower excess mortality in old age when both are compared with targeted welfare for needy people.

See Articles page 1633

Readers may find it difficult to examine all the authors' decisions about sampling, comparisons, and adjustments for confounders. Furthermore, the differences in mortality rates among most OECD countries are no longer striking. Those in southern Europe with higher mortality rates during the post-war years have largely caught up with northern European countries, and Spanish and Italian women now top the world league of lifetime expectancy. Welfare-state regimes are obviously only one of many conditions affecting public health and longevity. But, in Lundberg and colleagues' paper, there was an association in favour of universal coverage, beyond the assumption that low levels of welfare generosity do affect mortality in outlier countries, such as New Zealand and the USA.

Lundberg and colleagues' paper does not explicitly address social inequalities in health and mortality within countries. The original report does, and shows that absolute levels of mortality in manual workers in Norway and Sweden are lower than in most other countries.[3] However, a much debated issue is that there

Resident of Rost Island, Norway

Is universal welfare good for equity and equality in health?

- where did it begin?
- when did it begin?
- why did it begin?

…Each nation needs to develop its own memory of how solidarity systems were in fact developed through collective struggle,…

Julian Tudor Hart, 2007

The history…?

- a brief history of the Norwegian welfare state

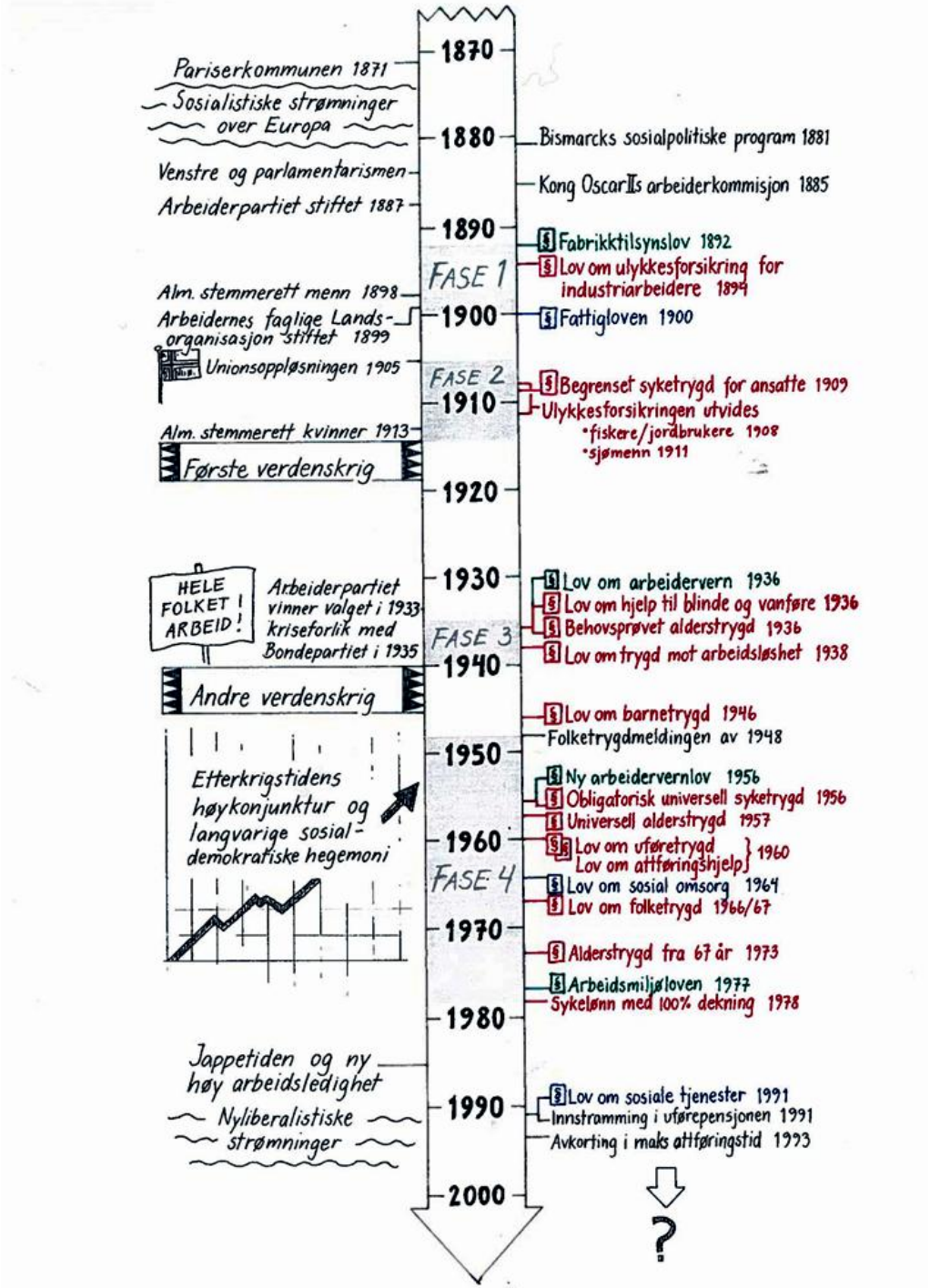
People care about health care…


People care about
health care…

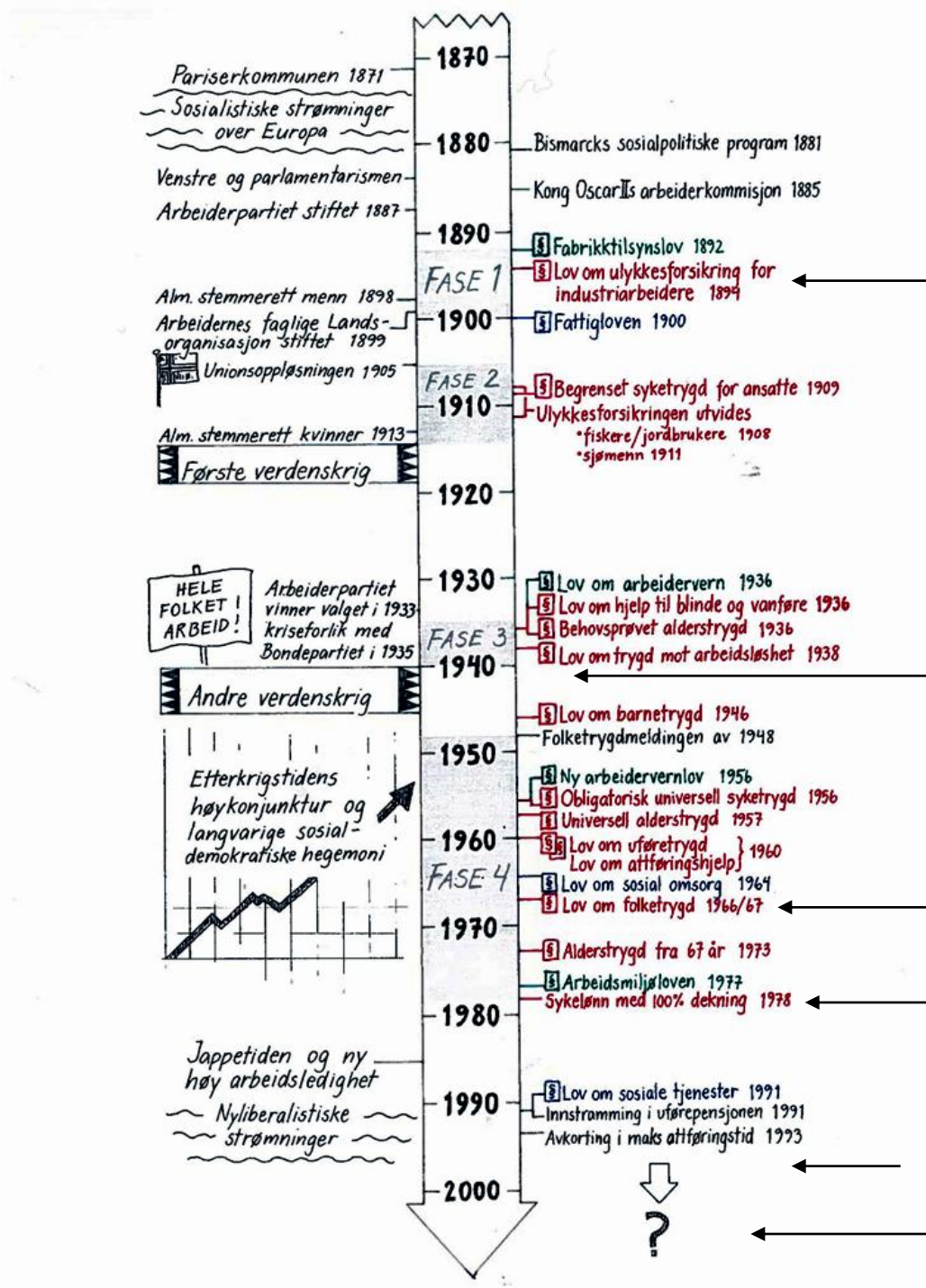
…And so they did in Oslo in 1889 (Fyrstikkarbeiderstreiken i Christiania)

Social unrest, strikes and ”the labour issues”, leading to state legislation

In 1894: First state based disability pension, ”industral labour injury act”



Westin & Pape 1999



Some highlights

1894: First state based disability pension, industral labour accidents

1942 Churchill/ Beveridge commision

1967: Universal coverage, – "Lov om Folketrygd"

1978: Sickness compensation 100 %

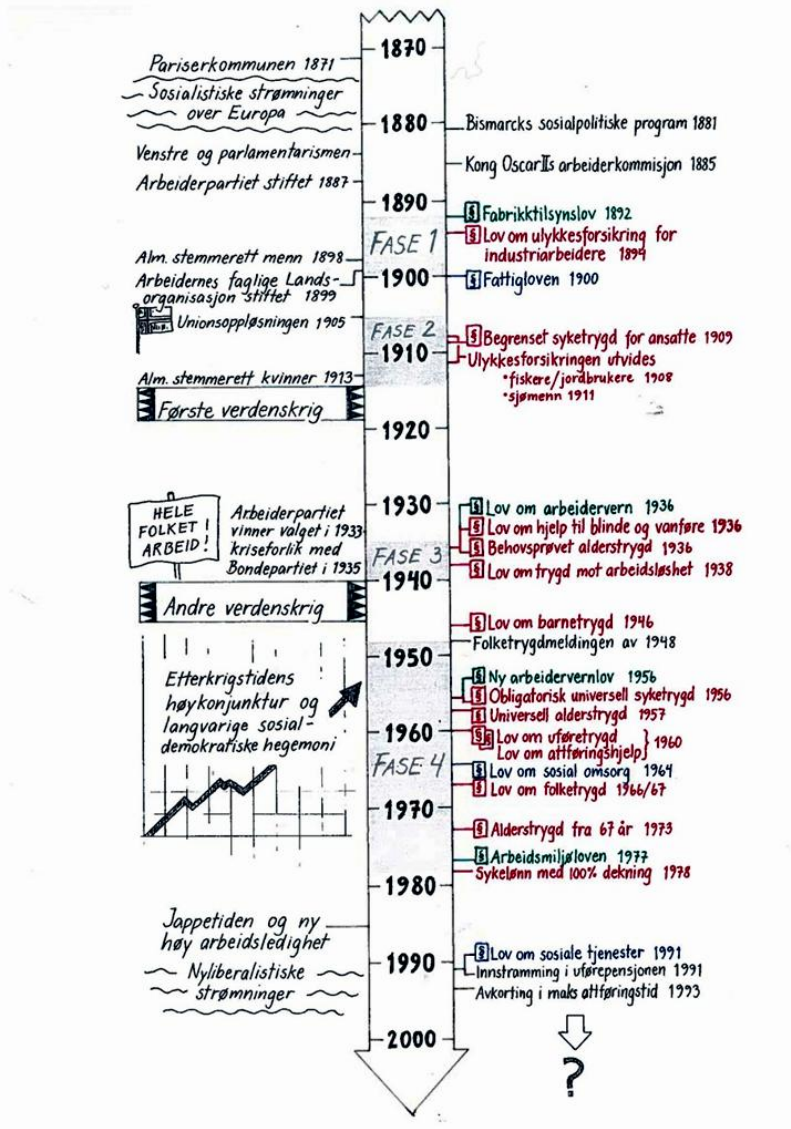
1994 ..celebrating 100 years

?

Otto von Bismarck (1815-98)

…implemented the first European state based social security laws

Symbolically… dynamics of the ”great social contract” – welfare, not warfare

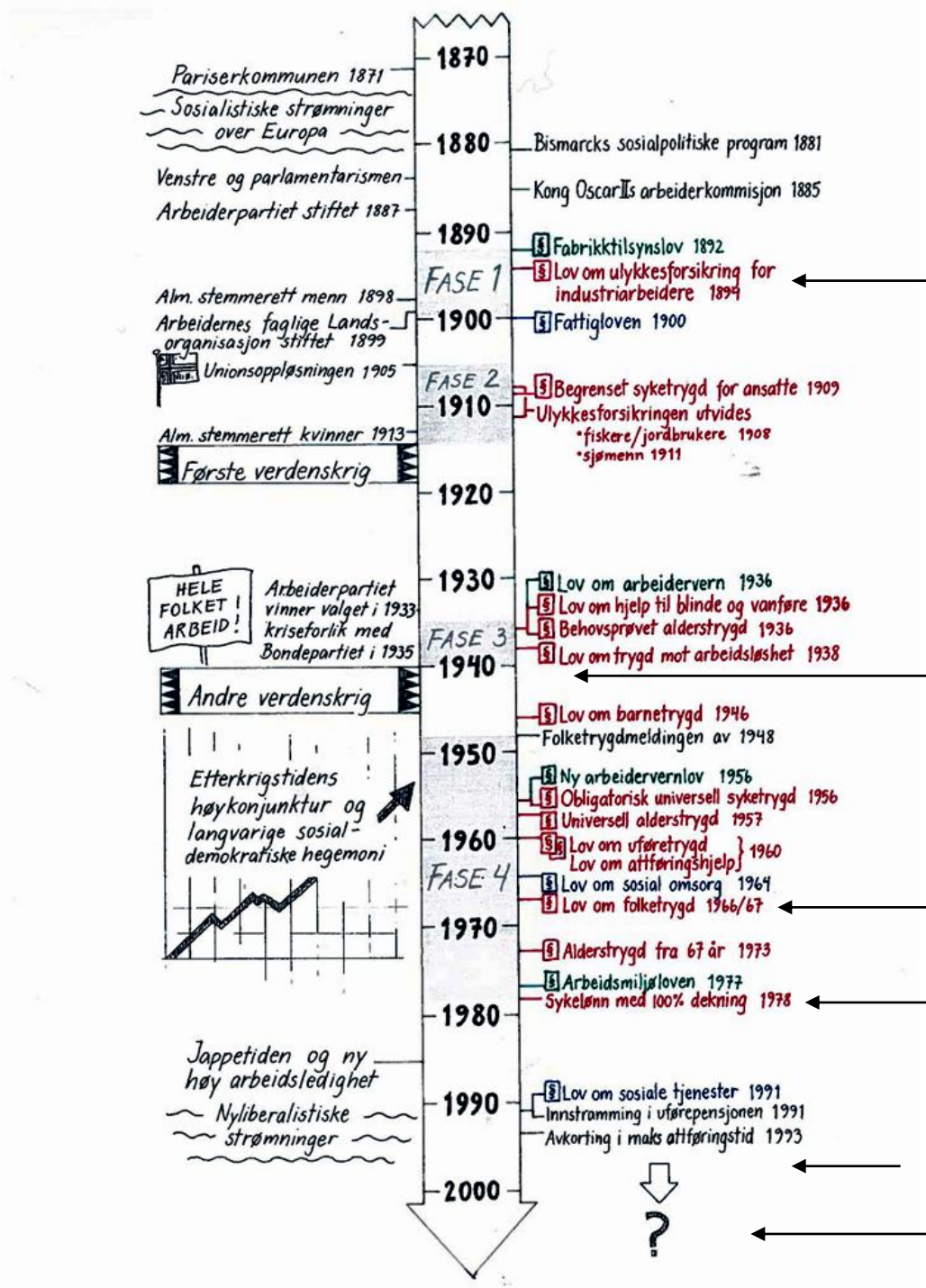


…”The great social contract”

A long lasting process of values and political power – ”the labourist view”

- A process of class struggle and compromises
- reforms instead of revolution
- inspired by ideas of social justice
- and of christian and humanistic values
- democracy and the right for all to vote
- labour unions playing an important role
- redistributive policies and progessive taxation – ”the rich” have to pay more

- but not a stable state…



1894: First state based disability pension, industral labour accidents

1942 Churchill/ Beveridge commision

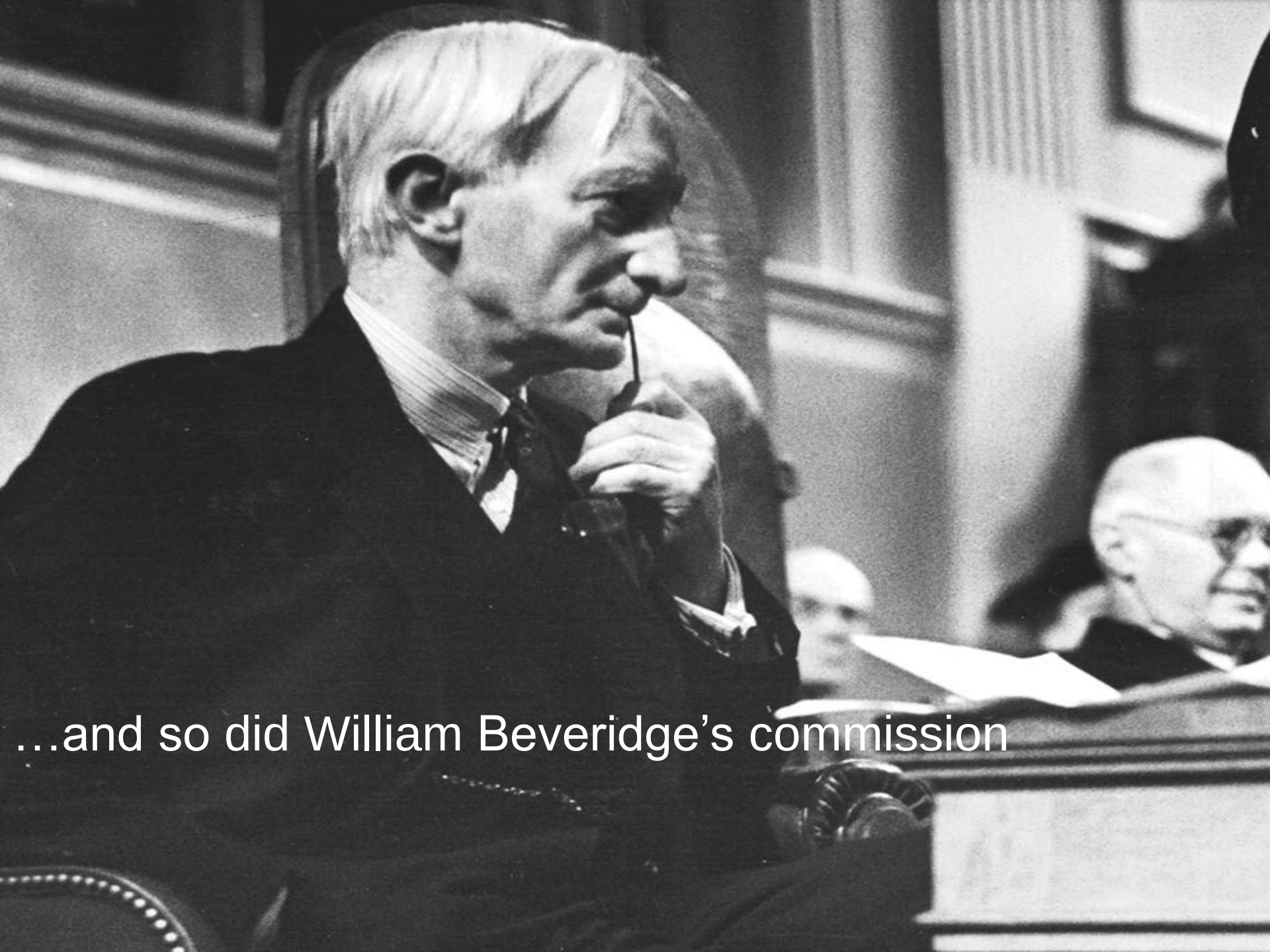
Visions of a welfare state…

… What motivated Winston Churchill and his war cabinette to set up a grand commission for social reforms in 1941 – under the leadership of William Beveridge – at a time when Hitler's bombs were still raining over London, and no one knew for sure how or when the war would end?

…Worth considering, today as well!

Hitler offered comprehensive social programs…

Cappelen, 1991



…and so did William Beveridge’s commission

Visions of a welfare state

The NHS's 50th anniversary

HULTON GETTY

Sir William Beveridge, architect of Britain's welfare state

beliefs about the NHS: a high professional and intellectual standard amidst rather meagre hospital resources, the lasting principle of providing health services "free at the point of use,"[1] and patient registration with general practitioners. The last two features are obviously interrelated and make Britain

a general practitioner may be coming in vogue again, since, apart from providing continuity of care, it seems to be one way of curbing the uncontrolled rise in healthcare costs.[3] It may certainly be a better alternative to what we see in other parts of the world, where rising healthcare costs have caused governments to throw in the towel and leave the problems to market forces. Needless to say, the market just isn't nice to the poor, and the NHS is still a model for providing universal health services according to need rather than according to wealth.

Challenges to the system

However, there have been alarming reports to the contrary.[4] The fundholding reforms of the Thatcher government made some predict the end of the seasoned ideological foundations of the NHS. "Where there were formerly one hundred nurses, there are now one hundred economists," was a saying heard among British doctors, and the relatively low administrative costs of the old NHS have indeed been replaced by increasing costs for negotiations, managing contracts, etc.[5] Market thinking and the metaphors of commodity production seem to have entered the health services on a large scale, and Julian Tudor Hart, the internationally known general practitioner and thinker, wrote about the two paths to health services—either to look at health services as a public responsibility and a human right on which any other market driven economy can flourish, or to let the market

Westin S. The NHS's 50th anniversary: A great leap for humankind? BMJ 1998: 317: 49-51. (William Beveridge in picture)

Modern History Sourcebook:
Sir William Beveridge:
Social and Allied Services (The Beveridge Report), 1942

Social Insurance and Allied Services

Report by Sir William Beveridge

Presented to Parliament by Command of His Majesty

November 1942

HMSO

CMND 6404

What follows is what would these days be called an executive summary of the report, together with the detailed section on Assumptions, Methods and Principles. The full report runs to 300 pages.

THREE GUIDING PRINCIPLES OF RECOMMENDATIONS

6. In proceeding from this first comprehensive survey of social insurance to the next task - of making recommendations - three guiding principles may be laid down at the outset.

7. The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience. Now, when the war is abolishing landmarks of every kind, is the opportunity for using experience in a clear field. A revolutionary moment in the world's history is a time for revolutions, not for patching.

World War II reinforcing ”the great social contract”

Archbishop of Canterbury, William Temple, in 1942 speaking in favour of (and probably coining) *”the welfare state”,* rather than the German *”warfare state”*

Social justice -
implying

Available (free) health services for everyone ("free at the point of use")
…with a list based system for general practice

Available (free) education for everyone

Based on one central principle:

Health care is a universal human right
- not a commodity in a market

Norwegian politicians took part in those discussions, among them the Surgeon General Karl Evang.

The post-war social contract between classes implied a wider social solidarity: The concept of welfare states with, (universal) social security for all, free education for all, and (almost) free health services for all


THURSDAY, MARCH 21, 1946

Evening Standard

FINAL NIGHT EXTRA

GODFREY DAVIS
SLOANE 0022

ONE PENNY

The National Health Bill is out. It will cost £152,000,000 a year

STATE TAKE OVER DOCTORS, HOSPITALS AND DENTISTS

'Free for all'—1948

PRIVATE PRACTICE STAYS, BUT NEW DOCTORS DIRECTED

From 1948 everybody's health will be looked after by the State without fee. That is Mr. Aneurin Bevan's new National Health Service, details of which are published to-day. It is estimated to cost £152,000,000 a year.

It comes under three main heads: the general practitioner service; the facilities to be provided by hospitals which are taken over; and the new Health Centres.

Publication of the plan will begin a great Parliamentary controversy which follows months of discussions outside Parliament. The big Parliamentary battles will be on the taking over of the voluntary hospitals, and the new conditions for the State doctors.

What you get—

Free treatment by doctors and dentists, and you can choose your present doctor or dentist if he takes part in the new scheme.

The relationship between the doctor and any patient on his personal list "will be similar to the ordinary relationship of doctor to patient as it is now known, except that the doctor's remuneration will come from public funds and not from the patient."

Doctors and dentists are to be free to join the new service or not as they choose.

Can they stay outside?

Evening Standard Political Correspondent

Under the new Bevan health plan a doctor who remains outside the scheme will automatically lose the grant made to him for his panel patients and will have to rely on a sufficient number of private patients who wish for medical treatment outside the National Service.

FIGURES

HAMBURG WITHOUT BREAD

Seventy per cent of the people of Hamburg have no bread.

PLANE DIVES ON SCHOOL

200 children at play: All safe

Evening Standard Correspondent: Tunbridge Wells, Thursday

A blazing Mosquito airplane crashed between two buildings of ... girls and infants' schools, near Tunbridge Wells, Kent, during the morning break to-day. Two hundred children in the playground escaped serious injury.

Mothers rushed to the school, but after a roll call it was found that every child was safe. The pilot and co-pilot were killed.

'Steep dive'

Mr. Claude de Bernales

'CIVIL PROCEEDINGS IMPENDING'

Mr. Claude de Bernales, the financier, sent the following statement to the Evening Standard to-day:

JOHN FROST COLLECTION

National Health Service, the NHS reform - 5th July 1948

BMA-doctors voting for - or against - the proposed National Health Service reform in 1948

HULTON GETTY

Bevan turned the NHS into a party political battleground

overcome the voluntary sector's predictable protests at being absorbed by the local authorities. Bevan solved that problem by bringing all the hospitals under the control of national government.

Bevan's decision to nationalise the hospitals provided an early demonstration of independent thought and display of power, which left him free to be unexpectedly flexible in other respects. He was convinced that he needed the hospital consultants on his side and so gave them the right to have private patients and allowed pay beds in NHS hospitals.

To general practitioners he conceded something which had not been on offer from Bevan's wartime Tory predecessor, Henry Willink: their self employed status, with payment mainly through capitation fees. Nevertheless, the BMA waged a long campaign and extracted further concessions. The bad publicity which that campaign caused Bevan gave the government the first warning that the BMA can seriously damage a minister's political health. But it also gave his own party the impression that he was determinedly implementing was also in marked contrast with practice elsewhere. According to Rivett, "few other countries, outside the Eastern bloc, followed the same route" that Britain took.[1] Yet Britain embarked on an uninsured health service with apparently little debate about the principle involved, or its sustainability.

It was a decision of inestimable significance, which owed nothing to previous British practice or experience, was little discussed at the time, and has been rarely queried since. Bevan convinced the British people that the NHS was the best system in the world. You might say that ever since then vested interests have tried to convince us that underfunding has made it the worst. But in both cases we have tended to be insular: few know about other countries' systems.

Following the creation of the NHS, there was almost immediately debate about what was meant by a "free health service." The issue of health service charges was to lead to Bevan's resignation from the cabinet. His adversary was the new Labour chancellor, Hugh Gaitskell, who believed that Bevan had taken too far his idea of a free health service, that it should not extend to providing things like spectacles and false teeth which were not linked to illness, and that prescription charges were needed in order to suppress unnecessary demand. The cabinet even considered charges for hospital stays.

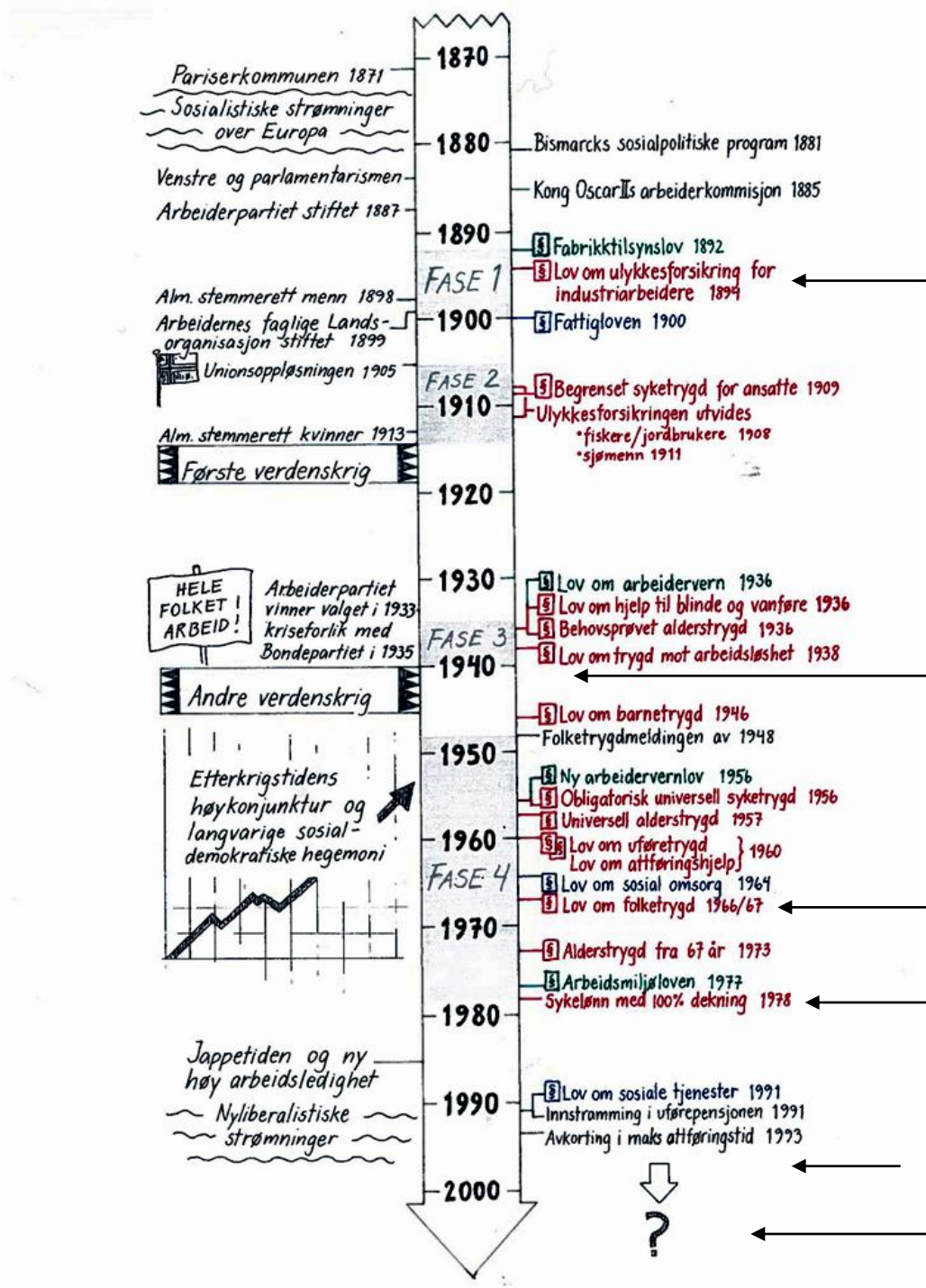
At the time of his resignation, Bevan had failed to convince either the cabinet or the left wing of his party of the matter of principle which mattered enough to him to sink his own career. In an extraordinarily bad tempered speech he increased resentment against him by referring to "my health service." According to Tony Benn's diaries, "He shook with rage and screamed… .The megalomania and neurosis and hatred and jealousy he displayed astounded us all."

Such reports make it really quite surprising that it did become widely accepted that Bevan was the father of the NHS, that his resignation had been on an important matter of principle and that a completely

”A new path entirely”

Secretary of State Aneurin Bevan on the 1948 reform:

”On July 5th there is no reason why the whole of the doctor-patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay fees – an aspect of practice already distasteful to many pratitioners…”



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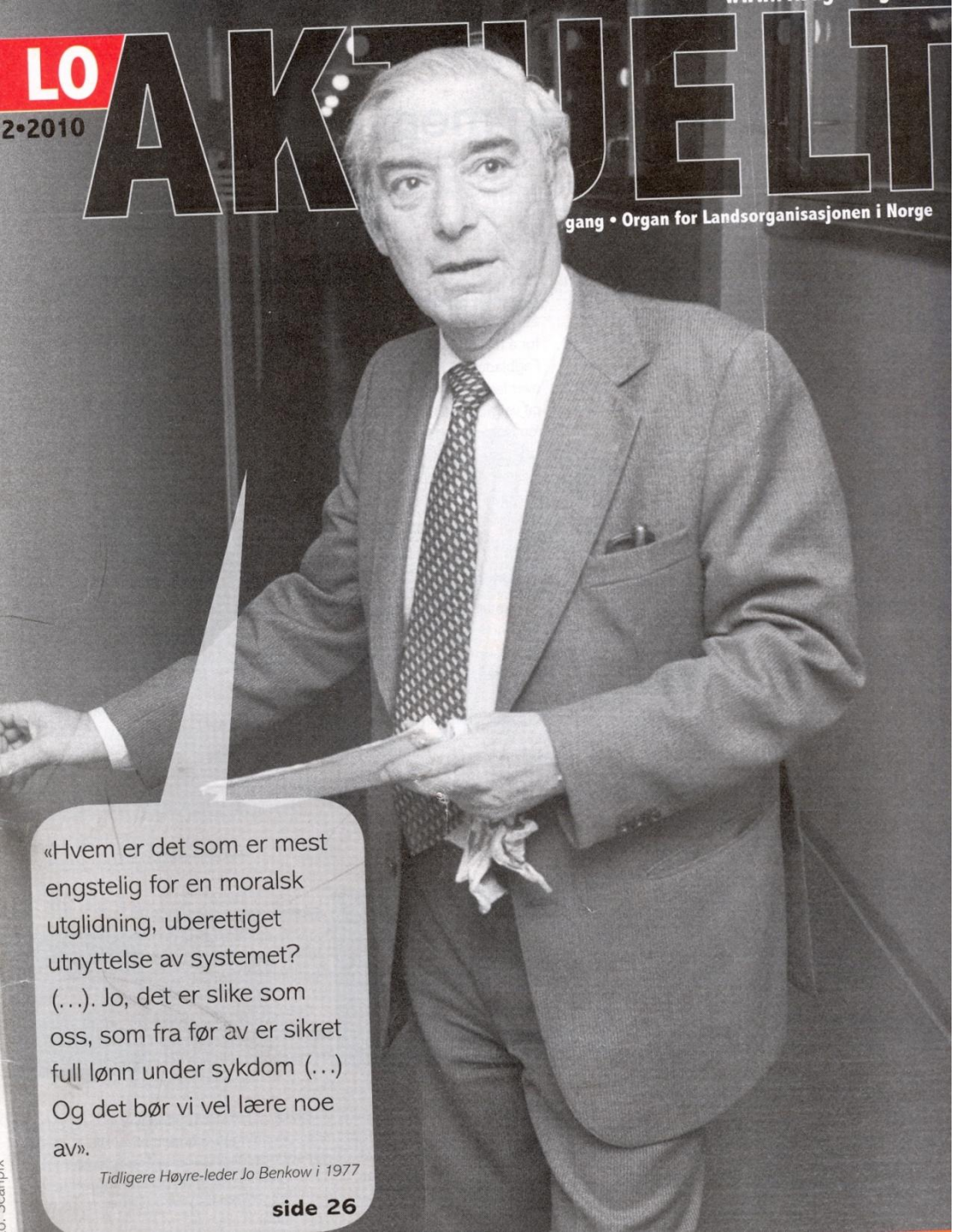
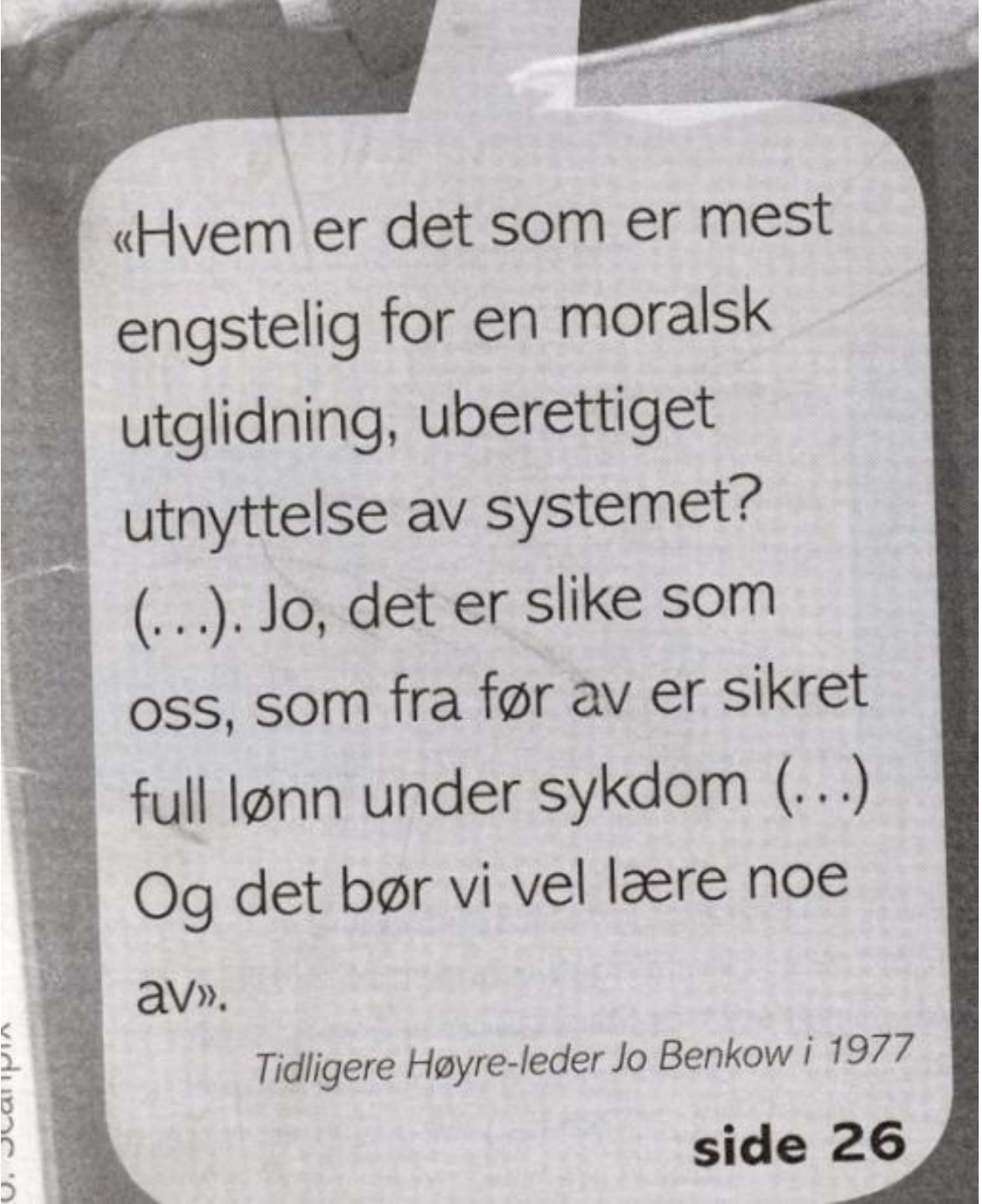


1978:

Sickness compensation 100 %

Conservativ MP: Jo Benkow



From Stortinget 1977:

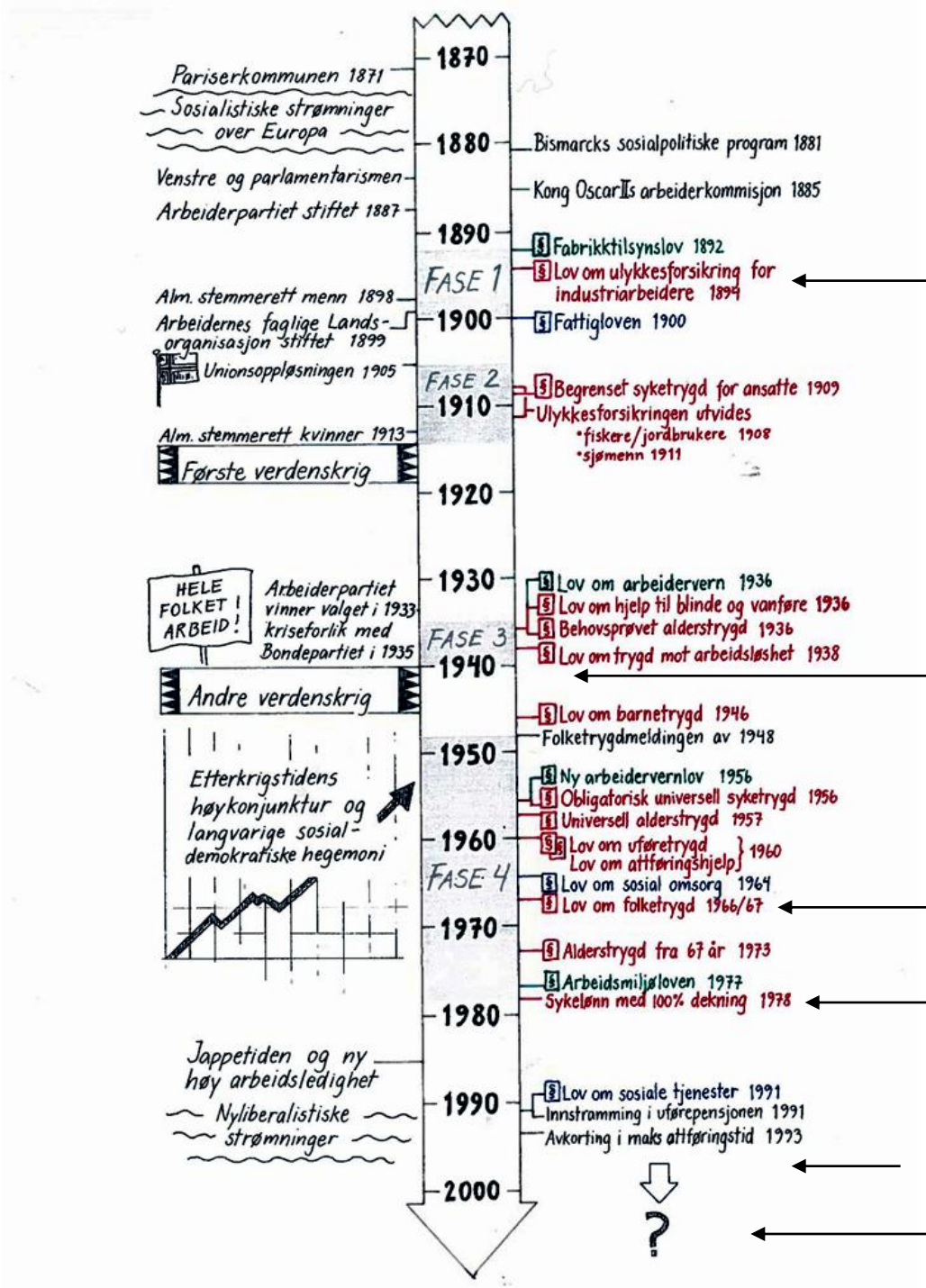
Who are those most afraid of the moral hazard, abuse of the programme?

(…) Yes, people like us, those who already have a full (100 %) sickness compensation.

(…). We may learn from that

Conservativ MP Jo Benkow

When discussing compensation levels, the language was about *social justice*, now it is about *incentives for work*



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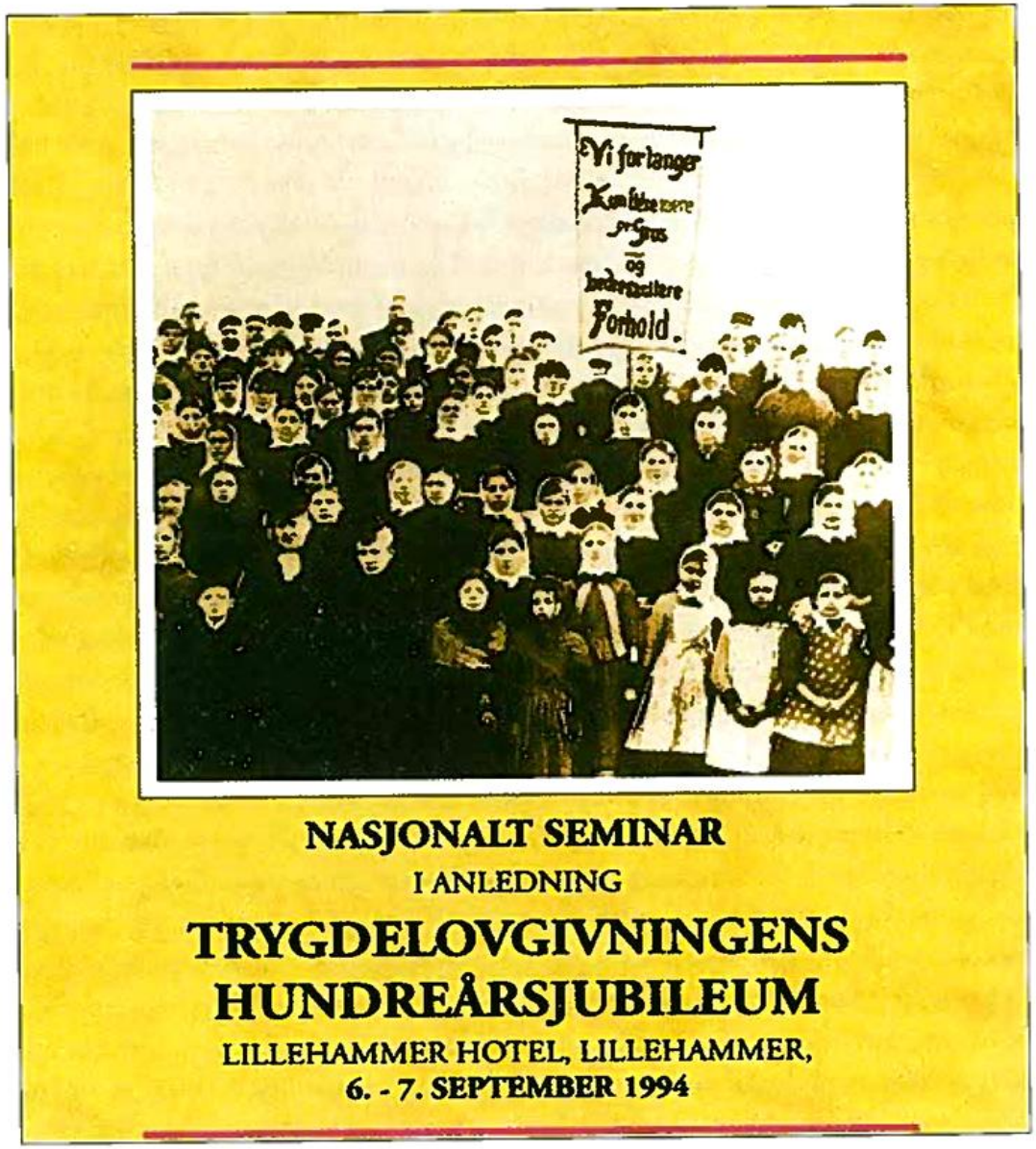

Figur 6.1 Faksimile av brosjyre fra feiringen av trygdelovgivningens hundreårsjubileum i 1994. Forsidebildet er fra fystikkarbeidernes streik i 1889, der også legen Oscar Nissen (1843–1911) var med i streikekomiteen. «Da fystikkarbeiderne i Kristiania gjorde streik, tog N. varmt disses parti, og snart efter gikk han ind i det socialdemokratiske parti, hvis formand han var fra 1906 til sin død», står det å lese i 1996-utgaven av *Norges leger*.

1994: Norwegian welfare legislation celebrating 100 years

The future

?

…not so bad

- The Nordic countries – at the top in many rankings…
- The welfare system established long before ”the oil”
- The bumble bee *can* fly
- High level of trust (ESS)
- High motivation for work (van der Wel & Halvorsen)
- Low unemployment (but recession does harm…)
- High rates of work participation

- but

- High on medicalized welfare
- Increasing disparities in wealth and health
- …as well as in social gradients in mortality
- Welfare reforms silently being rolled back
- A deeply ”unsocial” pension reform (Norway)
- …and OECD constantly telling us we need to lower taxes and roll back social welfare

Consequences of the pension reforms:

those with shortest education and the most health deteriorating and/or physically demanding jobs leave the labour force earlier
= reduced levels of compensation

those with shortest education have shorter life time expectancy, and will therefore get a lower return
= fewer years on a lower pension

What are the consequences of the present cut-backs and restructuring of European welfare and public health services?

…worries?

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Forskjellene øker raskere i Norge

NTB

Publisert: 26.05.2011 - 07:34 Oppdatert: 26.05.2011 - 08:23

Forskjellen mellom de rikeste husholdningene og de som har minst øker raskere i Norge enn gjennomsnittet i OECD-landene, ifølge ny rapport.

Ifølge rapporten fra Organisasjonen for økonomisk samarbeid og utvikling

DN.no 26.05.11

New OECD-report:

Inequities increase faster in Norway

Foto: Raymond Nilsson

KUTT I EUROPAS VELFERD KAN TA LIV

Forskere ved universitetet i Oxford advarer mot de drastiske kuttene i sosiale velferdsordninger som flere europeiske land nå gjennomfører. De har analysert sosialbudsjettet gjennom 25 år i 15 europeiske land, og konkludert med at det er nær sammenheng mellom hvor mye penger et land bruker på helsevesenet og støtteordninger til arbeidsledige, funksjonshemmede og småbarnsfamilier, og risikoen for at innbyggerne skal lide en for tidlig død. Kilde: British Medical Journal.

Seen the jokes?
RIP
”Rest in peace”:
Welfare and social services

- Er velferdsstaten truet?
- Står velferdsstaten under press i dagens Norge?
- Hva skjer i så fall med velferdsstaten – og hvorfor?

I denne boka legger forfatteren fram en analyse av velferdsstatens framvekst, med fokus på de maktpolitiske betingelsene og ut fra et utvidet velferdsstatsbegrep. Han viser hvordan maktforholdene er endret som et resultat av den markedsliberalistiske offensiven fra omkring 1980. Dernest beskriver han hvordan sterke kapitalinteresser og markedsliberalister motarbeider og undergraver de viktigste institusjonene som holder velferdsstaten oppe, nemlig fagbevegelsen og demokratiet.

Den mest sentrale kamparenaen av alle, arbeidslivet, blir drøftet inngående. Særlig påvises det hvordan politikken bak arbeidslinja representerer et brudd med velferdsstatens prinsipper. I stedet for at man angriper de samfunnsmessige drivkreftene, utvikler man en undertrykkende disiplineringspolitikk overfor ofrene for et stadig mer ekskluderende arbeids- og samfunnsliv.

I boka antyder forfatteren hvordan vi kan bekjempe den markedsliberalistiske offensiven og forsvare velferdsstatens landevinninger; ved en gjenoppliving av den politisk-ideologiske kampen, en bred alliansepolitikk, utvikling av konkrete alternativer til de markedsliberalistiske reformene – samt gjennom sterkere politisk selvstendiggjøring av fagbevegelsen.

Rise and fall of the welfare state?

9 788205 387799
GYLDENDAL ARBEIDSLIV

"The welfare trap"

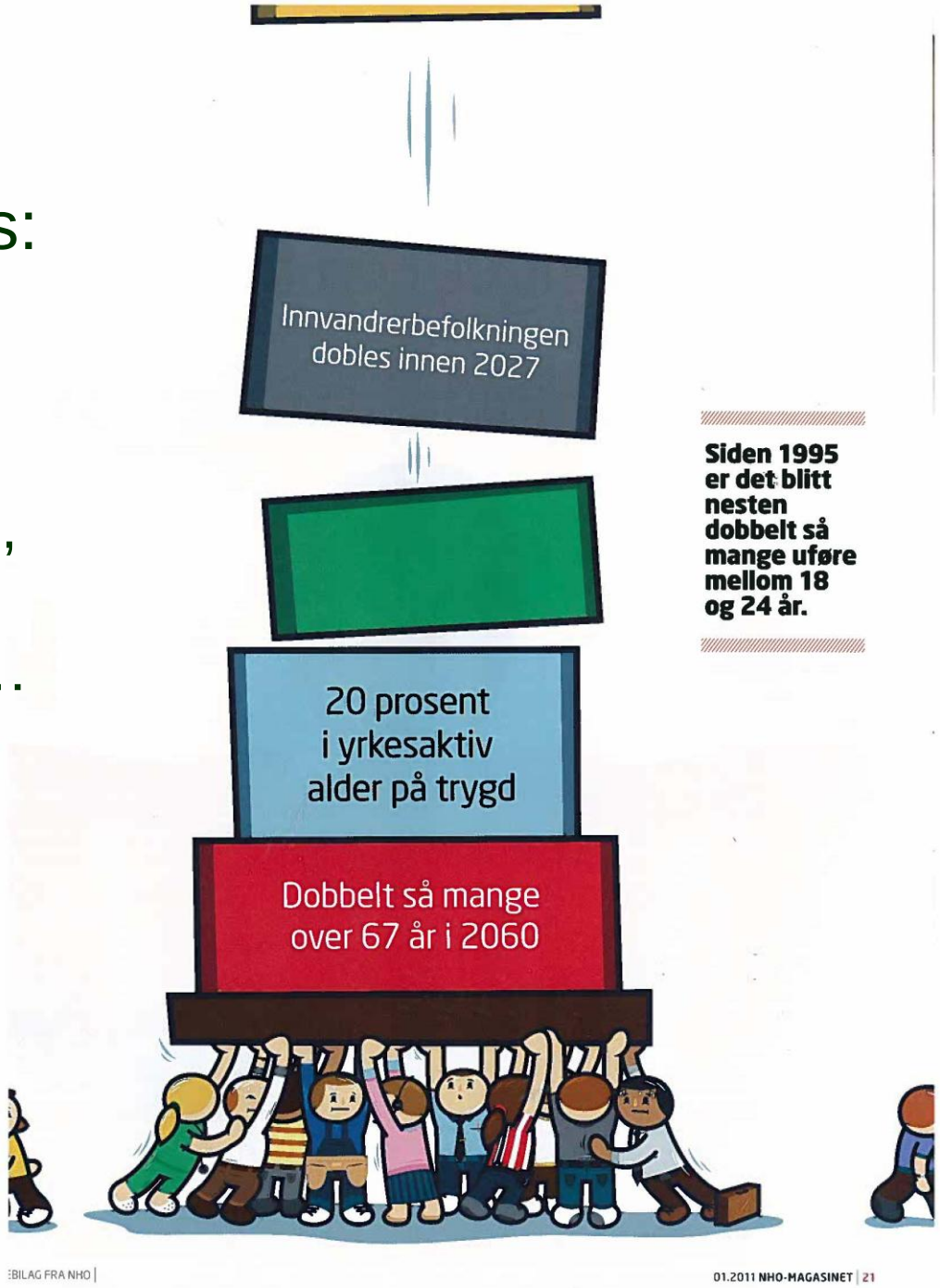
LES MER OM VELFERDSFELLEN:
LIVSLØGN I OLJELANDET
IVAR FRØNES OM RIKDOMMENS PRIS SIDE 18
VELFERD VED OLJENS SLUTT
FAKTA OM VELFERDSSTATEN SIDE 20
FANGET I EN FELLE
KNUT RØED OM PUSH- OG PULLFAKTORER SIDE 22

Velferdsfellen

Tre store trender vil prege oss allerede i vår levetid: Eldrebølgen, migrasjonsbølgen og trygdebølgen. Gjør vi ikke noe med dette, risiker vi å havne i velferdsfellen. Velferdsstaten har et finansieringsproble

New rethorics:

A ”tsunami”…?
of the elderly
and immigrants,
and people on
social security…



Fighting over facts…

Storbritannia, sier Aavitsland. ©NTB

Stavanger Aftenblad. ©NTB en slik topp var i 2008, da forbrul

NHO går i fakta-fella

BLØFF: NHO slår alarm om «trygdebølgen». I virkeligheten får vi færre uføretrygdede og lavere sykefravær. – De blåser opp tallene, sier LO-leder Roar Flåthen.

NHOs årskonferanse: VELFERDS-FELLEN

Av Johan Brox og Mimir Kristjánsson

– Gjør vi ikke noe med dette, risikerer vi å havne i velferdsfella, hevder Næringslivets Hovedorganisasjon (NHO).

Men organisasjonen går selv rett i faktafella. Stikk i strid med hva NHO hevder er ikke andelen utenfor arbeidslivet sterkt økende:

- En mindre del av befolkningen er på uføretrygd enn i 2001, ifølge Nav.
- Sykefraværet har minket fra år 2001 til i dag, ifølge Statistisk sentralbyrå (SSB).
- Arbeidsdeltakelsen ligger stabilt over 74 prosent. Det er

konferansens nettsider melder NHO at «andelen utenfor arbeidslivet har vært sterkt økende de seinere årene».

LO-leder Roar Flåthen reagerer sterkt på det han oppfatter som en skremmekampanje fra NHO.

– I motsetning til andre land i Europa har vi svært gode resultater. Gjør vi de riktige politiske valgene, er det ingenting som tilsier at vi ikke skal greie å opprettholde dagens velferdsordninger, sier Flåthen.

Han vedgår at det er en utfordring å få flere inn i arbeidslivet, men kjenner seg ikke igjen i NHOs «trygdebølge».

– De blåser opp tallene, og tegner et skremmebilde av situasjonen. Det er ingen kunst å gjøre det,

Roar Flåthen

sier NHO i sitt konferansemateriell.

Ifølge Navs statistikk mottok imidlertid 9,5 prosent av befolkningen uførepensjon i 2010, ned fra ti prosent i 2001.

Uføreandelen synker i alle aldre, unntatt dem mellom 18 og 24 år, som øker marginalt. Totalt er det snakk om 1211 flere unge uføretrygdede på ni år. I tillegg kommer mottakere av arbeidsavklaringspenger, som ikke er varig uføretrygd.

Flåthen advarer mot å stigmatisere uføre.

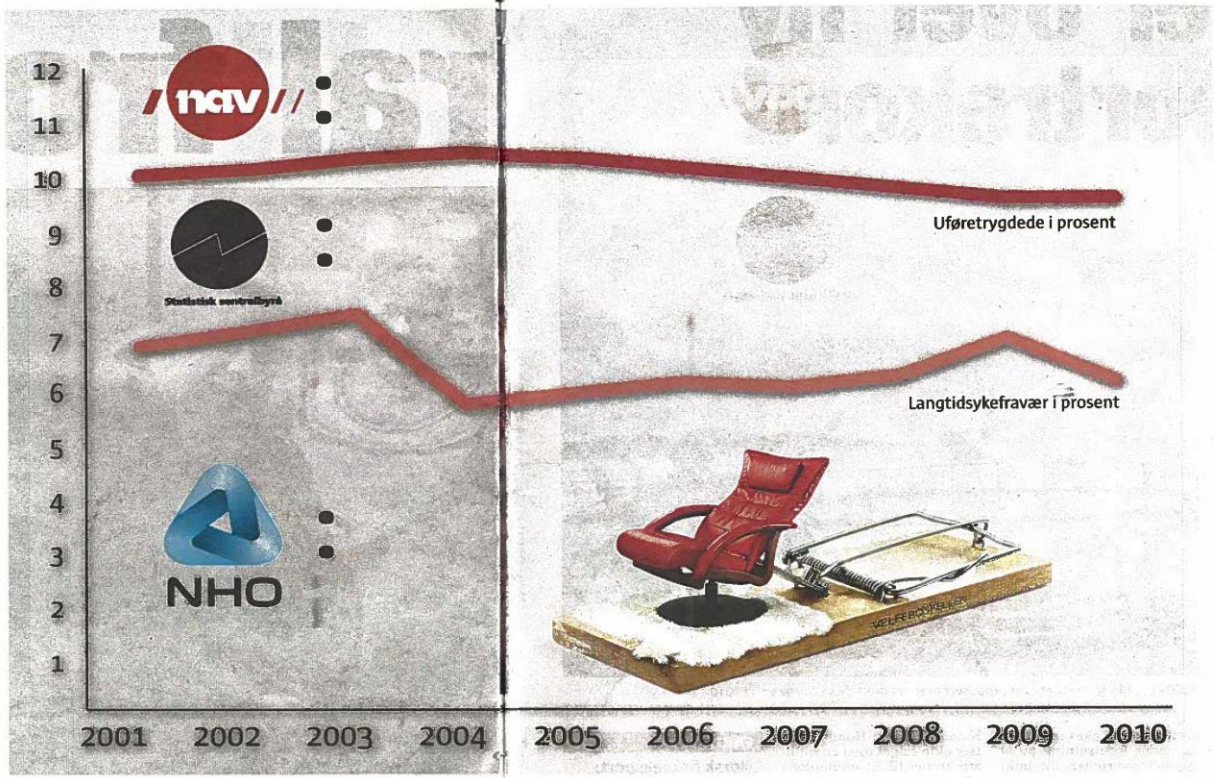
– Vi må ikke gjøre de trygdede til syndebukker. Vi må utarbeide et raust og inkluderende arbeidsliv, men da må også NHOs medlemsbedrifter ta sin del av ansvaret for det, sier han.

Han sier LO er villig til å være med å diskutere tiltak for å få flere uføre i arbeid, men setter foten ned på ett punkt:

– Vi blir ikke med å diskutere kutt i trygdeytelsene. Punktum.

På arbeidstoppen

Også SSBs sykefraværsstatistikk strider



ULIKE VERSJONER: Ifølge Nav og Statistisk sentralbyrå står vi ikke overfor noen velferdskrise. Likevel plasserer NHO lenestolen i musefella i logoen til sin årskonferanse. GRAFIKK: KLASSEKAMPEN

ret, også kalt langtidssykefraværet, viser tilsvarende utvikling: Hoppet fra høsten 2008 er fullstendig reversert, nå som svineinfluensaalarmen har stilnet.

OECD, organisasjonen som representerer de rikeste land i verden og dermed brorparten av Norges handelspartnere, er heller ikke tvil: Norge ligger på verdenstoppen i arbeidsdeltakelse.

I 2009 var 76,5 prosent av alle nordmenn i arbeid, mens gjennomsnittet for alle 34 OECD-land ligger helt nede på 64,8 prosent – på linje med USA etter finanskrisa.

Arbeidsdeltakelsen i Norge

kampen presentere tall fra Synovate som viser at 41 prosent forventer at det blir dårligere velferdsordninger i framtida. Bare ti prosent sier de tror velferdsordningene blir bedre.

– Vi har alle forutsetninger for å videreføre våre gode velferdsordninger. Men det er klart at dersom Høyre og Frp kommer til makten, og organisasjoner som Civita og NHO får gjennomslag for store skatteletter, vil det være den største utfordringen mot det velferdsnivået vi har i dag. Jeg

– Freidig av NHO

Asbjørn Wahl leder organisasjonen For velferdsstaten, som bestilte notatet fra forskingsstiftelsen De Facto.

Han mener det er «bemerkelsesverdig at en seriøs aktør som NHO har en så omtrentlig omgang med fakta». Særlig reagerer han på NHOs påstand om at Norge må akseptere større forskjeller når de trygdede skal tvinlikner Norge mest, det vil si har små sosiale forskjeller, sier Wahl.

I notatet er De Factos resonnement at når Norge har trygdeytelser og relativt høy minstelønn, vil ikke arbeiderne «låses inn i lavproduktive næringer», siden man ikke har råd til å sløse med arbeidskrafta

Også Julie Lødrup, leder av tenketanken Manifest Analyse, reagerer på NHOs trygdebølge-alarm.

– Det er direkte usant når NHO hevder at en stadig større andel er utenfor arbeidslivet. Statistikken viser at sysselsettingen har steget jevnt og trutt i 30 år. Vi reg-

And the annual OECD reports, ”warning” Norway:

Sick leave compensation too good

Norwgian work too little

Taxes are too high

etc

RAKA FANT

– Men nå trenger vi penger til høstens valgkamp for å få fornyet tillit. . .

Mer av gal medisin

Aftenposten 12.03.09

Sist helg tok jeg meg bryet med å lese den helt ferske rapporten fra OECD i Paris om forholdene i norsk arbeids- og trygdeliv.

Våre trygdeordninger er stadig for generøse, mener de derfra. Rehabiliteringspenger og attføringsstønad bør jekkes ned til samme nivå som arbeidsledighetstrygden, fra 66 til 62 prosent av tidligere lønn.

Men Nav-reformen skriver de pent om. Særlig om hvor viktig det er å videreutvikle sammenslåingen med sosialkontorene, slik at de ansatte på de tidligere trygdekontorene, Aetat og sosialkontorene kan få en felles identitet. De vil innføre sterkere ledelse med en «single chain of command», målstyring og resultatrapportering. Slike anbefalinger har de gitt til Norge i flere år. Vi kjenner dem igjen i forarbeidene til Nav-reformen.

Alt dette skal være virkemidler for å effektivisere arbeidet med å få de arbeidsledige og dem med sykdomsplager tilbake i arbeid. Bra det. Men rapporten berører ikke hva slags mekanismer som opprinnelig bidro til å jage folk ut av jobbene og over på sykdomsrelaterte trygdeordninger. De må jo komme fra et sted, alle disse som opplever at helsa ikke er forenlig med det arbeidslivet krever. Men slikt er altså ikke av interesse for økonomene i OECD.

Naturligvis er det flere årsaker til at folk sykmeldes, ikke minst sykdom. Men mange med sykdomsplager er også i jobb. Det er fra denne store porsjonen av halvsyke at vi stadig får nye kandidater til uførepensjonen. Vi

Konkurranse-emissærene fra ESA vasser gjennom norsk samfunnsliv med sine ødeleggende meldinger, som zombier som ikke forstår at deres tid er ute.

På den annen side

Steinar Westin

Prof. i sosialmedisin NTNU og fastlege Tempe legesenter

får dem, vi fastleger, når skruen dras til, på en eller annen måte, ved oppsigelser eller omstillinger eller andre hendelser på jobben som synliggjør at de ikke er «friske nok». Det er trykket av disse hendelsene som på merkelig vis ikke diskuteres. Som om dette ligger utenfor politikkens virkeområde.

Min mistanke er at denne siden av prosessen ikke diskuteres fordi det er ubehagelig. Det rokker ved tidens vedtatte sannheter om at konkurranse er bra, på nær sagt alle felt, og at hver liten enhet skal være økonomisk lønnsom, ikke bare i det private næringsliv, men siden 1990-tallet også i offentlig sektor. Nå skal alt ha en prislapp, alle skal sende regninger til hverandre, kostnader skal synliggjøres i alle enheter, konsesjoner og konkurransehindrende ordninger skal oppheves, og det meste skal på anbud. Kort sagt, mer marked, mer pengestyring, og mer av såkalt New Public Management i offentlig sektor. Det er dette OECD vil ha mer av. Fordi de fortsatt tror det er effektivt.

Nå er vi ikke lenger så sikre på det. Det kommer stadig forskningsrapporter som dokumenterer at disse spillereglene skaper en masse kostbart byråkrati, og dertil gjør at enkeltpersoner mobbes ut som ulønnsomme. Slik at vi får stadig flere i attføringskøen. Som videre har ledet politikere til å innføre Nav-reform og knappere trygdeytelser.

Kanskje var det et sammentreff at jeg nå i helgen hørte nyheten om at det europeiske overvåkingsorganet ESA vil anmelde den norske regjeringen til en eller annen domstol for konkurransevridende subsidiering av Hurtigruten. Den ble som kjent nylig berget av en samferdselsminister, til glede og nytte for hele kysten. Men til ergrelse for ESA. Og at det på bordet mitt også ligger et avisutklipp om at Posten skal konkurranseutsettes enda mer, også for brevpost, med undertittel: «Vi får et dyrt, dårlig og distriktsfiendtlig postvesen i 2011 om regjeringen følger EU». Er det noen som kan være i tvil om at disse institusjonene også vil rekruttere til uførepensjonen, dersom ESA vinner fram?

Jeg ser for meg et bilde av disse konkurranse-emissærene fra ESA som vasser gjennom norsk samfunnsliv med sine ødeleggende meldinger, som zombier som ikke forstår at deres tid er ute. Det er på tide at vi ser det. Og at vi avskilter dem. Vi har faktisk utviklet bedre oppskrifter i Norden på samvirke mellom privat næringsliv, støtteordninger og offentlig sektor. Det er liten grunn for oss i Norge til å ta mer av den gale medisinen.

steinar.westin@ntnu.no

I den royalistiske himmel.
Kong Olav: – Godt, min kronprinsesse, at vi rakk å gifte oss før politikerne visste bedre . . .

Krigen om velferdsstaten

I dagens arbeidsliv er det snart bare de rikeste og friskeste som greier å henge med i jobb til de fyller 67.

Ikke alle kriger føres med skarpe våpen som i Irak og Afghanistan. Noen går stillere for seg og utkjempes med andre midler. En stillferdig krig foregår nå om dagen om velferdsstatens og de nordiske velferdsordningenes framtid.

Slagmarkene er ikke umiddelbart synlige, men vi skal ikke undervurdere betydningen av utfallene på litt lengre sikt. Før den siste valgkampen dreide det seg om å gjøre arbeidsmiljøloven mer «fleksibel», da Victor Norman ville svekke oppsigelsesvernet og tøye grensene for overtid. Så kom NAV-reformen. I høst var det sykelønnsordningen, og i vår er det EUs tjenestedirektiv og pensjonsreformen.

> **For dem som ser verden ovenfra er det stadig et problem at velferden er «for dyr»**

Krigen dreier seg om velferdsstatenes to viktigste bærebjelker, arbeidervernlovgivningen og folketrygden. Begge har røtter tilbake fra slutten på 1800-tallet, da «arbeiderspørsmålet» for alvor kom på dagsorden. Det ny-industrielle Europa var i omforming. Revolusjonære bevegelser satte dagsorden. For makthaverne gjaldt det « . . . å holde den også innen vår arbeiderbefolkning begynnende bevegelse i sunne og sindige spor», som det het i Indredepartementets begrunnelse i 1885 for å foreslå en kommisjon til å utrede en fabrikktilsynslov og en statlig ulykkesforsikring for arbeidere, to lover som ble starten på det byggverket vi i dag omtaler som «velferdsstaten».

På den annen side

Prof. i sosialmedisin NTNU og fastlege ved Tempe legesenter
STEINAR WESTIN

Selve ordet velferdsstat er forresten atskillig yngre – foreslått av en biskop, erkebiskopen av Canterbury, William Temple, som i 1941 entusiastisk støttet bevegelsen for det han kalte et «welfare society», som motsats til Hitler-Tysklands «warfare society». Det gjaldt å skape visjoner for et samfunn som det var verdt å kjempe for – til og med dø for – enten man var arbeider eller aristokrat. Fordeling og sosial rettferdighet var oppskriften. De rike måtte gi av sin rikdom gjennom skatter og omfordeling. En slags revolusjonsforsikring. Det nye fellesskapet skulle sikre gratis utdanning og gratis helsetjeneste for alle. I dag er det de nordiske landene som mer enn noen bærer denne visjonen videre.

På 1990-tallet ble de nordiske velferdsstatene dømt nord og ned av verdens ledende økonomer, de som forfektet den nyliberale og grenseløse samfunnsorden. Velferden var for «dyr» og arbeidslivet for lite «fleksibelt». Vi er blitt vant til ekkoet fra det årvisse OECD-oraklet.

Men nå har pipen fått en annen lyd. I februar deltok jeg i 25-årsjubileet for Fagbevegelsen forskningsinstitutt, der Terje Rød-Larsen og Gudmund Hernes & co feiret Fafo's bidrag til samfunnsforståelsen, både her hjemme og ute i verden. To dager med høyt profilerte bidragsytere, også en kjent Harvard-økonom, bekreftet det jeg leser og hører stadig oftere: Rundt om i verden ser man med undring – og beundring – på at de nordiske økonomiene og sosiale systemene fremstår som både bærekraftige og vitale.

Men for dem som ser verden ovenfra er det stadig et problem at velferden er «for dyr». Dette synet har også preget pensjonsreformen. Regjeringen har arvet et såkalt bredt forlik fra Bondeviks tid, som innebærer at folk flest skal få alderspensjon etter hvor mye de har betalt inn i folketrygdavgift, med langt mindre omfordeling fra rik til fattig enn tidligere. Noen av mine pensjonskyndige kolleger påstår at vi nå forledes til å ta spranget fra en «solidaritets-folketrygd» til en «forsikrings-folketrygd». Krigens fremste slagord er at «det skal lønne seg å arbeide».

Tygg på betydningen av det motsatte: Det skal ikke lønne seg . . ., om du ikke henger med i jobb til du fyller 67. I dagens arbeidsliv er det snart bare de rikeste og friskeste som greier det. Hvis ikke, skal du straffes økonomisk inntil døden. Bokstavelig talt. Skal det bli en ny seier for de rikeste?

steinar.westin@ntnu.no

Adresseavisen 12.04.07

Program for forskning om årsaker til sykefravær og utstøting fra arbeidslivet

Nordisk forskerkonferanse 2011

Sykefravær og uførhet i Norden. Velferdsordninger under press?

Thon Hotel Lofoten, Svolvær, Norge

Søndag 29. mai

18:00-19:00 ***Åpning av konferansen***
Programstyreleder, professor Steinar Westin, Institutt for samfunnsmedisin, NTNU, Norge

Hur mår den Nordiska modellen?
Professor Joakim Palme, Direktør ved Institutet för framtidsstudier, Sverige

Symbolically… dynamics of the ”great social contract” – welfare, not warfare

?

The dynamics still shaping the future of welfare

…worries?

- increasing commodification of health
- increasing commercialisation of health
- increasing medicalisation – destabilising…
- increasing inequities in health?
- Increasing inequities in the health services?
- More market mechanisms – more inequities?

The Lancet · Saturday 27 February 1971

THE INVERSE CARE LAW

JULIAN TUDOR HART
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Interpreting the Evidence

THE existence of large social and geographical inequalities in mortality and morbidity in Britain is known, and not all of them are diminishing. Between 1934 and 1968, weighted mean standardised mortality from all causes in the Glamorgan and Monmouthshire valleys rose from 128% of England and Wales rates to 131%. Their weighted mean infant mortality rose from 115% of England and Wales rates to 124% between 1921 and 1968.[1] The Registrar General's last Decennial Supplement on Occupational Mortality

interpreted either as evidence of high morbidity among high users, or of disproportionate benefit drawn by them from the National Health Service. By piling up the valid evidence that poor people in Britain have higher consultation and referral rates at all levels of the N.H.S., and by denying that these reflect actual differences in morbidity, Rein [2,4] has tried to show that Titmuss's opinion is incorrect, and that there are no significant gradients in the quality or accessibility of medical care in the N.H.S. between social classes.

Class gradients in mortality are an obvious obstacle to this view. Of these Rein says:

"One conclusion reached . . . is that since the lower classes have higher death rates, then they must be both sicker or less likely to secure treatment than other classes . . . it is useful to examine selected diseases in which there is a clear mortality class gradient and then compare these rates with the proportion of patients in each class that consulted their physician for treatment of these diseases. . . ."

He cites figures to show that high death-rates may be associated with low consultation-rates for some diseases, and with high rates for others, but, since the pattern of each holds good through all social classes, he concludes that

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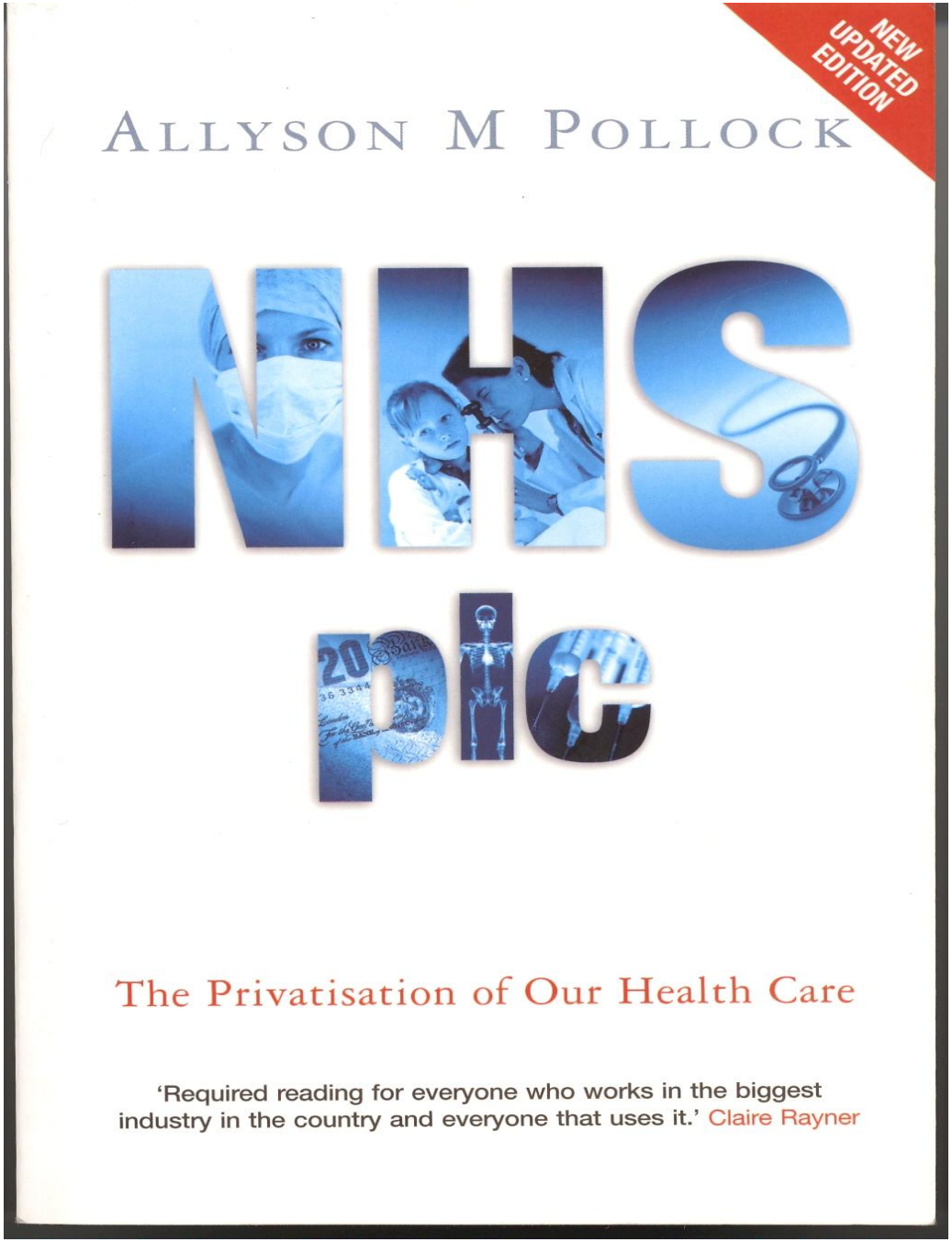
Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.



Pollock 2004:

About New Public Management in the NHS, ”competition” and privatizations: important parts of general practice offered to the private health market, thereby undermining continuity of care

…The government wants to transform the NHS into a devolved, market based model in which local commissioners (consortiums of GPs) and providers of health services are freed from central control.

Reuters/Scanpix

Helsetjeneste i oppløsning?

7.02.11

Nei, det er ikke den norske helsetjenesten jeg sikter til, selv om striden om akuttberedskap, fødeavdelinger og lokalsykehus kunne friste til en slik tittel.

Det er den britiske helsetjenesten, og det gjelder deres National Health Service, NHS, britenes stolthet og mest elskede offentlige institusjon gjennom etterkrigstiden. For der, på andre siden av Nordsjøen, raser det nå en debatt i mediene og i fagtidsskriftene som vi bør følge med den største oppmerksomhet. Ikke bare fordi britenes nasjonale helsetjeneste, med likeverdig og gratis tilgang for alle, har vært modell for mange lands helsetjenester. Men også fordi den har vært inspirasjonen for den norske fastlegeordningen.

I forrige uke skrev det anerkjente fagtidsskriftet The Lancet en lederartikkel med tittel «The end of our National Health Service» – slutten på den offentlige helsetjenesten – uten spørsmålstegn. Sjelden har jeg sett en så unison fordømmelse, både der og i andre fagtidsskrifter, over den reformen som nå er lansert av den nye borgerlig-liberale koalisjonsregjeringen. De vil kutte kostnader. Og det er for så vidt i tråd med det programmet de ble valgt på, med skattelettelser som sentralt element. Men David Cameron og de konservative hadde også annonsert seg selv som «partiet for NHS», med løfter om at de nå skulle sette fagligheten i sentrum, og ikke eksperimentere med flere politiske krumspring.

Så gjør de akkurat det motsatte. De har nå lansert slagordet «liberating the NHS» – å frisette NHS. Og måten de vil gjøre det på er å introdusere en kjøp og salg-modell som langt overgår det Margaret Thatcher første gang prøvde seg på tidlig på 1990-tallet med den såkalte fundholding-modellen. Den er i de fleste fagtidsskrifter oppsummerte som en politisk fiasko, som først og fremst bidro til en dramatisk økning i administrative kostnader, nettopp ved et system av interne markeder, som krevde et nytt stort sjikt av jurister og økonomer. «Der det før var 100 sykepleiere, er det nå 100 økonomer», hørte jeg av mine legekolleger der borte den gangen.

Signert

STEINAR WESTIN
Professor i sosialmedisin og fastlege

Karin Abraham
Tone Sofie Aglen
Rigmor Austgulen
Håkon Bleken
Arne Byrkjeflot
Axel Christophersen
Baba Danyagiri
Johan O. Jensen
Daniel Johansen
Ørjan Greiff Johnsen
Lars Haltbrekken
Per Edgar Kokkvold
Tor Langbach
Siv Limstrand
Kari Løvendahl Mogstad
Tale Næss
Nils A. Røkke
Gunnar Sand
Per Morten Schiefloe
Fredrik Skagen
Petter Stocke-Nicolaisen
Oddveig Storstad
Ola Svein Stugu
Steinar Westin

Nå er det denne modellen som skal gjenoppfriskes og forsterkes. Ansvaret for å styre helsetjenesten skal desentraliseres og langt på vei overlates til allmennlegene. Det kan i første omgang lyde smigrende for sånne som meg, også fastlege, og en anerkjennelse av allmennlegenes sentrale rolle som premissleverandører for hele helsetjenesten.

Men måten de gjør det på har en annen og vanskeligere side: Fastlegene skal selv få tildelt det meste av helsebudsjettene, og deretter inngå avtaler om alle andre slags helsetjenester. Og nå er det ikke lenger snakk om interne markeder, der avtaler skal gjøres med andre institusjoner i den offentlige helsetjenesten. Nå skal markedet bli «fritt», og allmennlegene må orientere seg i det som beskrives som en jungel av offentlige og private tilbydere.

Ikke vet jeg hvor mange økonomer og jurister vi i så fall måtte ansette om vi norske fastleger skulle bruke vår tid og våre ressurser på kontinuerlige forhandlinger og kontraktinngåelser for våre pasienter. Ikke er vi utdannet til det heller. Men det grunnleggende problemet er at britene nå tar skrittet helt ut til å se på helsetjenester som andre slags varer, som kan måles, veies og prises som om det dreier seg om tannpasta eller togreiser.

Diagnoser var aldri ment som prislapper. Og rå konkurranse om omsorgen for syke mennesker kan vise seg å bli akkurat så pervertert og kostbar som vi ser det i land som ennå ikke har oppfunnet en offentlig helsetjeneste.

Det bekymringsfulle er at vi ser elementer av den samme markedstenkningen også i den kommende norske samhandlingsreformen.

«Ansvaret for å styre helsetjenesten skal desentraliseres og langt på vei overlates til allmennlegene.»

Mr Lansley: please tell us the truth

The UK's Conservative Party made firm pledges before the May general election to back the National Health Service (NHS). "We will increase health spending every year", they wrote in their party manifesto. In particular, the Conservatives prided themselves on campaigning "to defend the NHS from Labour's cuts and reorganisations." Meanwhile, the Liberal Democrats promised savings in management costs, bureaucracy, and quangos. Money would be reinvested "back into the health care you need." There was remarkable consistency between the two political parties—to protect front-line services at the expense of NHS administration.

Since the election, the Liberal-Conservative coalition has made the same argument, even more forcefully. It was reiterated again in *Equity and Excellence: Liberating the NHS*, Health Minister Andrew Lansley's white paper on the health service. Here were the same commitments: "efficiency gains, with savings reinvested in frontline services"; and redirecting staff away from "excessive administration" to "front-line support".

The reality in the NHS is very different. *The Lancet* has been passed a document dated June, 2010, from Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust entitled, "Proposal for A/OA Organisational Change Paper." The document sets out details of proposed cuts in mental health front-line services for adults (A) and older adults (OA). Under a section headed "Financial Drivers for Change", the authors of the Oxfordshire document write: "The current income budget of the [Adult and Older Adult] Directorate is approximately £42 m. The savings to be achieved are £5·3 million over the next 4 years." In Appendix 3 and 4 of this proposal, staffing changes are set out in detail. For adult mental health services, three consultant psychiatrists out of 19 will lose their jobs. There will be 16 fewer care-coordinators and support workers, eight fewer allied health workers, and one less staff grade position, together with cuts in clinical psychologists. There will be an increase in a new category of support, time, and recovery worker, but their numbers and skills will not fully compensate for the loss of front-line health professionals, including the 15% cut in consultant psychiatrists. There are additional cuts in health professionals among staffing for older adults.

The proposal is grimly honest about the potential risks of these organisational changes. The authors acknowledge the possibility of "reduction in quality of service through staff changes"; "patient and carer dissatisfaction with the service"; "staff feeling unsettled and uncertain of their future"; "potential negative impact on staff from them perceiving an increase in their workload"; "poorer staff retention and reduction in staff satisfaction with their role"; "reduction in service capacity"; "poorer service response, patients waiting for care"; "stakeholder disquiet about changes in thresholds for access to services"; and "patients are likely to be discharged more quickly from secondary care services." In a further analysis, the proposal identifies the threat of "decreased patient satisfaction leading to poorer patient survey returns and possible patient withdrawal from care." Among the weaknesses in their proposal, the authors admit a potentially lethal flaw: "Possible reduction in the quality of service with less clinical resource available".

As the Oxfordshire plan acknowledges, the demand for mental health care is increasing, not decreasing—greater pressure on in-patient wards and increased severity of mental ill-health. There is a correspondingly greater need for clinical leadership. The proposed cuts in front-line services and consultant psychiatrists are unlikely to meet these greater demands, and the authors clearly set out their concerns about what they are being asked to do. For example, instead of bringing services closer to patients, home visits will be cut. But despite these detailed concerns, the reality remains that efficiency savings trump patient care and clinical outcomes, as the document makes clear.

When *The Lancet* asked senior leaders of the profession about these proposals, the collective answer was summarised in one word: "madness". As one put it, "This is absolute madness and it is no way to do workforce planning." We do not know how common these front-line service cuts are across the country. Those close to workforce planning tell us that cuts of around 14% over the next 3 years are faced by many deaneries in England. The only way these cuts will be realised is through loss of front-line staff. The Oxfordshire experience might be common. This is an issue that challenges a fundamental commitment by the Liberal-Conservative coalition.

And this is why we ask: Mr Lansley, will you tell us the truth about NHS cuts? Because the reality seems very different from your promise. ■ *The Lancet*

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The end of our National Health Service

There is a crisis in the National Health Service (NHS). The publication of the Health and Social Care Bill last week heralds dramatic changes for the NHS, which will affect the way public health and social care are provided in the UK. Those changes alone will have huge impact, but it is the formation of an NHS Commissioning Board, and commissioning consortia, that will once and for all remove the word "national" from the health service in England. The result, due to come into force in 2013, will be the catastrophic break up of the NHS.

Maintaining the status quo in the NHS is not an option. The NHS is not delivering the care that patients need. Patients with cancer, for example, are less likely to survive in the UK than in Australia, Canada, Sweden, or Norway. Michel Coleman and colleagues' *Lancet* Article, published last month, reports that the survival of patients with primary colorectal, lung, breast, or ovarian cancer is lower in the UK than in other countries with similar wealth, universal access to health care, and good cancer registration data. Survival is, they argue, "the key index of the overall effectiveness of health services in the management of patients with cancer".

Despite the huge sums of money pumped into the NHS over the past few years—particularly into the salary budget for staff—translation into benefits for patients is hard to identify. Moreover, the unyielding mountain of bureaucracy that is integral to the NHS stifles innovation, such that it is difficult to design the services needed for local populations.

Will the changes outlined in the Health and Social Care Bill solve these problems within the NHS and improve care for patients? The truth is that we do not know. What we do know is that putting general practitioners (GPs) in charge of commissioning health services for their patients is similar, in some respects, to the fundholding experiment in the 1990s. The principle then was that GPs controlled the budgets to buy the specialist care their patients needed. Fundholding took years to implement, but evidence on short-term or long-term benefits for patients is lacking. In the current Bill, health outcomes, including prevention of premature death, will be the responsibility of the NHS Commissioning Board, which has been asked to publish a business plan and annual reports on progress. That business plan is urgently needed to allow transparent appraisal of how the Board plans to monitor patients' outcomes.

The UK coalition Government has now been in power for about 8 months. Neither the Conservatives nor the Liberal Democrats included the formation of an NHS Commissioning Board, or GPs' commissioning consortia, in their health manifestos on which the electorate voted. The speed of the introduction of the Health and Social Care Bill is surprising, especially given the absence of relevant detail in the health manifestos. The Conservatives promised, if elected, to scrap "politically motivated targets that have no clinical justification" and called themselves the "party of the NHS"—a commitment that seems particularly hollow now.

Since its establishment in July, 1948, the aim of the NHS has been to offer a comprehensive service to improve health and prevent illness, available to all in England and Wales (and then extended throughout the UK), which is largely free of charge. Health care for all, for free, has been the common ethos and philosophy throughout the NHS. On July 3, 1948, in an editorial entitled "Our Service", *The Lancet* commented: "Now that everyone is entitled to full medical care, the doctor can provide that care without thinking of his own profit or his patient's loss, and can allocate his efforts more according to medical priority. The money barrier has of course protected him against people who do not really require help, but it has also separated him from people who really do." Now, GPs will return to the market place and will decide what care they can afford to provide for their patients, and who will be the provider. The emphasis will move from clinical need (GPs' forte) back to cost (not what GPs were trained to evaluate). The ethos will become that of the individual providers, and will differ accordingly throughout England, replacing the philosophy of a genuinely national health service.

Health professionals cannot say that no change is needed—it most certainly is. But there is sufficient uncertainty and concern about the changes outlined in the Health and Social Care Bill to pause, to learn from the past, and to consider what the changes mean for patients' outcomes. As it stands, the UK Government's new Bill spells the end of the NHS. ■ *The Lancet*

Press Association Images

For the **Health and Social Care Bill** see www.parliament.uk

For **Coleman and colleagues' paper on cancer survival** see **Articles** *Lancet* 2011; **377**: 127–38

For the ***Lancet* editorial on "Our service"** see *Lancet* 1948; **252**: 17

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Dr Lansley's Monster

Too soon to let it out of the lab

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Tony Delamothe deputy editor, *BMJ*
tdelamothe@bmj.com
Fiona Godlee editor in chief, *BMJ*, London WC1H 9JR, UK

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First impressions of the health bill

What do you call a government that embarks on the biggest upheaval of the NHS in its 63 year history, at breakneck speed, while simultaneously trying to make unprecedented financial savings? The politically correct answer has got to be: mad.

The scale of ambition should ring alarm bells. Sir David Nicholson, the NHS chief executive, has described the proposals as the biggest change management programme in the world—the only one so large "that you can actually see it from space." (More ominously, he added that one of the lessons of change management is that "most big change management systems fail."[1]) Of the annual 4% efficiency savings expected of the NHS over the next four years, the Commons health select committee said, "The scale of this is without precedent in NHS history; and there is no known example of such a feat being achieved by any other healthcare system in the world."[2] To pull off either of these challenges would therefore be breathtaking; to believe that you could manage both of them at once is deluded.

Like all the other structural reorganisations of the NHS, this one aims to improve health outcomes. What's lacking is any coherent account of how these particular reforms will produce the desired effects, a point only underlined by the prime minister's attempts to justify the reforms last week.[3]

This latest top down reorganisation has been whipped up in an awful hurry. It went unmentioned in the political manifestos of the coalition parties before the last general election, was specifically excluded in pledges given before and after the election, and didn't make it into the Coalition Agreement of 20 May 2010. Yet less than eight weeks later, its outline emerged in the white paper "*Equity and excellence: liberating the NHS*."[4]

The NHS was unsurprisingly absent from the 2010 election campaign because satisfaction levels with the NHS were at an all time high,[5] and for most of the electorate the NHS was a non-issue.[6] In the words of Simon Stevens, president of global health at UnitedHealth Group, a company that stands to benefit from the reforms, "The inconvenient truth is that on most indicators the English NHS is probably performing better than ever."[7]

The reforms put general practitioners in the driving seat. Out go strategic health authorities and 152 primary care trusts and in come several hundred general practitioner consortiums, responsible for commissioning £80bn (€95bn; $1.6bn) of NHS care from "any willing provider." As Kieran Walshe, professor of health policy and management, described in his *BMJ* editorial, it comes as but the latest in a bewildering array of forms and structures put in place to run primary care and commission secondary care.[8] Since the introduction of the internal market in 1991, there have been family practitioner committees, health authorities, GP fundholders, total purchasing consortiums, GP multifunds, primary care groups, primary care trusts, and external commissioning support agencies. Yet, crucially, wrote Walshe, "we have little evidence to suggest that any of these organisational structures for commissioning are better or worse than others, or that the proposed new consortiums will work any better than the current arrangements."

Informed opinion about GP commissioning, past and present, has been almost universally negative. The previous government's primary care tsar branded practice based commissioning "a corpse not for resuscitation." Last year's health select committee report on commissioning concluded that "if reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished."[9] This year's health select committee report on commissioning doesn't suggest abolition, but neither does it endorse the proposed reconfiguration as the best way to deliver the government's objectives. It says that general practitioners should "be seen as generalists who draw on specialist knowledge when required, not as the ultimate arbiters of all commissioning decisions."[2]

What's lacking is any coherent account of how these particular reforms will produce the desired effects

No matter how many GP consortiums eventually emerge, their number will probably greatly exceed the 152 primary care trusts they are replacing, which brings a set of new challenges. Smaller populations increase the chances that a few very expensive patients will blow a hole in budgets. More consortiums mean that commissioning skills, already in short supply nationally, will be spread even more thinly. Denied economies of scale, smaller consortiums may be tempted to cut corners on high quality infrastructure and management, thereby endangering their survival. These points emerge clearly from an examination of 20 years of US experience of handing the equivalent of commissioning budgets to groups of doctors. Some groups had severely underestimated the importance of high quality professional management support in their early days and gone bankrupt as a result.[10]

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How the secretary of state for health proposes to abolish the NHS in England

Allyson Pollock and **David Price** examine the proposed statutory changes to the NHS and raise concerns that the government's role could be reduced to that of payer

The coalition government's Health and Social Care Bill 2010-11 heralds the most controversial reform in the history of the NHS in England.[1-3] The government plans to replace the NHS system of public funding and mainly public provision and public administration with a competitive market of corporate providers in which government finances but does not provide healthcare.[4]

Primary care trusts and strategic health authorities are to be abolished and replaced by general practice commissioning consortiums, which all practices must join. As incorporated bodies, consortiums will not be directly controlled by the secretary of state for health and may enter into commercial contracts with "any willing provider" for all health services and will set terms and conditions of staff. They will have extraordinary discretionary powers to define entitlement to NHS provision and charge patients. Direct management and control of NHS providers will cease as foundation trust status becomes mandatory for all trusts. Provider regulation will be overseen by a market regulator, Monitor.

Since 1948 the government has had a duty to provide comprehensive healthcare free at the point of delivery. This duty is underpinned by structures, systems, and mechanisms that promote fairness and efficiency in resource allocation and facilitate planning of services according to geographical healthcare needs through risk pooling and service integration. These mechanisms have been eroded by a succession of major regulatory changes, including revision of funding and responsibility for provision of long term care; creation of an internal market; introduction of private providers and capital through the private finance initiative, independent treatment centres, foundation trusts, and the 2004 general practice contract; and creation of a tariff system of payment for providers.[5] We examine the proposed statutory protections of the duty to promote and provide comprehensive care in the bill.

Box 1 | Regulating providers through commercial contracts

The government proposes to regulate providers through commercial contracts:

"The Government's approach is that where specific control mechanisms are needed for providers, these should in general take effect through regulatory licensing and clinically-led contracting, rather than hierarchical management by regions or the centre."[3b]

Most economists agree health services cannot be sufficiently controlled through market regulation because the complexity and unpredictability of treatment makes it impossible to set out all eventualities in a contract.

This problem of incomplete contracts was first described by the founding father of health economics and Nobel laureate, Kenneth Arrow.[3j] He argued in 1963 that producers of health care services will always have more information than purchasers, who will never be able fully to evaluate the likely consequences of different services and so will never be completely certain that they have chosen the best provider or that the outcome is optimal.

When market contracts are used to regulate providers and commissioners, managers have an incentive to exploit the information deficit on the part of patients and government by reducing service quality in order to maximise profits.

According to Arrow, incomplete contracts can explain why "the association of profit-making with the supply of medical services arouses antagonism and suspicion on the part of patients and referring physicians."

Duty to provide a comprehensive public service

Although the bill retains the secretary of state's duty to promote a comprehensive service, the duty to provide a comprehensive health service in England is abolished.[4] It is replaced with a duty to "act with a view to securing" comprehensive services. The health secretary's general powers of direction over NHS bodies and providers are also abolished, and the focus of his or her role will shift to public health functions, which become the responsibility of local authorities.

Section 9 abolishes the duty on the health secretary to "provide [certain health services] throughout England, to such extent as he considers necessary to meet all reasonable requirements." Commissioning consortiums will "arrange for" the services necessary "to meet all reasonable requirements" and determine which services are "appropriate as parts of the health service" (section 9, 2a).[4] A consortium does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers appropriate" (section 10, 1). In making these arrangements, commissioning consortiums must ensure that their annual expenditure does not exceed their aggregate financial allocation (section 22, 223I-K). Consortiums may join together to form a single commissioning group for England (section 21, 14Q, 2b),[4] but they are not required to cover all persons or provide comprehensive healthcare when doing so.

The NHS Commissioning Board must "ensure that . . . commissioning consortia—(*a*) together cover the whole of England, and (*b*) do not coincide or overlap" (section 21, 14A, 2) but the board will not have a power of general direction over the health services for which consortiums contract or patients' entitlements. The secretary of state's influence is indirect, exercised through an annual "mandate" that will set out the objectives of the independent NHS Commissioning Board (section 19). The economic regulator, Monitor, also has no duty to ensure provision for all residents. Its main duty will be to "protect and promote the interests of people who use health services . . . by promoting competition."

The commissioning consortiums' duty to arrange for health service provision applies to their enrolled population. In contrast to primary care trusts, the populations of consortiums will

Is there a future for equity in care?

- and national health care systmes based on solidarity?

Is there a future for equity in care?

- and national health care systmes based on solidarity?

Or will people start bying health services for themselves…

… will people be led/tempted/convinced into relying on market models – ”bying something for themselves…”, rather than contributing to a common and equitable service?

…and what are the consequences of the present cut-backs and restructuring of European welfare and public health services?

Should I be as worried as I am?

Dr. Julian Tudor Hart, remember him?

From the message to the Nordic congress of general practice, Reykjavik 2007:

For politicians and professionals who are selling off the solidarity built by generations of struggle to lecture Scandinavians with even richer traditions of struggle and solidarity is an international insult.

We in the UK need you in Scandinavia to teach us, not the other way round – to help us regain confidence in solidarity, and a proper contempt for profit as motivation for our work.

For the past quarter century our leading politicians and professionals have travelled to USA to have their brains washed and their pockets filled in the socially most primitive, but technologically most advanced nation on earth. Only a trickle of pilgrims has travelled to Scandinavia. We need to reverse this by work at both ends.

Dr. Julian Tudor Hart, April 2007


Thank you for listening!