AIMS For a better birth...

Anything but Simple

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Jo Murphy-Lawless shows why we need to understand the 2012 Health and Social Care Act

Many thousands of articles and press reports about the changing NHS have appeared before and since March, 2012 when the Health and Social Care Act was passed. The volume of writing reflects the reality that the shift in status of the NHS, embodied in the Act, has struck a fearsome chord with a public who are feeling increasingly beset and marginalised in their daily lives.

We know we must make the best possible decisions about maintaining access to good health services which are a core need for every single family across the land. Yet in a painful affront to democratic process, we were completely locked-out from the crucial decision-making on the future of the NHS[1] The change in status brings with it tremendous consequences for social well-being as much as individual care well into the future, yet these are not immediately apparent due to the misleading language in which the Act has been dressed by its proponents. There are especially complex issues in respect of the maternity services which rightly have attracted fierce criticism for their failure to implement successive national framework policy documents since 1993. For at least the last six years, in the midst of a baby boom which was not predicted, services have been cut and the high-flung principles found in those official framework documents, of a woman's choice and the value of midwifery-led care, cast aside[2]

There are several recent accounts about the NHS which we think usefully exemplify the tensions and difficulties posed in understanding how these changes are impacting on a service which has been starved of funding for frontline staff and services since at least as far back as the 1979 Tory Party manifesto[3] We need a firm understanding of this complexity because we need to rethink how campaigning could evolve in respect of urgently needed substantive and sustainable improvements to maternity care for women across England (the Act does not apply in Wales, Scotland or Northern Ireland).

The first account comes from a 2013 article in The Practising Midwife. Unaccustomed to the official language in which the new look NHS has been set and unfamiliar with its complex history, many have possibly accepted the need to go along with the changes in commissioning and the abolition of primary care trusts which form a major plank of the Act, unsure if there can be any other course of action beyond acceptance of this fait accompli. In this vein, the authors of the TPM article tried to explain what the changes will mean. They stated:

'Reduction in budgets of £20 billion have contributed to some of the most significant service restructures in the history of the NHS.'[4]

'From April 2013 the pre-existing statutory bodies are replaced by organisations designed to embed clinical leadership in commissioning decisions.'[5] *We accept that getting to grips with the embedded meanings of the Act comes on top of huge workloads and that many rightly say they must simply get on with the work in hand. However statements like the above may contribute to making the Act sound a self-evident logical progression to a better NHS where the clinical voice and the voice of the patient or client are strongest. Nothing could be further from the truth. Leaving aside (if one can) the swingeing budget cuts which have affected frontline workers and public services so adversely since 2010,*[6] *there is no evidence whatsoever that clinical leadership and stronger patient and user voices will be the outcome of the Act, in fact quite the reverse.*

Rejection of these claims was at the heart of the massive protests against the Act which included every single Royal College. The details set out in these protests cast a very different light on the Act as it made its passage through Parliament. Dr Clare Gerada, chair of the Royal College of General Practitioners, condemned the bill as 'damaging, unnecessary and expensive', stating that it would 'cause irreparable damage to patient care and jeopardise the NHS'[7] while a BMJ editorial declared it 'Dr Lansley's Monster' pointing out that the 'informed opinion about GP commissioning ... has been almost universally negative.' [8] Cathy Warwick on behalf of the RCM was even more forthright:

'We have not heard anything that convinces us that the changes are necessary. The case has not been made. We remain unconvinced too that the changes will result in improvements in care. And we are disappointed that the legitimate fears and concerns expressed by health professionals and patients have not been addressed. As things stand, we face subjecting the NHS to full-blown competition and market forces at a time when those very same forces have thrown our economy onto the edge of the abyss. Why take the greed that almost destroyed our entire economy and choose to inject it directly into the heart of the NHS? Greed isn't good, it's bad, and it shouldn't be the driving force behind what motivates those who deliver healthcare within the NHS.[9]

This brings us to people with a far longer reach historically who understand too well from personal experience what is being lost with the new NHS. Harry Leslie Smith has published his memoir of growing up in poverty-stricken Barnsley in pre-NHS Britain.

'In those days, there was no national health service; you either had the dosh to pay for your medicine or you did without. Your only hope for some medical care was the council poorhouse that accepted indigent patients.'[10]

Born at home in 1923, he saw his parents struggle with the care of his older sister Marion who had contracted TB. The family was too poor to pay for a doctor or medicine for her, and finally had to remove her to the local workhouse infirmary where she died. An activist at ninety-one years of age, Smith lays down a plea to his readers to discover our courage and take back what we have lost in this undemocratic heist of the NHS:

'It has always been difficult for me to listen to politicians, proud possessors of health insurance and shares in private health care companies, when they talk about how the health service that we fought so hard to build must change… This act will see the NHS stripped down like a derelict house is by criminals for copper wiring... Where

will all of this end? What will be given the greatest priority in a new health care system that sends every service, from blood work to chemotherapy, out to the lowest bid tender? It ends where I began my life – in a Britain that believed health care depended on your social status. So if you were rich and insured you received timely medical treatment, while the rest of the country got the drippings. One-fifth of the lords who voted in the controversial act – which provides a gateway to privatise our health care system – were found to have connections to private health care companies. If that doesn't make you angry, nothing will.'

Smith echoes the thoughts and feelings of many elderly people who joined protest marches in the weeks coming up to the vote on the bill in March 2012.11 This unprecedented strength of feeling across so many personal and professional layers of English society deserves at the very least our attention and respect, no matter how complicated the Act is with its 309 sections.

The NHS and neoliberal economics

What are these 'tides of corporatism without conscience' to which Harry Leslie Smith refers? Where have they come from? What is their connection with the Health and Social Care Act?

First of all, the NHS has been far more than just a health service free at point of use. Dr Clare Gerada has described it this way:

*'The NHS is a system of distributing resources according to need, not according to want. So it's a distribution system, amongst other things; so we also have a National Health Service that also provides care that is free at the point of use, that is held together by systems of governance, employment, structures that underpin delivering this money to where it's required… It's also a social solidarity which we all adhere to because we know that if we're in a queue we will get the care that we need, but if we're in a rush and we need it we'll get it sooner.'*12

The bill was introduced with an overall promise to create greater clinical autonomy and individual patient choice, both valuable objectives when discussing improved care. As many AIMS members know, individual choice for women in respect of pregnancy and birth has been far more 'miss' than 'hit', with lack of resources and poor organisation frequently cited as reasons. Any route to improvement in this regard might be welcome.

GP commissioning of care was announced as the principal route to increased patient choice, implying that this would sweep away multiple layers of bureaucracy and interference with clinical decision-making. In fact the new clinical commissioning groups (CCGs) were disavowed by GPs themselves as diminishing their role. Amongst many other clinical voices, Dr Clare Gerada pointed out that GPs would not long remain in majority membership of the new CCGs because they lacked numbers, staff, and resources. Moreover the CCGs would merge into larger groups still so that the clinical involvement of GPs in a direct line with their patients would be entirely sidelined in the corporate mix.13 The move to commission maternity services through GP consortia was questioned by the RCM as being contrary to women's needs because GPs were not in a position to know what would be best.14 It has since been estimated that the CCGs will outsource the work of commissioning itself to private sector companies,

and here responsibility to shareholders will count far more than the voice of the independent GP speaking on behalf of patient need.15

In any case, it is not clear how the CCGs could lead to a reduction in management costs about which there have been concerns going back to the 1990s. Critics of the bill like Allyson Pollock had already questioned how the expansion of these to behemoth-like proportions had taken place and what the future would be: administration costs, which for 40 years had accounted for only 6 per cent of the entire NHS budget, had swollen to 12 per cent by 1991, when the internal market was fully introduced, and kept swelling apace thereafter;16 recent years have seen substantial sums of money transferred via consultancy contracts to global corporate management groups like McKinseys, KPMG and Price Waterhouse Cooper.17

The misleading language spills over into the use of the term 'patient choice' to describe one of the Act's intended outcomes. This sounds on the surface entirely beneficial in comparison with the rigid rules and regulations that have increasingly swamped users of the NHS. There are two crucial points to be made here. The first is that these restraints are directly related to the consistent lack of investment in frontline budgets, staff, availability, skills mix, beds, and hospital infrastructure from the 1970s onward, followed from 1990 by the introduction of the internal market through the NHS Health and Community Care Act which forced hospitals to manage and 'pay' for the care they 'bought', and mechanisms like public-private partnerships (PFIs/PPIs)18 and payment by results. Of course it was never any government's right to impose these: the NHS belongs to all its citizens, not to the marketplace, and these stealthy moves should have been confronted with strongest possible legal action from the outset many years ago.

What looks to be greater freedom of choice about hospitals, consultants and so on through mechanisms like 'personal budgets' is also an illusion. Because core NHS services are now so badly under-resourced, these personal budgets encourage people towards private sector services which appear more amenable and accessible, further draining the fragmented NHS which itself has been forced by legislation to adhere to trading restrictions and competitive practices as if the NHS were a public limited company (plc)19 We repeat: the NHS is a public service, not a plc. Yet hospitals and services are now failing, because of the way the NHS has been marketised, because of these restrictions, because of the punishing interest rates for PPIs, and because of cutbacks due to falling levels of revenue stemming from waves of marketisation. 20 In relation to postnatal depression (PND), for example, it was estimated in 2011, five months before the bill was passed, that as many as 35,000 women each year are experiencing postnatal depression with no available NHS diagnosis or treatment,21 yet AIMS members know that PND is far more likely for women who undergo birth in unsupported circumstances. Women, already beset by the burden of medicalisation, have paid the price of even poorer care and poorer outcomes, a direct result of the marketisation.



Campaigner June Hautot Standing at Westminster, holding a photo of Aneurin 'Nye' Bevan, MP for Ebbw Vale from 1929 until his death in 1960. As Minister of Health, Bevan spearheaded the National Health Service Act of 1946 to provide medical care free at point-of need to all Britons.

The additional problem for the unwary individual is that private for-profit providers and services themselves are highly selective as to what they will take on and are prone to cost-cutting to avoid commercial failure, as with the unsafe out of hours GP and hospital service run by Serco up to 2013 until a whistleblower exposed records of false response rates and a dangerous lack of clinical cover[22] We already know from American figures that the introduction of for-profit providers increases administrative costs to at least 30 per cent of overall costs which detracts from clinical care in efforts to retain maximum profit for shareholders. Furthermore, performance records become part of commercial confidentiality and can no longer be subject to direct scrutiny within any given community[23] The global corporates who dominate the contracts awarded to non- NHS providers (Care UK, Capita, Circle, Interserve, Serco, Virgin Care and United Health) with investor/ shareholders who include international hedge funds completely beyond our reach or influence, have all experienced difficulties in their actual service provision. Yet by far the largest number of contracts being awarded by CCGs are going to private sector providers, starving NHS frontline services still further; in the first 21 months following the passing of the Act, while £10.7 billions of NHS services were contracted out, 35,000 NHS staff were made redundant, including 5,600 nurses, with onethird of NHS walk in centres closed, and 10 per cent of Accident and Emergency units closed as of 2014.[24]

Social enterprise groups setting up as service providers may seem to provide an alternative to corporate providers or failing NHS trusts, but they too are severely limited. This is because these groups are also subject to the stringent conditions of the Act and its regulations; their funding comes from the public sector purse but they need to show significant savings over and above the cost of the project in order to be seen as competitive and 'value for money' under the terms of the legislation. This means they must keep their costs as low as possible which may lead to their needing to expand their client base while cutting staff time and associated costs to remain commercially viable. Thus they also run the risk of being taken over by larger corporate non-NHS providers when they cannot cover costs.

What is also important to bear in mind is that under the Act, the now hopelessly fragmented NHS cannot provide the same level of governance over care and professional standards that it once did (however flawed that was at times), but neither can the CCGs, nor the non-NHS service providers, nor the overseeing bodies such as Monitor, which itself is compromised by its principle duty (see below), nor the Care Quality Commission.

All these uncertain outcomes are why the Royal College of Nursing (RCN) published a briefing document in 2012, in which it stated that it saw no evidence that the bill would result in clinician-led, patient-centred care, reduced inefficiencies and improved standards, that in fact the bill would increase health inequalities because of the marketdriven approach to service delivery:

'The NHS already faces real issues with health inequalities, with people living in different parts of the country experiencing very different life expectancies and quality of life. Instead of solving the problem of inequality there is a fear that the reforms may actually further exacerbate these and create wider variations in quality and standards of care.'[26]

On these grounds, the College opposed the bill in the strongest possible terms. The British Medical Association has just announced at its 2014 annual conference that since the Act, investment has been cut throughout the NHS while tendering to private companies has been prioritised, making the first 12 months of the Act a 'bumper year' for multinational corporations, and that these developments have harmed patients.[27]

Despite consistent press statements from government politicians and from Whitehall that there is no government policy to privatise, the shadow operations of privatisation hang over all these developments to downgrade and outsource. An ever expanding number of routes to privatisation, some of which we have discussed above, have emerged to create this new stratified health economy[28] As a principal policy objective, opening up the health services to privatisation first appeared in the Tory Party election manifesto for 1979 (known as the 1979 Conservative Party General Election Manifesto). The 2012 Act, with many significant global financial innovations to aid more recent moves, has brought that 1979 ambition to its fullest expression.

Clive Peedell was co-chair of the NHS Consultants' Association, when he wrote in 2011 that full privatisation was 'inevitable' under the terms of the then bill. He quoted a WHO definition which states

that privatisation 'is a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services' and went on to write that 'the government's attempts to deny privatisation of the NHS by claiming that NHS services will remain publicly funded and free at the point of delivery does not escape the WHO definition.'[29] The Act has provided a legal route whereby to transfer our payments and taxes as citizens to the private sector, extending the basis for vast profit-taking, a classic ambition of neoliberal economics.

It is therefore no surprise that the primary duty of the new regulator of the NHS, Monitor, is to promote competition and prevent what the Act terms 'anticompetitive behaviour'. Nor should it come as any surprise that corporate greed involves a trail of influence leading straight back to key government and parliamentary politicians. Lord Carter of Coles, for example, was chair of the NHS Co-operation and Competition Panel, due to merge with Monitor after the Act was passed, but also the UK chair of the United States-owned healthcare company McKesson which has contracts with over 90 per cent of NHS organisations; Lord Carter receives a retainer of almost a million pounds for that latter post.[30] While this is not strictly illegal and is a declared interest on the parliamentary register of interests, it cannot inspire public confidence in fair-mindedness. The latest list of parliamentarians with financial links to private healthcare providers is extensive, ranging from people who are sole owners of small companies to chairmen, directors, consultants, shareholders, and so on.[31]

Finally, we want to return to the heist of democratic principles that is at the heart of the Act. At the outset of the establishment of the NHS in 1948 (and the reason why 81 year old Shirley Murgraff declared in 2011, just prior to her arrest during the Block the Bridge protest against the bill, that the NHS was 'the jewel in the crown'), the government under took to keep the NHS as entirely a publicly protected, public good for the whole of society. From 1948 to 2012, Ministers of Health had a 'duty to provide 'comprehensive health' for all citizens and, because we elect the government, each and every minister was accountable to us through Parliament under our parliamentary system. That link is now broken. Section 9 of the Act replaced that solemn duty to provide health care for all our citizens, with a duty merely 'to promote' and the Minister relinquished all responsibility for the running of the NHS to an arms-length body, NHS England. This means that unless or until the entirety of this Act is revoked, as citizens we no longer have any democratic connection to or control over our health services. This is a grievous loss in respect of democratic process as much as for the core need of a public health service.

The brutal outline of Harry Leslie Smith's 'tides of corporatism without conscience' is becoming clearer month on month since the Act was passed. Even though we continue to pay for the NHS through our taxes, that funding consistently leaks away from frontline care into corporate profit-taking, so much so that it is currently estimated by that same NHS watchdog on competition, Monitor, that 29 trusts were failing at the beginning of 2014 and this number was due to rise;[32] this has led to the disingenuous proposal by Lord Warner, a former health minister, that each citizen pay more through a flat upfront charge of £10 each month to 'prevent' the NHS 'from sliding into decline.'[33]

Again we must be clear : the way to save the NHS is to make it a fully public entity again. To paraphrase

the distinguished historian, Tony Judt, we need to prioritise collective responsibility over the individual needs agenda advanced by neoliberalism, an agenda that means only those with money to pay get the services they need.

AIMS faces complex new conditions for women, midwives, and maternity care

AIMS has campaigned over many decades on behalf of pregnant and birthing women and their needs as new mothers. These same decades in the NHS saw:

- underfunding in the 1960s and 1970s
- a tendency to centralise against evidence and local need
- the growth of a managerial bureaucracy on top of never tackled and continuing, but often unacknowledged, inter-professional rivalries
- Thatcher's election manifesto in 1979 to privatise the NHS
- the bill to establish the internal market in 1989
- gradual but consistent moves to increase outsourcing
- the growth of the 'expert' culture
- the final blow of the privatisation of the NHS through the Health and Social Care Act

These developments have cumulatively taken from us the chance to respond with a mantle of care around each pregnant woman to help her on her way in the best possible manner through those first steps of motherhood.



In February 2012, former teacher Shirley Murgraff, aged 81 (on the right), padlocked herself to chained protesters, who were outside the House of Lords, stopping traffic in Parliament Square, in protest against the Government's NHS reforms. Officers used bolt cutters to separate her from fellow protestors and carried Shirley away by her arms and legs.

Out of this complexity, AIMS perhaps needs to ask some straightforward questions beginning with this: why is it that in the increasing maelstrom that has engulfed the NHS, maternity services have continued to be sidelined in respect of best evidence and care?

At a much earlier point, the renowned Albany Midwifery practice went against the implications of these malign trends; working at community level for women's individual needs, it was able to provide the collective backdrop of a group midwifery practice backed up by an NHS hospital for the individual woman-midwife partnership to unfold at its best. It did so for an impoverished community, accepting all women who came to the practice.[34] It is highly doubtful that under the terms of the 2012 Act, such a contract arrangement would have survived the current legal constraints on non-NHS and voluntary providers.[35]

Given these strictures, what is the likely outlook for groups like One to One Midwives and Neighbourhood Midwives? Can such groups really co-exist for long with the legislation as it stands? Both require paid for care, up to £5,000 per woman. The position of contracting to a CCG, as with One to One, is unsustainable in the longterm for reasons set out above. How can AIMS best support these minority

undertakings? How can AIMS campaign for effective maternity services within the fragmented, privatised NHS for the vast majority of women, many of them experiencing social exclusion and poverty, who cannot pay for such services and who require best possible care? Should AIMS campaign for the 2012 Act to be repealed?

Conclusion

In exploring the collapse of the structures of a once proud NHS, we are nonetheless aware that many, many thousands of frontline health care workers still endeavour to provide daily the very best care they can in dispiriting conditions, and that as a whole, morale throughout the NHS has never been as low. In broad outline, we have sketched out the conditions for failures in the Mid Staffordshire hospital, of Morecambe Bay NHS and so on. In respect of maternity services, we know there are pockets of outstanding care for women, for example, the Serenity and Halcyon Birth Centres in Birmingham, which embody the unremitting commitment of consultant midwife Kathryn Gutteridge and her colleagues. However, readers of this Journal know all too well the extent to which good caseloading practices, birth centres and small well-liked maternity units work under threat of closure or have already been closed down. Salford HOPE maternity unit, a beacon of excellent care in an impoverished community, lost out to the behind the scenes wheeler dealing of a commercially–oriented NHS Trust[36] We believe that there is incontrovertible evidence that midwives do not wish to work as they are having to do at present. We also strongly believe that the English public, and the people of Northern Ireland, Scotland and Wales wish to have an NHS that is truly public, publicly accountable, freed from the vice-like grip of market profit-taking as if it were a commodity like mobile telephones or computers. We need a social, holistic, approach throughout the NHS and certainly in maternity care.

Indeed, there is general agreement among women, birth activists, many midwives and researchers about what good maternity care looks like and how it can be provided and a rising frustration that research such as the Birthplace Cohort study, and the Cochrane Review[37] on continuity of care have not been acted upon in any concerted or widespread way. We already know that under the changed terms of engagement in the NHS that maternity services have been very hard hit by cuts.[38]

Those of us working with AIMS and elsewhere have often experienced the NHS through its maternity services as cumbersome, ineffective and resistant to change. We have seen services increasingly concentrated in fewer and larger obstetric units, despite overwhelming evidence that community settings are more desirable for healthy mothers and babies. Some of us have experienced these services as brutal, even punitive, which has led to physical and emotional long term ill health. Independent Midwives and some of the new midwifery initiatives are providing the kind of maternity care that AIMS and other organisations have long campaigned for, but only a tiny minority of women can afford or have access to these, and only a tiny number of women will freebirth – another option about which women ask AIMS. AIMS' position has been to support a woman's plans, and that all women have the right to good maternity care and to be supported in their decisions about where, how and with whom to give birth irrespective of their economic situation.[39] Thus, it has always responded to the growing tensions in

maternity services by focusing first and foremost on the woman seeking support and has been endeavouring to work with the tensions forced upon us.

Any activism will necessarily need to continue to challenge vigorously the increasing and debilitating focus on risk and fear which is driving the centralisation of birth into large obstetric units, the medicalisation of birth, and the 'expert' culture where women's decisions are overridden, all of which plays into the now wholesale privatisation of the NHS

AIMS needs to put its thinking cap on as to how in these radically changed circumstances, to campaign for something we have never had reliably throughout the NHS: inspired, woman-centred care where the woman's voice matters most and where she finds the safety she requires to birth her baby in that relationship of trust. We need to campaign for that vision of an NHS that is reliably ours as women, mothers and citizens. AIMS must also respond to women who have been so broken by their experiences in an NHS service which has been indifferent and even cruel that they must go elsewhere to birth their baby safely.

It is not an impossible undertaking but it will require a renewed activism, a very different understanding of how this work is political and, probably, new allies. There are the beginnings of a new activism across the UK, focused on local democracy and collectivity.[40,41] John Gillies, Chair of the Scottish Royal College of GPs talks about a 'communitarian approach' and about lessons to learn from the so-called reforms in England, suggesting that all health care systems in 'Scotland, England, Ireland, Wales and internationally have to become more focused on the patient, and the person who is the patient' and that 'these are different things'. In Scotland, the Birth Project Group[42] following on from John Gillies, has called for a communitarian approach which entails a genuine inclusion of the community voice in the NHS and responsiveness to community need: decision-making on health care, including maternal health needs, made within the community.

AIMS has always sustained a strongly independent and respected voice. So one final question: where and how can we begin again to use our voice most effectively?

Jo Murphy-Lawless
Jo Murphy-Lawless is a sociologist in the School of Nursing and Midwifery, Trinity College Dublin
With
Nadine Edwards
Vice Chair of AIMS
Sarah Davies
Senior Lecturer in Midwifery at Salford University
Mavis Kirkham
Professor of Midwifery at the University of the West of Scotland

References and Footnotes

1. There was no mention whatsoever of any proposed legislative change to the NHS in the 2010

Tory Party manifesto which preceded the general election in that year, nor in the subsequent coalition agreement of their programme for government. The Health and Social Care Bill was introduced first to a startled public as a White Paper entitled 'Liberating the NHS' without warning, two months after the coalition took office. This means that voters in England never had the chance to express their approval or otherwise at the ballot box about what were fundamental changes to our health care system, that the bill had no public mandate at all. See Nick Timmins (2012) Never Again? The Story of the Health and Social Care Act 2012, London: King's Fund. http://www.kingsfund.org.uk/publications/never-again See also The Health and Social Care Act: the tale in a timeline, Kings Fund, http://www.kingsfund.org.uk/topics/nhs-reform/health-and-social-care-act-2012-timeline

2. From at least 2008, there have been consistent mainstream press reports about overstretched maternity services, acute midwifery shortages, and both ward and unit closures. The most recent of these comes from a BBC Freedom of Information request which shows that of 121 respondents, 62 NHS trusts, 51 per cent, closed units temporarily in 2013. See Nick Triggle (2014) Staff and bed shortages force maternity closures. BBC News, 11 July, 2014, http://www.bbc.com/news/health-27054688
3. See Allyson Pollock (2004) *NHS plc*, London: Verso; Richard Sennett (2008) *The Craftsman.* London: Allen Lane; Rosemary Mander and Jo Murphy-Lawless (2013) *The Politics of Maternity*, London, Routledge.
4. Charlotte Kenyon and Antony Nelson, Antony (2013) Changes in the NHS. *The Practising Midwife*, Vol. 16, no 4. 10-15. p. 10.
5. *ibid*
6. UK politicians who sought to cut public services from 2010 in the wake of the global economic collapse argued that our public services were out of control, contributing significantly to the economic crisis. This argument was advanced by 'deficit hawks' and led to the imposition of massive public spending cuts which formed 75 per cent of the austerity policies in the UK between 2010-2011. These moves were later acknowledged to be incorrect by the IMF. In fact, the financial crisis had been caused by extensive private sector failures which were then absorbed into what became a sovereign debt crisis with the rescue, through public funds, of the banking and financial services industry. See Dexter Whitfield (2013) Unmasking Austerity: lessons for Australia, Report prepared for Don Dunstan Foundation and Public Service Association of SA. http://www.adelaide.edu.au/wiser/pubs/. At the same time public sector cuts have had a starkly disproportionate and discriminatory impact on lower income households, including the very poorest and most at risk groups. See Jonathan Butterworth and Jamie Burton (2013) Equality, Human Rights and the Public Service Spending Cuts: Do UK Welfare Cuts Violate the Equal Right to Social Security?. The Equal Rights Review, Vol. Eleven, pp. 26-45; Annette Hastings et al. (2013) Coping with the cuts? Local government and poorer communities. York: Joseph Rowntree Foundation. There is also increasing evidence of massive tax avoidance by the private corporate sector which impacts on the funding for the public sector. It is estimated that UK Revenue Commissioners face a tax gap of at least £30 billion in any given year. See for example, Jimmy

Thompson (2013) Google fails to measure up on tax, and it's the UK public who has to pay. Guardian 4 October, 2013, http://www.theguardian.com/commentisfree/2013/oct/04/google-tax-avoidance-uk-public-pays; https://www.gov.uk/government/publications/measuring-tax-gaps-tables#4

7. Royal College of GPs calls for David Cameron to scrap health bill, *Guardian*, 3 February, 2012. http://www.theguardian.com/society/2012/feb/03/royal-college-gps-health-bill
8. Tony Delamothe and Fiona Godlee (2011) Dr Lansley's Monster, *BMJ*, 342, 21 January, 2011.
9. Cathy Warwick (2012) Time to pull the plug on this unloved health bill. *The New Statesman*, 22 January, 2012. http://www.newstatesman.com/blogs/the-staggers/2012/01/health-bill-nhs-private-care
10. Harry Leslie Smith (2014) A eulogy to the NHS: What happened to the world my generation built? *Guardian*, 4 June, http://www.theguardian.com/society/2014/jun/04/coalition-attacks-nhs-return-britain-age-workhouse
11. See the accounts of 75 year old June Hautot who spoke of her first child dying when she was five days old and her very sickly second baby who would not have survived except for the NHS (June Hautot, 2012, Why I had to confront Andrew Lansley about the NHS. *Guardian*, 21 February, 2012, http://www.theguardian.com/commentisfree/2012/feb/21/june-hautot-confront-andrew-lansley; http://www.mirror.co.uk/news/uk-news/june-hautot-why-i-confronted-andrew-lansley-692428) and 81 year old Shirley Murgraff who declared that the NHS is 'the most important institution we've ever had in this country, an organisation that has marked us out as a truly civilised society .. caring and helping those not so fortunate.' Shirley Murgraff (2011) 'I remember a pre-NHS Britain. I don't want to see a post-NHS one' *Guardian* 7 October, 2011. http://www.theguardian.com/commentisfree/2011/oct/07/nhs-uk-uncut-protest; http://www.mirror.co.uk/news/uk-news/shirley-81-carted-off-by-police-after-745612
12. Ian Goley (2013) Interview with Dr Clare Gerada, Chair of Royal College of General Practitioners. 21 May, 2013, http://www.sochealth.co.uk/2013/05/21/interview-with-dr-clare-gerada-chair-of-royal-college-of-general-practitioners/
13. *ibid*. This is borne out by the Royal College of Surgeons England report (2014) Access to Surgery A Postcode Lottery? The College has published its findings under a Freedom of information request on CCGs showing that most CCGs are now restricting access to routine surgery, with only 27 per cent of CCGs conforming to NICE guidelines on immediate access for those in pain. In other words, CCGs have already stopped responding to clinical evidence about patient need. https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/many-ccgs-are-ignoring-clinical-evidence-in-their-surgical-commissioning-policies A survey carried out by *Health Service Journal* in April 2014 of the 211 CCGs (with 93 CCGs responding to the survey), revealed that there was significant concern to open up their services to outside competition because they feared that otherwise they would be breaking the terms of the Act and would therefore face sanctions from Monitor, the competition regulator. See Dave West (2014) CCGs open services to competition out of fear of rules. Health Service Journal.c.article#.U8jwa0CGc4c See also Dave West (2014) CCG leaders: Reforms have not improved control of cost and activity *Health Service Journal*

, 4 April 2014. http://www.hsj.co.uk/leadership/barometers/ccg-barometer/

14. Report, Government could reverse commissioning policy.*Midwives*, December 2010, p. 12.
15. Colin Leys (2012) The engine behind GP-led commissioning? The private sector.*Guardian*, 11 December, 2012. http://www.theguardian.com/commentisfree/2012/dec/11/clinical-commissioning-groups-private-sector
16. Allyson Pollock (2009) The NHS is about care, not markets.*Guardian* 3 September 2009, http://www.theguardian.com/commentisfree/2009/sep/03/nhs-business-markets
17. In the financial year 2010-2011, to support the NHS 'transition', the government spent just short of £5.5m on 57 external management consultant companies. Daniel Boffey (2011) NHS reforms: American consultancy McKinsey in conflict-of-interest row.*Guardian*, 5 November, 2011, http://www.theguardian.com/society/2011/nov/05/nhs-reforms-mckinsey-conflict-interest
18. Pollock (2004), *op.cit.*
19. Dexter Whitfield (2014) National Coalition for Independent Action, Working Paper 4, NCIA Inquiry into the Future of Voluntary Services. http://www.european-services-strategy.org.uk/publications/books-and-articles-by-dexter-whitfield/inquiry-into-the-future-of-voluntary-services/
20. Pollock (2004) op. cit. pp. 2, 55-57, estimates PFI-funded hospital plant as costing between 12 and 14 per cent in interest charges alone of any given NHS trust budget for the following 30 years. In 2012, the NHS Trust for Barking, Havering and Redbridge, was cited by the Care Quality Commission for failure to meet adequate standards in maternity services in Queen's Hospital Romford. The Trust was facing a PFI bill for £50 million which it could not pay. In such circumstances, hospitals fail and costs mount leading to more frontline cuts, further damaging remaining services. See James Meikle (2012) Health watchdog concerned over NHS trust failing to meet care standards. *Guardian*, 27 June, 2012. http://www.theguardian.com/society/2012/jun/27/nhs-trust-poor-care-standards
21. Rowan Davies (2011) The mothers abandoned to postnatal depression,*Guardian*, 3 October, 2011, http://www.theguardian.com/commentisfree/2011/oct/03/mothers-postnatal-depression
22. Sean Farrell (2013) Serco to lose out-of-hours GP services and hospital management contracts. *Guardian*, 13 December, 2013.
23. See Pollock (2009) op.cit. and Jane Deith (2013) A healthy market? Lack of transparency raises doubts about NHS commissioning. BMJ 2013; 347, 4 December 2013. The extent to which commissioning further fragments maternity care is apparent in the £63,000,000 contract for maternity services awarded by the Wiltshire CCG in 2013. Although the contract was awarded to an NHS provider, the range of services which were outsourced detract from any policy of continuity of care and carer: they include breastfeeding, bloodspot screening, discussing choice, fathers' experience, and midwives managing minor problems.
24. See Michael White (2014) Circle's Hinchingbrooke win is not all good news.*Health Services Journal* , 21 May, 2014. http://www.hsj.co.uk/comment/circles-hinchingbrooke-win-is-not-all-good-news/5071044.article#.U8K5akCGc4c; Caroline Molloy (2013) Look Who's After the NHS's first billion pound privatisation, *Open Democracy*, 9 September 2013, http://www.opendemocracy.net/ournhs/caroline-molloy/look-whos-after-nhss-first-billion-pound-privatisation

; Dr Kailish Chand (2013) NHS on the brink of extinction,*Open Democracy*, 21 October 2013, http://www.opendemocracy.net/ournhs/kailash-chand/nhs-on-brink-of-extinction

25. Whitfield (2014) op. cit.
26. Why the RCN is opposing the Health and Social Act. RCN Briefing, January 2012. http://frontlinefirst.rcn.org.uk/blog/entry/news-rcn-moves-to-oppose-health-and-social-care-bill/
27. Haroon Siddique (2014) Doctors chief: we will fight government over NHS cuts and private tendering. *Guardian* 23 June, 2014. http://www.theguardian.com/society/2014/jun/23/bma-doctors-fight-goverment-nhs-cuts
28. Whitfield (2014) op.cit.
29. Clive Peedell (2011) Further privatisation is inevitable under the proposed NHS reforms.*BMJ*, 342:d2996 doi:10.1136/bmj.d2996
30. Juliette Jowit (2012) Whitehall defends dual health roles of NHS watchdog.*Guardian*, 4 March, 2012 http://www.theguardian.com/politics/2012/mar/04/nhs-watchdog-ccp-lord-carter
31. The list includes Baroness Julia Cumberledge who has extensive links with the pharmaceutical industry through her private company. See Social Investigations: in-depth research on political matters of social interest, Compilation of Parliamentary Financial Links to Private Healthcare. http://socialinvestigations.blogspot.ie/2014/03/compilation-of-parliamentary-financial.html
32. Guardian (2014) NHS trusts in financial difficulty double in number.*Guardian* 22 February, 2014. http://www.theguardian.com/society/2014/feb/22/nhs-trusts-financial-difficulty-double-year
33. Denis Campbell (2014) NHS users should pay £10 a month, says former health minister,*Guardian*, 31 March, 2014. http://www.theguardian.com/society/2014/mar/31/nhs-users-pay-membership-charge. In his attack, a report written for the think tank Reform, on what he terms a 'poor value for money' NHS, Lord Warner fails to draw attention to the fact that the funders of Reform include all the major private sector corporate players who will benefit handsomely from still further privatisation of the NHS, pushing it towards an American model of health care funded by private insurance. See Jacky Davis (2014) There's no financial, ethical or clinical justification for NHS charges. Guardian, 4 April 2014. See also the Reform report on moving the NHS towards an American model: http://www.reform.co.uk/content/34202/research/health/going_with_change The King's Fund has joined the call for such upfront charges. See http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england Warner himself has benefited from his extensive business interests as advisor to a number of corporate health service providers. See http://socialinvestigations.blogspot.ie/2012/03/one-in-six-labour-peers-have-financial.html
34. Christa Craven points out the dangers of home birth activism for home birth in the United States which disregards the needs of poorer women. This is the exact opposite of the ethical position that was at the core of the Albany practice. See Christa Craven (2014) Reproductive Rights in a Consumer Rights Era: Towards the Value of a "Constructive" Critique. In Christa Craven and Dána-Ain Davis, *Feminist Activist Ethnography: Counterpoints to Neoliberalism in North America* Lanham MA: Lexington Books.

35. The question still needs to be asked about why the Albany was abruptly closed down. Was its very existence somehow seen as little use in a developing corporate agenda? We know now that Kings under its CEO, Tim Smart, was moving towards the process of forming the powerful consortium of the largest 10 academic hospitals called the Shelford Group to protect its growing commercial interests. The Group has subsequently commissioned the think tank Reform (see note 33 above) 'to help 'project its message' about these interests. See Nigel Hawkes (2013) 'Welcome to the most exclusive club in the NHS'. *BMJ*, 347, 11 December, 2013.
36. One of us, Sarah Davies, was centrally involved in mobilising the community and midwives to fight for the unit. See Sarah Davies and Heather Rawlinson (2012) Manchester maternity reconfiguration: claims of success are premature. *Health Service Journal*, 27 September 2012 http://www.hsj.co.uk/opinion/columnists/premature-celebrations/5048091.article
37. J Sandall, H Soltani, S Gates, A Shennan, D Devane (2013). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev, 8 (2013) CD004667. 40-6736(13)61406-3 +(http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub3/abstract;jsessionid=D84747F2B26B1B5A8F37A5EE166F51D4.f01t02)
38. Denis Campbell (2013) 'Half of NHS regions cut maternity funding despite baby boom.' *Guardian*, Wednesday 13 November 2013, http://www.theguardian.com/society/2013/nov/13/maternity-care-funding-nhs-cuts
39. AIMS (2012) AIMS Position on Independent Midwifery. *AIMS Journal*, 24(2): 19.
40. For an example of this, see (https://www.opendemocracy.net/ourkingdom/juliet-swann/what-would-good-democracy-l)
41. http://www.independent.co.uk/news/uk/scottish-independence/scottish-independence-could-be-very-positive-for-health-says-sir-harry-burns-9619426.html
42. Birth Project Group (2013) http://pregnancyandparents.org.uk/birth-project-group/politics-of-midwifery-summary/