



Socialism and Health

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Editors Opening

Public campaigning has tapered off while the NHS Reform Bill has been in the Lords, as the Lords are not very amenable to public pressure. The amended Bill will be back in the Lords early in February and in the Commons about a month later. There will certainly be a renewed outbreak of activity around then, though the chances of actually defeating the Bill don't look very good.

The problems of managing the NHS in a time of financial stringency will become the focus of campaigning later in the year. The Government's approach at present seems to be avoiding difficult decisions, but it seems obvious that we will see elective surgery largely moved out of smaller hospitals, mostly done on a day basis to regional surgical factories. Regional trauma centres will be established and many A & E departments will be downgraded. No doubt other services will also be reorganised on a regional basis as has already happened with London Stroke services. Together with incentives to manage more long term medical conditions in the community maybe using telemedicine this will put huge strain on many smaller district hospitals, especially in suburban areas

Hospital closures are political poison, and Lansley still claims that he doesn't anticipate any, but it's difficult to imagine that there won't be quite a few. At least 25 trusts are in severe financial difficulty and some appear to also be in clinical difficulty such that it would be difficult to defend them in their present form. The day of the District General Hospital offering every clinical service is clearly past, but establishing new ways of working which are accepted by the population will be difficult.

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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

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Please send contributions or ideas for articles

LABOUR HEALTH POLICY – THE FUTURE

Labour left a legacy of a highly effective, popular and improving health service which will soon be wrecked by the Coalition reforms. These now have virtually every key health organisation up in arms against them.

Despite these politically and clinically toxic proposals, the Labour Party appears to have made little headway against the Coalition. And this despite the dangerous and unworkable health reforms being embedded in a sustained attack on people's standard of living and benefit cuts.

One reason for the public's ambiguity about Labour and the health reforms is that there appears no alternative vision from the party. Indeed, many people see Labour as not only opening the door to these changes, but in fact planning for them itself. On the other hand, at this stage in the political cycle, however, it does make sense to avoid committing to a policy that may be inappropriate or worse in 2 years time.

However, the SHA does not need to be handcuffed by these concerns. We intend to run a series of workshops beginning in February or March and running for at least a year or 18 months. These workshops will take place around the UK and focus on different health policy areas. It will be very important to include Wales and Scotland as they have so much to offer as alternative approaches.

We intend to involve at least one key speaker, perhaps academic, at each and then enable participants to work on the policy area collaboratively. After each workshop, the discussion will be circulated and a wider audience involved. Participants will be engaged in a rolling, enlarging group of interested and experienced participants in a wide-ranging policy development process. A social movement, perhaps.

The SHA has already produced documents

that can form a base for criticism and debate. They can be found at http://www.sochealth.co.uk/Policy/sha_policy.html

We have long agreed the following key principles:

- 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 equality of opportunity, affirmative action, and progressive taxation

We do not want this to be an isolated process. We want to engage with the Labour Party and the NPF as the discussion proceeds. We see it feeding into the NPF and for advisors and ministers to participate, particularly as we approach the next election. We are keen to include other organisations such as the unions and Compass.

There is all to play for. Let's do this together. And let's start soon.

Dr Brian Fisher

Health Policy Commission

The Director is an elected member of the Party's National Policy Forum. The NPF has met a few times since the election, but until now the commissions, the functional part of the NPF, have not got down to the task of formulating policy for the next General Election.

The Health Policy Commission is planning its work programme for the year, and as Brian Fisher explains on the opposite page we are planning a programme of events to support them.

Of course our policy interests are wider than health care, and we should include those wider interests in our programme, but at the moment we are asked to suggest (by 9th January) topics that the Commission should consider.

Below is a suggested list of topics which need a policy response. It isn't easy to disentangle some of them, so the grouping of ideas is pretty arbitrary.

The commission is only likely to meet about 8 times this year, so will not consider all these issues, and the Party is not going to consider detailed managerial issues. We may need to reserve some of our expertise for the next Labour Secretary of State. This exercise is all about winning the election.

- Social care — the boundary between health and social care, the personalisation agenda, supported housing and residential care, and our response to the Dilnot Commission
- The balance between central and local health care and the future of the District General Hospital. Developing community services, telecare etc.
- Abuse of drugs, smoking and alcohol
- Competition, markets and choice, the role of the private sector, commissioning and the internal market
- Wellbeing and mental health
- Family support, health visiting and dys-

functional families

- Integrated care, continuity and primary care
- Quality standards, safety, dignity, whistle blowing, mortality rates, Hospital acquired infections— and consideration of the factors which hamper the spread of innovation. This area is going to be dominated by the fall-out from the Stafford enquiry.
- Democratic accountability and patient involvement (both individual and collective), role of local authorities, Community Development, central and local decision making
- Food policy, especially in relation to children
- Transport and exercise
- Rationing, and the comprehensiveness of health services

No doubt there are plenty more topics we could raise!

One important issue for us is about Scotland, Wales and Northern Ireland. The Commission is only concerned with English health policy. What happens in the rest of the UK is increasingly different from what happens in England. We think the differences—which relate mostly to the internal market and public health— are worth discussion and that lessons may be usefully learned.

Our own programme of events need not be confined to this list, nor to what the Commission wants to talk about, and indeed some of the more difficult topics might be easier for us to tackle than an official Party body.

The Commission likes to hear from external experts. If you want to volunteer yourself, or someone else, to talk to the Commission, or to participate in one of our seminars, please say so.

Martin Rathfelder

Keep Campaigning

For a year Cameron's health reforms have been subjected to sustained opposition to the point where there are no longer any discernable supporters. The Bill is a mess but the rush to implement the changes before the legislation was passed, has already cause damage to our NHS not to mention increasing risks.

The core of the Bill which sets out the framework for making our healthcare into a regulated market will remain. There will no longer be any idea of an NHS which is there to provide services and decisions about priorities and funding will be taken by unelected quangos. The Secretary of State will become an observer and unable to intervene. Tthe only genuine political accountability will waste away.

Unless something happens, this rotten Bill will become law around March and mark the start of the end of our NHS as we have known and loved it. The final legislative hurdle will be 7 days on "report" in the Lords during which the key amendments will be debated – and if the LibDems remain true to form they will all be lost. At best a few more of the rougher edges will be taken off by Government amendments which the LibDems will claim they brought about.

So what are the things that could happen?

The most unlikely is that the LibDems peers rebel and force significant changes in the Lords. They could and they talk a lot but they won't. Even if they did their Commons colleagues would be even less likely to join an all party coalition to stop the Bill. Clegg signed the original Bill which was even worse than the current version and his MPs dutifully voted for it – or rather voted to protect their perks and tenuous role in the coalition.

Maybe the combined weight of clinical opinion could be mobilised. It would be of huge significance if all the Royal Colleges collectively just agreed to state without equivocation that they did not support the Bill as they believe that it will be bad for NHS patients. They could say the Bill should be dropped and other ways found to make the necessary reforms with their collaboration. They won't.

Or the GPs could say enough is enough. They have a central role, at least in the short term, in

implementing the changes. Without a high degree of cooperation and even occasional bouts of enthusiasm from a great many GPs it won't be possible to set up the new structures for real. This is the least unlikely but in the past GP opposition has been bought off or neutralised by concessions.

So despite winning all the arguments and despite the absence of support the LibDems will ensure Cameron gets his Bill and the unravelling of our NHS will accelerate.

The time is right for a much wider campaign to defend that NHS. There are many opportunities for us all to play a part.

- becoming members of Foundation Trusts and raising issues
- becoming governors of Foundation Trusts raising issues and challenging decisions
- for those who are existing NEDs on trusts asking awkward questions especially the PCT NEDs who are in limbo
- try for any public appointments to new bodies such as CCGs
- trade union representatives should become staff governors of Foundation Trusts
- trade union representatives can ask questions of Trust Boards through usual machinery for partnership working
- councillors can be appointed on to Health and Wellbeing Boards
- councillors can take every advantage offered by the overview and scrutiny functions
- councillors can put down motions to council
- we can all join patient representation groups
- we can get involved in early stages of HealthWatch creation
- we can attend consultations run locally over the changes or local reconfigurations
- we can support local "Save our" Groups
- we can write to local papers raising the issues
- and even Judicial Reviews of improper local decisions (one under way in Chelmsford).
- If opposition to implementing the Bill comes from the bottom up whilst political pressure is applied from the top down maybe we can halt the rush to the market.

Burnham Nicholson Challenge

The crucial changes required in our NHS do not need legislation or reorganisation – that will make it worse. Shoving complex legislative changes on top of the financial challenges is putting the whole NHS at severe risk.

PCT clusters are proper public bodies. Make the clusters into commissioning support organisations doing all the transactional and contracting stuff – keeping the scarce commissioning/procurement skills (this is already being done as 30 Commissioning Support Organisations are formed). Let them also be shared service hubs running all the transactional finance, HR, estates stuff. Complete the formation of Clinical Commissioning Groups with earned autonomy but insist on them being coterminous with local authorities; they can become formal committees within clusters and so properly publicly accountable. Appoint clinicians on the cluster Boards.

Leave the provider stuff generally alone. Complete Transforming Community Services changes. Keep Monitor as now, keep the Principles and rules for cooperation and competition as now, keep Co-operation and Competition Panel as now. Try and push the Foundation Trust pipeline along but leave the option of a few remaining NHS trusts. Leave licensing and regulation of private providers for a bit.

Upper tier local authorities can use existing wellbeing powers to form Health and Well Being Boards and they already do the needs analysis and should have a strategy for wellbeing. They can ensure clinicians of all kinds as well as patients are put onto the HWBBs alongside the councillors and key officials. Clusters can ensure all CCG commissioning plans are agreed with relevant HWBBs. Use existing powers for shared and place based budgets and provide incentives for sharing facilities, services, posts and budgets across health and social care as well as having integrated commissioning plans through HWBB.

Do not have a NHS Commissioning Board with the irony of a national body commissioning local primary care services! Do all commissioning through the CPCTs/CCGs/HWBBs except specialist commissioning through a new Special Health Authority. Radically slim down the Department of

Health (already happening) and phase out the powers exercised by Strategic Health Authorities—let's really have devolution and earned autonomy.

This would be a greater reduction in bureaucracy and management than that proposed in the Bill. It would also in effect give us proper Commissioning Authorities for defined largish populations as recommended by the Health Committee.

Give the Care Quality Commission more resources. Be nice to NICE. Develop an outcomes framework; develop better tariffs and new currencies but take time and do proper pilots first. Turn Links into Health Watch, with Health Watch England independent through being a Special Health Authority; give local authorities the money to do it properly this time.

Wait a bit and then do the transfer of public health to local authorities with a properly thought out public health strategy. Whoa— that bit might need legislation!

It can be done with leadership at local level in local authorities and from clinicians – especially the GPs. Leadership also from the top and from the professional bodies.

The problem is the same as the one which now confronts the Bill—how to shift from the system being managed top down with power wielded by managers not clinicians. If the centre (ie David Nicholson and his regional commissars) is accountable for the performance and the money then they will do what they always do – interfere dictate shout bully and do their version of management, no matter who is nominally doing the commissioning. The great triumph in the tragic progress of the Bill is how the power has all gone back to the centre with even less checks and balances than now.

The only way is genuine local autonomy set within national clinical standards, but that means those who have all the power now just giving it away; breaking up the Empire. We have more chance of killing the Bill than we have of changing decades of management by shouting at people. The only bit of the Bill I like is the fact that at some point there will be the inevitable NCB vs CCG clash – guess who will win!

Worth a try? - Kill the Bill – smash the Empire.

Irwin Brown

The Challenge for LibDems – Defend our NHS?

Do the LibDems really support the reorganisation of our NHS into a regulated economic market? Will they really vote through the most disruptive and far reaching changes to the NHS in its history? Sadly it appears the answer is yes to both.

The LibDems have voted consistently for a Bill based on the core principle that we can approach health care as a utility like gas, water, electricity or telecoms. They have defended the reorganisation from a managed system, politically and managerially accountable through a secretary of state, to a market system overseen by a powerful economic regulator. No longer will our NHS provide us with health care, instead we can choose from a range of providers of all shapes, sizes and structures – except public ownership - to many this is privatisation.

Despite the most recent changes to the Bill there can be no doubt the core, based on setting up the economic regulation necessary for the market, remains in place. It may take a while longer to get to the end state of a genuine market but once the traditional structures of the NHS have been dismantled and the culture shifted to an economic outlook then the outcome is inevitable.

Most commentators and all three main political parties agree that patient choice and some elements of competition have a part to play within the NHS. But no party has ever stood on an election platform committed to putting competition at the heart of the NHS and treating health care in the same way as the privatised utilities; making patients into consumers, choice into shopping and turning health services into commodities. This was not in any manifesto and not in the Coalition Agreement.

In presenting the Bill the government played down the regulation aspect and claimed the Bill was about patient choice, clinical involvement and reducing bureaucracy. But

as many pointed out these widely accepted issues could be dealt with without the biggest top down reorganisation in the entire history of the NHS. But in any event the explanatory notes accompanying the Bill were clear enough to those that chose to read them – *“These Clauses (the 92 covering economic regulation) have drawn upon precedents from the other utilities”*. As Health Minister Simon Burns’ set out in a Newsnight interview on 19 January 2011, *“It is going to be a genuine market. It is going to be genuine competition”*.

Lest there is any doubt of the intention to continue with this policy, the government confirmed in June this year as part of its response to the “pause”:

*“these changes preserve the core tenet of the Bill: that properly **regulated competition**, when used appropriately, has the potential to improve the efficiency, quality and responsiveness of **public services**, to the benefit of those that use them and the **taxpayer**.”*

And this is just the same argument as set out cogently in 2005 by Andrew Lansley, speaking to the NHS Confederation.

“So let me start with the question of overall structure for public service reform. Public Service Reform is an omnibus term. We should understand it to embrace economic services as well as social services – telecoms, water, rail and postal services as well as health, education and policing. The combination of the introduction of competition with a strong independent regulator delivered immense consumer value and economic benefits.

So the first guiding principle is this: maximise competition. There are, of course, potential benefits from privatisation in terms of access to capital, flexibility, and creating new markets; but private sector ownership is a secondary consideration to competition, which is the primary objective.”

And any remaining scepticism about the intention of the government to treat health care like a utility can be dispelled by the man appointed to head up the new powerful

economic regulator. In an interview with the Times after his appointment Mr Bennett said:

“I worked for a very long while in lots of different countries in the energy sectors, in power and gas, doing exactly this sort of thing. There’s lots of evidence of benefits being produced. It is too easy to say, ‘How can you compare buying electricity with buying healthcare services?’ Of course they are different. I would say ... there are important similarities and that’s what convinces me that choice and competition will work in the NHS as it did in those other sectors. We did it in gas, we did it in power, we did it in telecoms, we’ve done it in rail, we’ve done it in water, so there’s actually 20 years of experience in taking monopolistic, monolithic markets and providers and exposing them to economic regulation.”

There are those on the Tory right who have long argued openly for market solutions and many claims that opening up health care to a genuine market with the entry of private sector providers will bring greater efficiency, innovation and more choice. The evidence to support the claims is at best patchy! How many LibDems believe in this “markets best” mantra?

If the Bill passes it is LibDem MPs and Peers who will have to take responsibility for the end of the NHS as we know it; it can’t be done without them. They can claim that their influence within the coalition has changed the Bill but they must know that is only at the margins – Andrew Lansley has said so, and in the real world the changes are actually being made and the NHS is going backwards.

They may believe that there are balancing features to offset the market impact, but that is like being a little less pregnant. The relatively weak role for health and wellbeing boards is the nearest the Bill comes to allowing any democratic influences into health care but it is clearly subordinate to the drive from the centre for genuine competition for most NHS services. The regulator may no longer be required to “promote” competition but it does not have to – the whole thrust of

policy does that, and the regulator steps in when that policy direction is challenged by any anti-competitive behaviour.

Greater involvement of clinicians in planning NHS services would be welcomed by all, but the Bill puts them within an overarching structure which has a policy of competition from the top, enforced through licencing and regulation, and increasingly through the courts. Having created an economic system for our health care the protection from the full force of competition law no longer applies, and of course that is actually the intention – to put competition at the heart.

The Bill cannot be amended to remove its core purpose, it can only be amended to reduce the impact that it will have. And any LibDem who believes this Bill is not really about economics, markets and regulation simply has not read it.

Aside from the chaos, confusion and cost that this reorganisation is causing the risks in making our health care into a market are real enough. Since the market decides we lose any chance of influence over services and priorities through our communities or through democratic action. Nobody is accountable for the system anymore; providers come and go but the market decides what is provided and where. Inevitably there will be a layered service with those who can pay being able to get earlier intervention or a higher than the basic standard of care. Charges will come in round the margins and then take hold. A basic service will be free but the rest will be left to your ability to engage with the market, and to help you out there will be insurance schemes. Greater inequality is inevitable. We can become like America where around a quarter of health spending goes just on running the system.

A market based NHS is not what we want so why are the LibDems allowing their Tory chums to force one on us?

Irwin Brown

Denigration of the NHS

In order to justify the programme of “Reform” the Government has had to make out a case that the NHS is broken. This started with the often repeated claims that mortality from cancer and heart disease was much better in other countries—which neglected to mention that over the last 10 years the UK’s performance in these areas had improved more than any other countries, and was due to overtake them in 2012.

Now we have the “scandal” of people readmitted to hospital. In 2009/10, there were 16.8 million hospital admissions in the UK. 3% were readmitted within 28 days. This is a 78% increase over 10 years— but over that period there was a 38% increase in admissions and the average age of patients went up considerably. Old people are more likely to suffer complications.

On public satisfaction, the message from the British Social Attitudes Survey is clear: 70% of respondents in 2010 reported that they were overall satisfied with the NHS. This is the highest figure ever recorded by the long-running survey – and for reference, the lowest was 34% in 1997, at the end of the Conservatives’ 18-year tenure.

The Dr Foster Hospital Guide 2001-2011 states: Improvements in patient safety, reductions in infection rates and better waiting times have all contributed to an improved NHS. There has been a remarkable fall in mortality rates. The death rate among the population is over 20 per cent lower than it was a decade ago, helped by better hospital care.

Fewer adults went without recommended care, did not see a doctor when sick, or failed to fill prescriptions because of costs in the UK than in any of the other 11 countries surveyed by the Commonwealth Fund last year.

We have the lowest inequity in the world for access to a GP or a specialist according to the OECD. Money is less of a barrier to access a specialist in the UK than in any of the seventeen OECD countries surveyed.

UK healthcare costs per capita are amongst the lowest in Europe. According to the OECD they are less than countries our politicians commonly compare us with, including France, Netherlands, Germany, Sweden, Belgium, Austria

Satisfaction has never been higher. Two-thirds of people are now either very or quite happy with the state-run health care, the largest proportion since the in-depth British Social Attitudes study began in 1983.

Desire for change is the lowest in the world: Members of the public were surveyed from 11 countries; UK, Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the US. They were asked that if they looked at the health system as a whole, do they think it needs minor changes in the system; fundamental changes; or do you think it should be rebuilt completely.

3% in the UK think the system needs to be rebuilt completely (the lowest in the world). 34% think there needs to be fundamental changes, and 62% think that only minor changes are needed. The UK public think their health care system needs changing less than any of the other countries surveyed.

According to the Commonwealth Fund 2010 report the UK comes out first for efficiency. The US, last. If Mr Dorrell or anyone else says the NHS needs to be more efficient, they need to firstly explain their basis for claiming the NHS is inefficient. They need to compare NHS efficiency with other systems of universal healthcare. They also they need to define efficiency.

The NHS excels in access to healthcare on the basis of need. It has controlled costs more than almost any comparable country and is probably therefore the most efficient system of universal healthcare in the world.

The denigration of the NHS by proponents of reform is not only inexcusable, but the motives are ‘suspect in the extreme’. The aims of the reforms are to destroy a successful public service and replace it with a series of healthcare markets, risking the very core principles of equitable, needs based, cost-effective care for all.

We have a lot to boast about in Labour’s record on the NHS.

Martin Rathfelder

Beyond the Frame: Contemporary Cuban Art



A rare opportunity to view and purchase new works by leading Cuban artists

In support of the Miami 5

With the exception of *Socialist Lawyer*, the British media has been silent on the case of the five Cubans who were working to expose the extent of United States terrorist acts against Cuba. For twelve years these five Cubans have been held in the US in confined spaces, with minimal



opportunities for contact with the outside world.

To challenge this media silence, London and Glasgow will host a ground-breaking exhibition, showcasing the work of up to 30 of Cuba's most established artists.



Beyond the Frame: Contemporary Cuban Art is set for April 23rd – 28th, 2012,

at Gallery 27, Cork St., London. It will draw together a wealth of styles which reflect the richness of cultural life in Cuba today and will also include work by eminent British artists. The exhibition will move to Glasgow in May, 2012.

Produced in collaboration with the Visual Arts Council of Havana and co-ordinated by the Cuba Solidarity Campaign, *Beyond the Frame* will be a dynamic addition to the cultural calendar. Art as a medium for political expression, without being propaganda, will be the core of the event. To this end, the exhibition will include works by two of the Miami 5 – Antonio Guerrero and Gerardo Hernandez.



Socialist Health Events

2020 Health Children's Health under the Coalition Government

Maureen Collins One to One (North West) Ltd

Lady Glenys Thornton

Councillor Imran Hussein

Dave Munday Unite/Community Practitioners' & Health Visitors' Association.

Saturday 3rd March 11am to 4pm Manningham Mills Bradford BD9 5BD Please book

Does the NHS run better without an Internal Market?

Dr Julian Tudor Hart

Dr Tony Beddow

Mark Drakeford AM

2pm Saturday 4th February Kings Hotel Newport Gwent NP20 1QU Please book

The NHS Reform Bill

Lord Hunt of Kings Heath

Saturday 28 January 2012 at 10.30. a.m.

Brandhall Labour Club, Tame Road, Oldbury, West Midlands, B68 0JT

What does NHS Reform mean for Milton Keynes?

The Buszy 401 Elder Gate Central Milton Keynes MK9 1LR

11am Friday 20th January Please book

What does NHS Reform mean for West London?

Dr Onkar S Sahota Director, Family Health Practices Group

2pm Thursday 19th January Ealing Town Hall Please book

What can we learn from past NHS reorganisations?

with Professor Steve Harrison of the Health Policy, Politics & Organisation Research Group School of Community-based Medicine University of Manchester.

at Try Thai 52-54 Faulkner Street, Manchester, M1 4FH

Monday 16th January 7pm Please book

Membership of the Socialist Health Association

Free entrance to local branch and central council meetings; reduced fees for our conferences;

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 Labour health policies.

Membership costs £10 for individuals with low income, £25 for Individuals, £25 for Local organisations

To join post or email your details to: admin@sochealth.co.uk

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