The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

Urgent changes needed to failing covid response

DITHERING, CRONYISM and numerous strategic failures have left the country stuck in a cycle of lockdowns. More than 100,000 dead, top of the international table of death rates by size of the population, and with one of the worst-affected economies.

It is an immense challenge for every government, but Boris Johnson's strategy has so far failed to adequately protect the population and their livelihoods.

The rollout of the vaccine offers hope with first jabs already given to 7m – only Israel and the UAE have vaccinated more (per 100,000 of population) – but the government must urgently fix the other elements of its strategy – test and trace, economic support, local and national co-ordination – if it is to finally grasp control of the virus.

We must do more than rollout the vaccine

The UK variant of the virus is up to 70 per cent more transmissible and appears to have around a 30 per cent higher mortality rate among some age groups, and scientists tell us that wider vaccine coverage will be needed to dampen its effects, which will take longer.

Experts also expect the virus to mutate and that new versions of the vaccines will need to be developed, so we need strong public health measures to run alongside vaccines.

Scientists still don't know if the current vaccines reduce transmission, or how long coverage will last and what effect there will be on the effectiveness of the vaccine by delaying the second jabs by up to 12 weeks in order to give more people a first jab. It is also clear that hospitalisation is now higher in younger age groups, and it will be several months before all these groups get the jab.

So, the government must not focus only on the vaccine rollout, it must also face up to the critical flaws in its strategy to develop a long-term way of living with the virus.

There are calls for urgent improvement in three key parts of the Covid response:

Support for people going into isolation

This week the BBC's Newsnight revealed how few people were managing to access payments to help them self-isolate. Research by the Labour Party suggested just 12,069 of 49,877 applications were successful.

The mayor of Newham, one of the poorest areass in London, told the BBC that the majority of residents in her borough applying for isolation payments cannot access them because they don't qualify.

Prof Susan Michie, an adviser on the government's Scientific Pandemic Insights Group on Behaviours, told BBC Radio 4's Today programme that the lack of

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financial support offered to people having to self-isolate was a “key weakness” of the government’s strategy. She stated that only 18 per cent of people with symptoms were self-isolating for ten days.

Covid is hitting the poorest areas hardest: those with more cramped living conditions, insecure jobs and incomes. No surprise then that too few people are abiding by the instructions of the government app to go into isolation.

A public network of test and trace

£10bn in test and trace contracts were hastily passed to commercial companies to manage these key elements of the response, bypassing the network of NHS labs and the tracing expertise that already exists in local public health. And the PM promised a “world-beating system”.

After a slow and stuttering start, PCR testing capacity has been raised – 5 per cent of the population were tested in the second week of January, but despite Serco and Sitel hiring 18,000 contact tracers this centralised system has regularly failed to reach 80 per cent of the contacts of infected people – the minimum the SAGE group quoted for it to be effective.

In contrast, where local council teams have undertaken tracing they have been able to reach this target, but they are currently only dealing with around 4 per cent of covid cases.

Calls are mounting to bring the management back in-house, and integrate the Lighthouse labs and tracing centres with existing local NHS and public health resources.

Stronger travel restrictions

At the last count, the UK had 146 deaths per 100,000, the highest rate worldwide. By comparison, Australia on the same day had zero new cases; achieved by locking down early, closing borders on 20 March last year and imposing a mandatory 14-day quarantine in a designated facility for international arrivals. The UK government is only now stepping up its targeted restrictions on inward travel, but these steps have been criticised for coming far too late.

Paul Evans

Unions urge PM to provide pay boost in depths of covid crisis

HEALTH UNIONS have written to the PM urging him to intervene and speed up the NHS pay review process. The letter – from 14 unions including Unison, the Royal College of Nursing and the Royal College of Midwives – says “hospitals are stretched to the limit”, with many “demoralised and traumatised”, staff facing burnout, such is the pressure they’re under..

They are calling for a substantial pay rise – between 12.5% per cent and 15 per cent – to restore levels of pay, as rises have failed to keep up with inflation over the last decade, with the most experienced frontline nurses seeing a real-terms pay cut of around £6,144 per year.

The letter was sent on the final day for submissions to the NHS Pay Review Body (PRB), which advises the government on pay rises for the NHS. Staff are at the end of a three-year pay deal with a pay rise due in April, but the PRB is not due to report until May, and the unions say this will mean a pay rise is not likely to happen until July at the very earliest.

Benefits to the economy

A rise has been promised by the chancellor, Rishi Sunak, but not until after the PRB reports back in May. In recent years the average pay of NHS staff in England across all levels has lagged far behind inflation, leading to a significant decline in real total pay between 2010-2021.

Health secretary Matt Hancock has said any pay rise must be determined by ‘affordability’. As part of its evidence to the PRB, the unions have addressed this issue with a report published on

“Researchers say 81 per cent of the cost of a pay rise would be recovered via higher tax payments and more spending in local businesses”

18 January by the think tank London Economics based on independent data, which looks at the bigger picture. It notes the benefits to the economy of giving NHS staff a substantial pay rise, not just the loss to the Treasury. The researchers say 81 per cent of the cost of a 5 per cent or 10 per cent pay rise would in fact be recovered via higher tax payments and more spending in local businesses. In addition, a substantial pay rise would reduce the costs of future recruitment and retention.

Not feeling valued

The cost to the exchequer of a 10 per cent pay increase would be £3.4bn this year on paper, note the researchers, but because of the wider benefits of increasing the pay of NHS staff, the actual cost would be down to just £660m.

A survey by commissioned by Unison, published 18 January, found that a huge majority of NHS staff say the government doesn't value their extraordinary efforts during the pandemic and many are considering their future in the NHS.

The survey of 10,000 NHS staff reveals that health workers feel deeply dissatisfied with their treatment, with only one in ten saying the government values NHS staff and more than four out of five (85 per cent) angry at how NHS staff are being treated by the government.

Almost two thirds (64 per cent) said the government's approach to NHS pay makes them question their future in the health service.

The research found that a pay rise awarded now would reassure staff that their efforts are being recognised. More than four-fifths (83 per cent) say it would make them feel confident to continue working in the NHS. This survey has been submitted as evidence to the PRB by Unison and it is calling on the government to give all NHS workers a pay rise of at least £2,000.

Sara Gorton, head of health at Unison, said a pay rise now would help exhausted health staff feel their efforts were appreciated. "Staff will spend any pay rise locally, giving struggling retail, hospitality, leisure and entertainment venues a much-needed boost as lockdown eases."

"Staff will spend any pay rise locally, giving struggling retail, hospitality, leisure and entertainment venues a much-needed boost"

The survey covered Scotland but here it found lower rates of anger and disillusionment, which Unison reports could be linked to moves from the Scottish government in 2020, including a bonus and commitment to an early, backdated pay rise.

Public opinion is also behind the pay rise to be brought forward. A recent poll of 2,000 people showed that a majority (53 per cent) thought the government should bring forward a wage increase for all NHS staff.

The results of the poll, commissioned from Savanta ComRes by healthcare unions, also highlights how the majority of people (86 per cent) back some level of pay rise, with 40 per cent supporting a significant increase.

Sylvia Donaldson/Paul Evans

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NHS to take over six private hospitals at high cost

ACCORDING TO the HSJ, NHS England (NHSE) has invoked a 'surge' clause in its covid-19 contracts with private hospitals, and given six private hospitals in London a week's notice that their entire capacity is to be taken over by the NHS to ensure hundreds of urgent cancer operations can go ahead.

The surge clause allows the NHS to override the commercial priorities of private hospitals which would otherwise continue treating insured or self-pay private patients to keep income flowing in.

However, the HSJ report suggests it's likely the NHS will have to pay higher fees to BMI Healthcare, which owns five of the hospitals, and to Aspen Healthcare.

The change of attitude and harder line from NHSE comes amid unprecedented pressure on NHS beds and high levels of staff sickness absence, and just a week after the HSJ reported that private hospital chains BMI and Ramsay in Manchester, prioritising their profitable business, were "pushing back" against NHS requests that they take additional patients.

The private sector's reluctance to forego its lucrative but non-urgent private patients undermined the NHSE hype about a "partnership" between public and private sectors.

New framework

The contracts that secured almost the whole capacity of the private acute hospital sector for NHS use last spring ended in December. Only 14 companies signed up for continued support for the NHS between January and the end of March.

From then a four-year £10bn framework agreement comes into force, encouraging NHS trusts to use private beds in order to tackle the mounting delays in waiting list treatment – and raising concerns that it will divert resources out of the NHS while leaving thousands of NHS beds empty.

Time for a few bonuses

There was no mention of the 'surge' clause that has now been invoked in Spire Healthcare's pre-Christmas press release announcing the interim contract with NHSE which it had agreed along with 13 other independent providers.

The contract was to provide a "volume-based commitment" aimed at reducing NHS waiting lists "when the existing contract with NHSE (as varied on 13 August 2020) ends on 31 December 2020", and "provide a smooth transition for NHS services in England from the current cost-based contract to the new NHS framework for purchasing additional activity from the independent sector."

Spire was so delighted at the boost to its finances that it announced a £500 per person bonus for its staff to recognise their 'outstanding contribution' during the year – an example NHSE has sadly not been willing to follow.

Meanwhile the private sector continued with its own agenda of profit-seeking acquisitions and mergers, with the Priory Group of 450 mental health and addiction rehabilitation facilities across the UK being sold off by its US owners Acadia to Dutch buy-out firm Waterland. The sale, worth an estimated £1.1bn, comes almost five years after Acadia acquired the Priory Group from Advent International for £1.3bn.

Acadia now plans to focus on its US operations, while Waterland intends to combine Priory with Median, Germany's largest provider of rehabilitation, neurology and orthopaedic treatments to create one of Europe's main providers of rehabilitation and mental health services.

The Financial Times notes that the UK government's cost-cutting in mental health over the past decade has benefited the private sector, which provides about a quarter of NHS mental healthcare beds in England. According to business analysts Candesic, 98 per cent of the private facilities' earnings come from the NHS.

The deal will be used to cut Acadia's debt, so offloading the Priory Group even at a loss brought an increase in Acadia's share price, which closed up 3.6 per cent on the Nasdaq index.

John Lister

Bills for NHS maintenance were rocketing even before covid struck

THE LATEST FIGURES for 2019-20 show that the total NHS backlog maintenance bill has rocketed by 38 per cent in a single year – to £9bn – almost the whole of the latest capital allocation.

The official figures highlighting this new, higher backlog bill state: "This is also known as 'backlog maintenance' and is a measure of how much would need to be invested to restore a building to a certain state based on a state of assessed risk criteria. It does not include planned maintenance work (rather, it is work that should already have taken place)."

A look at the details reveals that the number of trusts struggling with backlog bills of over £100m has increased from 12 in 2018-19 to 16 in 2019-20.

Big increases in the reported backlog pushed Guy's and St Thomas's into the list with the second highest total of £562m, while Imperial Health care in north-west London still has the largest backlog, slightly reduced to £671m.

Backlog costs up by 23 per cent

Other freshly increased backlogs have pushed East Kent and East Sussex over the £100m mark, together with Lewisham & Greenwich Hospitals reporting a massive £63m maintenance problem at the PFI-funded Queen Elizabeth Hospital in Woolwich, which only opened 20 years ago, and for which the trust is still forking out "unitary charge" payments that should cover maintenance. Thirty-six more trusts have reported total maintenance backlogs of more than £40m: and almost 90 per cent of the total backlog is classified as "high", "significant" or "moderate" risk, with only 12 per cent "low risk". Clearly the building stock is deteriorating faster than the government is willing to recognise, and the covid impact will make this worse.

Our backlog list over £100m (see online at https://lowdownnhs.info/) does not include two apparently erroneous entries which show stupendous new backlogs on Mid-Cheshire Hospitals (£373.9m) and West Suffolk Hospital Trust in Bury St Edmonds which shows as a monster total of £634.9m – surely more than enough to completely demolish and rebuild the 450-bed hospital more than once.

Even if these apparently rogue figures are set aside the total backlog still rises to £8bn – 23 per cent up in a year, before the covid pandemic.

Urgent action needed

The backlog means it is certain to get bigger still, as NHS trusts prioritise work to adapt buildings to cope with covid, and with capital spending set to fall again in real terms next year.

The announcement by health secretary Matt Hancock of a new £600m investment into NHS hospitals across England, apparently aimed at "upgrading and refurbishing" hospital sites, does not change the picture, not least because the money has to be spent quickly – by the end of March. It has already been earmarked for almost 1,800 projects across 178 trusts – mostly smaller overdue projects for maintenance and new equipment.

John Lister

For more details on this story, see...
https://lowdownnhs.info/news/nhs-trusts-with-over-100m-backlog-in-repairs/

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Vaccine distribution: saving the world's rich and poor alike?

- **Richer countries are stockpiling covid vaccines, making people in poorer countries wait**
- **Countries with 14 per cent of the world's populations have bought 53 per cent of supplies**
- **200 pharma companies are chasing profits on an estimated £10bn sales annually of products funded largely by the public sector.**

THE SEEMINGLY ALTRUISTIC race to develop and test a vaccine to immunise the world's population against covid-19 has been fascinating to witness, and is by no means over yet. But the roll-outs of the various end-products have so far displayed worrying signs of profiteering and geopolitical posturing.

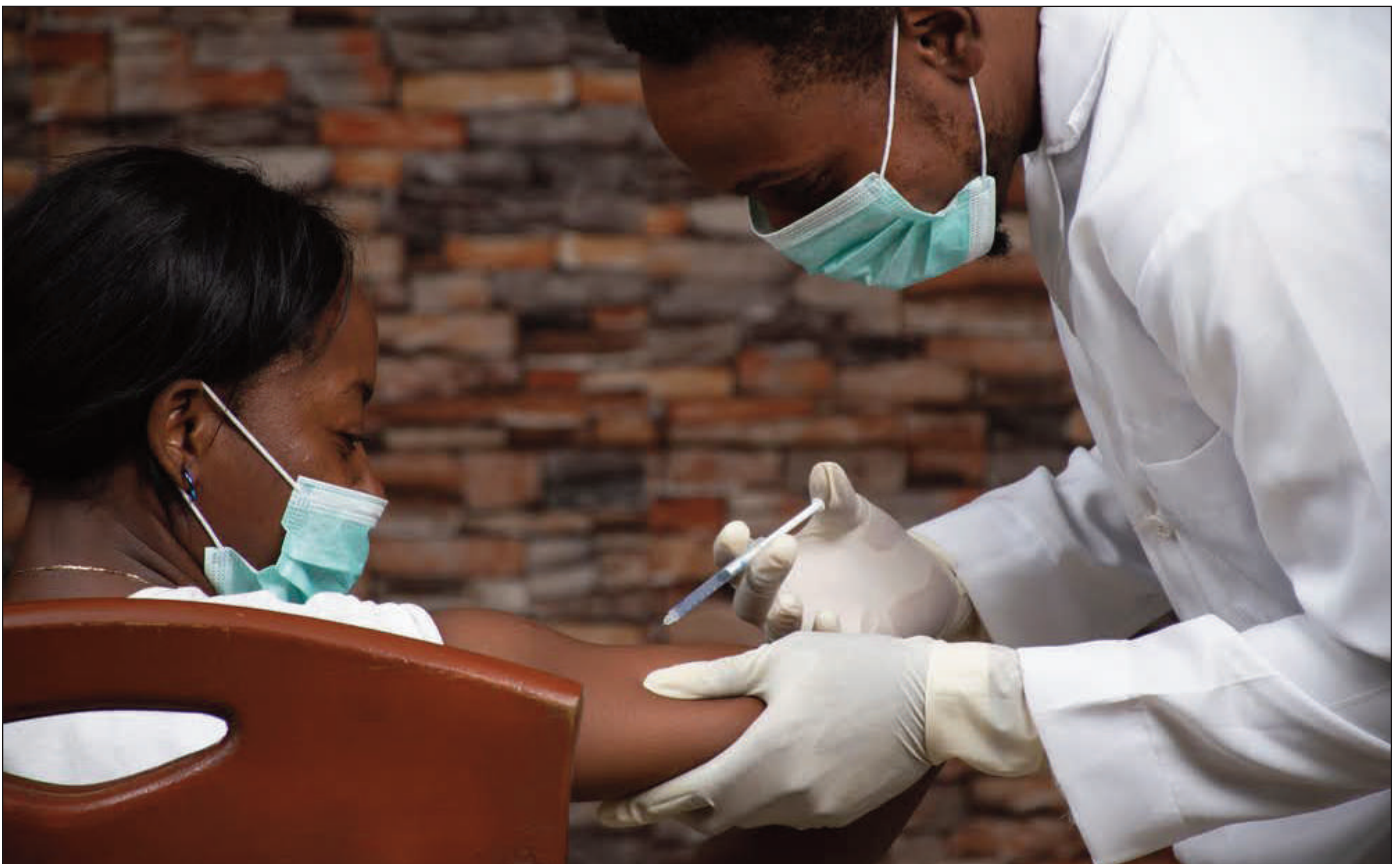
On 20 January Mariangela Simao – assistant director-general of the World Health Organization (WHO), which has negotiated supply deals with five manufacturers to supply 2bn doses via the Covax programme – excitedly told poorer countries, "No one needs to panic, you're going to get a vaccine."

But despite this optimism, and the undoubtedly welcome news that the US is returning to the WHO fold following Joe Biden's ascent to the White House, the UN body's director-general Dr Tedros Adhanom Ghebreyesus spoke a week earlier of a looming "catastrophic moral failure" in the world, suggesting one poor country – thought to be Guinea – had received just 25 (yes, just 25, not 25m) vaccine doses, while 39m had gone to "at least 49 higher-income" nations.

"Even as vaccines bring hope to some, they become another brick in the wall of inequality between the world's haves and have-nots," said Dr Tedros, before adding, "Most manufacturers have prioritised regulatory approval in rich countries, where the profits are highest."

News from one key producer involved in the WHO-backed Covax programme – the Serum Institute of India – neatly summed up the situation when, weeks after countries in Europe had already begun vaccinating their citizens, it announced earlier this month that it would be unable to deliver to WHO clients until March or April, a potentially disastrous delay.

US research organisation the Duke Global Health Innovation



Center (DGHIC) estimates that there will not be enough vaccines to cover the world's population entirely until 2023 or 2024.

While many high- and middle-income countries have committed to funding the Covax programme – which aims to reach just 20 per cent of recipient countries' citizens, a figure thought by some to be insufficient to stop transmission – many have also made direct deals with manufacturers to cover their own populations several times over (five times over, in the case of Canada). DGHIC estimates that high-income countries currently hold 4.2bn vaccine doses, while low- to middle-income countries, which often lack the infrastructure for mass immunisation campaigns, hold just 270m.

Patently unfair

The People's Vaccines Alliance – a recently established coalition of scientists, activists and not-for-profits like Amnesty International, Oxfam and UNAids – makes a similar point, warning that 90 per cent of people in low-income countries won't receive vaccinations any time this year, because their governments can't compete with richer nations stockpiling vaccines for their own citizens.

The alliance claims countries representing just 14 per cent of the world's population have bought up more than 53 per cent of the most-promising vaccines – including 96 per cent of Pfizer/BioNTech's expected production.

Among the alliance's aims is a drive to prevent monopolies by making public funding for R&D conditional on pharmaceutical companies freely sharing data and IP. But sadly, when India and South Africa asked the World Trade Organisation last year to allow its member countries to ignore patents on covid-related vaccines – allowing the production of cheap, generic copies – until global immunity had been achieved, their proposal was blocked.

And another WHO programme, set up last year, for pharmaceutical companies to voluntarily share pandemic-related knowledge, attracted no contributions at all.

The Medicines Patent Tool (MPP), another UN-backed platform, has also failed to negotiate any covid-19 deals. MPP executive director Charles Gore has said this represented a failure to tackle the pandemic in a global way, and claimed there was "a little too much of 'me first'" going on.

In response, one pharmaceutical industry spokesman archly defended the status quo, saying, "Circumventing IP rights will not solve perceived access challenges." This despite all the major advances in vaccines over the past year having been supported by massive amounts of taxpayer investment.

Let's take a couple of examples to see the impact of how this global supply imbalance is playing out. Africa, of course, faces huge challenges in accessing, let alone buying vaccines, but the

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Why the US can easily afford universal healthcare

THE DEPARTURE of Donald Trump and inauguration of Joe Biden as the 46th US President in the midst of a pandemic that has killed over 400,000 Americans is likely to be swiftly followed by a fresh debate over reforming the disastrous, costly and inequitable US healthcare system.

One of the main arguments for the need for fundamental change is that lack of or inadequate insurance among the poorest and most socially deprived Americans leads to extremely high numbers failing to seek or access healthcare checks or treatment compared with other high-income countries.

Indeed in 2010 the Commonwealth Fund comparison of 11 OECD countries showed that in the US even 20 per cent of Americans of above average income (and 29 per cent of those below average) experienced financially-driven unmet need and either did not visit a doctor with a medical problem, did not get recommended care, or did not fill – or – skipped prescriptions.

Not a lot changed over the seven years to 2017: a 2020 study showed that while Obamacare and other changes had brought a decrease in the numbers uninsured, there had been a larger increase in the proportion unable to see a physician owing to cost, and the proportion of persons with chronic medical conditions who were unable to see a physician because of cost also increased for most conditions, while the proportion of chronically ill adults receiving check-ups did not change.

Pent-up demand?

The covid-19 pandemic arrived in a US healthcare financing system that was already under strain, with increasing numbers of people uninsured and more finding healthcare unaffordable. The financial impact of the virus on the US economy is likely to further constrain Biden from implementing his already limited promises to expand coverage.

One of the major objections raised to a "single payer" system that would extend coverage to the whole US population has been the argument that it would trigger a tsunami of pent-up demand from people who would previously have been excluded by cost – forcing up health spending. But now an important new

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study by veteran campaigners from Physicians for a National Health Program has looked at the evidence of what actually happened after previous expansions of health coverage – from New Zealand in 1938 and the UK in 1948 through to the Obamacare reforms of 2010 in the US.

Savings, not costs

It begins by making two important points: firstly that while adding new health services would inevitably add new costs, a change in the way of funding the existing healthcare system would not – since it is already being paid for:

"Ultimately, every dollar of these expenditures comes from households in the form of deductions from workers' paychecks (for their share of premiums and lost wages due to employers' health benefit costs), taxes that pay for government programs such as Medicare, and out-of-pocket health spending. Reforms that substitute government expenditures for current private outlays may raise political hurdles but would not impose new costs on households."

Indeed by streamlining the system, eliminating waste and a huge level of billing and invoicing, and stripping out the colossal profits pocketed by insurance companies and major hospital chains (and the telephone number salaries of their CEOs) a single-payer system could generate very significant savings.

The second important point however is that even the extension of health coverage to millions of Americans currently excluded by cost would not create an exponential expansion of healthcare provision because of the "finite supply of medical professionals and hospital resources".

The study looks at a series of previous estimates of the "induced costs" of additional demand for health services if out-of-pocket costs were reduced or eliminated.

The assumption made in previous studies is that people would use more healthcare if the price they had to pay was lower (the "moral hazard" argument) – whereas demand for healthcare in systems with universal coverage is in practice limited by need rather than price (who wants extra "free" radiotherapy or an extra "free" amputation?). The false assumption led to extremely high predictions of increased health spending, with a 1993 Congressional Budget Office estimate of a 33 per cent increase in spending on physicians and 21 per cent on hospitals. In 2016 the Urban Institute estimated a 16.9 per cent increase in national health expenditure, and in 2019 another report from the same body warned the cost could be an extra 20.6 per cent despite a large average decrease in prices.

By contrast the analysis of the actual increases in use of services after widely expanded coverage in ten countries (New Zealand, Great Britain, Sweden, Canada, US [Medicare and Obamacare], Australia, Portugal, Greece, Spain) showed substantially smaller increases than US studies assumed. Indeed allowing for previous upward trends in health spending almost all of them came out lower than might have been predicted.

Investment still needed

In Britain when the NHS was established in 1948 about 60 per cent of the population was uninsured: yet the actual increase in using physicians was around 11 per cent and use of hospital care fell compared to preceding trends (including the end of World War II). Larger increases in healthcare use among groups which had been most excluded (older people and women) were partially offset by small reductions among those on high incomes. As we know, any expansion in the total provision of care was constrained in the early NHS by the scale, condition and age of the hospital system and limited numbers of professionals.

The authors convincingly make the case that the US would not face exponential growth in use of healthcare if out-of-pocket costs were removed – but there is a lingering concern that the campaigners have conceded too much to those seeking to constrain use and cost growth, and under-estimated the scale of under-treatment that could come to the surface if America's poorest (not least in terms of mental health) are at last included in collective provision of healthcare – and the need for investment and expansion to fill gaps in care in those parts of the US that the private sector has deemed unprofitable .

John Lister

Leicester: four key problems question 'Better Hospitals' plan

QUESTIONS OF COST and capacity hang over the planned reconfigurations of hospitals in Leicester, where a consultation with limited scope for public involvement concluded on 21 December.

There are four main grounds for concern: the limited capacity of the new hospital and lack of any pandemic awareness or preparedness in the plan; the centralisation of almost all of Leicester's maternity services in a massive new "baby factory" maternity hospital in Leicester Royal Infirmary, handling 11,000 births a year and the closure of the free-standing midwife-led unit at St Mary's; and growing questions over the affordability of the project within the allocated sum of £450m.

The financial concern is underlined by the fourth problem: the hopes that the acute hospital plans could be viable without any increase in capacity hinge on expansion of community-based services – for which there are no detailed plans – and no funding available.

Rushing ahead

The consultation document states clearly that: "This consultation does NOT include community hospitals, GP practices, mental health and other services provided in the community or in people's homes." Separating the hospital plan from community health services effectively means discussing only half the plan, with the other half reliant on wishful thinking.

The underlying plan as set out in the 600-page Pre-Consultation Business Case (PCBC), with over 200 pages of appendices, was drafted in obsessive secrecy, finalised in 2019, and eventually signed off in January 2020 – just before the covid-19 pandemic struck in full force.

All of the "public engagement" it refers to was years ago, in a different time completely.

But as we reported in The Lowdown, rather than pause the already delayed process to allow a proper evaluation of the longer-term implications of the pandemic for the design and capacity of hospital services, the decision was taken last September to rush ahead with a 12-week consultation on a £450m scheme that will irreversibly change local hospital services by selling off land and buildings. Only a flimsy retrospective four-page preface to the PCBC makes even passing reference to covid-19.

Critics warn the plan is far from covid-proof, especially since it involves extensive sales of land and buildings on the Leicester General site, and they have pointed out the PCBC promises and speeches promising additional acute beds are not borne out by the actual plans put forward in the consultation document.

The PCBC states (page 11): "A bed model has been produced to support the reconfiguration plans and the proposal is to increase the current level of beds from 2,033 to 2,333. Therefore there are no proposals to decrease bed numbers."

However a closer look at the actual proposals reveals that

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the 300 additional beds are largely imaginary: indeed there is NO plan to build any additional beds at all. The consultation document states a completely different target total of 2172 beds: "UHL has calculated that there would be a need for another 139 acute beds by 2023-24. This would be an increase of 7 per cent on the current total of 2,033 beds."

In fact none of the official figures reported in recent NHS statistics show anything like 2,033 beds available in Leicester.

The most recent bed availability and occupancy figures (July-September 2020) show the Trust had a total of 1,668 beds open overnight, 1,554 of which were front-line "general and acute" (G&A) beds, of which 1,202 (77.8 per cent) were occupied. In addition there were 116 'day only' beds, 60 per cent of which were occupied. This gives a maximum total of 1,784 beds.

Concerns over planning

The most recent figures available on winter pressures show UHL had even fewer G&A beds available in January, with just 1,492 beds, 1,270 of which (85 per cent) were occupied; while the weekly covid admissions reports to 19 January show an even lower total of 1,448 G&A beds, 91 per cent of which were occupied, 412 of them (28 per cent) covid patients – with another 60 covid patients in ICU beds.

The actual figures at no point connect with the picture drawn in the consultation document – but are consistent with the high levels of pressure on NHS services generated by the covid pandemic. None of this gives any confidence that the planning is coherent or robust in the new reality for the NHS.

Meanwhile the focus of campaigners has shifted to the worrying proposals to create Europe's largest single-unit maternity hospital at Leicester Royal Infirmary, handling 11,000 births a year, far higher than the 8,000 in England's largest single unit, in Liverpool, and the 10,000 per year in Dublin's National Maternity Hospital.

The new unit would result in the closure of services at Leicester General as well as the loss of the free-standing midwife-led unit at St Mary's in Melton Mowbray – a double blow for women in the immediate area, East Leicestershire and Rutland, who would lose the local choice of St Mary's and the easier access to Leicester General, and face much more onerous and lengthy congested journeys to the Royal.

There are doubts over the future of free-standing midwife-led births in Leicestershire, since the plan only commits to a 12-month trial of a unit to be located on the Leicester General site: it has been set a target of at least 500 births a year to secure ongoing funding. Critics point out this is almost certain to fail, since it will not offer the post-natal beds and additional support available at St Mary's, and because the limited trial period means that from four months onwards women will be less likely to choose to give birth in a unit that might be closed when they need it.

An excellent detailed critique of the plan by De Montfort University's Dr Sally Ruane and Kathy Reynolds also points out that the plan appears to diverge from the insistence on choice in national policy guidance, the risks of concentrating all births in one building (and distances to any alternative services) and warns that the new model of care would increase levels of medicalisation and intervention, and prove less satisfying work for midwives, raising the question of recruitment and staff shortages as well as patient care.

The Royal College of Midwives head of policy Sean O'Sullivan told The Lowdown that the plan has not sought the views of the college, and that his immediate reaction to a single unit that large was a "degree of scepticism" over the practicalities of staffing. "A unit that large would need to be running two rotas of medical staff in addition to consultant cover." The other obvious question was whether it was wise to press ahead with such a plan in the midst of a pandemic in which energies and attention were largely focused elsewhere.

Add to this the strong likelihood that the eventual cost of the Leicester project will far outstrip the £450m allocated – as has happened with new hospital projects in Shrewsbury (where the capital cost was estimated at £312m, but swiftly rose to £498m in a report leaked in December 2019, and was most recently said by STP chair Sir Neil McKay to be £533m) and south-west London (where the Epsom & St Helier Hospital Trust board meeting in January heard that the timeline for the Outline Business Case phase of the Building Your Future Hospital programme is now seen as "very ambitious" and that there have been significant changes in what needs to be incorporated within the programme "including covid design implications" which make the project much more expensive, with the risk that the final design becomes "unaffordable").

Wise managers would heed the warnings from campaigners, experts and academics, pause the project until the pandemic is clearly under control and revisit the scheme, the capacity required in hospital care, the scale of associated community health developments that are required, and the combined actual costs – and check its viability in the post-covid "new normal," and whether adequate funding will be available.

Sadly nobody expects Leicester bosses to follow that course, unless campaigners can persuade local politicians of all parties to start to take the problems seriously and pile pressure on the trust and the three local CCGs to do the sensible thing before serious damage is done.

John Lister

Tories MPs rip up proposed protections in the Trade Bill

MPs have rejected key amendments to the Trade Bill made by the House of Lords that campaigners say would offer important protection to the NHS. .

At the same time MPs also ditched amendments that: guaranteed MPs a vote on trade deals; protected food, animal welfare and environment standards; and prevented trade deals with countries engaged in acts of genocide or serious human rights violations.

Jean Blaylock, trade campaigner at Global Justice Now said: "Yet again MPs have rejected a series of amendments which would have offered some protection from this government's toxic trade agenda. Most shocking of all, they have refused to give themselves the power to meaningfully scrutinise or stop trade deals, writing Boris Johnson a blank cheque to negotiate away our rights and protections in trade talks with countries like the USA."

Promises likely to be broken

In December the House of Lords had passed a clause that prevented any agreement that impeded the UK's ability to provide "a comprehensive publicly funded health service free at the point of delivery." The amendment also suggested controls on drug pricing and the sale of patient data.

However on the return of the bill to the Commons the amendment was voted down by 357 votes to 266, with only Tory MPs voting against the protections.

The Independent reported that Trade Minister Greg Hands said there was no need to protect the health service with legislation because "the NHS is not and never will be for sale". But the Independent notes that government ministers made similar promises not to undermine workers' rights before Brexit, only to move to water down EU rules on rest breaks, holiday pay, and overtime.

Johnbosco Nwogbo from the anti-privatisation campaign group We Own It warned: "We're now at risk of higher drug prices, private companies having increased access to our NHS and those same companies being able to sue the government if it tries to limit their ability to profit from our healthcare."

What is the trade bill and why does it matter?

What are campaigners doing now? The main focus of campaigners is the future negotiations between the US and UK. The government announced in mid-March 2020 that it is committed to restarting negotiations as soon as possible. These will be conducted in secrecy and will not be subject to any scrutiny if the Trade Bill in its current form is passed by Parliament.

On 23 March 2020, 17 organisations signed a letter to the Prime Minister and Secretary of State for International Trade, urging the government to delay negotiations and calling for proper Parliamentary and public scrutiny.

"These are high-risk issues that need considered public debate and democratic scrutiny, but this debate cannot happen amidst national lockdown and with Parliament closed. Outside of a time of crisis, when the government has the time and resources to dedicate to negotiations, we expect full public and Parliamentary engagement with appropriate scrutiny and transparency throughout the process.

"We call on the government to pause all trade negotiations until the covid-19 crisis is under control and to inform both the public and potential trade partners of this necessary action."

The calls come as a new poll has found that three-quarters of Britons are worried about the impact a trade deal with the US could have on the price the NHS pays for drugs.

The poll, conducted by Survation, and commissioned by We Own It, found that 77 per cent of the public were worried that a trade deal with the US would increase the price the NHS pays for drugs, compared to just 18 per cent who say they are not worried.

Paul Evans/Sylvia Donaldson

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Covax programme is yet to launch on the continent, and currently relies solely on the Pfizer/BioNTech vaccine which needs to be stored at -70C, obviously not ideal for many of the continent's 1.2bn populace.

Palestine, meanwhile, has been left to its own devices during the pandemic, with Israel reported to have refused an informal request from the WHO to urgently supply vaccines for more than 4.5m Palestinian residents (including health workers) in the occupied territories of the West Bank and Gaza – ironically undermining the PR spin-off deriving from the success of Israel's Pfizer/BioNTech-based vaccination programme for its own citizens (25 per cent of whom have already been inoculated) – merely citing a shortage of jabs.

But production problems experienced by the major vaccine suppliers –Pfizer/BioNTech and AstraZeneca – have hit rich and poor countries alike over the past few weeks.

Socialising the risk

The increasingly disputed 12-week delay between administration of the first and second doses of the Pfizer/BioNTech vaccine in the UK has more than likely been driven by supply disruptions.

Similar disruptions have led to a reported drop of up to 50 per cent in vaccine deliveries from this manufacturer to other European countries, casting doubt on whether it will be able to deliver on its pledge last week to provide "up to" 40m doses to poorer countries (on a hard-to-challenge non-profit basis) any time soon.

And these production issues combine with a less-savoury aspect of the global covid vaccine supply chain, dulling the shine on any claims of commercial altruism.

The pandemic began in late-2019, but it was another four months before 'Big Pharma' announced plans for vaccine development. Over the following eight months more than 200 companies had followed suit, and almost 50 products were in clinical trials. The reason? Huge levels of public funding – £6.5bn from governments and £1.5bn from not-for-profits, according to research outfit Airfinity, although some sources suggest a total nearer $26bn – and the likely profits that would follow, arising from projected annual sales of vaccines up to $10bn.

As the head of one US campaign group put it, with government cash funding high-risk research, "We're socialising all the risk and privatising all the profit."

To finish, here are two more illustrations of the power of the dollar during the pandemic: New Republic magazine revealed last November how executives at vaccine suppliers Pfizer and Moderna appeared to be scheduling lucrative stock sell-offs to coincide with market rallies driven by the release of positive news about their employer's covid-related products in development.

And the Israeli vaccination programme, referred to earlier, is reported to depend on a controversial deal to provide vast troves of medical data, triggering ethical and privacy concerns, to Pfizer/BioNTech in order to ensure ongoing supplies, even though – according to Israeli media – the country has paid at least 50 per cent more than other countries for those supplies.

Martin Shelley

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Our goal is to inform people, hold our politicians to account and help to build change through evidence-based ideas. Everyone should have access to comprehensive healthcare, but our NHS needs support.

You can help us to continue to counter bad policy, battle neglect of the NHS and correct dangerous mis-information. Supporters of the NHS are crucial in sustaining our health service and with your help we will be able to engage more people in securing its future.

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

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