



# Socialism and Health

the magazine of the  
Socialist Health Association

December 2010

## Editors Opening

Welcome to the latest edition of the Socialism and Health. We intend to produce an e-edition each month. We will try to include topical articles and some of the best bits from the news. If you have any suggestions or items for inclusion please email [Irwin@sochealth.co.uk](mailto:Irwin@sochealth.co.uk).

The battle for the future of the NHS is beginning to take shape and the various forces are beginning to line up. We will soon know how much attention the Coalition has paid to the generally critical responses to its proposals. Will it compromise? Will it slow the pace of change? Just about everyone agrees that the changes being proposed and indeed being implemented already across the NHS, are too much too soon—even though some of the outcomes may be desirable.

More importantly at the centre of the conflict is a straightforward choice—do we want an NHS based on the foundations of cooperation, integration and professional responsibility with mostly public providers or do we want an NHS which is founded on choice and competition between mostly non public providers. To say the “evidence” is mixed is fair but one might argue that those who wish to make the change need to be able to provide enough compelling evidence to justify it—and that is not the case. For us the case is ideological as well as evidence based. We do not believe that an NHS based on self interested individualism and driven by financial competition is desirable.

We are expecting further coalition policies around public health, funding for social care as well as their response to the consultation over the white paper. Early next year we expect to see the health bill and we will publish our analysis soon after.

**Irwin Brown**

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### Our Aims ..

**Universal Healthcare** meeting patients' needs, free at the point of use, funded by taxation

**Democracy** based on freedom of information, election not selection and local decision making

**Equality** based on equal opportunity, affirmative action, and progressive taxation



Please send contributions for the next issue  
to [Irwin@sochealth.co.uk](mailto:Irwin@sochealth.co.uk)

## News and Comments

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**Dr Clare Gerada**, who took over as RCGP chair last week, has signalled an abrupt shift in the college's relationship with the Government by warning she will directly oppose key elements of the NHS white paper.

She told Pulse she had fundamental concerns over elements of health secretary Andrew Lansley's plans and that GPs faced being 'corralled and de-professionalised' by their new commissioning responsibilities.

Despite her desire not to let the NHS reforms define her role, Dr Gerada is keen to protect GPs. She fears GPs' 'professionalism' will be undermined as patients and the public begin to blame them for the cuts and lack of resources in the NHS.

'I know how that might sound among all the other concerns that people might have, like the any willing provider policy, the market and the cost,' she says. 'But my main concern when it really boils down to it is that GPs will be blamed for the shortages of resources in the NHS. And what we will see initially is GPs being corralled into commissioning groups and we will see a loss of freedoms for GPs, particularly around prescribing and referrals.'

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NHS national director for improvement and efficiency **Jim Easton** has claimed staff in the NHS hate learning from each other and put professional pride before the care of patients.

Addressing junior doctors and managers at a King's Fund conference in London last week, Mr Easton – who leads the DH's quality, innovation, productivity and prevention programme – strongly criticised the health service's current record on sharing best practice.

The problem was in our appalling, egotistical, self-interested culture.

**Jon Restell**, Chief executive of Managers in Partnership

"Our chief concern at the moment is that the Government is trying to achieve too much, on too many fronts, too fast. We believe that staff and the public share our priorities for the health service: financial stability, savings and the quality of services. Both the White Paper reforms and the management cost reductions should be carefully considered - and if necessary re-considered - in light of how they meet these priorities. If you haven't got the people to do the job, the job won't get done."

Restell's concerns echo those of Stephen Dorrell, senior Conservative MP and Chair of the House of Commons Health Select Committee, who last week expressed worry over the pace and complexity of proposed reforms. He warned the Government that radical reforms to commissioning must not take priority over the sound economic management of the health service and the securing of efficiency savings.

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**Natasha Curry and Chris Ham (from the Kings Fund)**

The evidence brought together in this paper shows that moves to achieve closer integration of care in the English NHS should continue. Organisational integration alone is unlikely to deliver better outcomes and effort must focus on clinical and service integration. Action is needed at the macro, meso and micro levels, and multiple strategies should be pursued at all three levels.

General practice commissioning offers a platform on which to develop integration provided that practices involved in commissioning consortia are encouraged to commission and provide services in collaboration with clinicians in community health services and secondary care.

Policy-makers should encourage the emergence of clinically integrated groups and integrated provider networks based on patient choice wherever possible and linked through contractual integration.

## Asking a Different Question (professionalism?)

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Reading the transcripts of the Mid Staffordshire hospital enquiry and hearing another series of bad news stories about the NHS in the media should make us all think hard. We accept the Kings Fund conclusion that the NHS delivers good care for most patients most of the time; that is what the “evidence” tells us. What Mid Staffs poses is the issue of how common is care that is not good – do we achieve the more fundamental requirement that an appropriate minimum standard of care must be delivered all the time – with any exception being the subject of serious action?

There is far less reliable evidence about patient care than about finance or process target compliance or even health outcomes – you can have a successful outcome and an experience far worse than it needed to be. You are unlikely to “have a nice day” but you are entitled to respect and expect your experience to be managed to reduce the pain, stress and fear.

There is rightly great scepticism about data collected about patient’s experience, about surveys and about the analysis of formal complaints. For some the only real test is to walk about, especially at night or the weekend and feel the atmosphere, about as far from objective evidence as you can get. Based on personal experience standards of care in the technical sense continue to improve but that there are far too many instances of poor care. That can be at a low level with, say, nurses ignoring a patient in pain or basic communications being totally inadequate, but can also be serious incidents where harm happens or was likely.

It has been noted that there are three aspects of the culture within the NHS which have emerged from Mid Staffs and previous reports. To paraphrase - there is a culture of fear in which staff do not feel able to report concerns; systems to support whistle blowing are ineffective or (rightly) not trusted; senior managers are told to sort out problems, not report them as concerns. There is a culture of secrecy in which the

management shut themselves off, especially from patients, preventing honest and open reporting of problems. And there is the top down, shouting at people, style of management in the NHS – a culture of bullying - which prevents people doing their jobs properly.

What we need is a major change in the culture of the NHS not in the organisational structure. If the health professionals want to be in charge then they have to address the issues arising from their collective failures so far. Caring professionals do not generally conspire to collectively demand high quality care. Professionalism should be a force which delivers quality of care in all senses, not a version of trade unionism; although we need strong and confident trade unions too, especially to support staff who dare to raise concerns.

Sadly, our current discussions around the NHS are focused on reducing expenditure by £20bn, which everyone understands will imply less front line staff, and on the reorganisation of the NHS proposed in the White Paper. Neither of these changes are likely to improve patient care, and there is a strong sense of foreboding that financial cut backs will lead to longer waits, restricted access and greater risk of poor patient care.

The expenditure reduction programme (QIPP) makes a strong case for quality being linked to efficiency in that changing ways of working will improve quality of care as well as reduce expenditure. In some instances this must be true, doing things properly benefits all. Easier access to a GP, fewer admissions from A&E, shorter stays in hospital are better for the patients and should cost the NHS less.

But NHS history tells us that improving care often requires additional investment, possibly only in the short term, not cuts. It also shows how NHS organisations, faced with enormous top down pressure to meet financial targets, respond with slash and burn, technical adjustments and short term fixes. I am not sure we have a strong enough baseline of “quality” to know whether QIPP actually delivers improved care overall, or not. Probably not.

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## Asking a Different Question (professionalism?)

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The central thrust of policy is however that the power of markets will be the way change is brought into our NHS. The theory is that better information will be used by patients to make choices about where they go for treatment, and the good providers will flourish and the bad will close down. Thus the quality of care, just as the quality of consumer products, improves through innovation and competition within a market. Maybe, but how long exactly does that take and what is the collateral damage along the way?

If the market reforms continue then actually the architecture is the same. The culture won't change. The people in power will be the same, even if the names are different! Culture trumps strategy every time (or so it says in the expensive text books). What could we do instead?

We ought to pass the challenge to the professions themselves. How would they bring the highest standards to the NHS and make it genuinely centred on the patients? Do they think a market for healthcare and competition will bring about better professional behaviour? Will market conditions make the NHS more open to scrutiny, more supportive of staff with concerns, more attentive to complaints, more ready to acknowledge and learn from clinical problems, more likely to spend on clinical audit and peer review? What do they think, not just for their own profession or tribe but across an integrated NHS which is supposed to value partnership, cooperation and openness.

We have had at least three goes at change through markets and commissioning, none have worked.

A fourth way?

**Irwin Brown**

## More News and Comments

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**Earl Howe**, one of the Tory health ministers, in response to a question about any willing provider competition problematising successful integration of care in Cumbria:

"The drive to competition and 'any willing provider' is a shorthand away of saying that Monitor is there to police unfairness in competition; not to drum up artificial competition where there is none.

"Where services work well, delivering good outcomes, I don't think services have much to fear. Where they're falling short, getting too expensive or could be more cost-effective, there ought to be scope for other to do better."

(Sounds like preferred provider to me Ed).

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**Stephen Dorrell**, chair of the Commons Health committee: the 'main game' is delivering efficiency. The health committee chair argues the white paper should not be the NHS's top priority. Instead, the service should take its lead from its chief executive - leading the major programme of change.

The change he refers to is not the abolition of primary care trusts and their replacement with GP consortia, but rather the ambition to achieve up to £20bn in productivity gains - something Mr Dorrell dubs "the Nicholson challenge".

(So the powerful committee chair agrees with us)



## The Arguments in Favour of Healthcare Markets

*(and why they don't stand up to scrutiny)*

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The consensus in British politics appears to be moving in favour of reorganising the NHS so that there is greater competition between providers of care. There is little new about the idea of using competition in the NHS – we've had it in one form or another since the 1980s. What is new is the extent of the proposed competition, and with it the presumption that using market mechanisms is the best way to reform healthcare. What are the arguments in favour of this, and on what evidence are they based?

A first argument comes from writers such as Julian Le Grand – a former Labour health policy advisor so a voice we have to take seriously. Le Grand argues that we should have a greater emphasis on markets in healthcare because pilot programmes such as the London patient choice project have worked, and even if this approach has limitations, it is less worse than using voice mechanisms (such as greater local democracy or greater user involvement). The problem with this is that the London patient choice pilot was entirely unrepresentative of the way that patient choice was introduced in the rest of the country (besides the structure of health services in London being unrepresentative) and, although voice mechanisms have tended to be poor in the NHS in the past, this does not take into account more recent attempts to achieve greater user participation through innovations such as public juries. It is also very noticeable that Le Grand has changed his position considerably over time – in the early 1990s he appeared sceptical about the prospects for the use of markets in healthcare because of the potential for market failure, and hasn't really explained why he changed his position so considerably.

A second argument came recently from Civitas, who having found very little evidence for increased competition driving improvement in the NHS, suggested what we need is more competition. This argument, that markets aren't working because we don't have enough of them, is

very much what Labour claimed in the early 2000s when allowing greater involvement from the private and not-for-profit sectors in the NHS – that if only we had more competition then market mechanisms would lead to greater service responsiveness to user need. This argument, however – that something isn't working because we don't have enough of it – isn't a good one. When exactly will we have 'enough' competition to see its effects? Do we just keep extending a policy of increasing competition, even if it doesn't seem like it is working, based on nothing except the presumption that sometime soon it might work?

A third argument comes from Carol Propper and her colleagues at the London School of Economics. This argument is based on correlations they have found between the clinical quality of services and the density of hospitals in an area. The relationship they have found shows that a small range of clinical indicators improves as density increases – the more hospitals in a 30km area, the better the clinical quality. They argue that more hospitals means competition, so this, in turn means competition is leading to clinical improvement. But this argument doesn't work either – it is based on one data point so we can't see if things are getting better or worse, and just because there are more hospitals in an area that doesn't mean they are competing with one another – the effect could be down to collaboration as much as competition. Equally, it could just be that areas with more hospitals have better access to staff and so provide better clinical outcomes.

All of these arguments make generalisations from assumptions that are not supported by sufficient evidence, and we need to be extremely wary of reforming the NHS based upon them. None of them explain exactly how competition drives improvement, or checks that the mechanisms they presuppose (such as competition) are actually in place. Reforming healthcare is too important to be based on the application of theory that might not apply (economists' theory of markets) or assumptions that have not been tested.

**Prof. Ian Greener**

## A Cunning Plan for our NHS?

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Last December as we approached the election the then administration set out the latest Vision for an NHS which was to go from good to great and be preventative, people-centred and productive. It was also going to deliver £15bn to £20bn of expenditure cuts through a programme called QIPP (quality, improvement, prevention and partnership).

QIPP was really traditional NHS in terms of nationally led and managed, driven from above, lots of targets and information going to the DH and relying on mostly old ideas which had been tried before and had not worked – one more heave. The SHAs and PCTs were fired up and enthused to lead the campaigns, the provider trusts began to work out how to survive on lower income flows and less growth in patient flows. Aspiring Foundation Trusts reworked their business plans, crossed their fingers, and thanked the fact that Bill Moyes had gone from Monitor. The plans have to be in by the end of November.

In the background the PCTs were formally splitting up, with their provider arms having to go elsewhere, generally being absorbed by another trust or forming a stand alone Social Enterprise (?) or Community Trust. With a few mergers and a bit of sectoring all the PCTs would be genuine, if not yet world class, commissioners by 2011. And the provider side was slowly but still remorselessly moving to an all Foundation Trust model. This gave the quasi market structure its key components; commissioning and provision split; plurality in provision; choice; and money flowing with the patient. Competition for patients was in place (for planned care) and competition for services was enabled through the preferred provider model. But it was a half hearted market still set within a familiar NHS organisational structure.

Delivering QIPP had little linkage to markets or competition. It was “do-able” if tough, provided (and this was a big ask) the politicians for once allowed reconfigurations and service rationalisations to actually take place without joining the inevitable “save our whatever”

campaigns. Then came the white paper announcement of the biggest reorganisation in NHS history with the SHAs and PCTs were being abolished and being run down pretty much from now. This leads to a loss of management capability as key people leave and less than key people get slotted into the prime jobs. The cost of reorganisation alone, probably at least £2bn, adds to the financial woe and organisational focus gets deflected from delivering patient care.

The market reforms of the white paper don't even start for 3 years and even then would take many years to actually impact as new entrants, especially private sector providers, come in and old players go to the wall. So in the meantime you have to have QIPP or FRED or whatever to get efficiency gains through the non market, shouting at people, traditional NHS way. You do this in a way that ensures the last of the old management reorganise themselves out of their jobs just as the new regime takes off – a clever trick to pull off. Accomplish this by a pretty ruthless centralisation of power and then stand it all on its head on go for bottom up and market driven.

A big risk is that QIPP is not going to deliver the savings necessary because of our old friend optimism bias – not being able to translate aspirations into outcomes and benefits realisation. The likelihood is that in 2011/12 there will be a 2006 situation of overspending, made far worse because the DH reserves are far less now than they were then and many clever wheezes have already been used. So we should expect the usual panic that will lead to more slash and burn reactions.

There may be one or two real horror stories of closed wards cancellation and long waits. Stuff will shut and staff numbers cut. Break out the placard. Plus there are also some nasty issues around some large hospital trusts going down the FT route which will force them to reduce their cost base significantly. More slash and burn and closures of whole hospitals are inevitable. More mergers of PCTs will lead to loss of good staff, loss of corporate memory and not enough management ability.

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It is going to be very hard to cope with all these unpleasant aspects of the need to adapt to lower funding levels. To manage the many complex change programmes this requires with far less managers and no access to external consultants is probably impossible. But if you add on the transformation programme to move to a whole new structure for the NHS it is highly risky.

The Baldrick approach would have been to have something more like a 5 year plan. First get QIPP (and QIPP2) delivered to ensure a stable financial base. Stop the haemorrhage of capable managers and of management capability and stop the demonisation of managers as a class – you need them more than ever to get the changes through. In the meanwhile start developing GPs as commissioners, give them a much greater say in the running of a reducing number of PCTs, and run some realistic pilots of the key changes.

The commissioning only PCTs could gradually move closer to local authorities ideally sharing premises and back office services. Allow the greater strategic role for authorities envisaged through Well Being Boards (or whatever) to begin to develop, allowing local authorities to take the lead on integration of services, needs assessment and public health, take down the iron curtain!

Stop any more initiatives by reducing the DH to a minimal residual state! Keep the capabilities within SHAs even if they become regional offices of some Commissioning Board. Cancel as many projects and programmes as you can. Reduce the complexities in the system for example by putting emergency care and mental health on a stable funding basis (not payment by results) and simplifying contracts. Stop pointless tick box procurements and concentrate on those areas where a genuine opportunity to use the market already exists. Mandate shared services, especially for procurement. Flog off redundant premises. Use an evolutionary approach.

You might just be in with a chance, and the risk to patients will be greatly reduced – never forget the patients.

**Irwin Brown**

## **Andrew Lansley has a problem.**

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The new Chair of the Royal College of General Practitioners has broken through the equivocation of the medical establishment and attacked the Coalition's plans for the NHS. Dr. Clare Gerada, a South London GP, says that Lansley's planned reforms represent the "end of the NHS as we currently know it, which is a national, unified health service, with central policies and central planning, in the way that Bevan imagined". If the reforms go through and GPs are conscripted into fundholding on a scale not dreamed of by John Major's government, the result will be postcode lotteries for treatment and political strife in the surgeries.

This outspoken attack is, in effect, a declaration of war against the government. The acceptance of General Practitioners as purchasers of specialist services, instead of NHS management bodies like Primary Care Trusts, is central to Coalition plans. Without GP acceptance and involvement, the reforms cannot proceed.

It also puts the British Medical Association in a difficult position. The BMA is the doctors' trades union, representing GPs and hospital specialists. Its hospital specialist members are not so keen on the idea of GPs holding the purse strings, but are careful not to offend their GP colleagues in case they eventually do. The very political GPs in the BMA hierarchy are anxious that the reforms are unrealistic or downright hazardous to the NHS, but some are also tempted by the possibility of gaining control of most of the NHS budget.

All doctors benefit from the NHS's high salaries, lavish bonuses (for many consultants) and generous pensions, and they will not let these go easily. Not surprisingly, the BMA leadership has avoided taking a polarised position toward Coalition plans. It has warned of the risks they pose to the NHS, but notes positive features and potential benefits. It may not be able to stay so equivocal after Clare Gerada's statement, and pressure from members for a special conference to debate the issues is likely to grow.

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The charge begun by the Royal College of General Practitioners may draw in other medical Royal College. If the Colleges of Physicians, Surgeons or Gynaecologists decide that the reforms could potentially undermine the quality of care that their members can offer, the Coalition will be hit hard. The Royal College of Nursing, already critical of the planned reforms, will have powerful allies, as will the smaller Colleges of the professions allied to medicine, should they join the attack.

Lansley now has to manoeuvre quickly. He still has some advantages, and he can be conciliatory or bullish towards general practitioners. Not all GPs are as opposed as Clare Gerada to the plans for GP budget-holding consortia. Her predecessor was in favour of constructive engagement with the government, and could see advantages to general practice in the Lansley's plans. General practitioners know that since 1948 general practice has been a low-status discipline in medicine, getting disproportionately low levels of investment compared with the hospital sector. The chain of new health centres proposed by the Dawson Report in 1920 and dreamed of by the Socialist Medical Association in the 1940s has still not materialised. Nor has the nineties notion of a 'primary care led NHS'.

The planned GP consortia offer a once-in-a-lifetime opportunity to turn the power relationships upside down, and put GPs in charge. About a quarter of GPs surveyed recently by the Kings Fund thought that the Coalition plans could improve patient care. If they were those already advising Primary Care Trusts on commissioning, Lansley already has enough movers and shakers to start the reform process. Even the College of GPs is recruiting 'Commissioning Champions' to strengthen GP commissioning.

He can also play a consumerist card, appealing over the head of the medical profession to the public. Clare Gerada referred to this risk when speaking to the Guardian. She warned that patients might start lobbying GPs, saying "you've got a nice new BMW but you will not allow me to have this (cancer) drug that will give me three more months of life!" General practitioners do not want to become the new rationers in the Coalition's reformed NHS, but Lansley knows that they already are but are not admitting to it.

General practice is a government franchise. The government subsidises it, but its members are organised into small-scale for-profit co-operatives. There is no fixed salary, incomes depend on making a surplus. Successive governments have ensured that GPs have traded at a profit, and the discipline has done well out of this, becoming probably the best paid family doctors in the world. But co-operatives that are virtually guaranteed a profit tend to be conservative in their investment decisions. There a long wait for NHS physiotherapy in many places, and GPs could solve this by hiring physiotherapists, but they do not do so because this would reduce their surpluses. So, whilst GPs are not yet actively denying patients expensive cancer drugs, they are already passively rationing some services. This is the discipline's Achilles Heel.

My guess is that Lansley will opt for conciliation first. He will hear the concerns expressed by the College of GPs, most of which have already reached him through his own party membership, and seek to reassure the medical profession that he will do nothing hasty. Rapid outsourcing to the private sector, or the full-scale transfer of budget management to commercial auditors will not be encouraged. The reform will be rolled out slowly and carefully, without destabilising the NHS's economy. Primary Care Trusts, which will not surrender their power over money willingly, will assist him. They will fix contracts with NHS hospitals and ensure that money for investment in commercial providers is limited in the transition years after 2013, perhaps to no more than 10% of the budget, possibly much less. Market forces will not run riot and the NHS will not melt down in this benign account of the reform process.

Sweet reasonableness will mask a determination to keep to the reform's timetable, by creating shadow GP Consortia, building the economic models for purchasing services and training GP commissioners. In private Lansley may want to strike back at the College of GPs, and somehow the Daily Mail will hear of this. Watch out for the tabloid exposure of GP fat cats, and the critical reporting of GP performance. In them you will see Lansley's kite flying.

**Prof. Steve Iliffe**

## Troubles Already?

### New lot not interested in competition?

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Private providers of NHS services have lodged a formal complaint with the health department over plans that will see almost £10bn of care handed over to other parts of the health service or to social enterprise without being put out to tender.

Under the previous Labour government, private providers were told there were “real opportunities” for them to bid to take over the community hospitals, district nursing and home and GP therapy services that are run by primary care trusts. By April, these “provider arms” of PCTs will be separated from the PCTs’ commissioning arms. However, under the Conservative-led coalition – and despite its public commitment to competition and choice in health – the health department has disclosed that only 4 per cent of the provider arms are to be put out to tender to the private and voluntary sectors.

Some 86 per cent are being passed over to other parts of the NHS to run, or are being turned into a form of NHS foundation trust. The remaining 10 per cent, providing £900m worth of services, are being handed over to staff to run as social enterprises, without any formal competition, in what critics see as “sweetheart” deals.

David Worskett, director of the NHS Partners Network that represents private providers of NHS care, said: “We have been told for some years now that there would be significant opportunities for the private and voluntary sectors to bid for this work. “Just before the election we were reassured by health department officials that perhaps 20 per cent of this business would be put out to tender. Now it appears that only 4 per cent will be going to market,” he said. “How can the health department possibly be sure that the arrangements being put in place will offer best value to the NHS at a time when it is completely vital for the service that this happens?”

There were “fantastic opportunities” for the private and voluntary sectors to provide more NHS care, a senior health department official publicly said as recently as September. The partners’ network, Mr Worskett said, had lodged a formal objection with the health department, asking it to refer the issue to the Co-operation and Competition Panel, which has the power to investigate market abuse in the NHS when asked by the health department. The department said it had “no plans” to refer on a complaint that in effect challenges its own behaviour. Susan Anderson, head of public services at the CBI employers’ organisation, said the coalition should be more radical. “Simply re-badging services is not the answer.” The best provider should be found to run them, she said. Simon Burns, the health minister, said the arrangements would put “frontline staff in the driving seat to improve quality and integrate services to ensure the most effective outcomes for patients”.

Unison, the health union, said it was “delighted” that “despite a massive push from the government” only 10 per cent of provider arms at most would become social enterprises, where staff quit the NHS to sell their services back.

The health department confirmed contracts for social enterprises were likely to be for three to five years. Mr Worskett said such providers would become entrenched, meaning “the scope to test the value of these services will be denied for the better part of a decade”.



## Turning the Socialist Health Association into a campaigning organisation

We have now been in opposition for seven months, and the SHA is turning into a real campaigning . Opposition is hectic – the director is planning to go full time. So far we have:

- recruited 70 new members – 10% more than in May
- established a small campaign committee – Richard Bourne, Brian Fisher, Neil Goulborne and the Director to direct campaigns
- Built up our relationships with the Labour Party, especially the Health team, and with the Trades Unions. Unite have agreed to help us with some regional campaigning. We are in demand to supply speakers for local Labour Parties, and the Director has been elected to be a member of the Party's National Policy Forum Health Commission and the Joint Policy Committee
- established a productive collaboration with 38 Degrees, a web based campaigning organisation, and assisted them with events they are organising across England
- Written letters and articles and interviews for health papers/mags
- contacted all English councillors and CLPs with advice
- developing a campaign with several local Labour Parties
- established 4 separate places on the internet:
  1. Our main website  
<http://www.sochealth.co.uk/>  
Around 760 documents, reports, historical material and details of our coming events. It gets quite a lot of visitors (13731 in November), but it isn't interactive
  2. Our Facebook page  
<http://www.facebook.com/pages/Socialist-Health-Association/240638256645?ref=ts>  
This has lots of contemporary news and a bit of discussion. Items are read by up to 1000 people
  3. Dropbox space. This is only open to people we invite. It can help us to produce policy documents collaboratively, especially if we need to do so in private.  
<https://www.dropbox.com/home#:::22147803>
  4. Our new wiki  
<http://socialisthealth.wikidot.com/>

This is open and interactive - a bit like a blog, or wikipedia. Anyone can add documents, pictures etc., leave comments, start and contribute to discussions. This is where we put documents we find interesting or stimulating, ours or other people's. We can also use it to organise campaigning.

We have a substantial presence on other sites – Health Matters, Health Policy Insight, and are contributing to political and health blog sites.

We are also working on some new campaigning ideas:

- Flash singing – Stunts in railway stations, or possibly in hospitals, where a group of people gather to sing a song with a political message and quickly disperse.
- Foundation Trust elections – We could stand candidates for Governor on a Socialist Health platform. We might not get elected, but we would have the opportunity to put our position to a lot of people. There are 36 Foundation Trusts who take members from all over England. If we got people to join we could probably get them elected in that category. The running of hospitals will obviously become controversial, and this gives us a platform.

Politically we have been concentrating on

- Encouraging clinicians, especially GPs, with coalition supporting MPs to talk to those MPs and raise questions about coalition health policy. We have, rather unexpectedly, had some success with active Conservative GPs.
- The risks of coalition health policy.

Both members and campaigners are anxious to establish an alternative policy to that put forward by the coalition, and in particular to the Health White Paper. The Shadow Cabinet is understandably being very cautious about making policy commitments. The more the Lib Dem vote collapses the less likely is an early election. By 2015 the world will have changing in ways that we cannot now imagine.

Martin Rathfelder

Director

## Letwin to scrutinise NHS power shift

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Oliver Letwin, the cabinet's policy guru and fixer, has been charged with scrutinising the Department of Health's plans for a shift of power and accountability in the NHS, amid mounting concern at the Treasury and Downing Street over its implementation.

Both Number 10 and Andrew Lansley, health secretary, insist there is no significance in publication of the NHS bill being pushed back to January, and that there is no rowing back on plans to hand up to 80 per cent of the NHS budget to GP commissioning consortia.

But after Sir David Nicholson, the NHS chief executive, conceded last week that primary care trusts, which currently control the budget, are "in meltdown" and that "Stalinist" central controls will be needed to keep the NHS finances in place, Number 10 sources say Mr Letwin has been charged with challenging the implementation plans.

The Treasury expressed reservations in July about the shift to GP commissioning. But one senior Treasury official said: "We have now got to get a grip on this," amid fears that the NHS could lose financial control in the run-up to the changes.

One Number 10 insider said: "There is no change in the policy. But Oliver is starting to ask all the important questions that need answers." Another added: "Andrew [Lansley] has all the answers when he is asked the questions about how the implementation of all this will work. We are just not sure they are the right ones." A senior Lib Dem source in the coalition said: "It is only right that we have a second pair of eyes looking at all this. We can't afford to get this wrong."

Aides to Mr Lansley are adamant there is no rowing back and that "David Cameron is 100 per cent behind all this". Mr Lansley insisted on Tuesday there was no rethink under way, and said a response to the consultation on the white paper will emerge before Christmas. But he added: "It does not mean that we will do everything in the way that we first suggested in the white paper. "There are aspects of implementation of the

reform that people have made comments on, and we will take them on board."

The prime minister has made much virtue of acting as "chairman" and not "chief operating officer" of the government, trusting policy lieutenants such as Michael Gove at education, Iain Duncan Smith on welfare and Mr Lansley to get on with reforms they conceived in opposition.

But partly as a result, both Downing Street insiders and outsiders say Number 10 lacks the subject specialists such as Andrew Adonis, Paul Corrigan and Simon Stevens in education, health and elsewhere who inhabited Labour's policy and delivery units.

"There just isn't anyone in Downing Street with the expertise to challenge Andrew's assertions," one insider said.

**Nicholas Timmins and Alex Barker**  
**Financial Times**

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### John Healey's Questions

*In response to the announcement of the scrutiny of health plans John has written to the Prime Minister.*

There are questions which the Health Secretary has been unable yet to answer, and on which you and Oliver Letwin will want to be fully satisfied if you are to allow him to press ahead with his plans. The ten must-answer questions for the Health Secretary are:

1. How does the Health Secretary justify breaking the promise you and the Deputy Prime Minister made to the Country in the Coalition Agreement, as your programme for Government?
2. How does the Health Secretary justify to the public and to patients, the £3 billion cost of internal reorganisation, especially within the financial pressures on the NHS over this Parliament?
3. To what extent will the Health Secretary's internal reorganisation distract from and make more difficult the action needed to meet the immediate challenge of sound financial efficiencies, whilst improving patient care?

4. Why have the Health Secretary's plans attracted universal concern from health experts, professional bodies and patients' groups about the risks, and why do fewer than 1 in 4 of GPs – who all other NHS professionals see as the „winners“ in his new system – believe the reorganisation will improve patient care?

5. Why will there be more state (statutory) organisations in the NHS after the Health Secretary's changes than there are now, and why will there be more civil servants in the DoH than there are now?

6. How can the Health Secretary claim that his plans will lead to a "patient-led" NHS, when decisions on commissioning which will drive the provision of services will be made not by patients, or with the direct involvement of patients, but by "GP consortia"?

7. What financial risk assessment and due diligence has been done on the Health Secretary's plans which in 2 years' time will see £80 billion a

year of taxpayers' money spent by organisations that do not yet exist?

8. What Parliamentary and public accountability will there be for failures in patient safety or services and for failures in financial management or probity under the Health Secretary's plans?

9. Is your Government prepared to see trust in the patient-GP relationship put at risk because GPs will make rationing as well as referral decisions on treatment, so that patients will question whether their GP is doing what is best for them or best for the GP's own budget and consortia business?

10. Is your Government prepared to see a two-tier health service as patients find important services will be commissioned and available in some areas but not in others?

**John Healey**  
**Shadow Secretary of State**

## **Membership of the Socialist Health Association**

Free entrance to local branch and central council meetings; reduced fees for our conferences; SHA Journal *Socialism & Health* and frequent email bulletins about developments in health politics; voting rights as a member of a Socialist Society affiliated to the Labour Party; opportunities to contribute to the development of health policies.

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**Conservative Health Policy—what does it mean for the NHS?**

**The Diskus Centre Unite House Theobald's Road London WC1X 8TN**

**Tuesday 25th January**

**With Roy Lilley and others to be confirmed**