HEALTH EMERGENCY

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No 24

Bulletin of
Hands Off Our Health Service

SIX YEARS HARD LABOUR

has put London Health Emergency at the centre of the fight to defend the NHS in the capital and across the country. But we have had to fight for every penny of funding to carry on the work. Now, despite the generosity of those who donated to our Christmas Appeal (for which we thank you!) on our sixth anniversary we are again desperate for cash.

If you want more information and leaflets on the NHS Bill and help in fighting the cuts, please get your organisation to rush us a donation so that we can keep up the good work.

Send cheques/POs to LONDON HEALTH EMERGENCY APPEAL, 446, Uxbridge Rd, London W12 0NS.

NHS Bill to be law by summer

COUNTDOWN TO THE CARVE UP!

John Harris (IFL)

Ambulance dispute has diverted attention from Bill

By John Lister

WHILE THE EYES of the media have been confined largely to the ambulance pay dispute, the government's fiercely unpopular NHS and Community Care Bill has been quietly pushing its way through parliament.

Ignoring 70-80% opposition from the public, 90% opposition from health workers and near-unanimous opposition from professional and medical bodies, the government is relentless in its determination to impose this new legislation.

Now nearing the end of its committee stage, the Bill seems likely to receive the Royal Assent as early as May this year. If this happens:

■ The Bill's new-style, less representative health authorities – with the present local authority and trade union representatives kicked off, and half the seats handed over to NHS managers – could be functioning by the late summer. A Department of Health leaflet aimed at attracting new members for health authorities is plainly aimed at business figures.

■ As soon as the Bill becomes law, Kenneth Clarke will announce his selected list of hospitals that will 'opt out' of local health authority control to become self-contained businesses as 'NHS Trusts'. There will then be a 3-month charade of 'consultation' in which these hospitals go through the motions of testing local support for opting out: but no ballots or democratic test of opinion will be permitted, and the final decision rests entirely in the hands of Kenneth Clarke himself.

By the autumn, the hospitals that have been given the go-ahead to opt out will set up shadow 'NHS Trusts', each stuffed with five full- time managers and various business and other political appointees hand-picked by Kenneth Clarke.

■ Under the Bill, the opted out and directly-managed hospitals will all have to compete against each other for patients on a new 'internal market' from April 1991. A burgeoning, bureaucratic system of costing, pricing and charging for treatment will lead to health authorities sending each other bills whenever residents of one district are treated in another's hospitals. This will require thousands more staff, and cost at least £200m to administer: **yet nobody knows if it will work!**

■ While hospitals that 'succeed' in attracting extra patients will gain revenue, they will almost certainly have to squeeze out local patients or close down other less profitable specialities in order to treat them. Nobody knows if this will lead to a glut of beds in some specialities – but we can safely predict that it will lead to a further cutback in beds for the costly, low-profit care of the elderly and chronic sick.

Hospitals which lose out in the internal market will lose patients and revenue, and may have to close whole departments to make ends meet.

■ Meanwhile the opting out hospitals will gain the 'freedom' to tear up nationally-negotiated agreements covering pay and conditions for health workers. **They may even refuse to recognise trade unions at all!**

So who can fight the Bill once it becomes an Act? The health unions stand to lose most, but are best placed to lead the fight to prevent the worst aspects of the Bill destroying patient care.

The costing, pricing and billing systems of the internal market need a constant flow of information keyed in to computer systems: this will mean increased work for nurses, clerical and other support staff, many of whom are union members. If this flow of information were to be disrupted, the new financial system could not work.

Nurses and other health workers joined the NHS to care for patients not tend balance sheets: they could ensure that their unions and organisations adopt a policy of *boycotting* any work on internal market information systems, refusing to carry out work not directly linked to patient care – for which they are already short-staffed.

Clerical workers could refuse to cover new work created by the NHS Bill or to cover for unfilled vacancies, leaving management and accountants high and dry.

Such a policy would be popular, tapping the same reservoir of public support for the NHS and opposition to the NHS Bill that has sustained the ambulance workers. It would create the best conditions to hold up the internal market proposals until the next election, when the people could have *their* say on the NHS Bill.

GUYS BALLOT BLOW FOR CLARKE

By GEOFF MARTIN

The latest in the rolling campaign of hospital opt-out ballots has just been completed at Guys Hospital in South London and has produced the most damaging result so far for Kenneth Clarke and his supporters.

The ballot, organised by the Hands Off Guys! campaign, gave all staff at Guys, Lewisham, Hither Green and Sydenham Childrens Hospital an opportunity to have a say on opting out. The final result was 134 for (9.3%); 1,320 against (90.7%)

The 90% opposition was reflected in the ballot results from each of the individual units. Local managers were invited to participate in the ballot – but having refused they then proceded to make the organisation of the vote as difficult as possible. Their reaction to the result started off with stony silence, but when they did eventually comment it was to say that ballots on opting-out should be confined to consultants only!

The Guys vote is particularly bad news for the small group of shady individuals pushing hospitals to go it alone. At the launch of the White Paper back in January 1989 Ian McColl, Professor of Surgery at Guys and the only medic on the Prime Minister's secret review team, said that Guys "couldn't wait" to opt-out.

McColl has since disappeared to the House of Lords, but others have taken over where he left off. Peter Griffiths, former general manager at both Guys and the South East Thames Region, now heads the Self Governing Trust Unit at the Department of Health, with his £100,000 costs paid for by the Queensway carpet magnate Sir Phillip Harris.

It's no secret that part of Peter Griffiths' brief is to work closely with Guys. The hospital has been the flagship of the government's proposed fleet of opted-out units. The fact that the flagship has now been badly holed is good news for campaigners right across the country.

The significance of the Guys result is also mirrored in the ballot results from other London hospitals. The aggregate vote from Guys, North Middlesex, Central Middlesex, and St Georges shows 93% of staff against opting-out, leaving Kenneth Clarke in need of a 44% swing between now and July to justify his plans.

John Harris (IFL)

None too pleased

Crisis hits St Thomas's

An internal inquiry has been launched into the financial management of West Lambeth health authority, to discover how the authority's deficit rose from £534,000 to £1.5m between October and November 1989, and then to a projected deficit of £3m this year and £8.9m by April 1991.

The Regional Health Authority has agreed that West Lambeth can carry forward a £1.5m debt into the next financial year, and has promised there will be no service reductions up to April 1. However a massive package of cuts is already being proposed to slash spending in the new financial year, including closure of 73 more beds (on top of 100-plus already 'temporarily' closed, and the axing of 13 doctors, 68 nurses and 53 other jobs at St Thomas's hospital. Another £3.7m of cuts hangs over the 'Priority Services Unit'.

At the DHA's December meeting there were calls for general manager Dr Stephen Jenkins and Director of Finance Chris Savory to resign. These were rejected, but it was later agreed in private to hold an internal inquiry into the financial running of the authority.

Members heard that under Savory the DHA had spent £500,000 in six months on financial consultants - allegedly because of a shortage of qualified staff in its central finance office.

Payments have included £500 a day for a financial controller, £800 a day for a computer expert and £800 a week for an accountant.

Many NHS ancillary staff don't earn £800 in two months. £200,000 a year for screwing up the finances of a major health district sounds like a nice little earner to us!

In early January, Savory was allowed to resign with six months pay and a gift of a car, believed to be a Rover 820 fastback (a new Rover 820 ranges in price from £14,395 to £22,390).

Savory had been in post for less than a year on a salary of at least £35,000 after an abrupt departure from Bloomsbury DHA, where he also ran up huge bills for financial consultants, and which subsequently discovered itself to be £7m in the red. Somebody in the NHS must really like him: despite his abysmal record, Savory has now been guaranteed further work at exorbitant rates as a financial consultant for SE Thames region.

Meanwhile Health Secretary Kenneth Clarke will be none too pleased: this new disaster seems to have exposed the complete failure of management, and scuttled any chance of floating off St Thomas's as an opted-out Trust later in the year.

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Cash crisis bites into London districts

1989-90 was yet another disastrous year in the long-term under- funding of health services across Greater London. Two widely-reported surveys by London Health Emergency, *Autumn Crunch* and *Christmas Crisis*, detailed the full impact on patient services of the £50 million cash shortfall.

Now, with all four Thames regions setting their revenue allocations for the 1990-91 financial year, it is clear that a new financial crisis is looming. Two major factors have ensured that the districts will once again be faced with inadequate budgets:

- Orders from the Department of Health to wipe out previous years' deficits;
- Under-funding of pay and price inflation.

'Level playing field'

Districts will be required to balance their books from April 1991: this means clearing up underlying deficits accumulated over the last few years. The order to create this so-called 'level playing field' is part of the NHS Bill's proposals for the introduction of funding based on a new capitation basis, and the operation of the new 'internal market'.

Most districts have built up deficits of between £1-£2 million, while some deficits are much higher. Balancing the books this year can only be achieved through major cuts in service.

Inflation

The government's inflation allocation for 1990-91 is a ludicrously low 5%. In addition the four Thames regions have been allocated an average of 2.2% 'growth' money, ranging from 1.4% in North East Thames to 3% in South East Thames.

Figures from the regions indicate that the 'growth money' will be used up in wiping off previous years' deficits.

On pay, the government has allocated an additional £205 million nationally to meet the recent Pay Review Body awards, leaving a shortfall of £44 million – £13m of which will fall to the four Thames regions.

Added to this, the general under-funding of price inflation (assuming a conservative inflation level of 7.5%) will leave London and the South East another £25 million short – building in a total cash gap of £38m before the financial year has even started!

By GEOFF MARTIN and JOHN LISTER

Even the Chartered Institute of Public Finance and Accountancy has warned that this means health authorities will have to use any money they make from 'income generation' and cost improvements "simply to maintain the status quo". CIPFA puts the underlying deficits of the Thames regions at £80m (NW Thames £27.5m; NE Thames £23m; SW Thames £11.5m; SE Thames £18m).

The implications: NW THAMES

The Region has instructed all Districts, with the exception of Parkside and Riverside, to wipe out their underlying deficits this year. The order will have a major impact on patient services in a number of key Districts:

Hounslow

The District has accumulated a £1.9 million deficit which will have to be tackled in 1990/91. Leaving aside the underfunding of inflation, Hounslow is already looking at a £1.33 million cuts package. The District has not yet revealed exactly where the axe will fall, but North West Thames Region admit that:

"Where services are being reduced this is principally in the acute sector".

Hillingdon

Hillingdon will be going into 1990/91 £1.38 million in the red. The District has identified £500,000 of cuts, but are still looking to slash a further £427,000. Hillingdon have always prided themselves on their tight, entrepreneurial style of management, unfortunately this has not prevented them from sliding towards bankruptcy.

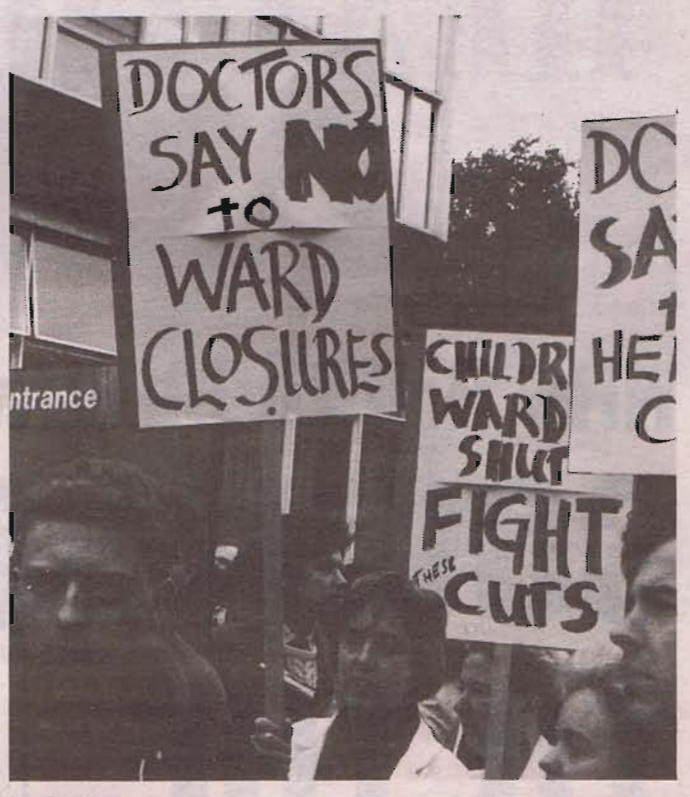
Ealing

The Ealing District will be expected to pull back from a £1.24 million deficit. The Authority are claiming that they can balance the books by expanding their income generation programme. The harsh reality is that income generation schemes never raise the amount of cash originally anticipated. This, alongside the underfunding of pay and price inflation, will guarantee a round of panic cuts in Ealing later this year.

Parkside/Riverside

Both these mega-districts are juggling cash deficits around the £5 million mark. The severe problems that they both face have forced the North West Thames Region to give them an extra year to balance their books. However, the Districts are planning major cutbacks in 1990/91. Parkside are looking at cuts around the £1.25 million mark with Riverside just behind at £1.15 million.

Dave Shields



Andrea Campbell

What future for these and thousands more nurses as cuts hit jobs?

SE THAMES

The financial situation in South East Thames region ranges from the £8.9m nightmare in West Lambeth (see elsewhere in this Health Emergency) to a predicted 'break even' in sunny South East Kent.

Bexley

£350,000 overspent (1.1% of budget), the district has closed seven out of ten family planning clinics. All Bexley's secondary school nurses have been axed, and planned orders of medical equipment, improvements to a health centre, and new windows at Queen Mary's Hospital have been cancelled.

Bromley

On course for a £400,000 overspend, Bromley DHA have implemented a 50% reduction in community dental services. This cut runs alongside a £130,000 reduction in the district nursing budget.

The CHC have reported that most occupational therapy posts in their district remain unfilled, and that there are no local respite care services for carers. £78,000 has been cut from family planning services, and plans to provide Bromley with a sexually transmitted diseases clinic have been shelved.

The current grim position is expected to deteriorate in 1990-91: acute services are expected to be £1 million underfunded, and 16 elderly acute beds have already been axed in advance from the yet to be built new District General Hospital.

Camberwell

Looking at a £1.3m overspend by the end of March, Camberwell have been keeping six acute wards closed. One result has been women with suspected breast cancer being kept waiting up to 40 days for surgery for lack of beds. The recent closure of a medical ward has led to emergency admissions waiting in casualty for up to 14 hours for a bed.

Camberwell is now refusing to accept patients referred from other districts – even when referred from the Emergency Bed Service.

Greenwich

Greenwich DHA is on course for a total overspend of some £859,000 (1.1%), which management hope to deal with by using reserves and delaying payment of bills – a tactic that only stores up new problems for next year.

Specific problems have arisen at the Brook Unit, where a £350,000 overspend is expected as a result of underfunding of the regional cardiac services and overspending on nursing.

Lewisham & N. Southwark

Always a problem district, Lewisham is on course for another £1.5 million overspend this year: however the underlying deficit is estimated to be closer to £6 million.

Cuts in services to the elderly, mentally ill, community services and to people with mental handicaps are being considered. One ward at Lewisham Hospital has been closed for 6 months in an effort to claw back a £400,000: health chiefs estimate they need an extra 10% in funding for 1990-91 to maintain present levels of service.

SOUTH WEST THAMES

The press release from SW Thames region announcing 1990-91 cash allocations is a classic example of the need always to study the small print.

"...growth in revenue... is calculated at 2.6% above inflation (assuming inflation to be 5%)".

Hold on a minute! Inflation at 5%? The government's own forecast for inflation is 7%, and most economists are expecting it to be 8% or higher. This means that the "growth" of 2.6% will be immediately swallowed up, and the cuts machine will swing into action.

Croydon

£1.67 million overspent to the end of November (3.3% of budget), and expecting a massive £2m deficit by the end of March.

Wandsworth

£2.2 million overspent by Christmas (2.8%) and projecting a shortfall of well over £3 million – including more than £2 million on local services – by April 1. The DHA is engaged in a "consultation" exercise over a draconian package of cutbacks to come on top of a December cut of 25 beds. These could include:

- Closure of a further two wards (50 beds) at St George's Hospital, hitting medical, surgical and gynae patients;
- Closure of 12 post-natal maternity beds;
- Closure of an operating theatre at St George's;
- Cutting the number of children's beds
- Speeding the closure of the Morris Markowe mental health unit and a ward at Springfield psychiatric hospital.
- Cutting day care places for the elderly
- Closing 10 neurosurgery beds
- Cuts in clinics, family planning and in backlog maintenance.

Kingston

Under pressure from SW Thames region to take "radical measures" to tackle a £2m deficit up to April 1991, Kingston Hospital, a target for opting out, has decided to close two wards. This could add another 2,000 to the fastest-growing waiting list in London (up 29% – to 3,885 – in the six months to September 1989; numbers waiting over a year up 81% to 1,559; and numbers waiting for day surgery up 40% to 3,911).

NORTH EAST THAMES

Five out of eleven London districts in NE Thames face underlying deficits of upwards of £1 million, topped by Bloomsbury with a projected underlying shortfall of £6.5m.

Barking Havering & Brentwood

After cuts of £2m last year, the DHA has been implementing a 9- month freeze on waiting list admission for orthopaedic surgery, and a huge 'validation exercise' designed to trim the District's huge waiting lists by chopping names off the list rather than treating more patients. Ambitious plans for expanded numbers of acute and elderly beds on two main general hospital sites – Oldchurch and Harold Wood – have been scrapped, with management now looking to a much-reduced number of beds ("less than 1,000") concentrated in a new, single site DGH sometime in the future.

Hampstead

The DHA faces an underlying deficit of £562,000 despite the continued closure of 121 acute beds at the Royal Free Hospital (filled with long-stay elderly patients).

Bloomsbury

Management have still not elaborated plans that could hope to redress the District's huge £6.5m shortfall without seriously hitting services.

Plans to hive off part of Bloomsbury's catchment population to Parkside and to press-gang the remainder of the district into a merger with Islington DHA throw a major doubt over the chances of the proposed new 'mega' hospital to replace UCH and the Middlesex.

City & Hackney

Underlying deficit £2.36m Last autumn saw the cash-motivated closure of 75 acute beds at Barts and 48 at the Homerton hospitals, alongside other cutbacks. The plans for Phase II at Homerton have been held up by the region's capital crisis and now seem certain to involve further major reductions in acute beds.

Islington

Underlying deficit £477,000: last autumn saw panic cuts to meet a £1.6m shortafll, including closures of 65 acute beds, restrictions on outpatient appointments (including a spcialist diabetic clinic), and an expected 50% reduction in routine surgery.

Newham

Though not itself faced with cuts, Newham is up against the indefinite postponement of Phase III at Newham General, and the fall- out from cuts in neighbouring districts.

Redbridge

Underlying deficit £1.3m, waiting lists rising, and plans for new Goodmayes general hospital (linked to closure of Barking Hospital) being hotly contested by Newham and Barking DHAs.

Tower Hamlets

Underlying deficit £2.3m: 1989-90 shortfall estimated at £1.5m. Repeated attempts to force through cuts packages rejected by DHA in October and November.

Waltham Forest

Underlying deficit £1.14m: planned Phase II development of Whipps Cross Hospital (with associated controversial plans to close acute services at Wanstead Hospital) has now been postponed indefinitely as a result of crisis in regional capital programme. Waltham Forest suffered two major 'red alerts' for bed shortages long before the 'flu epidemic overstretched resources elsewhere in London.

Overall, a pattern is emerging in which the rounds of serious cutbacks London's health districts have suffered in 1989 will be overshadowed by the funding gap looming for 1990-91.

Cashing in on waiting list scheme

A £55m government scheme to send 10,000 NHS waiting list patients for private operations – promoted while John Moore was Secretary of State – proved a bonanza for commercial hospitals, according to the National Audit Office.

Costs of the operations turned out to be as much as 94% above the NHS costs for the same treatment. Authorities are warned to ensure that any future such deals give them value for money.

The same report also urges health authorities to check that their part and full-time consultants are fulfilling their contractual obligations to the NHS, and not using NHS time for private work. It discovered that virtually no health authorities ever checked up on this.

Freeman's gothic horror

We have been lectured about Victorian values: now the NHS seems doomed to function for another few decades in Victorian buildings, if Health Minister Roger Freeman gets his way.

Some may remember watching then Secretary of State Norman Fowler unfurling a long – largely fraudulent – list of new NHS building schemes in front of television cameras and his own party supporters.

Now the same government that (falsely) boasted its role as the sponsors of new buildings for the health service is urging health authorities to hang on to 'much-loved' crumbling 19th century heaps.

The decrepit buildings, run down not least by years of savage cash limits squeezing out vital maintenance work – and also by health chiefs looking for pretexts to close them down – are now apparently the cornerstone of government health strategy into the 21st century.

This proposal runs alongside the retreat in mental health policy from a full-fledged drive towards community care (which requires considerable capital investment) into keeping open the present long- stay hospitals.

John Harris (IFL)

THE AMBULANCE PAY dispute is ending its sixth month as we go to press: and while remaining the most popular pay fight of all time (with 85% public support) it is taking a heavy toll.

More and more ambulance workers – especially the more highly- trained emergency crews – disgusted at the government's contempt for them, are threatening to quit the service as soon as they get their back pay. Even disillusioned army medics, brought in to scab on the dispute, are now talking of getting out.

Police chiefs admit (and St John's ambulance 'volunteers' try to conceal) the fact that they cannot provide a proper service, while NHS management and the government show only that they don't care how much they spend, how many patients suffer or how many lives are lost as long as the ambulance workers are not seen to win.

Health workers and campaigners have already shown where they stand: they know that without decent pay there will be no ambulance staff and no service. The huge response to the January 13 events and the TUC's supporting action on January 30 show that the whole labour movement would respond to any further call for support.

The ambulance crew are fighting for pay – but also to defend the NHS. They must be supported.

Lining their wallets

Ministers and managers may be taking a hard line against pay demands from ambulance staff, against nurses' regrading and over pay for other support staff, but top NHS bosses are busily feathering their own nests.

Not only is anti-ambulance hard man Duncan Nichol in line for a thumping £90 per week (£4,750) salary increase under the 'Top People's Salary Review Board' (just the type of external body that could answer the demands of the ambulance drivers), but NHS general managers are also to be more 'flexibly' rewarded for their hard graft closing wards, opting out hospitals and cutting staffing levels.

Their new package will cost an extra 9% per year – the same percentage increase that was offered to the ambulance staff over 18 months. But managers would pick up much larger sums of money: their new scales would run from £45,000 to £65,000 (plus perks) for a regional general manager, and include a starting scale of £24,000 for a unit general manager.

We are told by Mr Nichol that managers (apparently unlike other staff) need such a pay structure to 'help motivate' them. yet it seems that other NHS staff are supposed to be 'motivated' by low pay coupled with regular doses of abuse from Kenneth Clarke!

Property slump devastates building plans

By Geoff Martin

The slump in property prices has devastated plans for new hospital buildings across London and the South East.

The four Thames regional health authorities had planned to finance new building works through the sale of surplus land, but high interest rates have brought house building to a virtual halt with the result that residential land values have slumped by between 50 and 75%.

Worst hit of all the Regions is North West Thames. Here the problem has been compounded by the escalating cost of the new Westminster and Chelsea Hospital which is now reaching Channel Tunnel style proportions.

The cost of this politically sensitive development has shot up from £78 million in July 1988 to a staggering £173 million. North West Thames are determined to protect the Westminster and Chelsea project, presumably because any move to delay it would be a serious jolt to the government.

At their meeting on the 18th January the RHA voted to scrap all new building projects across the Region and to divert all available resources into the Westminster and Chelsea project. Even after taking these drastic measures the Region will still be £19 million in the red on their capital account leaving them technically bankrupt.

Brum hospitals scheme in ruins

NW THAMES IS NOT the only region to face a runaway increase in estimated building costs.

West Midlands RHA has found itself increasingly at sea on its plans for the reorganisation of Birmingham's hospitals, with capital costs reportedly up from £130 million to £500 million, and estimated running costs increased by £37 million in just eight months since last April.

The RHA now seems certain to opt for a reduction in planned activity levels and a longer time-span to carry out the rebuilding including the long overdue reconstruction of Birmingham Children's Hospital, not now due to start until the next century.

(Information from West Midlands Health Service Monitoring Unit)

Newham on the warpath

Even before the NHS Bill does its damage, Newham is faced with a second-rate hospital service and the indefinite postponement of the long-awaited Phase III of Newham General Hospital.

The Phase III development included the closure of the 130-year old St Andrews Hospital – previously a workhouse – and the transfer of wards to the proposed new building on the Newham General site in Plaistow.

Newham Health Emergency, set up last April with support from Newham council, local unions and community organisations, is determined to fight back against these attacks on our NHS, and has recently published leaflets opposing the Bill.

Contact NHE c/o PO Box 699, London E13 9DD (01-471-1175)

"No confidence" from the shires

An angry North Herts DHA, frustrated at the revelation that all capital programmes other than the Westminster and Chelsea Hospital have been scrapped in NW Thames region, passed a 'no confidence' motion at the end of January, and called upon Kenneth Clarke to review activity in the Region and intervene. The resolution deplored the way in which:

"The Regional Health Authority has failed to redeploy resources from London to the Districts; failed to prevent the development of chronic overspending during the 1980s; failed to monitor rising costs of capital projects (especially in Central London, where the cost of one project alone has escalated by 221% since June 1988); and failed to recognise the desperate capital needs of the Districts".

Meanwhile in North West Herts DHA, management in the mental health unit are contemplating the total ruins of their strategy, as the planned 80 new acute beds to be established on general hospital sites have been scrapped for lack of cash to run them, and the NW Thames capital programme crisis has brought plans for community care of the mentally ill to a grinding halt. Now plans are being drawn up to close acute services at St Albans City Hospital, and centralise at Hemel Hempstead, to save £1.7m.

The January NW Thames RHA meeting received a paper from Finance and Planning directors which admitted:

"In common with other care groups, most mental illness schemes have had to be postponed and few remain in the category where capital is firmly allocated".

'Caring for People'

Community care White Paper ditches the 'positive' points of Griffiths

By JOHN LISTER

The government's White Paper on community care, published only days before its contents were included in the NHS and Community Care Bill, marks an important shift from the initial ideas in the 1988 Griffiths Report.

While many critics of the government were caught unawares by Griffiths, latching on to aspects of his report which they felt should be supported (even forming the ludicrous 'Griffths Now' lobby), the government has scrapped almost all of these 'progressive' elements.

Gone is the proposal for a new ministry for community care – with the implicit acceptance of central government responsibility for local provision of services.

Gone too is the Griffiths proposal for community care funding to be paid to councils by central government in the form of earmarked ("ringfenced") cash, the spending of which would be monitored.

Also dropped is Griffiths' wholly inadequate proposals for the transfer of NHS staff to local government social services.

■ Retained is Griffiths' insistence that community care for the elderly should be largely switched from the NHS (where it is free at point of use) to means-tested social services.

■ Retained is the core Griffiths view that local authorities are useful for this purpose because they can be left to carry the can for policy failures due to lack of resources, keeping Whitehall's hands clean.

■ Retained is the insistence that services should be supplied not on the basis of need, but subject to rigid cash limits.

■ Retained is Griffiths' proposal that *all* community care services, including domiciliary services, should be put out to tender, with councils obliged to show how they had worked to 'stimulate' private sector involvement.

"Put it this way — if you don't expire soon, our life savings will."

■ Retained is Griffiths' separation of community care for the elderly (many of whom have houses and/or savings available for means-testing) from the mentally ill (few of whom have any substantial means).

■ Added to the White Paper (and the Bill) is the refinement of a *cash penalty* on any council that sends elderly patients to its own directly-managed residential homes rather than to the 'independent sector'. A likely consequence is that the lion's share of council-run homes will in due course be sold off to the 'independent sector' or closed down as uneconomic.

■ Dropped from the Griffiths' plans are proposals for a new skivvying grade of 'community carer' to carry out the day to day work of domiciliary care. This is regarded as unnecessary in the light of the proposals for competitive tendering to bring down pay and conditions.

■ The White Paper is much more elaborate in its discussion of means- testing than was Griffiths: the discussion of charges recurs as a theme. *Caring for People* declares from the outset that while the rich can of course purchase whatever form of care they choose, "the provision of care at the public expense should be preceded by a proper assessment of the individual's needs". (3.1.3)

In case any misguided soul reads this as anything other than ensuring the bare minimum is spent on any individual, the terms "financial control" and "available resources" crop up repeatedly throughout the White Paper, which insists upon 'linking case management with delegated authority for budgetary management'.

Under the heading *Paying for Places*, the central element of means-testing is spelled out: while social services will actually pay the bills for care, "the authority will then be required to assess the ability of each individual to contribute towards the cost of the care they will be receiving". (3.7.6)

There are a few ritual platitudes about equality, claiming that:

"In practice, many consumers of social services cannot afford the full cost of the service, and ability to pay should not in nay way influence decisions on the services to be provided". (3.8.1)

However it is clear that all decisions will be taken "subject to the availability of resources", after the authority had decided how much it is able to pay. There will be one set of limited 'choices' for the poor, and a much wider choice for the wealthy:

"If relatives or friends wish, and are able, to make a contribution towards the cost of care, an individual may decide to look for a place in a more expensive home".

Who knows? If they are rich enough, elderly people may even wind up rubbing shoulders in a few years with Sir Roy Griffiths in a real upmarket home! The whole White Paper echoes

Thousands more elderly patients will have to pay for lo

Griffiths' starting point of:

"the Government's general policy on charges for local services: those able to meet all or part of the economic cost should be expected to do so". (3.8.1)

Already means-tested charges for social services raise over 10% of the £3.4 billion annual expenditure: the new proposals will increase this, and at the same time reduce the free provision of care under the NHS. The White Paper also restates the commitment to means-tested charges for other forms of community care – home helps, home care, meals provision and day care services.

Caring for People ignores the fact that the NHS Bill is removing local authority representatives from health authorities: it calls for each health authority to "agree the level of care it proposes ... with the relevant local authorities to ensure that health and local authority plans are compatible and comprehensive". Yet each authority is locked by cash limits into a competition to pass the buck of community care to the other (or in the bland words of the White Paper 'trying to achieve the best value for public money'.)

Though the Health Secretary receives new powers to direct the work of local authority social services, this is to be enforced in such a way as to avoid taking any central responsibility: though it will have the right to intervene (and point the finger at local councils),

None of the proposals offer any comfort to the estimated 6 million people in Britain – mostly women – who contribute largely unpaid and unsupported services conservatively estimated to be worth £15 billion a year (two thirds the size of the NHS budget).

The focus on "needs assessment" coupled with cash limits is likely to restrict rather than enhance the level of care available to any patient – and the extent to which relatives can be roped in to provide free care at home is likely to be used as a pretext for even less social service support.

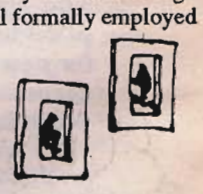
Not only do the frail elderly lose their rights to DHSS support in residential care (this is now subject to the agreement of their 'case manager') but their relatives are equally deprived of much hope of release from the drudgery of unremitting domestic labour.

Worse, the danger that home help and other services could be handed over to cheapskate cowboy contractors (who have already done severe damage to hygeine and standards in many NHS hospitals) adds a new threat to the frail elderly in their own homes, and piles a new pressure onto their relatives and neighbours.

Meanwhile NHS staff in long-stay geriatric and mental illness hospitals face a future of growing insecurity. After years of being 'reorganised' by NHS management, they might find themselves faced with a number of possible situations:

■ Some may find that they remain within the NHS, but part of a much reduced service for the frail elderly or mentally ill;

■ Some may find that though they are still formally employed



'IT MIGHT CONCEIVA

Stefano Cagnoni (Report)

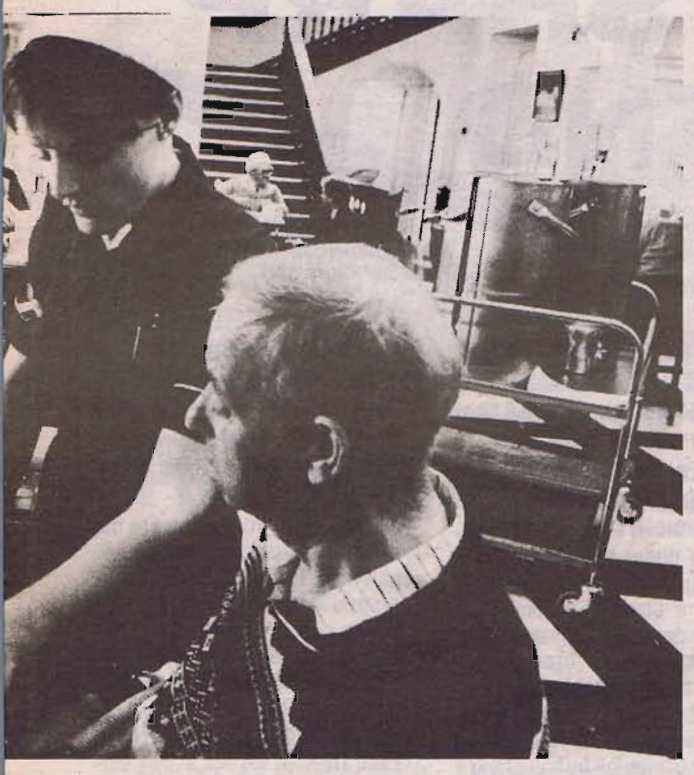
Beds crisis:

End of the

By early December 1989, cash and staff shortages in London's hospitals had brought the total of "temporary" closures of acute beds in the current year to over 750.

Several high- spending health authorities, including Riverside, Bloomsbury, Tower Hamlets and Wandsworth, were still deciding how to cut multi-million overspends.

Almost 10,000 acute beds have permanently closed in the capital in the five year period



-term care

by the NHS, the unit in which they work has either 'opted out' or become a 'provider' unit, supplying care on a contract basis to social services. This could threaten their existing pay and conditions of service;

■ Others may be faced with a transfer to work in the community, but find themselves offered little if any retraining and support;

■ Some may be forced to transfer from NHS jobs to local government, with very different terms, conditions, union representation and staffing levels;

Finally a completely separate chapter looks at the issue of community care for people with mental illness.

The White Paper promises a 'specific grant' to social services authorities from 1991-2, but gives no clues as to how large or small this might be. At the same time the government has been back- pedalling on community care policies for the mentally ill, urging health authorities not to speed up the closure of large psychiatric hospitals until alternative community services are available: this comes long after pressure groups have been complaining of the thousands of discharged former patients who have 'disappeared' into the community with no support whatever.

Local authorities have historically made little provision for mental health, allocating less than 3% of spending to these services. Health authorities, too, have been spending a declining percentage of cash on mental health services: the current share is just 15%.

The temptation must be for health authorities desperate for cash to divert the savings from the run-down of the large hospitals into the more glamourous acute services.

Cashing in on "community care"

By JOHN LISTER

Even before the government's NHS and Community Care Bill comes in, with its aim of pressurising local authorities to sell off their residential accomodation for the elderly, the last ten years has seen a mushrooming growth of profit-seeking private homes.

Private provision for the elderly now outstrips the number of places available in long-stay hospital beds and council-run residential and nursing homes.

Latest figures show 231,000 private places available, (143,000 residential; 88,000 in nursing homes), and 50,000 in the voluntary sector, compared to 215,000 in the public sector – comprising 136,000 places in local authority Part III accomodation and 80,000 long-stay NHS beds (49,000 geriatric, 31,000 elderly mentally ill).

The government's objective is to reduce much further the numbers cared for in NHS beds (which are funded from taxation and free at point of use), and increase the numbers subjected to means-testing in the care of social services.

This is the reasoning behind the Community Care proposals in the NHS Bill, which set out to remove the long-term care of the frail elderly from the responsibility of the NHS, and place it instead in the domain of local government.

The government has guarded against local authorities using this new extension of their brief to build up a new 'empire' of residential and nursing homes by insisting that central government subsidies will only be paid towards the keep of elderly people in private or voluntary homes: the councils will have to bear the full cost of every client they decide to accomodate in a council-run place.

Even before this latest boost, privately-owned residential and nursing homes for the elderly represented a 'nice little earner' for thousands of small-time and larger proprietors. A full home can reckon to turn in a 30-40% net profit on its turnover after paying overheads, staff wages and food bills.

With soaring numbers of potential 'customers' – especially people aged over 85, who are expected to rise in numbers by 50% in the next ten years – it is small wonder that numbers of private sector places have more than trebled since 1981, while local authority provision has remained static.

1,000 residential homes change hands each year, with some 15,000 registered, averaging 14 rooms and 17 residents each.

£1.5 billion is already invested in this type of private care for the elderly, and while 80% of homes are still owned by individuals, big corporations are increasingly moving in: four British firms alone have spent over £123 million in buying up suitable properties in the last two years, one of them, Court Cavendish, having spent £45 million in just 15 months. This kind of investment only comes when there is a sure smell of profits to come.

At least 40% of the residents are paying their own way or topping-up means-tested benefits from savings or through contributions from relatives.

Average fees are £258 a week for a single room and £229 for a shared room: yet local authorities will pay only £140-200 for residential accomodation, while DHSS payments for nursing homes have been limited to £190-235, leaving relatives or the residents' own savings (and housing assets) to make up the difference.

Your hospital – or their business?

If anyone doubts that opted-out hospitals represent a stepping stone towards a two-tier and increasingly privatised health service, they should look more closely at the 'business plans' being submitted by major hospitals as part of their bids for self-governing status.

The *Sunday Correspondent* on January 7 reaveled plans by managers of Newcastle's Freeman Hospital to utilise 'spare capacity' to carry out private operations on patients from Europe, while NHS hip replacements have already been cut back by 16% for lack of cash.

The Freeman bosses don't just want to bid for private work: they want to offer the private patients and their insurance companies super cut-price bargains – at the expense of the taxpayer and NHS waiting list patients whose beds will be used for wealthy queue-jumpers.

An initial tariff has been drawn up by Freeman bosses showing costings that under-cut private BUPA hospitals by almost 50% on a tonsillectomy (£533 compared to £1,011) and varicose vein operations (£563 compared to £1,166), while lopping almost a third off the cost of hip replacements (£2,512 compared to £3,879).

Managers argue that this leaves scope for adding a profit margin while still beating the prices of private hospitals. NHS patients will no doubt wonder why NHS chiefs are so keen to squeeze them out and replace them with private customers at a marginal maximum profit of a couple of hundred pounds per head – assuming each case is uncomplicated.

NHS consultants may also query the assumption that they will continue to do private operations in opted-out hospitals for a fraction of the fee they could charge in a private hospital. NHS managers claim orthopaedic surgeons would perform private hip replacements for £100 in the Freeman hospital, compared to a fee of £1,000 in a private hospital.

Even if this preferential rate were to be available, it surely flies in the face of the government's calls for a 'level playing field' in competition between the NHS and the private sector – and would not last long.

The *Correspondent* quotes other cut-price operation 'menus' being drawn up in East Anglian hospitals; but it is in the opting-out hospitals that the new 'freedom' to switch NHS beds to private use (incorporated in the NHS Bill) is being most keenly awaited.

Management at Harefields Hospital near Hillingdon, for example, are looking towards a big expansion of private care to eradicate their chronic financial deficit. Their documents on their viability as an opted-out 'public corporation' spell out the logic:

"The prospects are good for private patient work: the market is expansing and the unit has already demonstrated its ability to attract a considerable caseload from this source. Income from private patients is currently in excess of £2m per annum ...".

There is, significantly, no corresponding figure for the *costs* of private treatment or the rate of profit it generates.

Harefields chiefs rejoice in the idea of swapping NHS for private work, and of putting other local hospitals out of business through 'competition' on the internal market:

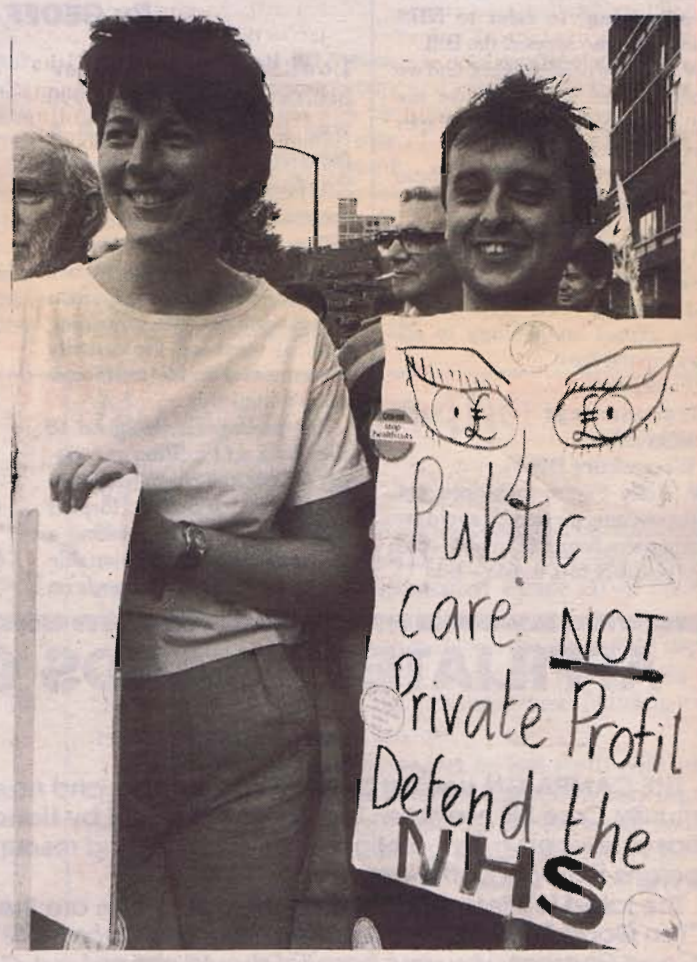
"although a major increase in health service demand is unlikely, the prospects for the future are good [!]. Opportunities may also exist to increase workload at the expense of other hospitals, particularly district general hospitals ...".

Meanwhile at St Thomas's, management have spelled out their commitment to increased private beds, partly filled with 'overseas referrals' speeded in after the completion of the Channel Tunnel.

Ignoring the more humdrum services such as general surgery, the St Thomas's prospectus on development of services focusses on space-age specialties at the frontiers of modern technique, before spelling out that :

"There will be an expansion of private patient services including a range of choice for accomodation".

There is no reference in the opt-out proposal to the 7,000-plus waiting list patients who would appreciate *any* hospital bed at St Thomas's, nor any discussion of how extra private beds could be opened and staffed without cutting services to NHS patients.



greenhouse' effect?

1984-89, representing a cut of some 22% on the 1984 total of 43,817 beds: the current wave of temporary closures comes on top of this.

What will happen after "opting out"?

December's flu epidemic triggered "yellow" and then "red" alert restrictions on waiting list admissions covering most of London.

However the present problems encountered by the Emergency Bed Service will be multiplied many times over by the proposals in the new NHS Bill. Under the Bill, health care other than Accident and Emergency cover will be provided only on a pre-arranged contractual basis, with each unit gearing its capacity to a predetermined caseload.

The problem could be even more difficult in the case of the dozen or more major London hospitals which seem likely to "opt out" of local health authority control and become "self governing trusts".

Hounslow in chaos as scheme collapses

By John Lister

"We can now plan with confidence for a brand new hospital for the year 2000 and beyond," came the brave words from Hounslow & Spelthorne health chief Peter Droog last December.

He was welcoming the 10-6 decision of Hounslow DHA to accept a plan drawn up by city analysts Price-Waterhouse for a single new district general hospital with 900 beds to replace the two existing general hospitals (West Middlesex and Ashford) with 1306 beds (many of which are 'temporarily' closed).

The celebration was premature: NW Thames region has since frozen all capital programmes (see article elsewhere in this paper); the Hounslow hospital scheme is already being further reduced in numbers of beds; and the West Middlesex unit general manager is so lacking in confidence for the future (and reportedly also confidence in Mr Droog) that she has now resigned. The district's plans are in a complete shambles.

15 years ago the West Mid alone had 1,000 beds

The Price Waterhouse report was not a good starting point. At £200,000 to produce, it weighed in at £1,000 a page. It presumed that 15,000 Accident and Emergency patients and 1,152 acute admissions could be simply diverted to other hospitals (even though the same report confesses that there is no spare capacity in either Kingston Hospital or Queen Mary's Roehampton, and no prospect of any without additional investment).

The report does not impress as a work of high quality research: it sets out to confuse the statistics by ignoring the numbers of beds already 'temporarily' closed, to produce a revised current total of only 1067 beds rather than the actual available total of 1306.

Other contradictions in the report (perhaps written in a Rover fastback?) include falsely optimistic travelling times for public transport – one bus journey claimed as 37 minutes is timetabled for 57. Local health campaign Hospital Alert has described the train journey times quoted in the report as 'laughable'.

The new single site general hospital is costed at £141m on a greenfield site. This would render the DHS liable to capital charges of at least £8m a year.

The proposal is now out for a 3-month 'consultation' – during which time a combination of building price inflation and regional cutbacks in capital spending seem likely to prune it back and postpone it considerably.

Hospital Alert and the CHC have vowed to fight on against this serious threat to health care in a district covering 300,000 people.

Hospital Alert can be contacted at 51, Grove Rd, Hounslow, TW3 3PR.

Headbangers hit back

Dear Hands Off Our NHS,

We have just read your leaflet 'Ten Good Reasons to Kill the Bill', and we object to the derogatory use of the term 'headbanging' to refer to NHS managers who support the Bill.

We are two headbangers, and we work for the NHS: but we are definitely against the White Paper proposals and the Bill.

In future, please refer to these people as 'house' or 'acid' managers, since these represent the most crap and pointless music we can think of (except for country and western).

We expect an apology to all heavy metal fans.

Thankyou

Braindamage and Skullkrusher

(Bloomsbury DHA)

● Dolly Parton fans need not bother writing in: we will avoid attacking any forms of music – except possibly folk music – Ed.

Axe swings in Merton

By GEOFF MARTIN

London's first major health cuts package of 1990 was pushed through a meeting of the Merton and Sutton DHA early in January.

The Authority confirmed plans to totally close the 80 bed Wilson Hospital in Mitcham along with the last remaining surgical ward and the casualty department at the Nelson Hospital in Wimbledon.

The package is designed to claw back a £1 million underlying deficit, and centralise acute services on the Sutton Hospital and St Helier sites, creating a monopoly which will enable Sutton and St Helier to press on with plans to form an opted-out trust.

However, a further round of cuts is already being lined up. As well as the £1 million underlying deficit the District is a further £650,000 overspent this year. The Nelson Hospital, which after the current cutbacks will be reduced to a geriatric unit, has clearly been earmarked for total closure in the near future.

At a recent meeting, the Chair of the South West Thames Region Julia Cumberledge said that there could be "no guarantees" as to the future of the Nelson.

Meanwhile, local campaigners are battling on.

What's the colour of money?

QEII Hospital in Welwyn Garden City is joining the new NHS bandwagon – inviting companies to sponsor beds.

According to how generously inclined a sponsor may feel (and how potentially rewarding the sites on offer), firms may sponsor individual beds, clusters of four beds, or whole wards ("lease terms and fees would be negotiable").

The wards would be named after the company (the Arthur Daley ward?) and "if the company wished, the ward could be painted in the company's corporate colours [!]".

Sunglasses on for the Jif lemon ward!

Unit manager Derek Hathaway claimed that "This scheme is not about finding alternative ways to pay for services ... It is about finding imaginative new ways to invest in extra facilities and to improve the general appearance of the hospital."

How 'imaginative' is it to go cap in hand to local employers? How does the splurging of scarce resources on painting wards a motley array of garish company colours to make it look like a bizarre trade exhibition, together with adopting a series of wacky and demeaning names for wards, help improve the hospital?

This is clearly a mystery revealed only to those who have become today's breed of general manager.

AFFILIATE to HANDS OFF OUR NHS!

THE CAMPAIGN against the NHS White Paper and now the NHS and Community Care Bill has been led at national level by Hands Off Our NHS, which has produced a range of publicity material and resources for local campaigns throughout the country.

The latest leaflets produced by the campaign are the popular A5-size "Ten Good Reasons" leaflets: *Ten Good Reasons to Kill the NHS Bill* **and** *Ten Good Reasons why your hospital should not opt out.* **Copies are still available at £2.50 per 100 or £20 per 1,000. Also available:** *20 Questions on hospitals opting out* **(4pp A4): single copies 40p inc postage, 10 for £2.50, 100 for £20.**

Also available Hands Off Our NHS badges and balloons, and long or round car stickers (£2 for 10); and T-shirts ("Hands Off, Clarkie!") £5. Still available: the pamphlet that replies to the original White Paper, *Hands Off Our Hospitals,* **now only £6 for 10 copies.**

PLEASE AFFILIATE OUR ORGANISATION TO HANDS OFF OUR NHS. I ENCLOSE £...

Name.....

Address.....

.....

Organisation (if any) .....

Position held .....

Send to Hands Off Our NHS, 446, Uxbridge Rd, London W12 0NS.

The SHARP END

Compiled by GEOFF MARTIN (Our man in the social club bar)

CLARKIE'S FAN CLUB

Interesting that the Department of Health decided that it was within their brief to issue a press release announcing the formation of the Kenneth Clarke fan club.

Going under the name of the NHS Reform Group, this tiny bunch of Clarkie Groupies held their inaugural meeting in Virginia Bottomley's broom cupboard, having decided that her wardrobe was too large a venue.

The Deform Group have kicked off their campaign by launching a "Destroy The NHS Now!" petition, which they hope will attract "quite a few" signatures. Watch out for them.

COMPLETELY BONKERS SECTION

With calls for democratic reform sweeping through various parts of the world, Sharp End can report that in the little-known statelets of Mertonia and Suttonia the hardliners are still in control

As the District pressed ahead with plans to opt-out their general hospital, St Helier, the two local Councils that cover the area both passed motions calling for a public ballot of the community.

The response from the Health Authority is simply an admission that they can't and won't justify opting-out;

"...balloting is inappropriate as not enough information is available about the benefits of self-governing status," (Because there are NO benefits! - ed). "...Consultation is thought to be more meaningful and less expensive than balloting."!!!!!

These lines appear to have been "lifted" from that well-known text 'Democracy: I did it My Way', by the late, great Ferdinand Marcos!

KNIGHT FEVER

A press release fron North East Thames tells me that their Chair, David Berriman, received a knighthood in the New Year Honours.

Much more interesting are the brief biographical details. Apparently Sir David has a background in merchant banking (I'm saying nothing) and was the first chairman of Sky Television.

With the commercialisation of health care under the NHS Bill can the lucky patients in North East Thames expect a free sattelite dish with every hernia? Derek Jameson and Frank Bough dropping in to cheer them up on the wards at Newham General? Or maybe compulsory 24 hour Australian soap operas in every hospital?

That little package should speed up the patient throughput.

SPIVEY GETS THE HUMP

John Spivey, Unit General Manager at the Nuffield Orthopaedic Centre in Oxford, is not at all happy with the Hands Off Our Hospitals! campaign.

The Nuffield management is keen to opt-out, and Spivey has made it clear in a quite extraordinary letter to Hands Off! that he doesn't want leaflets opposing opting out distributed in HIS hospital without HIS permission.

Little does Spivey know that a propaganda sheet that his managers produced, giving staff 20 reasons why opting-out is a good idea has been turned round by Hands Off! into a leaflet giving twenty reasons why opting-out is bad news for staff. Many thousands have been distributed across the country.

Brent campaign

Brent Health Action is a new campaign in defence of the NHS. A non- party organisation, it aims to coordinate activity in the borough between health workers and the general public.

Until now, support for the ambulance workers has been seen as the key priority, with regular reports from local ambulance worker John O'Connor.

Brent Health Action is campaigning against the NHS Bill, and for much greater popular control over the NHS. Activities include support for the Million Signature Campaign launched by SOS NHS, and plans for a Public Meeting on March 13 - at the Irish Centre, Salusbury Rd, NW10 - at which speakers will include local MPs Ken Livingstone and Paul Boateng.

Contact Secretary Ursula McLean, 62 Wrentham Ave, London NW10 3HG 01- 968-8289. Chair Marie Lynam 965-2869

Manchester 'no' to opting out

Central Manchester Health Emergency is planning activities for March to mark the first anniversary of the 'Secret Expression of Interest' in opting out, steamrollered through by controversial DHA Chair Ken Collis.

Campaigners are also fighting the DHA's plans to launch a charity appeal to fund a new Children's Hospital, and fighting 'cuts and profiteering in the NHS'. Affiliations and active support are invited: contact Colleen Darby, CMHE, 6, Isobel Walk, Manchester 16 (061-226-1600).

Greenwich lurches from crisis to crisis

By a Special Correspondent

Wayne Edginton

"I am writing to inform you that the health visiting service in this District will be curtailed with effect from 2nd January 1990".

With this stark message to parents of young children and health visiting staff, Greenwich health chiefs ushered in a new decade which, if the last ten years is anything to go by, spells misery for local NHS staff and users, with women and their dependents being hardest hit as usual.

Only a few years after the inquiry into the death of Kimberley Carlile recommended an extra 17 health vistors on top of the funded establishment, Greenwich finds itself 12 staff below – creating the situation where the 16,000-plus caseload will be slashed to 2-3,000 'priority' cases.

Greenwich health authority trained twelve health visitors last year, but on qualification only half were offered jobs, despite the clearly mounting staff shortage.

By the end of 1989 the Community Unit which runs the health visiting service, was £58,000 overspent, and set to end the year £100,000 in the red, largely as a consequence of overspending (underfunding) of the community nursing budget.

In December four health visitors, unable to take the strain any longer, handed in their notice. As quick as a flash management seized upon the opportunity to reduce the level of overspending and 'revise' their year-end predicted overspend to £70,000.

As a Christmas gesture of goodwill, Community Unit manager Simon Robbins axed the Glyndon childcare clinic with hardly any notice, notwithstanding the fact that Glyndon has a high concentration of young children in a very socially deprived area.

Not content with this, Greenwich's managers continued in their efforts to force the dwindling numbers of health visitors to take on even heavier caseloads – to the extent that they were in breach of their professional code.

It was only when lawyers representing SE Thames region upheld the HVA's objections that Mr Robbins – backed by the authority's senior managers – decided to axe the comprehensive service, to replace it with a 'fire-fighting' service only.

Last August the government produced figures showing Greenwich to have the 2nd highest infant mortality rate in the whole of London, and the 15th highest in England and Wales.

Now staff are saying that vital services have suffered enough: there is a growing campaign to restore the health visiting service, spearheaded by a combination of the clergy, mothers, health visitors, the CHC and community organisations.

While campaigners are confident, there is less certainty over the future of Simon Robbins as an angry District general manager and DHA chair Neville 'Ceausescu' Thompson cast around for a scapegoat.

Blood money?

By GEOFF MARTIN

A review of the Blood Transfusion Service by management consultants Deloittes, Haskins, Selles has recommended rationalisation and the eventual opting-out of the entire service south of the river.

South London's BTS is the only bi-regional service in the country – and also the biggest, covering a total population of 6.5 million.

The service currently runs from two main centres, one in Lewisham and the other in Tooting. Deloittes recommend the closure of the Lewisham centre, with services centralised at Tooting.

The report stresses the importance of the BTS becoming "more business-like in its approach, particularly in the light of an increasingly commercial NHS market".

You wouldn't really expect a firm like Deloittes to suggest anything other than a business style approach: and budding entrepreneurs will not be disappointed. Just look at these main recommendations:

- Replacement of the BTS panel with an 'executive board';
- External appointment of a managing director with the necessary commercial experience;
- Cross-charging for the use of blood and blood products to be introduced from April 1991;
- Application to the Department of Health for self-governing status under the provisions of the NHS Bill.

The SW Thames region reacted angrily when London Health Emergency drew press attention to these proposals and claimed that the Deloittes report was a blueprint for eventual privatisation of the service: but the facts speak for themselves.

If the South London BTS were to be restructured along commercial lines, introduce cross-charging and then opt out, it would only be a short and easy step to fully privatise the service.

The South London BTS already buys in around 10% of its supplies because of a lack of donors. This situation would be certain to deteriorate after "commercialisation". Who would want to donate for nothing a pint of their bodily fluid in the knowledge that it would later be traded at a "commercial" rate further up the chain?

Worse, if the new business-style BTS stood to make more money by selling its supplies elsewhere – to other health authorities, to the private sector or abroad – the new system could, in pursuit of "business methods", literally drain the lifeblood of the South East, while delivering a cash profit!

The implementation of the Deloittes report would inevitably lead to the introduction of the kind of blood donor system that exists in big American cities, where the going rate is five dollars a pint. And of course it fits in neatly with the business ethos of the new NHS Bill.

Privatising the "low profile" ambulance service?

IN THE MIDST of the ambulance crews' pay dispute, another report has been produced by Deloittes for South West Thames RHA, proposing that the London Ambulance Service be floated off as a "Self Governing Trust", with the non-emergency service (the lion's share of the LAS workload) put out to private tender.

Why only the *non-emergency* service? Because even Deloittes admit that while private forms may be *cheaper* – offering less attractive pay and conditions to their staff, and cutting various corners – they offer a much less dependable and poorer *service*. Thus Deloittes argue that:

"The emergency ambulance service should not be contracted out because the obligation on the Secretary of State for Health to provide emergency ambulance services has to be met *in the context that it is a high profile service in the eyes of Parliament*

The Secretary of State and the public, with a low threshold of tolerance of failure.

"Management within the NHS means that management is directly responsible for meeting all levels of demand in a highly flexible manner *without taking refuge in contractual limits.* (...) Although a private contractor could theoretically provide an equally responsive service, there are greater risks of contractual limitations to response, of higher cost, and of discontinuity if and when contractors changed".

For these reasons, Deloitte focus their privatisation proposals on the lower-profile non-emergency service, where they argue (contrary to the medical criteria for eligibility for ambulance transport) that "many of the people so transported do not require an ambulance at all".

Their proposals follow on a process of running down the entire non-emergency ambulance service which has decimated its workload even at a time when rising numbers of elderly and disabled patients and an increasing reliance on day care and day surgery should be leading to a steady increase.

Between 1984 and 1986, the non-emergency caseload was cut by 30%. The Deloittes report refers to continual complaints over the levels of service since 1986, but also gives away the reason why: the number of non-emergency patient journeys performed by the LAS have been *cut by another 20%*, from 2 million a year in 1986 to only 1.6 million now.

Clarke's cash lure to GPs

The same Kenneth Clarke who last year taunted BMA opponents of his NHS White Paper as 'fooling for their wallets' has now offered family doctors cash incentives of up to £32,000 a year, plus discounts of up to 75% on computer equipment in a bid to persuade them to become independent 'budget holders'.

And the government has also dropped the minimum size of GP list that would qualify for the new scheme from an initial 11,000 to 9,000 in the hope of drumming up sufficient recruits to make the launch of the new scheme viable.

The £32,000 would be "management allowance" to enable them to employ management staff or buy in advice: but it clearly offers money-grabbing GPs the chance to defray other practice costs.

Clarke has also attempted to soften the White Paper's initial hard line on overspending GPs, now suggesting that "the ceiling is not going to fall in on the doctor who overspends" on a practice budget.

However the total money available for GP services will still be cash- limited through regional health authorities, and the discipline imposed on budget-holding GPs will be open to the discretion of regional and national NHS managers: none of the original objections to the changes in GP funding have been answered by the government.

Consultants say no to opt-outs:

BMA calls for ballots

Consultants in many of the hospitals on Kenneth Clarke's 74-strong 'hit list' for opting out share the reservations of other health workers and the public, according to a BMA survey.

Out of the units to which BMA questionnaires were sent, 68 replies were received, covering 4.600 consultants. In no less than 50 of these the consultants were either against opting out or undecided.

In at least 19 hospitals, the opt-out bid is proceeding in the teeth of consultant opposition, while positive decisions to support come from less than ten hospitals.

This apparently does not trouble managers who believe that with Kenneth Clarke taking the final decision regradless of local support they can ride roughshod over the opposition.

In Kings Lynn, a 33-7 vote against opting out by consultants was brushed aside by a 10-9 vote of the health authority; at Lymington a 22-1 vote against from consultants was outflanked by an opt-out bid submitted by the League of Friends!

At a recent debate on opting out at St Thomas's hospital, one consultant got up to complain that consultants had not been asked their views, and most were against: indeed the BMA survey shows that ballots of consultants have been held in only 32 hospitals on the list, and in some of those the poll was on whether or not to 'express an interest' and seek further information, rather than a mandate to opt out.

The BMA is now urging ballots as a key part of the fight against the Bill, arguing that "It would be much harder for the Secretary of State to approve an application if he were presented with the results of ballots of various groups ... all showing opposition to the proposal."

Wayne Edginton

A health authority meeting: soon they will be slashed in size

National meeting discusses fightback

Hands Off campaigners and Health Emergency groups from London, Yorkshire and Lancashire held a lively and successful discussion on the next steps in the fight at a meeting in Sheffield on January 27.

The need to link up the fight against cuts and hospital closures – and support for the ambulance workers – with the political fight against the NHS Bill emerged strongly in the discussion.

In London and Manchester, major closures and 'rationalisation' run alongside moves towards opting out and the 'internal market': in Sheffield, too, campaigners face the threat that four hospitals may opt out while health chiefs close down the rest.

The popular support and rapid spread of health campaigns in the North West was reported, with activity in Central and South Manchester, Salford, Stockport, Bury, Trafford, Leigh/Wigan and Rochdale; there have been calls for a NW Regional campaign.

Campaigners all echoed the wish for a national network to link and strengthen the various quite distinct local campaigns, giving them some form of common focus without overriding their individual strengths.

With this in mind, London Health Emergency suggested that the organisations present should consider affiliation to the new NHS Supporters Federation: this was agreed.

Operations a la carte?

West Essex health authority has written to all GPs in the area with a price list for private operations in their day surgery unit.

A termination costs £250.

The day unit was opened only six months ago, when money was allocated to it because the district was one of 22 with the longest waiting lists in the country, and only a small proportion of women were having their abortions on the NHS.

But instead of meeting this need, the unit is being used to develop private services.

Meanwhile, Hammersmith Hospital is offering private caesarian sections in competition with the private Portland Hospital, and another London teaching hospital is encouraging medical school staff to do private sessions in Harley Street to generate income.

(From GLACHC Update, January 1990)

Mid Staffordshire says NO!

A ballot of staff at St George's Hospital in Mid Staffordshire has produced the now routine massive majority against proposals that it should opt out. Of 507 voting, 474 (93%) said 'no'.

Management, as usual, took refuge in criticising the wording, but have refused to organise their own ballot. A poll of consultants also produced a majority in opposition to opting out.

NHS FED LAUNCHED

A new national initiative aimed at pulling together health service campaign groups under one umbrella was launched in London three days after Christmas.

The new group, called the NHS FEDERATION, has a set of five broad objectives;

1) To build a better NHS, responsive locally and nationally to public needs and aspirations and democratically accountable.

2) To protect patient care from commercialisation within the NHS.

3) To promote co-operation to achieve national purposes for the NHS.

4) To renovate, innovate and evaluate for a better future health service.

5) To ensure public funding appropriate to meet these needs of the NHS.

Any organisation supporting these goals can link up with the Fed. London Health Emergency and the Hands Off! campaign have already signed up and are represented on the Fed's Steering Group by Geoff Martin.

Organisations who join the Federation will remain autonomous, with the NHS Fed operating as a national umbrella, co-ordinating, liaising and maximising impact.

For further details on the Fed, affiliation rates, campaign news, etc, please contact:

Ann Carlton,
NHS FED,
c/o Citicare,
60 Hanbury Street,
London E1 5JL

Fightback in Walsall

Walsall NHS Defence Campaign is battling against management plans to 'opt out' the large, modern Manor Hospital.

They have been collecting signatures on a petition of opposition for the DHA, and have held ballots of staff and consultants, showing massive (if predictable) opposition. Local GPs too have registered their rejection of the opt-out plans.

Among the plans of the campaigners is a possible major benefit concert to be held in March.

The campaign can be contacted c/o Ian Robertson, 87, Belvedere Rd, Walsall, WS1 3AU.

Down to 50 mega-districts?

Even the scaled-down 11-person appointed health authorities (5 of whom would be managers) proposed by Kenneth Clarke's NHS Bill may seem a paragon of democracy, accountability and accessibility compared to a new idea dreamed up in the think tanks of the Kings Fund College.

A conference of the National Association of Health Authorities in January heard Kings Fund director Gordon Best suggest a massive programme of mergers to reduce the present 190 health districts to just 50, each with a minimum catchment population of 650,000.

Such huge districts would be necessary to allow management to 'buy in' services for patients more efficiently, claimed Mr Best, basing his arguments on experiences in California – (where of course there is no National Health Service).

He argued that the medical needs of inner London should be purchased by one or two authorities rather than the dozen or so existing districts: but like so many similar 'consumerist' notions of health care, his ideas fell short of explaining how these health authorities should be made in any way responsive to the needs and demands of local communities.

In fact management advocates of the NHS Bill are already eargerly pressing for the formation of purchaser cartels – one is already planned to link three districts in South East London covered by Kings, Guys and St Thomas's hospitals; another is projected for East London.

How long before we are told the whole NHS should be based on the Californian model?

Affiliate now!

London Health Emergency has now been running for six years, surviving the downfall of the GLC and narrowly enduring repeated financial crises (see Appeal on front page!).

We are now the best-known watchdog and pressure group providing information on all aspects of London's health services to the media, and help for local trade unionists and campaigns fighting to defend the NHS.

We now have over 250 affiliates, including national, regional and branch level support from COHSE, and regions and branches of NALGO, MSF and TGWU, branches of NUPE, and many non-health trade and student unions, local health campaigns, Labour Parties, pensioners' groups and community organisations. We are funded by London boroughs including Camden, Newham, Hounslow, Ealing, Southwark, Lambeth, Lewisham, Hackney, Greenwich and Hammersmith and Fulham.

Affiliates receive copies of our quarterly newspaper *Health Emergency*, mailings, and discount on bulk orders of LHE's pamphlets, reports and other publications, as well as advice and assistance on local campaigns and publicity.

Make sure your organisation affiliates!

Affiliation is still only £15 (basic) or £25 (organisations with over 500 members). Individual subscription £5 per year.

London HEALTH EMERGENCY

Please affiliate our organisation to London Health Emergency. I enclose £15/£25 plus a donation of £...

I also enclose £... for ..... extra copies of *Health Emergency*. Total enclosed £.....

Name.....

Position held .....

Organisation.....

Address for correspondence.....

.....

Signature.....

Return to London Health Emergency, 446, Uxbridge Rd, London W12 0NS

Welsh campaigners fighting to Kill the Bill

No hospitals have yet put their names forward to 'opt out' in Wales, but Welsh campaigners are still busily fighting the NHS and Community Care Bill.

The Hands Off Our NHS campaign leaflet 'Ten Good Reasons to Kill the Bill' has been translated into Welsh, and there was strong support in North Wales for the London area's January 24 'Day of Information' leafletting against the Bill. Wrexham Maelor and Glan Clwyd hospitals were leafletted, along with the main Gwynedd hospital, Ysbyty Gwynedd Bangor: major GP surgeries and community hospitals were also the target of leafletting.

In South Wales, the Cardiff Hands Off Our NHS campaign has won trade union and other support, and has ordered 1,000 of the 'Ten Good Reasons' leaflets.

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