LOBBY WATCH **Hannah Bass**

Guttmacher Institute

What does it do?

Named after the pro-choice obstetrician and gynaecologist Alan Guttmacher (1898-1974), the institute is on a "mission" to advance sexual health and reproductive rights. With offices in New York and Washington, DC, the institute is concerned with global health but prioritises issues in the United States in the belief that US policy can have an effect worldwide.

Its work encompasses everything from access to contraception to sex education for teenagers. Top of the agenda is safe, legal, and accessible abortion, which is far from a global right and is under increasing threat in the United States.

The institute does some public awareness work: in 2011 it used a YouTube video to dispel common myths and misconceptions about abortion in the US (http://bit.ly/wzpzaP). However, its strength is in research and policy analysis. As the US abortion debate is dominated by the Christian right, the Guttmacher Institute provides non-partisan insight into the facts and figures.

Its spokeswoman, Rebecca Wind, calls this the "Guttmacher's fundamental theory of social change." She explained: "That scientific evidence, when rigorously collected, compellingly presented, and systematically disseminated can make a difference in policies, programmes, and healthcare practice has been validated by four decades of experience."

What challenge is it facing now?

Preserving access to legal abortion is the Guttmacher Institute's greatest challenge. A record number of abortion restrictions were enacted across the US in 2011. More than 1000 provisions concerning reproductive health and rights were introduced, shows research by the institute, and 135 of these were enacted, 92 affecting abortion. The previous record was 34 laws passed in 2005.

Three states adopted waiting time requirements, so that now in 26 states women have to wait a set period between counselling and the abortion procedure (*BMJ* 2010;340:c2527). Sixteen states have now restricted state health insurance to cover abortion only in cases of rape, incest, or life endangerment, while eight states have even restricted private health insurance coverage. Five states now require a woman to be shown an ultrasound image of the fetus before she can have an abortion.

A high profile vote, narrowly defeated in Mississippi, would have defined personhood as starting "from the moment of fertilisation" (*BMJ* 2011;343:d7313). Had it been successful, abortion and even some forms of contraception would have become illegal in the state. Undeterred, campaigners have vowed to take their cause to other states. Roe versus Wade, the landmark 1973 case that effectively established US women's right to an abortion, is under increasing threat. And if it is ever overturned many states have "trigger laws" that will come into effect, making abortion illegal once more.

This is the political atmosphere in which the Guttmacher Institute is working. Ms Wind said, "The biggest risk the institute faces is in being the target of misinformation campaigns. Opponents of sexual and reproductive health and rights often make their claims based on ideology, which cannot be substantiated, or are directly contradictory to the available evidence. They frequently make false claims about the institute's work and who we are or attack the integrity of the institute or its individual staff in an attempt to discredit the work we do."

On a mission: Alan Guttmacher (left)

Who funds it?

Founded in 1968, the institute was initially a research centre housed within the Planned Parenthood Federation of America. That affiliation ended in 2007, and funding was phased out. In 2010 Planned Parenthood contributed only 0.6% of the institute's total annual budget of around $14m (£9m; €11m).

Its money now comes mostly from private US foundations: 68% in 2010. A considerable contribution is made by global organisations and foreign governments, including the World Health Organization, the World Bank, and the UK Department for International Development. Money from US government departments made up 8% of the funding in 2010.

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LIFE AND DEATH **Iona Heath**

The NHS gift economy is in peril

Those who view the NHS as a gift economy feel betrayed by the emphasis on for-profit businesses in health policy

As the festive season recedes and children wait for their birthdays, it seems a good moment to think about the place of gifts within society in general and within healthcare in particular. The best gifts bring delight to both the giver and the recipient, and these delights are mutually reinforcing. Scholars, including the French sociologist Marcel Mauss (1872-1950) and, more recently, the US anthropologist David Graeber, have described the extent to which gifts have played a core role in societies throughout history and that economies that are based on gifts preceded those based on barter. And how could I have discovered all this if not through Wikipedia, perhaps the pre-eminent gift endeavour of our time?

It was Mauss who coined the term "gift economy" in his celebrated *Essai sur le Don*, published in 1925. Mauss defined gifts as "presentations that are in theory voluntary, disinterested, and spontaneous but are in fact obligatory and interested." In his 2002 book *Towards an Anthropological Theory of Value* Graeber notes that this is often but not necessarily true and that "gifts act as a way of creating social relations" serving to emphasise bonds of love, affection, and loyalty within families and friendship groups. Barter occurs in quite different situations and usually between strangers where there is no sense of mutual obligation.

So on 5 December, just when the annual gift frenzy was ratcheting up, the Department of Health for England published *Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS* (www.dh.gov.uk/health/2011/12/nhs-adopting-innovation). David Nicholson, the chief executive of the NHS in England, began his foreword with sentiments that resonate across the United Kingdom: "The NHS is a national success story. It is woven into the fabric of our society, and is a public expression of our social values. It is part and parcel of our national DNA. It touches all of us and all of us have a stake in its future." Ian Carruthers, who led the review behind the report, writes about the need to make the NHS "a better place to do business." There is a disjunction of motive here that, for me, underpins much of the widespread disquiet that has resulted from the proposals in the Health and Social Care Bill.

In this new publication there is no suggestion of the huge presence of a vigorous gift economy within the NHS as currently constituted. This is exemplified by blood and organ donors; volunteers in hospitals; patients who consent to being recruited into research studies in the hope of improving the knowledge base of the health sciences; people who embark on a whole range of careers and jobs in the health service because they want to be a tangible part of Nicholson's "fabric of society" rather than simply because it might be in their economic interest to do so; and staff who every day do more than they are contracted to do simply to keep the show on the road. All these people feel betrayed by the current emphasis on the interests of for-profit businesses within the coalition government's health policy.

Nicholson tells us that "the NHS has faced increasing demands: a growing population with an extending lifespan; an increase in its own capability, fuelled by advances in knowledge, science and technology; and ever-increasing expectations from the public it serves," but makes no mention of the health consequences of the structural violence being visited on poor and vulnerable people, the rapid dismantling of any semblance of social cohesion, or indeed the role of industry in inflaming ever increasing public expectations. We learn that the NHS must be enabled "to make its contribution as a major investor and wealth creator in the UK." Apparently the NHS conducts over 700 million laboratory tests a year, which is an average of 13 per person. This claim is made without any question as to whether this level is appropriate or any attempt to analyse the likely effect of wealth creation becoming a major driver of health service policy.

"The conclusion must be that we should foster the gift economy in healthcare because, as we know all too well, people are actively harmed when others become indifferent to their fate"

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Graeber wrote that, in stark contrast to relationships in a gift economy, "relations of violence and economic self-interest . . . are really just variations of the same thing: both reflect the way one acts with people towards whose fate one is indifferent." The conclusion must be that we should foster the gift economy in healthcare because, as we know all too well, people are actively harmed when others become indifferent to their fate. As Mauss understood, a gift economy creates a sense of obligation and, in a system facing severe financial constraints, can promote responsible and altruistic use of the service and contain demand for futile treatments. A market economy works in precisely the opposite direction.

Nicholson rightly insists, "Patient data can provide great insight for health research, which in turn improves the quality of diagnosis, treatments and other interventions. It is a key goal of the NHS for every willing patient to be a research patient, enabling them to access novel treatments earlier. The greater the number of patients involved in research, the wider the public benefit." And here is the huge missed opportunity. The government is proposing a new relationship with industry supposedly for the benefit of patients and the UK economy. Patients' involvement in research is a gift that could and should be reciprocated by governments insisting on easy open access to all data arising from clinical trials (*Trials* 2011;12:249). Untold harm has been done to patients through the concealing of research data in the name of commercial self interest. It is well time for the obligation inherent in the gift of patients to be recognised and honoured.

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