HEALTH EMERGENCY

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Bulletin of Hands Off Our NHS

PHOTO: John Harris

Health Secretary William Waldegrave

Waldegrave will not rescue 'losers' in health market

MANAGERS promoting opted-out Trusts have attempted to assure staff and the public that Trusts would not be allowed to go bankrupt; but Health Secretary William Waldegrave has different ideas on what the 'internal market' really means.

In an interview with the *Health Service Journal* to mark the start of the new NHS reforms, he declared that:

"When the internal market begins to work and signals that there are winners and losers, it's going to be essential that we don't give in to lobbying and bale out the losers."

"It is essential that we let the internal market indicate what is needed in London, and we will then have to respond to those signals, which will force us politicians to take some decisions which have been postponed for much too long."

MAKING YOUR NHS INTO A BUSINESS!

By JOHN LISTER

BEFORE the Poll tax is even dead, April 1 has seen the launch of yet another 'reform' that almost nobody supports – the NHS and Community Care Act.

Opposed by over 70% in opinion polls, the Act combines the worst of all worlds – the haphazard heartlessness of the market with the rigid cash limits of the public sector.

Its community care plans have already been shelved for two years, to avoid embarrassment before a general election. But, as this issue of *Health Emergency* shows, the rest of the Act is already causing havoc.

The Act was intended to bring competition into the NHS, creating an 'internal market' by ending the system whereby health authorities were responsible for planning a balance of services in their locally-run hospitals.

Now smaller, less accountable health authorities can only use their cash-limited budgets to 'purchase' health care for their population, from separately managed or opted-out 'provider units' locally or further afield.

Unfortunately this new 'market' needs *prices*, and the providers must issue the purchasers with bills. So an expensive new bureaucracy has been created to cost, price and issue bills for each patient treated.

Despite ministers' attempts to put the brakes on the Act, and minimise changes in the first year, dog-eat-dog battles have already erupted between districts over the 'poaching' of patients, and patients allegedly 'treated for nowt'.

Indeed for many NHS managers, patients are now seen as simply customers, or just potential sums of money in an increasingly commercialised and impersonal *business*.

Yet the new system is a sad, under-funded parody of a proper business. Instead the Act has brought:

- the wasteful charade of unenforcible Toytown 'contracts' for treatment;
- opted-out Trusts, trying to create make-believe 'surpluses' by ripping off purchasing authorities to create cutbacks elsewhere;
- the end of any planning, with competition now deciding the reallocation of funds from one hospital to another.

It is a system that offers no benefits to patients or staff. Its pricing and billing arrangements however could represent a staging post towards a privatised health service.

Christie's rip-off

One Trust's "surplus" must mean another district's closed beds or reduced services: concrete proof of this is offered by Manchester's opted-out Christie Hospital.

Christie management offered 26 health authorities queue-jumping preferential access to beds for cancer patients – provided they paid an extra £10,000-£25,000 a year.

Any DHA which paid up would be promised that its patients could skip past the normal 6-week wait for treatment, and be guaranteed admission to the Christie within a fortnight.

The money to fund this 'premium' service for cancer sufferers would have to be milked from other services purchased by health authorities.

Contract chaos grips new-style NHS

MORE health authorities and Trusts in the capital have admitted getting caught in the contract chaos brought about by the NHS Act.

Tower Hamlets DHA is in dispute with the Royal London Hospital Trust and with Bart's Hospital in City & Hackney DHA, over the numbers of patients to be treated.

The Trust is insisting on a 3% cut in numbers unless more money is put on the table, while Bart's wants 15% fewer: in each case hospital chiefs claim that the reduction is needed to compensate for historic under-funding of services provided.

Meanwhile three Essex DHAs (West, North East and Mid Essex) have had to be *instructed* to continue sending patients into London for treatment that is more expensive than using local hospitals.

A survey of half the DHAs in England by Shadow Health Secretary Robin Cook has shown that 70% had signed contracts to treat just the same number of patients as last year, eight were contracting to treat *fewer* patients, and only seven proposed any increase in numbers.

Most GPs will have *less* choice where they refer patients, with 77 DHAs setting aside 2% or less of their budget as contingency funds to cover 'extra contractual referrals' including emergency cases.

HANDS OFF OUR HOSPITALS!

The chaos created by the new reforms has dovetailed in with the cuts imposed in the attempt to eradicate deficits and create a 'level playing field' for the new NHS 'internal market'.

The BMA calculates that 340,000 operations were delayed and 3,250 beds permanently closed for cash reasons last year, 1,180 of them in the four Thames regions. 4,400 more beds closed temporarily, while 1,520 more went in 'rationalisation' of services, bringing a tally of over 9,000 beds closed at some point in the financial year.

According to the BMA, 1,120 operating sessions were cancelled because of shortages of cash or staff, resulting in a loss of 400 operations a week in England and Wales.

With many districts kicking off the 1991-2 financial year with more cuts and temporary closures, the prospects again look gloomy.

Are NHS pay-beds trading at a loss?

By John Lister

A MAJORITY of first wave Trusts proposed to increase their private patient capacity, many simply assuming that there is an untapped pool of would-be customers itching to use an NHS pay- bed.

Many second-wave Trusts are also trying to get in on the act, with plans for private wings, wards and clinics. But where are the punters queuing up to use them?

In the run-up to April 1, the Central Manchester Health Trust proudly announced a new 'preferred provider' agreement with a private health insurance firm in an effort to fill some of their private beds, 50% of which are empty. Policy-holders will be entitled to a 10% discount if they go to a Central Manchester pay-bed.

This raises the question: how large is the profit margin on NHS private health care?

Why do private health firms claim it is so much cheaper to send their patients through NHS pay-beds than to use provincial private hospitals, where fees can be £400 a night for a bed?

Is the taxpayer subsidising private medicine?

If only 50% of existing NHS pay-beds are filled, it seems highly doubtful that private wards could be making a profit. But of course once a Trust is launched, its finances will be securely guarded from public scrutiny.

The veil of 'commercial confidentiality' can protect the NHS's failed entrepreneurs from the anger of a ripped-off public.

£92-a-day pay beds?

With NHS pay bed prices underwritten by the tax-payer, it is scarcely surprising that NHS private patient income should be rising faster in percentage terms than that of the private sector.

However the NHS share of this market is still insignificant, and the 'income' it generates is minuscule in the context of a £30 billion NHS budget.

Spending on private acute health care rose 17% in 1989 to £1.2 billion, according to business consultants Laing and Buisson: but while the NHS share rose 19%, it still amounted to just £99m – 8% of the total.

This income was drawn from 3,000 NHS pay beds, showing an average income of just £92 per day.

Against this income figure must be set the high running costs of each NHS pay bed (and now the capital charges payable by DHAs and Trusts). It seems more than likely that far from being 'income generation', private medicine *loses* money for the NHS as a whole and many individual hospitals.

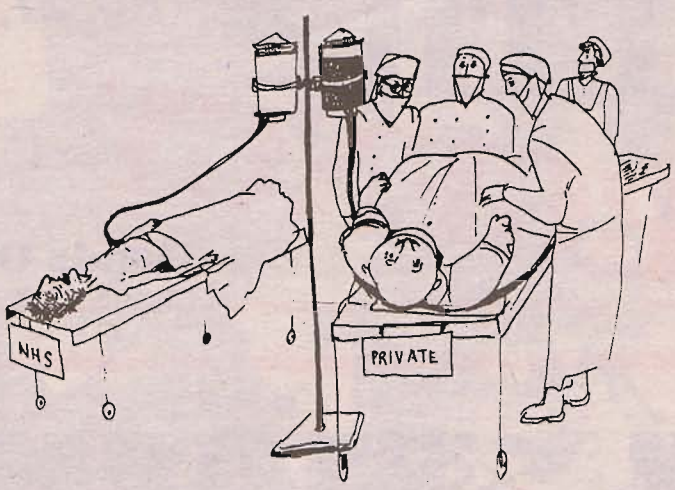
Searching for customers

PRIVATE health insurers are angry that the government's attempts to drum them up new business among the elderly population have failed abysmally, costing them money rather than generating trade.

After the 1990 Budget gave tax relief on private health insurance for the over-60s, BUPA spent £3 million to set up a scheme for older subscribers: but it has nowhere near recouped these costs.

Rivals Western Provident spent £1 million on a new scheme that attracted only 120 new punters. Private Patients Plan also reports the scheme to be a fiasco.

Since the costs of health premium payments are linked to the likely claims, even after tax relief the policies are still expensive: and (predictably) policies for the over-60s who make heavier demands on health services, are rising in price faster than those for people of working age, who make relatively few claims.



Cut-throat competition could cost an arm and a leg!

WITH SO MANY of its beds empty, the private medical sector is getting as desperate as any other retailer to attract customers.

No surprise, therefore, to find a spring sale at Compass Healthcare's Garden Hospital in Hendon.

Punters without health insurance wanting to buy operations for cash up front between February and April were offered a '15% discount'.

On turning up with a suitably large wad of used fivers, they could then take advantage of a 'fixed price scheme', which guarantees to cover the cost of the operation.

However you had better hope you don't develop any complications. Another Compass hospital recently refused to readmit one customer, in whose abdomen their surgeon had mistakenly sewn up a pair of forceps after his operation.

Management argued that he could only be readmitted as a 'planned admission'. Meanwhile the forceps did serious unplanned internal damage: in the event the good old NHS had to step in once again to provide the necessary emergency facilities to save his life.

It is unlikely that future price reductions will entice him back to private care!

Cutting costs – and standards

PRIVATISATION of hospital support services is once more raising its dirty little head, as a fresh wave of services are put out to competitive tender.

In Oxford, the DHA brushed aside a petition of 600 members of staff, opposition from the CHC and warnings from consultant and former general manager Chris Payne that privatisation could seriously undercut standards, and decided to award the portering contract at the John Radcliffe Hospital to Mediclean, as well as imposing a package of £2.2m cuts from April 1.

COHSE porters had staged an official half-day strike to lobby the DHA.

In West Berkshire DHA, management have gone even further, with the proposal to put the whole of the district's support services – including admin and clerical work – out to tender under the heading 'total facilities management'.

Front runners for the mega £16m contract are union-busters P&O (of Zeebrugge ferry fame), and Pall Mall, a subsidiary of rent-a-car firm Godfrey Davis.

West Berks management are asking if the firms will take on existing NHS staff: not from any concern for staff welfare, simply to "reduce the health authority's redundancy costs"!

How long before Trusts go bust?

By John Lister

JUST AFTER our last issue of *Health Emergency* went to press, Health Secretary William Waldegrave rubber-stamped 57 of the 65 opt-out bids he had received.

In doing so he brushed aside almost universal public opposition, and the dire warnings of city analysts Coopers and Lybrand that only 14 of the bids were financially viable.

Then came government announcements that further threaten the financial survival of many of the new Trusts, leaving several to begin life on April 1 already in the red:

■ The Department of Health revealed that with a few – unnamed – exceptions, Trusts will have to pay interest at 11% on 50% of the assets they take over.

This will have come as a shock to many Trust bosses: at least a third of the application documents had specifically based their financial projections on the assumption that they would pay interest on just 33% of their assets. This extra, unbudgeted cost – in several cases millions each year – is enough in a number of cases to push a Trust from a small surplus into deficit.

■ This kidney punch was followed by a boot in the teeth for managers who had claimed that Trusts would be free to borrow money to fund new developments: the government announced strict cash limits which mean that far from being able to borrow more money, two thirds of Trusts will have to *repay* money they have already borrowed!

Ludicrously unrealistic proposals had been put forward, with the 57 first-round opt-outs hoping to borrow almost £1 *billion* (almost equivalent to a whole year's NHS capital allocation) over three years.

Especially hard hit by this restriction – which will certainly apply to second wave Trusts – was the Royal London Hospital Trust, which was given a 'negative' borrowing limit, requiring it to repay £7.3m. The result is likely to be cuts in health and safety and in patient services.

As a token gesture to mitigate this damage, Waldegrave authorised a total of just £11m – £190,000 each – as 'start-up' money to set Trusts rolling down the slippery slope.

Despite this rough ride for the first wave applicants, managers of another 120 units have so far signed up to declare an interest in making a second wave opt-out bid.

There is little doubt that arms are being seriously twisted behind the scenes to press-gang reluctant health chiefs into the gamble of opting out.

In East Anglia, regional general manager Alasdair Liddell, who wants to see *every* unit opted out, has urged managers to ignore the considerable opposition they face from consultants, and forge ahead with bids.

He gave a rap on the knuckles to West Suffolk's DGM, in a letter urging him to 'reconsider his leadership role' after he had dragged his feet on opting out. Liddell professed himself "concerned about the lack of interest from the acute unit" in West Suffolk. Meanwhile East Suffolk consultants have voted 69 to 11 against opting out.

How many Trusts will find it profitable to care for the elderly?

Opt-outs: the second wave gets rolling

Milton Keynes

DHA Chair Tom Benyon intervened at the last moment to prevent top managers participating in a public debate on opting out, organised by the local council.

Over 100 people turned up anyway, to find empty display boards and projection equipment requested by managers, and a DHA minion on the door distributing a leaflet by Mr Benyon denouncing the debate, and claiming that there had been plenty of opportunity for public consultation – three months earlier!

The meeting went ahead, with speakers attacking the opt-out bid which contains no financial details, and no commitment to recognise unions.

Pembrokeshire

Efforts to bludgeon staff into submission to an opt-out bid have included over 20 management-led meetings and a gerrymandered "ballot", in which ballot papers were given to less than 50% of the staff, at management's discretion. Management claimed an unbelievable 90% response rate, with 609 in favour and just 120 against: yet even this highly dubious 'poll' still shows only a third of staff in favour!

A deliberately deceptive "Questions and Answers" document drawn up by managers claims that opting out would keep services 'local', but skirts round the prospect that the rump DHA would be merged into a common purchasing authority with rival neighbouring DHA East Dyfed.

Management have also attempted to blackmail support staff into backing an opt-out by threatening that if they remain directly managed services would be out to competitive tender.

Ealing

The acute unit opt-out document includes financial information "laundered" to avoid reference to last year's £1.2m cuts package, or previous years' panic cutbacks.

The bid contains not only plans for new private beds and private outpatient services, but also some classically wacky 'income generation' ideas, including dry cleaning services, 'perfume sales' [bed to bed?], 'television filming', a 'photography service' and Cellnet rental.

Waltham Forest

As health unions and local campaigners joined forces with the council to launch a local fightback, their request for facilities to hold a meeting in Whipps Cross Hospital were met by management insistence that they, too, should have speaking time on the platform!

Management has meanwhile been specifically told by the Department of Health that a Trust will not get its grubby hands on the land assets of Claybury psychiatric hospital.

Camberwell

Management belatedly withdrew a first-wave bid for Kings College Hospital, and are now coming back for a second try, this time seeking to opt out all of the district's services.

This will have been assisted by the surreptitious £3.5m 'sweetener' from SE Thames region, who have handed over a lump sum to cover the DHA's huge overspend.

What was that about a 'level playing field'?

Barnet

The bid to opt out both Edgware and Barnet General Hospitals as a single Trust could well result in the rapid demise of Edgware Hospital, according to local campaigners. Ominously, management are looking to site a new private hospital on the present Edgware car-park, making the NHS hospital almost unusable to the majority who attend clinics or visit relatives by car.

One of the first decisions pushed through behind closed doors by a new Trust could be the closure and sale of Edgware Hospital, to centralise services at Barnet General.

Meanwhile management are adamant that staff should be given no say on opting out. The Personnel Director argues that "Now that a decision has been taken (by clinical directorate) ... there is no basis for us to ballot on the matter".

An alliance of nine health unions, backed by Barnet Health Campaign, has formed to fight the opt-out.

Contact Barnet Health Campaign on 081-444-4652.

Who's kidding who in Mid Essex?

Chris Minett, General Manager of Mid Essex hospitals, became distinctly hesitant when he tried to field questions from the public at a Chelmsford public meeting on February 25, writes CHRIS BUTLER.

He had asked the meeting to believe that trust status would 'cut out bureaucracy', offer better planning and more money.

But when Dr Roy Chad, a hospital consultant, asked how the district would have done better over the last five years as a Trust, Minett could only reply 'I don't know'.

One thing Chris Minett *was* clear about was that there would be no local ballot or referendum on opting out. He argued that the only democratic procedure that could affect the outcome was through the ballot box at a General Election.

PHOTO: John Harris

Urgently needed: pressure for mental health services

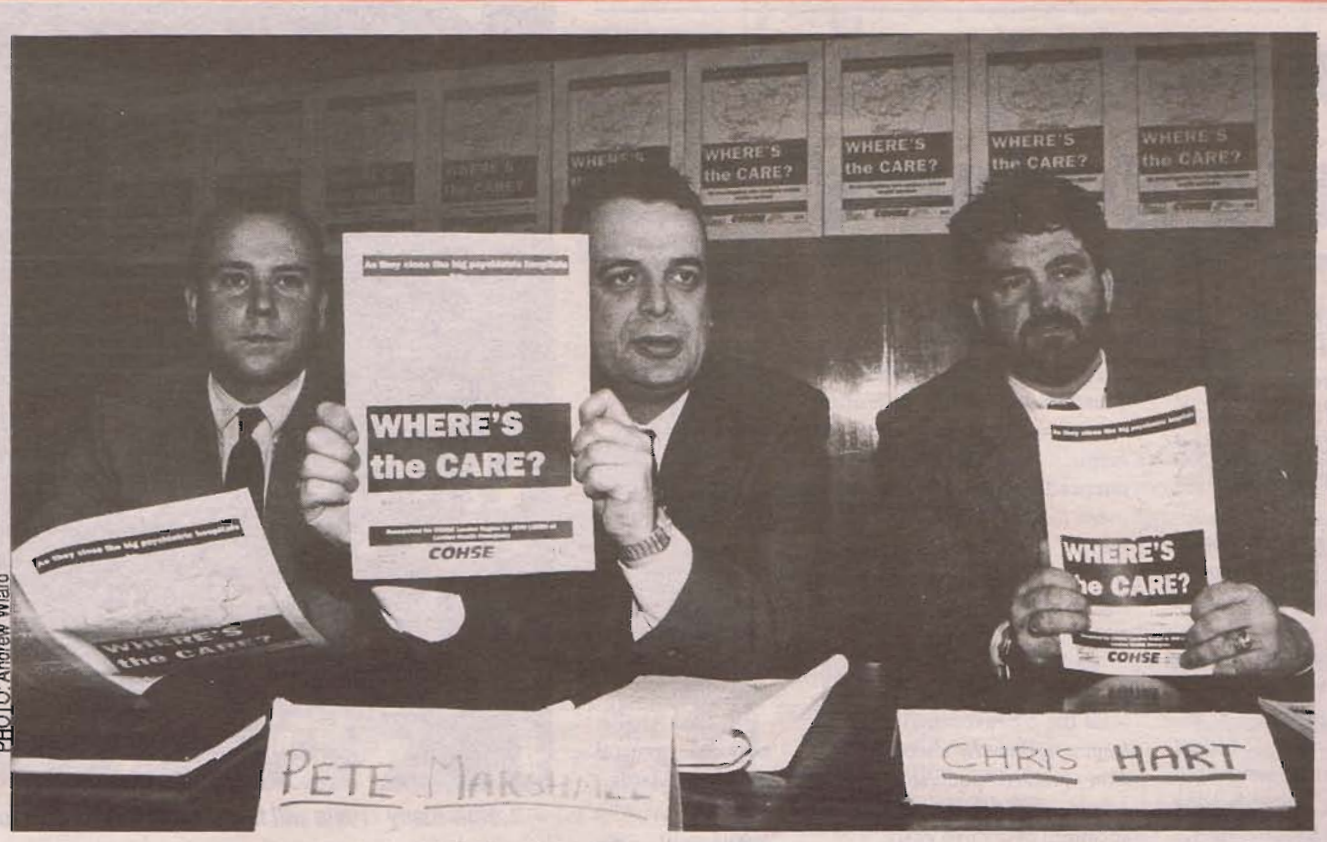


PHOTO: Andrew Wiard

COHSE's London Regional Secretary Pete Marshall brandishes the Where's the Care? report at a press conference

GP fund holders

Who will 'pocket the difference'?

It is now clear that the cash limits imposed on 'budget-holding' family doctors will amount to an average of just £100 per patient.

From this total, the fund-holder will be required to finance all aspects of health care purchased for the patients on his/her list, up to a maximum cost of £5,000 on any one individual in a single year.

More expensive cases should be paid for from contingency funds held by regional health authorities: but it is far from certain whether such funds will be adequate in an untested system.

This leaves a real possibility that some or all of the 306 practices, involving 1,720 GPs (covering 3.6 million patients), which have 'opted out' in the first round could find themselves overspent before the end of the financial year.

Perhaps this helps explain why it is that more than 500 of the 850 practices which had been reported as expressing an interest in budget holding dropped out of the scheme before April 1.

Health Secretary William Waldegrave claims that a practice which overspends could simply ask the region for more money. What, then, is the significance of the initial cash limits? And what happens if the region itself is broke? There is also the vexed question of what happens to any *surplus* at the end of the year. In NW Thames and Yorkshire, GPs have agreed to restrict their right to retain all of any unspent surplus, in exchange for RHA pledges to make up any shortfall.

But it is clear than one major selling point of the scheme to the more materially-minded GPs has been that it offers them the chance to 'pocket the difference'.

From now on, patients in budget-holding practices will never really know if a course of treatment is prescribed for the sake of their health or as a tonic for their GP's bank balance.

Mental health services face mystery of vanishing beds

Where is the care?

By John Lister

The closure of beds in London's big psychiatric hospitals has accelerated during the late 1980s: but in many districts there is little sign of the alternative forms of community-based care that were supposed to take their place.

According to the *Hospital and Health Services Yearbook*, bed totals at 15 of London's larger psychiatric hospitals added up to 14,236 in 1984, reducing to 10,311 in 14 in 1989 (Banstead Hospital had closed); by 1990 there were just 9,344 – a reduction of 34%.

This rate of closure is far faster than the national decline in numbers of mental illness beds: throughout the country some 44% of mental illness beds closed over a *ten* year period, reducing from 89,000 in 1979 to 50,000 in 1989.

In practice the cutback in the big London hospitals has been much greater: over 2,000 of the beds listed in the 1990 *Yearbook* are already closed: Goodmayes Hospital, for example, listed as still having 780 beds, had just 527 open last April. Some are down to around half the beds suggested in the latest *Yearbook*. (See Table)

Meanwhile there no reason to believe that demand for mental health services has decreased in recent years. Mental illness equals heart and circulatory disorders as one of the two most prevalent health problems in Britain.

According to the Mental Health Foundation there are an estimated *six million* sufferers, one in ten of the population – three times the number affected by cancer. Mental illness is also a major killer, accounting for some 20,000 deaths each year, more than four times the toll from road accidents.

While numbers of psychiatric beds have been cut, out-patient attendances in England have remained almost constant over a 10- year period 1979-89, rising from 1.6 million in 1979 to a peak of 1.8 million in 1985 and 1986, before falling back again to 1.6 million a year since 1987.

Even new out-patient attendances, which should reflect the new policies of treating mental illness outside of hospital admissions have risen only by an average of 0.7% a year since 1979, from 180,000 in 1979 to around 200,000 since 1985.

Other figures suggest that of an estimated 3.7 million people each year suffering from *severe* mental illness, only one in ten – 350,000 – even attend psychiatric outpatient departments.

A maximum of 28,000 NHS psychiatric day care places are available throughout the country, though it is not clear how many people actually use them.

Of the 25% of over 65s who suffer from mental illness, only one in fifteen was in any form of institutional care in the mid 1980s, with many of these in local authority homes or geriatric hospitals rather than a psychiatric unit.

What has been cut substantially is the number in long-stay psychiatric beds – down from around 50,000 in hospital for 5 years or more (out of 100,000 in-patients) in the early 1970s to around 17,000 (out of a total of 50,000 in-patients) by the mid 1980s.

Beds for elderly

As a result of these drastic reductions it is now questionable whether sufficient resources are available to deal with the growing numbers of elderly people suffering from forms of mental illness, notably dementia and Alzheimer's disease. The latest estimates suggest that nationally 750,000 elderly people are suffering from dementia, and an additional 500,000 from Alzheimer's disease.

During the 1980s it was estimated that as a result of the growing elderly population, up to 20,000 more Londoners would be suffering from dementia in 1991 than in 1981 – an increase of 30%. There has been no attempt to expand

Bed closures in London's big psychiatric hospitals 1984-91

Hospital	1984	1989	1990	Actual	Beds lost	% lost
St Bernards	1120	764	651	526	594	53%
Shenley	1239	769	769	620	619	50%
Napsbury	1005	933	933	524	481	48%
Horton	(1873)	937	937	692	1181	64%
Claybury	1205	848	730	500	705	58%
Friern	962	830	680	598	364	38%
Goodmayes	780	780	780	527	253	32%
Warley	929	800	711	630	299	32%
Cane Hill	953	564	477	257	696	73%
Bexley	994	737	504	449	545	55%
Tooting Bec	906	600	615	323	583	64%
Long Grove	813	550	550	434	379	46%
Springfield	(982)	(808)	(616)	563	419	43%
Warlingham Park	475	391	391	240	235	49%
Totals	**14236**	**10311**	**9344**	**6963**	**7273**	**51%**

Sources: 1984, 1989, 1990: *Hospitals and Health Services Yearbook*. Horton figure for 1984 includes Banstead, now closed: Springfield 1984-90 includes Morris Markowe Unit, now closed. 'Actual' figures are latest available totals of beds open, compiled from DHAs, RHA papers or from unit management.

NHS or other services to deal with this problem.

In many cases these people are unsuitable for treatment in short- stay acute beds; yet while the NHS capacity to give long-term care has been drastically reduced, ther is no sign that local authorities, the voluntary sector, or private enterprise are in any position to take on the responsibility.

No research

According to the South West Thames RHA, no serious research has yet been done on the numbers of residential places required to run a community-based mental health service.

But there is no real doubt that the present provision falls far short of replacing the lost beds or meeting the level of demand. England has only 25,000 local authority-funded residential and day-care places in the community (just 4,000 of them in London). Most of these are allocated to discharged former in-patients.

Department of Health figures show that the numbers of local authority *residential* places for the mentally ill in the capital have actually *fallen* by 4% between 1981 and 1989, with most of this reduction (14%) concentrated in inner London, where eight out of twelve authorities now offer less places than in 1981.

The DoH figures also show a dramatic *fall* in numbers of local authority supported residents in homes and hostels for the mentally ill in England: in the seven years since 1982, the numbers have dropped 25%, from 4,880 to just 3,600 in 1989.

Rising costs

However a major problem in the planning of NHS replacement services for hospital beds is that the costs of in-patient treatment tend to *increase* as the number of in-patients goes down.

The all-party Commons Social Services Committee discovered in 1990 that while mental illness in-patient numbers fell 27% in 10 years – from 77,000 in 1979 to 56,000 in 1989 – the overall cost of mental illness in-patient services *rose* by 7% (from £1,179m to £1,262m) [in 1989 prices], with the cost per case rocketing by 47%.

The Social Services Committee argues that to provide a satisfactory level of social care in the community costs £2,752 per person per year.

By this reckoning, to provide social care for the 3.7 million sufferers from severe mental illness would cost £8,256 *million* (£8.256 *billion*) a year. This is around a third of the whole NHS annual budget, and more than *four times* the present NHS spending on mental health!

London's share alone would be at least £1 billion!

The same committee estimates that it costs about eight times as much – £21,366 a year – to provide a satisfactory level of residential and day care services to people discharged from psychiatric hospitals.

This helps explain the lack of government commitment to plug the obvious gaps in the service. To put right what is wrong in mental health care would cost far more than this government is prepared to spend.

Bridging loans

The grim reality of the promised government 'bridging loans' (to enable health authorities to build new community services before closing mental hospitals) began to emerge in January 1990.

Health Minister Roger Freeman announced that the *total* sum involved *nationally* was just £50m over three years, with a mere £30m available in the first year, and this to be split between mental health and mental handicap services.

(All of this money was repayable in full, with interest!)

Even so, the Department of Health was deluged with 140 applications from DHAs desperate for bridging loans. Just ten DHAs – in nine regions – received pitifully small sums of money, while the others were left empty-handed.

SE Thames region alone successfully bid for some £17m for two schemes – leaving just £13m for the rest. SW Thames, on the other hand, submitted claims totalling £33m, and received only £184,000 for a single scheme in Croydon!

Mental illness specific grant

In May 1990 the government unveiled its plans for a new 'mental illness specific grant'. It was to contribute only to the *revenue* costs of services for 'people whose mental illness (including dementia) is so severe that they are being treated by the specialist psychiatric services or would clearly benefit from those services' (DoH Draft Circular, May 1990).

Yet the grant proved to involve a *total* of just £21m of government money (this to be made up to the publicly quoted figure of £30m by compelling local authority social service departments to make up the difference).

No guarantee

Though it is to cover *revenue* costs of *new* services, the grant runs only for three years, with no guarantee of renewal.

The total for Greater London is just £4.2m – just over a quarter of the amount of money set aside for Joint Finance of community care projects with local authorities back in 1983-4.

In practice, it is such a tiny amount for most London boroughs (averaging £130,000, and with seven outer London boroughs receiving less than £100,000) that its effect will be extremely small.

Recent figures published by shadow community care spokesperson Jeff Rooker MP show widely varying levels of council spending on mental health services.

31 pence per head

Among the London districts the top spenders per head of population were Kensington and Chelsea (£15.85) and Lambeth (£10.57): lowest were Bromley (£0.31), Havering (£1.81) and Redbridge (£2.90).

All six of the London boroughs which failed in 1981 to provide any day centres for the mentally ill also failed to do so eight years later, in 1989. In fact numbers of day centre places have *declined* in London, despite growing demand, with this decline concentrated on the inner-city boroughs.

The picture is no brighter on residential care: four of the six boroughs which provided no residential homes for the mentally ill in 1981 still provided none in 1989, while one cash-starved borough closed down its places.

Greater London has seen new residential places emerge at an average rate of just 21 a year since 1981: but within this figure twelve of the 32 boroughs have *cut* their provision in eight years of supposed transition to community care.

Acute services cut

Starved of capital to remodel the service on community lines, NHS mental health units have been simultaneously hit by cuts in revenue that compel cuts in the acute services.

In the autumn of 1990, an article in the *British Medical Journal* argued that bed reductions have left acute psychiatric services in London under huge pressure.

Surveying 48 acute units in Greater London over peak Bank Holiday periods when community services are largely unavailable, they found more than 95% of beds were occupied, with beds in a third of districts completely full. 23 units were running above the accepted efficiency level of 85% occupancy. Their report argued that:

"Widespread pressure on beds and overcrowding allows less scope for admissions of other than the most severely disturbed patients ...

"We think ...that there has been an acceleration in the rate of closure of beds without adequate increase in the provision of services and especially of day care."

How will this be changed? Only by sustained pressure from health workers, camapaigners, voluntary and user groups to push mental health services into the public eye.

Health union COHSE has taken the lead in this by commissioning and seeking to publicise a major report on London's mental health services, researched by London Health Emergency.

But much more support is needed before this hidden scandal can be brought properly to light and the necessary resources allocated to Britain's biggest illness.

Blowing the gaffe on community care

A TOP ADVISOR to the government has warned that the postponed community care proposals of the NHS Act could hit the elderly.

Speaking to social workers at the British Association of Social Work conference, Lady Wagner, chair of a government-commissioned 1988 report on residential care emphasised the restrictions on choice that the new Act will impose.

In practice, rigid cash limits imposed on local authorities will prove more influential in deciding the level and type of care provided than any element of 'choice' on the part of an elderly client, she argued. Councils will not have enough money to pay for residential care places.

Lady Wagner also exposed the essence of means-testing that lies at the centre of the government's NHS reforms:

"It seems to be part of the government's strategy not to provide all the cash needed for fees. Ministers are implying that relatives are part of the income support package. It is a monstrous way of going on."

More perceptively than many council officers and voluntary organisations, who still hang on to the idea that the community care proposals are a step forward, she added:

"Social workers naively and politicians perversely have failed to spot some of the deficiencies of the market in ensuring that people have choices."

Maybe the good Lady has been reading London Health Emergency's publications?

Top up or clear off

A REPORT has shown that only half of British residential and nursing homes are prepared to accept elderly clients who cannot afford to 'top up' social security payments from their own pockets.

The average gap between fees and benefit levels is this year predicted to reach £29 a week for residential homes and £52 in nursing homes.

Meanwhile three quarters of health authorities surveyed by the Association of CHCs had cut the number of long-stay beds for the elderly in the last three years.

Squeezing councils

The Department of Health admits that social services need a 23% increase in funding to take on their new responsibilities for community care.

But Michael Heseltine's Environment Department has imposed cash limits that prevent councils raising this money. More than half of all social service departments face *cuts* this financial year.

Also clobbered by the local government cash limits have been voluntary organisations: London boroughs alone have cut over 10% from an original £148m in grants to the voluntary sector.

Booming private homes

A huge expansion of private nursing homes has been revealed in new figures published by Shadow Health Minister Harriet Harman.

The number of UK private nursing home beds for the elderly increased by a massive 27% in a year, from 88,600 in 1989 to 112,600 in 1990, while residential places went up 9% to 155,600.

The eight year comparison of 1982 and 1990 figures shows an even more dramatic four-fold increase in private provision in England, from 18,197 places in private nursing homes to 92,457.

Biggest increases over that period came in the Northern region, with a near twenty-fold (1,994%) increase from 244 to 5,109 places. Other mega-increases were recorded in Yorkshire (925%), with Trent, Mersey and North West regions all topping 800%: the smallest rises were in the four Thames regions.

Bloomsbury contract chaos

By Geoff Martin

Anyone who doesn't believe that the NHS and Community Care Act has caused chaos throughout the health service should take a look at the Bloomsbury and Islington Health Authority.

In a remarkably candid report to the March meeting of the Authority, the Finance Director revealed that they would have to chop a staggering £7.1 million from their budget as a direct result of the new health care regime.

Bloomsbury and Islington have been lumped with the administrative nightmare of trying to secure contracts with 72 different purchasing authorities. Ten days before the April 1st deadline not a single contract had been signed.

In his report, the Finance Director points out that a number of purchasers are ignoring Government instructions to maintain existing referral patterns, the so-called "steady state";

"A number of purchasers are seeking to establish contracts which withold the funding required to buy the traditional level of service and hence disturb the 'steady state'".

Bloomsbury are left guessing as to how much income they can expect during 1991/92, but know only too well that it will significantly less than they got in 90/91.

This, combined with a provision of £2.4 million to cover referrals to hospitals with which they have no contract, has forced them to line up immediate cuts of £7.1 million. The Authority recognise that even this might not be enough to balance their books.

The precarious financial position of Bloomsbury and Islington is reinforced by the comments of the Director of Acute Services;

"The task of recovering income from some 200 authorities in all, plus many GP fundholders, is recognised as the most complex nationally and places a high risk on the ability to maintain "steady state"in 1991/92."

The brunt of the cuts will be borne by the Whittington and Royal Northern Hospitals where at least £2.5 to £3 million will be taken out of the budget. One option under consideration involves the closure of *all* beds at the Royal Northern.

Other proposals likely to be rubber stamped include the closure of the Royal London Homoeopathic Hospital, axing of an A&E ward at UCH and cuts in the ENT services at the Middlesex.

The crisis is summed up by Islington CHC Chair Doreen Scott;

"The Government's reforms have caused chaos, uncertainty, and now cuts; in return there have been no benefits for patients or staff."

Market madness grips NHS

Managers kicked up the ECRs

By Geoff Martin

Managers across the country are tearing themselves apart trying to work out what to do with Extra Contractural Referrals (ECRs) under the new health care system.

An ECR is the referral of a Health Authority resident to a health care unit with which the Authority has no contract. There are two types of ECR, emergency and non-emergency. The parent health authority is obliged to pay for emergency ECRs but they are not obliged to pay for non-emergencies, unless it has given authorisation to the hospital prior to treatment.

There are two main circumstances under which an Extra Contractural Referral is likely to occur. The first is where a person is taken ill or is injured whilst outside of the boundaries of their local Health Authority (at work, on holiday etc.) The second is when a GP seeks to refer a patient with a specific condition to a hospital where the local DHA has no contract.

The chaos caused by the new contract system is already being felt by patients caught up in the middle. Just days after the changes were enforced a woman was refused a sterilisation operation at Guys Hospital despite being referred by her GP because her Health Authority in Kent did not have a contract with the hospital.

In Riverside, DGM David Knowles has already ordered a review of the accounting procedures at Charing Cross and Westminster after one week of running the new system. Knowles is worried that some patients are being treated "for nowt" (perish the thought) and is threatening to step up his debt collection and to invoice DHAs retrospectively.

Wandsworth Health Authority has set down guidelines for dealing with ECRs which actually involve the deliberate witholding of information from patients. In a document passed by the Authority GPs are instructed to make sure that;

"... the patient should remain unaware of the process of the purchaser:provider discussion."

Patients will be kept in the dark, whilst GPs and managers decide behind closed doors on whether or not they get the treatment they need. So much for the patient choice that the Government said would flow from their reforms.

Wandsworth openly admit that the deciding factor in the treatment of Extra Contractural Referrals will be their government-imposed cash limit;

"...GPs'... freedom to refer to the speciality hospital of their choice ... [will be] ... within the overriding constraint of the DHA's cash limit."

The determination to keep their behind-the-scenes manoeuvring firmly under wraps also extends to the media and the general public;

"... decisions about whether or not to authorise ECRs about individual patients may also become more overt and public. This has implications politically and with respect to the DHA's public relations."

The new-style Health Authorities, with dissenting voices removed last September, give much greater scope for secrecy and mis-information. The kind of policies agreed by Wandsworth in relation to ECRs, and worse, are being rubber-stamped behind closed doors by DHAs across the country.

Hospitals and Healt Authorities will be locked int bureaucratic rows about wh pays for what, whilst t patients caught in the cross fi will be left languishing on wa ing lists wondering what the h is going on.

So that's what they mean b 'patient choice'!

Ripping up the Whitley handbook

Anyone who believed all the claptrap in the Trust application documents about maintaining Whitley Council pay and conditions should prepare themselves for a shock.

Some whizkid up in Crewe of all places has been busy transferring the Whitley handbooks to a computer disk and is now touting copies to opted-out hospitals at 400 quid a throw.

The idea is that once you've got Whitley on disk, your personnel chief can strike out whole chunks of it with the press of a button. Here's an extract from the sales blurb;

"Think of it – you can get rid of all references to Whitley Councils at the touch of a button ... call up each section of the handbooks and make your decision – does it stay, does it go or do you amend it?"

The thought of yuppie personnel bosses tucked up in their offices with a glass of Perrier in one hand while slicing through Whitley pay and conditions with the other should set the alarm bells ringing amongst the staff.

The NHS Management Board have been sending out clear signals that both Whitley Councils and the Pay Review Bodies are doomed. The key question is how quickly will they move to get rid of them?

The SHARP END

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

EXTERMINATE! EXTERMINATE!

The first issue of Bloomsbury and Islington DHA's new newspaper is glossy and lavish even by current health service propaganda standards.

In amongst all the usual back-slapping and "action shots" of assorted boring bureaucrats, one little snippet caught the Sharp End's eye.

Apparently the District's Chief of Parasitology has been put forward for some sort of award.

With the new health service heavily populated with overpaid top brass, accountants and PR men it's probably fair enough that the Chief of Parasitology should be in line for a gong.

ANGRY OF TOTTENHAM

A recent trawl by LHE of opting-out units in an effort to find out what prices they will be quoting GP budget holders produced little reponse.

However, one extremely interesting letter from the Chief Exec of the North Middlesex Hospital "Trust" did land on our door mat.

To say that the North Mid have got the hump with the N. E. Thames Region is a whopping great understatement. Apparently the Region have cobbled together some sort of price list without even telling the hospitals concerned. Listen to what North Mid supremo Dave Hirst thinks about that:

"We have seen with some surprise what purports to be a price list published by Region.... This contains so many inaccuracies and peculiarities, including giving a price for procedures not carried out at the hospital, and giving a ludicrously high price for some extremely minor procedures, that we have to say we disown it entirely, and are astonished that it may have been published by the Region without our advice, consent or knowledge."

Sharp End is more than happy to give Angry of Tottenham a chance to vent his spleen. We welcome letters from other senior managers who've got something they want to get off their chest.

SINGING IN THE RAIN

Over to St Helier Hospital in Carshalton, where on a rainy day in South London, Labour's Prospective Parliamentary Candidate for Sutton and Cheam has been booked to do a TV interview the day after opting-out.

Huddled for shelter in the hospital porch, the crew are informed by a neandertal man from the private security company that the hospital commandant, Mr Sewell, will not allow interviews with opt-out opponents on hospital grounds.

Standing in the pouring rain on the pavement outside the hospital the interview went something like this;

TV Reporter – What would you say to Mr Sewell if he were here now?

Labour's PPC – I would tell him that he's a complete and utter b*****d.

I think we'll take a show of hands on that from the people of Merton and Sutton.

BIG JOBS

Amazing the number of chief pen-pushers who are using the NHS Management Executive as a revolving door to spin them on to top jobs at the Trusts that they themselves have encouraged.

Job-hopper supreme has to be Peter Griffiths.

The former Chief of both Lewisham and North Southwark District and South East Thames Region went on to lead the NHS Management Board but is now switching back to his old manor as Chief Exec of the flagship Guys Trust on an annual earner touching a hundred grand.

Rumours are rife that Eric Caines, Personnel Director at the NHS Board, is in the frame to become the new Chief Exec at St Thomas's. Tommy's' past financial failures have become a major embarrassment to the government, their opt-out bid failed miserably and West Lambeth DGM Stephen Jenkins is on the way out.

If Caines is given the job of trying to prevent St Thomas's from sinking slowly into the Thames we can expect an early revival of their opt-out bid, possibly as a late addition to the second round contenders.

With unemployment heading back up towards two and a half million, Sharp End will be providing a valuable NHS Big Jobs Monitoring Service to our readers.

Make 'em wait!

MANAGEMENT in West Glamorgan are looking to cash in on the long waits of outpatients for their clinic appointments.

They are hoping to earn £15,000 a year from advertising on 11 television screens at Swansea's Morriston Hospital. Old TV programmes will be interspersed with 13 minutes of adverts every hour.

The problem is that to keep the advertisers happy, there will be an incentive to keep patients waiting even *longer*, to ensure a captive audience pushes up viewing figures by keeping their eyes on the screens.

Greenwich

Brook closure plans 'bite the dust'

Plans by Greenwich health authority to close the 500-bed Brook General Hospital as part of an 'acute services strategy' have, in the words of DHA chair Neville Thompson "bitten the dust".

His announcement was made at a packed meeting of the DHA early in April and followed an unprecedented campaign of opposition to the plans by hospital staff and members of the local community.

Since October over 60,000 signatures opposing closure have been collected; regular stalls have been set up in key shopping centres, public meetings held and housing estates leafletted – even before the DHA produced their consultation paper!

Clive Efford, chair of the community-based Brook Hospital Defence Campaign, has warned against complacency, pointing out that DHA managers are to bring forward new plans in September.

He is now calling for a campaign to reverse the minister's decision to transfer neurosciences from the Brook to King's College Hospital in Camberwell, claiming that the £50 million plus cost of that transfer could go a long way towards the much- needed refurbishment of the Brook.

Highest infant mortality rate in London

A Greenwich council report on infant deaths in the 1980s shows the borough to be experiencing the worst rates in the capital, higher than those for Liverpool over the same period.

Within Greenwich itself, babies born in deprived electoral wards were over three times more likely to have died before their first birthday than those born in affluent areas.

Commenting on the report, John Austin-Walker, chair of Greenwich council's Health Committee argues that behind the popular impression of leafy parks and wide open spaces, the borough faces severe health problems as a result of social deprivation.

Further cuts imposed by poll-tax capping and NHS budget restrictions could be "counted in the lives of young children whose deaths could otherwise have been prevented," the report grimly concludes.

Copies of the report are available (price £5) from Greenwich council's Health Advisor, DECS, 6th Floor, Riverside House, Woolwich High St, London SE18 6DN.

PHOTO: John Harris

Following the success of anti-cuts struggles (above) that saved wards in Daventry, Rushden health workers are taking up the fight

Fighting for Rushden Hospital

By Tracey Lambert

Around 150 health workers, members of COHSE, NUPE and RCN, joined a strong, vocal lobby of Kettering DHA's March meeting, but failed to prevent a massive package of £1.7 million cuts being rubber-stamped.

The DHA chair admitted that the cuts were required to balance the books of the health authority prior to the implementation of the NHS Act. Yet, significantly, one of the cuts involved sabotaging the internal market by scrapping any contingency fund to pay for local GPs to send patients to other districts for treatment.

NUPE branch secretary Glenda Watson was allowed to address the DHA in the packed, noisy room, which saw opponents of the cuts cheered and loud boos for management. Ironically, the only opposition to the cuts from DHA members came from two Tory councillors.

The result of the cuts package will be an increase in orthopaedic waiting lists following the closure of 18 beds, and a complete halt to NHS sterilisation operations – forcing 800 women a year to go private or go without.

41 beds for the elderly are to close; 27 in Wellingborough and 14 in Crane Ward, a GP unit at Rushden Hospital.

However the fight is being stepped up to save Crane Ward, which is closing to save just £75,000. A 50-strong meeting of NUPE and COHSE members at the Hospital resolved to hold a demonstration through the town on April 27, to mobilise local people who have not been consulted but who are against the closure; and the campaign has been joined by NALGO and the RCN.

Bexley and Bromley: a tale of two failures

Beset by continual crises of underfunding, Bexley's District General Manager David Pinchin abruptly resigned in March, without another job to go to. he told the *Health Service Journal*:

"I got to the point of thinking I just cannot take any more ... resources to the district are so restricted."

By February 1991, Bexley was on course for a projected overspend of £1.2m – 2.4% of its revenue budget.

Meanwhile Bromley DGM David Milner also resigned amid bitter recriminations over the incompetence of the district's two failed first round opt-out bids, which were laughed almost as loudly out of court by the SE Thames region as by London Health Emergency.

Bromley has also been embroiled in a bitter row over its plans for a new District General Hospital on a site where they have no planning permission.

In February the CHC demanded William Waldegrave step in after the DHA proposed to spend another £1.5 million on designs, while slashing £1m from services.

Having failed as a manager of services, Mr Milner is off to try his hand at purchasing them, becoming a director of the new SE London commissioning agency, which has now supplanted the three health authorities of Camberwell, West Lambeth and Lewisham & N. Southwark.

Oldham strikers defy scabbing

34 medical records staff remain on official strike at the Royal Oldham Hospital, despite management announcements that they have been sacked and replaced by scab labour.

65 NALGO members took strike action demanding regrading from A&C grade II to III, a pay rise of less than £700 a year.

31 of the strikers were then intimidated back to work across the NALGO picket line, while management resorted to the confrontational tactics that have become more traditional in private industry.

The remaining strikers are stading firm, supported by NALGO nationally; a rally in their support was held on April 13, and health unions are urged to send messages of support and donations to the strike fund, c/o NALGO Secretary Clive Bass, West Hulme Hospital, Chadderton Way, Oldham.

Barking fights carve up

Proposals for a single site District General Hospital at Harold Wood are being bulldozed through the Barking, Havering and Brentwood Health Authority in the face of massive public opposition.

The plan involves the closure of Oldchurch, Rush Green and St George's Hospitals with the long term intention of building a new 1,000 bed hospital on the Harold Wood site.

The railroading through of the plan has thrown up a blanket of opposition which includes local Tory MPs, Barking & Dagenham and Havering councils, trade unions and voluntary organisations.

Barking and Dagenham council's formal response, *A Need for Accessible Health Care*, which highlights areas of deprivation and appalling transport problems to Harold Wood. However the Health Authority rubber-stamped the plans at their March meeting.

To add to the confusion both Harold Wood and Oldchurch Hospitals have launched separate bids to opt-out in the second round. The Oldchurch bid, which incorporates Rush Green, has been naively launched as a lifeboat by a group of consultants, though the government has made it clear that no doomed hospital can be saved by opting out.

Fears are now being expressed that NE Thames region have no real intention of developing the Harold Wood site, but that the current plan is really a staging post towards the merger of BHB and Redbridge Districts with services eventually centralised at the new Goodmayes Hospital.

Joyce expects ...

THE AUTOCRATIC style of today's NHS management is well demonstrated by the crusty circulars issued by Greenwich health supremo Bruce Joyce. Underlings have been curtly warned that because its budget is reduced by 14m this year, Greenwich "has *no* development funds, *no* contingency funds":

Like Admiral Nelson, Joyce has great expectations:

"I expect each Directly Managed Unit not to rely on DHA to continue to bail them out ...

"I expect that once the budget is approved by DHA each DMU will achieve the above. ... I do not expect to see some of the massive variations we have been experiencing."

We expect Mr Joyce to be sorely disappointed!

Hillingdon & District COHSE 618

(First established as National Union of County Officers)

Chair: Michael Walker
Secretary: Nancy Westwood

In October 1937 NUCO's Guild of Nurses was founded. Its members faced immediate opposition and harassment from the nursing establishment in its fight to unionise general nurses. We therefore pay tribute on the 54th anniversary to the Guild's pioneers, Doris Westmacott, Mary Burns, Iris Brook, Tudor O. Morgan, Pat McHugh, Beatrice Crapper, N. Dunkley and Thora Silverthorne.

For a new union and a new 'Guild of Nurses'

Level playing field turns into a quagmire

Instructions from the Government forcing all hospitals to balance their books by the 1st of April led to the closure of over 2,000 beds across London and yet, incredibly, many Health Authorities remain massively overspent.

The instruction to balance the books was supposed to create a "level playing field" so that all hospitals would be able to introduce the NHS Act reforms with a clear balance sheet. The order resulted in colossal across the board cuts. The worst hit Districts were West Lambeth with £9.8 million worth of overspending to wipe out and Riverside with £6.8 million.

Many other Districts were pushed into cutbacks over the million pound mark on top of previous rounds of chopping and trimming to meet the general underfunding of health services.

But a new survey by London Health Emergency reveals that a large number of key Districts have failed to balance their books despite the ripping apart of services and the creation of misery and uncertainty for both patients and staff. The worst outstanding deficits, drawn from Regional Health Authority papers, include;

- Camberwell £4 million
- Lewisham & N. Southwark £3.7 million
- West Lambeth £2 million
- Parkside £1.7 million
- North West Surrey £1 million
- Bexley £1 million
- Croydon £0.9 million
- Tunbridge Wells £0.8 million

What happens to Districts who have breached the Government's spending limits remains unclear. Some are hoping to be bailed out with one-off funding from waiting list reserves but that only defers the problem for 12 months. The Government will simply demand their pound of flesh next year.

The cuts which have been left as a lingering hangover from last year are only part of the problem. Districts are only just starting to realise that the implementation of the NHS Act is also going to cost them an arm and a leg with no help from the government. Bloomsbury are already planning £7.1 million of cuts to meet these contingencies, others will be forced to follow suit.

It's possible that we could be staring down the barrel of some of the biggest NHS cuts ever seen but many health chiefs simply don't seem to realise what's about to hit them . You have been warned

PHOTO: Andrew Wiard

With hundreds of grading claims still outstanding, management want to get their teeth in again

'Flexibility' on top pay, wage cuts for the rest

By JOHN LISTER

MANAGEMENT in opted-out Trusts are doubly keen to smash up nationally-negotiated Whitley council pay structures that regulate wages and conditions of health workers.

On the one side, the sky is now the limit for top bosses' pay. On the other, they want to hold down or even *cut* the pay of lower grades.

The new Chief Executive of the Guy's and Lewisham Trust is reported to be receiving a salary of £90,000 – £5,000 more than the NHS Chief Executive Duncan Nichol: nobody will confirm or deny the salary, arguing that it is a 'personal matter'.

The Royal London Hospital Trust, and St Thomas's Hospital, still hoping to become a Trust, are each offering £70,000 a year for a chief executive, while the Royal London pays £50,000 plus a car to its finance director.

Trust bosses reacted angrily to embarrassed government ministers who urged them not to pay themselves excessive salaries. A January appeal from the DoH argued that top salaries should be "publicly defensible". But this is hardly likely to trouble managers who have flown in the teeth of public opposition to opt out in the first place.

Meanwhile managers are getting down to the job of slashing the pay of staff who actually *deliver* health care: a breakaway federation of 40 Trusts has pledged itself to avoid creating any 'wage spiral'.

Front runners in the efforts to smash up Whitley pay scales are ambulance service trusts.

Most radical so far is the Northumbria ambulance Trust, which put forward an 18-20% increase above Whitley rates for emergency staff – but not for non-emergency crews: the catch was that the cash was in exchange for acceptance of 12-hour shifts, and a wholesale scrapping of premium rates for shift working.

The offer was made over the heads of the unions, which have still not been recognised: indeed Personnel Director Ron Smith is sizing up the prospects of establishing "a staff association rather than a conventional trade union".

In Lincolnshire, temporary staff and any new recruits to the non- emergency ambulance service have suffered a £46 a week pay cut at the hands of the new Trust. NUPE points out that this means full time ambulance workers will need to claim social security assistance to survive.

With 'flexibility' like this on offer, how many health workers can afford to let their units opt out?.

Bosses bid to 'blow up' Whitley

IT'S NOT ONLY Trusts that will be looking to slash the pay of lower-grade health workers while boosting the pay packets of top managers.

NHS personnel directors have been urged by the Department of Health to create new grades of staff outside the existing Whitley council structures, so as to 'blow apart' the system of national pay bargaining.

A circular authorises local management 'lawfully and legitimately' to create new 'job groups' designed to get around existing pay scales and disrupt the arrangements that have functioned since the NHS was established.

"You can have all the freedom you like," NHS Personnel Director Eric Caines told health managers in March.

Now, as one manager told the *Health Service Journal*, "Personnel directors can get their teeth into local pay in a discreet way."

How many health workers want managers to get their teeth into their pay packets?

The old motto still holds good: *their* 'flexibility is likely to be *your* wage cut!

PEOPLE LOSE OUT IF OUR HOSPITAL OPTS OUT.

Affiliate to Hands Off Our NHS!

The biggest campaign against the NHS Bill and now the Act, with over 100 affiliates across the country, Hands Off Our NHS needs your support to continue the fight into 1991.

Organisations are urged to affiliate (£20 a year minimum, plus any donation you can afford), and individuals to subscribe (£10 a year, pensioners £5).

PUBLICATIONS AND CAMPAIGNING MATERIALS

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Hands Off supporters can also get 50% reductions on the two LHE surveys of opt-out bids, *Blueprint for Chaos* (London units, £2.50) and *Acute Agony* (most other acute units, £5).

We will shortly be producing a new general campaign leaflet on the NHS Act, similar in style to our popular 'Ten Good Reasons' leaflets. Order now!

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London Health Emergency has been running since 1984, and is now the best-known watchdog and pressure group, providing information and arguments to defend all aspects of London's health services.

We have over 250 affiliates in London and across the country, including national, regional and branch level support from COHSE and regions and branches of NALGO, NUPE, MSF and TGWU as well as many non-health trade unions, pensioners groups and community organisations.

A year's affiliation is only £15 (basic) or £25 for organisations with over 500 members. Make sure your organisation affiliates for 1991!

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

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