HEALTH EMERGENCY

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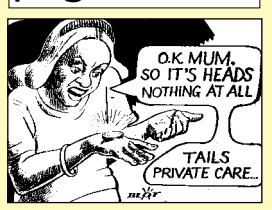
INSIDE

Things you should know about private medicine – page 3



Elderly held to ransom – BACK PAGE

As Manic Milburn revives internal market, will it be

RAILTRACK on the wards, and ENRON in Trust boardrooms?

UNISON nurses try to show Alan Milburn the error of his ways

HEALTH SECRETARY Alan Milburn's plans to "franchise" the management of failing hospitals, with the threat to bring in managers from the private sector, along with the establishment of "foundation hospitals" free from national controls have been denounced by health unions as "Railtrack on the wards".

There are widespread fears that the continued fragmentation of the NHS, and growing inroads of the private sector, siphoning profitable contracts, cash and staff out of the NHS, will steadily erode morale and undermine our most popular public service.

Many of Milburn's plans echo the failed – and costly – "internal market" reforms wheeled in by Margaret Thatcher's government in 1989-90.

"Foundation hospitals" will not only pocket extra cash and escape many central controls, but they will also have many of the rights originally promised for NHS Trusts by the Thatcher reforms, notably the right to run as a non-profit company, to retain any profits from the sale of property and land assets, and the right to fix local pay and conditions for their staff.

The plan will certainly result in a two-tier NHS, with a widening gulf between the high-flyers, which will also be allowed to compete for extra contracts to treat waiting list patients, and those at the bottom of the league tables.

There could hardly be a bigger contrast between these "freedoms" for the

hospitals which are already the best-resourced within the NHS and the threat to impose "franchised" external management on the minority of hospitals judged to have failed in the new "star ratings" systems.

The first four failing Trusts which have now been announced as guinea pigs in this latest experiment – Barnet & Chase Farm, Ashford & St Peters, Dartford & Gravesham, and Portsmouth – are all struggling to cope with inadequate numbers of beds and problems discharging patients to under-funded social services with too few nursing home places available. It is doubtful if new managers can change much without new money.

Milburn has stressed that while the first franchises will go to successful NHS managers, future franchising would be open to teams from outside the NHS, including the private sector. The *Health Service Journal* has warned that this is the first step on a road to "the prospect of all health service provision resting in private hands".

It is clear that with a privileged minority of hospitals floating off in one direction, the worst-performing Trusts sinking in another, with most hospital Trusts struggling to meet a non-stop succession of targets, and with new Primary Care Trusts taking over responsibility for huge budgets from April, the NHS is being transformed into an ever-more complex and fragmented system, with little evidence that the extra money will deliver the expected improvements.

Both UNISON and the GMB have warned that the new system amounts to a break-up of the NHS, and back-door privatisation, grimly reminiscent of Railtrack.

Indeed while the NHS as a whole is remodelled on the failed Railtrack, key policies appear to rest on the accountancy methods that recently brought the collapse of Enron, the seventh biggest corporation in the USA.

● Milburn has conducted no independent value for money audit to show that it is cost-effective for the NHS to buy treatment from private hospitals rather than expand NHS capacity.

● His controversial plans to scrap Community Health Councils with a baffling new system could cost almost ten times their current budget.

● Even bigger sums of money are at stake in the controversial use of the Private Finance Initiative (PFI) to build £7 billion worth of new hospitals and lease them to the NHS. Yet the ONLY "objective" report claiming to show that PFI represents better value for money than a publicly-funded alternative was written for the Treasury by Enron's auditors Arthur Andersen two years ago – and has since been widely challenged (see p6).

As they struggle to keep up with the high-speed succession of quack remedies, many of them apparently made up on the hoof by ministers addicted to deals with the private sector, it is small wonder that the morale of health workers has been plunging.

After regaining national pay bargaining under New Labour, they will not be cheered by the prospect of Trusts/foundation hospitals regaining local autonomy on pay, which in the early 1990s gave huge pay increases to top Trust bosses and little or nothing to most front-line staff.

Health workers and their unions will note that Milburn's reforms have only been bold and radical in the direction of greater privatisation and fragmentation: by contrast the much-vaunted Agenda for Change negotiations on a new, fairer pay structure for the NHS have ground to a halt for lack of cash.

Build a new campaign network!

The latest "reforms" to the NHS bring a double danger that local services might face privatisation.

The top "3-star" NHS Trusts are being promised new local "freedoms" to set up companies and to take decisions without reference to Whitehall;

But management of failing "no-star" Trusts is already being "franchised" off – initially to other NHS managers, but potentially to private firms.

As the *Health Service Journal* points out, the process may begin with private managers running NHS hospitals, but "at the end of the long road … lies the prospect of all health service provision resting in private hands".

In the fight to keep this vital public service public, information is key. That's why Health Emergency is establishing a NEW e-mail network to enable campaigners and union activists to access and share the latest news on local developments.

To join, e-mail us today: health.emergency@virgin.net

Feast for first English patients

THE MENU on offer seemed to be a top concern for much of the media coverage of the first nine patients sent in January for treatment to a French hospital at NHS expense.

But since the NHS was paying top dollar for places in the private hospital in Lille, the availability of superior food, spacious single rooms and TV sets was hardly a surprise.

What is less clear is how much the whole exercise will *cost*, not only for the first group of patients, but also for the remaining 200 or so who are expected to get their operations across the channel.

While the patients concerned – who live near the channel ports – benefit from getting their operations earlier than they would have done, the numbers involved are small in relation to the English waiting list. And there is little prospect of patients from the midlands, the north or Scotland and Wales making the much longer journeys to the continent for treatment.

■ Meanwhile French doctors and nurses have been embroiled in strikes demanding increased staffing and resources to compensate for the introduction of a 35 hour week.

The lack of cash to hire additional staff has resulted in a novel spectacle of trolley waits, queues and huge pressure on staff in what had been seen as one of Europe's flagship health services.

Plenty of NICE ideas – but no cash to carry them out

THE GOVERNMENT is not giving health authorities nearly enough money to carry out even its topmost priorities, according to evidence given to MPs.

Croydon Health Authority told the Commons Health Committee that simply to implement the top 20 priorities would cost an extra £70m a year – ten times the extra cash it had been given to improve services.

Lambeth Southwark and Lewisham HA estimates that just carrying out the guidance of the National Institute for Clinical Excellence (NICE), which rule on the cost efectiveness of new drugs, would cost an extra £15m next year – which would leave no money left over for other drugs which are known to be effective. Last year LSL had less than half the £4.6m it would have needed to implement the NICE recommendations.

LSL's director of public health said that the HA had effectively ignored much of the NICE guidance and concentrated instead on other government priorities for emergency care, because they thought it was "a sacking offence not to".

But now the HA was facing a demand to meet NICE guidelines on cancer treatment as well. The government had given more money, but simultaneously increased the targets.

A recent LSL report on its Local Modernisation Review concluded that only a fraction of the plan could be afforded:

"The overall costs identified in the LMR action plans are far in excess of the funding available for 2002/3 investment. First cut costs total approximately £140 million – although it should be noted tat he acute sector element of this figure, £60 million, represents Trust wide rather than an LSL figure.

"… Securing the levels of capital funding identified in the LMR submissions is not considered to be realistic and further consideration of contingency options is required."

The story is similar in Ealing Hammersmith & Hounslow, where a Local Modernisation review update found that:

"delivering the modernisation necessary to deliver the revised access targets in elective and emergency care could cost around £15m (2.5% of our turnover). Making the progress expected next year on mental health could cost a further £3.6m.

Total costs "for delivering all the action plans identified through our LMR process" could add up to £40m (6.5%)

But with extra cash required to clear underlying deficits in local Trusts, problems generating cash savings, and local boroughs facing major financial pressure on social care services next year which could lead to cuts in services, there seems little chance that all of the planned changes can be afforded:

"…It is clearly not possible to say that all targets and milestones for next year can or will be met… Current estimates put the money needed to achieve local action plans AND achieve a balanced financial plan at close to 12%."

Even Kensington Chelsea and Westminster, which has received the largest cash increase of any health authority, sees trouble ahead. Its "Draft Financial Framework" warns that:

"The preparation of this SAFF has been characterised by three main factors:

● Despite the high level of cash uplift, resources are still inadequate to maintain existing services, meet new cost pressures and make full progress against NHS Plan targets.

● The financial situation at St Mary's [a recurrent £9.3m deficit]

● An unrealistic timetable"

The document warns the HA that:

"Assuming a cash increase of 8.5% in 2003/4 (5% inflation, 3.5% growth), this does not allow for any new national targets, new generic cost increases or underfunding of pay settlements, further development of primary care or new local cost pressures." … "Overall we envisage the need for significant additional resources and/or savings in 2003/4 if the local health economy is to be in financial balance."

Why more dental patients are saying aaagh!

ANYONE wanting to see how expensive private medicine could be if the NHS were no longer available should take a look at the soaraway prices for private dental treatment.

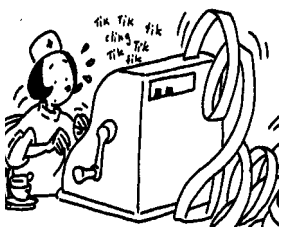
Lack of competition is allowing private dentists to charge up to six times the cost of the same procedure under the NHS, according to a report by the Consumers Association.

Private fees for a simple examination and scale and polish varied from £24 to £88.50, compared with £13.20 on the NHS.

Many dentists refuse to reveal their prices before treatment, and many more have simply walked away from the NHS, and refusing to accept new patients.

With little threat of competition from the NHS, they are taking the opportunity to charge what they like, in yet another case of market failure.

What was that again about a "partnership" with the private sector?



GPs look for part time work

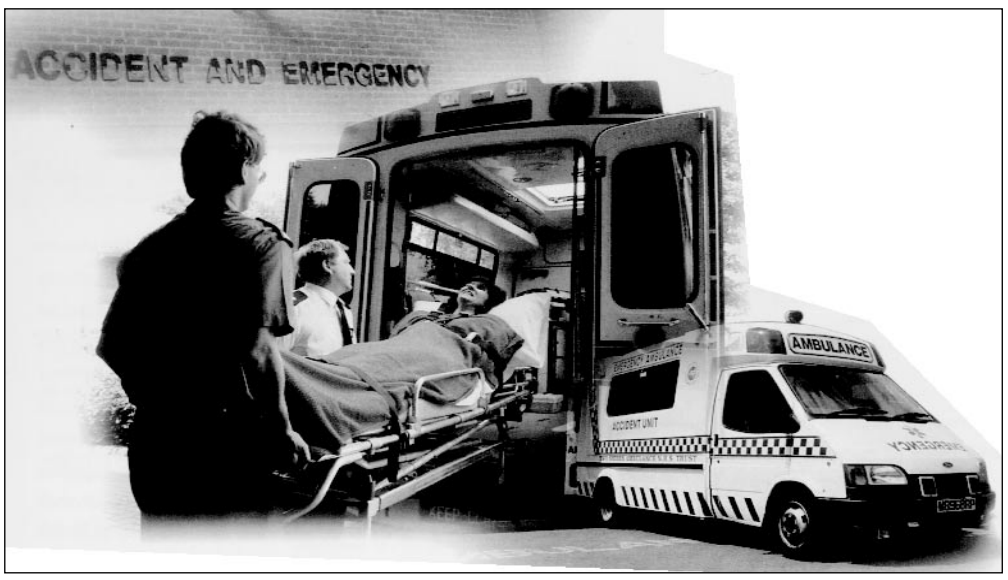
More than 75% of GPs aged under 30 are now women, and 40% of them want to reduce their hours of work in the next five years, most of them in order to start a family and spend time with their children.

These shock findings in a BMA survey last December will be seen as a stark warning that the government will struggle to meet its targets of reducing delays in seeing a GP, and its efforts to expand primary care services.

Ministers have said that they hope to expand GP numbers by 2,000 by 2004 – compared with BMA estimates that an extra 10,000 are required.

But if significant numbers of the new intake work only part time, then the number of practise hours available will be insufficient to bring down the wait to see a GP to a maximum of 48 hours.

However the good news from the same BMA survey is that younger GPs were more positive and enthusiastic than their older colleagues, and that GPs of all ages are overwhelmingly committed to the NHS as the framework for general practice.



High price of NHS Direct

Health Emergency has consistently questioned the cost-effectiveness of the "NHS Direct" hotline service, which we have characterised as a service for the worried well.

We receive a consistent trickle of complaints that patients worried about health problems are generally told when they eventually get through to NHS Direct to do what they would have done before it existed – and get down to their local A&E unit, or call out a GP.

Lambeth, Southwark and Lewisham Health Authority's Performance Management report recently concluded that NHS Direct may actually be worsening rather than relieving pressures on A&E:

"There is evidence that a number of NHS Direct calls result in patients being sent to the Out of Hours service of their GP or to the A&E Departments."

But the recent tragic case in which a young baby died of meningitis after being wrongly diagnosed over the phone underlines the fact that this system can also get things seriously and fatally wrong. The mother was told that the symptoms sounded like colic. She took the advice seriously, and as a result is was hours before the baby was rushed into hospital and correctly diagnosed.

Claiming that the problem was a "software fault", an NHS Direct service manager told the inquest in Southwark that "The service is not there to make a diagnosis, but whether a patient needs to be seen."

For all the investment in the system, it seems that it is still too risky for patients or parents to gamble on it with their lives.

Consultants' private work hampers NHS

The part time contracts of many NHS consultants allow them almost as much activity in the private sector as they wish, and this is part of the problems in gearing up the NHS to meet government targets.

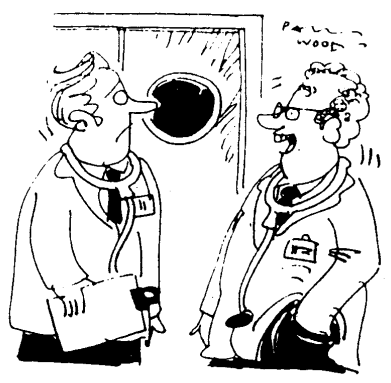
That is the view of John Yates, the Birmingham University Professor who made his name squeezing down waiting lists.

Yates shows that a part time surgeon working 5-6 sessions a week for the NHS with additional flexible commitments could expect to earn between £51,00 and £87,000 a year. But by working just 4-5 sessions a week in the private sector the same surgeon could earn £250,000 a year.

Once lured into this work, Yates points out, there is little incentive for surgeons to do more for the NHS.

"Work in the private sector is yet another factor … contributing to the reduction in NHS productivity."

But this also raises questions over government plans to make more use of private treatment to bring down NHS waiting lists.



"I'm a plastic surgeon. I only operate after I've seen their credit card"

"Is there sufficient spare capacity in the private sector? … Without tight control, the proposals are in danger of simply transferring activity from the NHS to the private sector, at overall increased expense, with decreasing NHS efficiency." (***HSJ*** 10 Jan 2002)

NHS pays through the nose for private beds

The deal announced at the end of last year with BUPA's Redwood Hospital, next door to the East Surrey Hospital in Redhill, involves the private hospital treating 5,000 NHS "routine operations such as hip and knee replacements" each year.

No details have been published on how much this will cost the NHS. But BUPA's standard prices are all at least 50% higher than the latest average NHS Reference Costs.

There are also doubts over the extent to which this deal represents any extension of NHS capacity.

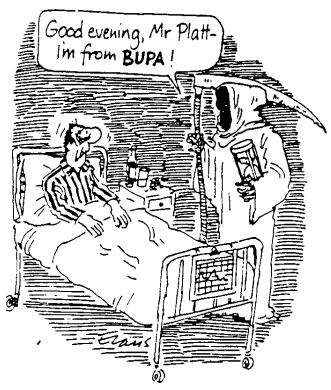
27 NHS nursing staff will move from the East Surrey to the BUPA hospital to staff it up for the increased work.

And all of the surgical consultants listed as working at BUPA's Redwood Hospital are NHS consultants – all but one of them employed by the Surrey & Sussex NHS Trust which runs the East Surrey Hospital.

The extra time these consultants work fulfilling the BUPA contract will mean less time available for their NHS work. The issue of the use of NHS resources to support the private sector will be more blurred than ever.

While both the NHS and BUPA have been coy over publishing the cost of the deal, it is worth noting that nearby Kingston & Richmond Health Authority in its latest Modernisation Review calculated that an alternative way to reduce occupancy levels in NHS beds would be to purchase 2,500 in-patient cases from the private sector, which it estimated would require 35 beds (almost the size of the 36-bed Redwood Hospital) and cost £3,000 per case – a hefty £7.5 million.

By contrast, Merton, Sutton and Wandsworth Health Authority last September discussed



opening additional beds to cope with waiting list pressures at Epsom & St Helier Trust (adjacent to Redhill). The cost of keeping open 82 medical beds, including nursing, support staff and physiotherapy and occupational therapy staff, was estimated at £2.44m.

The same Health Authority meeting discussed the cost of opening an additional ward and theatre at St George's Hospital, a few miles further into London.

The plan was for 20 surgical and 8 cardiac beds in addition to an operating theatre, at "a capital cost of £2.2m and revenue of £700k".

A temporary Cardiac Theatre could also be purchased at St George's for £480k. An additional 28 bed medical observation ward in A&E could also be established for a capital cost of £1.4m and revenue cost of £780k.

In other words for £4.1m in capital and just £1.5m in revenue costs (including London weighting), NHS capacity could be increased by 56 beds (28 surgical, 28 medical).

So for less than the cost of the 35 private beds priced up by Kingston & Richmond, the NHS in SW London could open and run an extra operating theatre plus 138 medical and surgical beds. By any estimate that represents a very expensive "partnership" for the NHS.

PFI delays Queen Mary's development

The building of the new community hospital on the Queen Mary's Hospital site, Roehampton in South West London has been dragged back by the slow and tortuous Private Finance Initiative process.

Although the private companies responsible for the scheme have at last agreed a deal on staffing arrangements with UNISON, the new hospital is still just an expanse of bulldozed rubble.

Health and social care services in South West London needed this new hospital to be built swiftly - but nothing happens quickly when the PFI is clogging up the works.

■ Meanwhile a new £67m PFI hospital in Bishop Auckland has been branded a "white elephant" before it opens.

But options are limited: regardless of any changes in local policies, the NHS is committed to a watertight deal to lease the new building for 27 years, guaranteeing the profits of the PFI consortium.

Private hospitals say no to private contractors

Virtually none of the country's main private hospitals is willing to use private contractors to provide their cleaning and catering services, according to a survey by London Health Emergency.

So while NHS patients face the risk of increasing sectors of support services being handed over to private contractors as part of PFI deals and regular rounds of competitive tendering, private hospitals recognise that high quality and efficient care is best provided by an in-house team.

A telephone poll covering almost 200 private hospitals, including both individual hospitals and all the major providers of private operations and treatment in England, found that only eight used external contractors for these highly visible support services.

Significantly these eight hospitals are part of the Amicus group (not to be confused with the recently renamed Engineering union) previously owned by a parent company (Compass) which also ran the Medirest contract company.

The survey found that all of the major chains of private hospitals – BUPA, Nuffield Hospitals and BMI – have a nationwide policy of delivering cleaning and catering services in-house.

American-owned HCA limited which runs some of London's "top" and best-known private hospitals including the Harley Street Clinic, the Wellington, the Lister, and the London Bridge Hospitals) also uses in-house services, which it describes as "more efficient".

The only support service frequently delivered to private hospitals by external contractors is laundry, frequently because in smaller private hospitals there is not the space for laundry equipment, or sufficient regular demand to sustain an in-house service.

"These findings are startling," commented LHE's John Lister. "Private hospital chiefs have given a massive thumbs down to the contractors we are supposed to put up with in NHS hospitals. So much for the government suggestion that the best way to ensure quality is to bring in the private sector."

More cream for NHS fat cats

Chief Executives of NHS Trusts pocketed an average pay increase of 6.2% last year – equivalent to £5,000.

More recent figures show that more than 25% of Trust bosses are earning six figure salaries.

But of course they are all keen to claim that this is simply because they are now shouldering more responsibility. Mergers are one reason why Trusts have become larger and more complex to manage, although this will reinforce the view among health unions that mergers are promoted more in the interests of NHS managers than those of patients.

Yet only one chief exec in five now has their pay linked to performance, compared with almost a third who picked up performance bonuses the previous year.

And news that four top NHS bosses caught fiddling waiting list figures last year left their jobs with secret pay-offs totalling over £250,000 – and that the ousted Chief Exec of the Epsom & St Helier Trust, branded the "worst hospital in Britain" by government inspectors, left with a pay-off based on a salary of £115,000 – will do little to reassure staff that the high salaries are compensation for risky short term contracts.

Meanwhile the talks on simplifying and restructuring the immensely complex Whitley Council pay structure for ordinary mortals working in the NHS appear to have ground to a halt after ministers got cold feet at the increased pay bill they were going to face.

Health unions which have invested time and energy cooperating in pilot schemes for the so-called "Agenda for Change", hoping to see closer links between the pay of doctors, nursing and professional staff and the remainder of the million-strong NHS workforce are reportedly far from impressed at the government's retreat.

Things you should know about private medicine

In Britain despite years of promotion by the Thatcher government, private health care is:

■ Unpopular (only 11% of the population has any private medical cover).

■ Parasitic: it exploits gaps in the NHS, and derives most income from workplace insurance policies covering the more prosperous adults of working age, who are least likely to get ill. Excludes elderly and chronic sick by charging hefty premium for very limited range of services.

■ Dodgy in its quality of care: its hospitals have little on-site medical cover: over 140,000 UK patients were sent from private hospitals to NHS hospitals in 2000.

The private sector provides no emergency services, no care for catastrophic illness, no support for patients with long-term or difficult conditions.

Britain's private hospitals predominantly deal with the "five Hs" — hip replacements, hernias, hysterectomies, heart conditions and haemorrhoids.

Doctor: What did you operate on Jones for?
Surgeon: A hundred pounds.
Doctor: No, I mean what had he got?
Surgeon: A hundred pounds.

Under New Labour's 'Concordat' NHS bought 70,000 operations from private sector last year – more than twice as many as the year before, but little more than 1% of the 6 million operations carried out by NHS hospitals .

The whole private sector carried out 800,000 operations in 2000. Yet it trains no doctors or nurses: instead it drains cash and trained staff from NHS, worsening problems in the most pressurised Trusts

Removing more waiting list operations from the NHS leaves the private sector with the profits, and the NHS with the most difficult and expensive cases.

If the private sector were to expand to take a significant number of NHS patients, NHS general hospitals could be reduced to A&E and geriatric units. If this happened to teaching hospitals, who would train doctors and nursing staff?

Private health care US-style

● Runaway costs: the USA has 3-4% of world's population, but accounts for 35-40% of world health spending (14% of US GDP). A fifth of this goes on administration.

● 44 million people are uninsured in USA, and millions more under-insured.

● 200,000 people each year DIE in USA through improper medical interventions.

● US Department of Health estimates that it overpays private hospitals by $23 billion a year. UK has no mechanism to protect us against this type of problem.

● For-profit hospital treatment within USA is 25% more expensive than not for profit, and poorer in quality. The combined spending on admin and profits is 48% higher in for-profit Health Maintenance Organisations.

Enron auditors gave key thumbs up to PFI

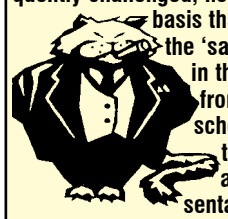
Andersen Consulting (now Accenture) separated in the UK from parent company Arthur Andersen in 2000. But prior to that, the company – now embroiled in the investigations into the collapse of US energy corporation Enron, had already established a position as a trusted advisor to the British government.

One of its reports, commissioned by the Treasury and published in January 2000 by the Office of Government Commerce, has played a key role in the Labour government's promotion of the Private Finance Initiative.

In collaboration with the consultancy arm of the London School of Economics ('Enterprise LSE') Andersen consultants wrote a report *Value for Money Drivers in the Private Finance Initiative*, which has been repeatedly cited by ministers seeking to back up their claims that PFI does in fact represent good value.

However Andersen's were hardly impartial or objective observers, since they were already involved in consultancy work on 32 PFI schemes covering hospitals, schools, roads and the controversial PPP project on the London Underground. The total value of the PFI/PPP deals in which Andersen has been involved exceeds £10.1 billion, and the company – like other private sector accountants, business consultants and lawyers – clearly stood to benefit from PFI continuing as government policy.

The validity of their key finding – that the budgeted costs of 29 actual PFI projects appeared to show an average saving of 17% over the projected costs of the schemes had they been publicly funded – has been frequently challenged, not least on the basis that 50% of all the 'savings' reported in the study came from just one scheme, making the 17% "average" unrepresentative.



In fact the report does not compare actual costs, but *projected* costs, contrasting a hypothetical public sector comparator (PSC) with the planned cost of the privately-funded project.

But an equally serious flaw in the argument is that 60% of the claimed 'savings' are based on the highly contentious notion that "risk" is transferred from the public to the private sector. Most of this claimed "saving" is undefined.

Despite these and other obvious flaws, the Andersen Report has been widely touted by Labour ministers, including Health Minister John Hutton and Treasury Secretary Andrew Smith, desperate to show evidence that PFI is a good deal for taxpayers. As Lib Dem spokesman Matthew Taylor pointed out in the Commons on June 21 last year:

"The Government always quote the Arthur Andersen report because it is the only one to support their position. The survey was based on expected savings, rather than delivered savings."

With fresh questions being asked over the competence and independence of the Arthur Andersen organisation, perhaps ministers may be wondering whether they too should have been putting at least one of its documents in the shredder.

1962 and all that, 40 years on

Which is the biggest ever hospital plan?

Oxford's John Radcliffe Hospital: one of the class of 1962

Labour ministers have repeatedly defended their policy of seeking to build hospitals using the controversial Private Finance Initiative by claiming that PFI has enabled them to embark upon the "biggest ever programme of hospital building in the NHS". But does their claim stand up to scrutiny? JOHN LISTER has been looking back at previous policies.

ALAN MILBURN's NHS Plan calls for a total of 100 new hospitals between 2000 and 2010.[1] On the face of it, this would appear to be bigger – and indeed the sums of money involved in such an investment programme are obviously larger – than the previous major programme of hospital modernisation, the 1962 Hospital Plan for England and Wales, almost exactly 40 years ago.

1948: Nye Bevan lays a foundation stone for a new health centre: but capital investment was minimal in the early years of the NHS

That scheme, eventually approved by the then Conservative government on the urgings of then Health Minister Enoch Powell, spelled out proposals for 90 new hospitals and another 134 major redevelopment programmes.

The 280-page Plan also listed a further 356 schemes costing over £100,000 each (equivalent to almost £500,000 today) and also acknowledged the need for many more smaller schemes "which represent a large volume of modernisation and upgrading". [2]

The Hospital Plan initially costed its programme at £707 million – the equivalent of £2.85 billion today. But this was almost three quarters of the entire NHS budget of that year (£971m) – so it might be argued a similar proportional share of spending today would amount to a £30 billion-plus investment in new hospitals, far bigger than Milburn's plan.

£500m was to be to be spent between 1962 and 1971 – an average of £50m a year, more than double the going rate at the time. Indeed the Conservative election manifesto had included a commitment to double the NHS capital programme, while Labour in opposition had called for spending of £50m a year. [3]

The Hospital Plan recognised that such a massive leap in public investment would represent a major change of policy, after years in which NHS capital to modernise the aged building stock nationalised in 1948 had been in desperately short supply.

In 1962 the government was spending just over half the current share of national wealth on the NHS, just 3.4% of GDP – compared with just over 6% today.

Within this limited pot of cash, NHS capital budgets in turn consistently accounted for less than 3% each year (though allocations had increased slightly, peaking at £24m in 1960-61). This was well below the level of around 5% that had been recommended back in 1956 by the Tory government's own Guillebaud Committee.

As a result, there was not enough capital to enable any substantial modernisation or even systematic repairs to buildings which were often unsuitable for modern medicine: 70% of hospitals taken over by the NHS in 1948 had fewer than 100 beds, and 20% of the building stock was found to be over 100 years old in 1962.

The situation called for a major change of policy: but perhaps surprisingly given Enoch Powell's right wing leanings, the entire 1962 investment programme was to be funded by the government from general taxation – and the completed hospitals would also be assets wholly owned by the NHS. There was no serious discussion of seeking the finance from elsewhere: the only debate within the Tory cabinet was over how much or how little should be invested in the modernisation of the NHS.

The Hospital Plan pioneered the concept of the District General Hospital of 600-800 beds covering a catchment population of around 150,000 as the key building block for acute (short stay) hospital services.

It involved a 6% reduction in numbers of acute hospital beds, but (reflecting the medical model of the time) a 35% increase in numbers of maternity beds. 1,250 hospitals – most of them small or very small – would close in the process.

Nation-wide

It also took an important step towards setting up a nation-wide plan and a coherent policy. It laid down norms for minimum levels of bed provision per head of population for each specialist service, and addressed the issue of staffing levels, both within the NHS as it then was, and within the Local Authority Health and Welfare Services (many of which are now council social services).

The Hospital Plan recognised that the schemes would take time to get up and running, and "assumed" spending of £200m in the first five years rising to £300m in the following five years. It accepted that "the sums which will eventually become available may be somewhat more or less, dependent on the state of the economy." In fact the costs were much higher than expected: but a change had been made.

By 1968 large schemes (carrying out building work costing over £1m a year) accounted for more than half of the NHS capital programme: there were 66 of these schemes – 6 of which were projects planned to cost over £10m. Capital expenditure that year was almost 10 percent of current NHS spending, and it continued to rise to a peak of 12.8% in 1973-4, before being cut back again to 9.9% in 1974-5.

Costings were distorted by high levels of inflation in the increasingly turbulent economic situation: but the new Royal Free Hospital with its tower block was completed in 1973 at what today seems an incredibly modest cost of £20m.

Only six new hospitals had been built between 1955 and 1965: but between 1966 and 1975 another 71 were started – and some completed, changing the shape of health care for a generation.

The 1970s saw a change in the economic climate, and a retreat by successive governments from investment, not only in the NHS, but throughout the public sector.

Government net capital spending plunged from a peak of £28.8 billion in 1974-5 to just £12.5 billion in 1979-80, and fell again to a nadir of just £1.9 billion in 1988-89. Only in one year during the 1980s (1983-84) did public sector capital investment reach £10 billion. And though it rose again briefly to double figures (with a peak of £14.2 billion in 1992-93), it fell back again sharply in the second half of the 1990s. (Figures are all at 1999-2000 prices)[4]

This cut in government spending was accelerated in the 1990s by the introduction of the Private Finance Initiative from 1992, which was accompanied in the case of the NHS by a steady reduction in government capital allocations. The 1995 budget projected successive cuts in NHS capital spending – by 17% in 1996-97, another 5% in 1997-98, and 6.5% the following year: PFI investment was supposed to increase year by year, from £47m in 1995-96 to

£300m in 1998-99. [5]

But PFI – and NHS land sales, which had become a regular feature of the Tory government's asset-stripping approach to the NHS – weren't the only ways in which governments found ways to claim to be investing generously in the NHS, while injecting comparatively little new capital.

During the mid 1990s the establishment of NHS Trusts within the Tory "internal market" reforms brought with it the introduction of capital charges to be levied on each Trust's land and property assets. This meant that a growing percentage of the NHS budget each year was generated internally from these "capital refunds".

Beginning at 1.2% of NHS total spending in 1993-94, these capital refunds steadily increased in scale as new Trusts were formed and more began paying charges on a greater share of their assets. By 1998-99 capital refunds amounted to a hefty 8% of the NHS budget. [6]

Less capital

So despite the appearance of allocating large sums for investment in new hospitals and other NHS facilities, and despite the apparent upturn in allocations since Labour took office in 19977, in practice the government has been injecting even less public capital for major hospital projects in real terms than the miserly amounts available in 1961.

Indeed in the two years 1997-98 and 1998-9, the injection of Treasury capital for Hospital and Community Health Services (HCHS) was more than outweighed by the cash generated from land sales and the refund to the government of capital charges paid by NHS Trusts on their assets.

Far from pumping in desperately-needed capital, the government effectively pocketed a surplus from existing NHS assets in these two years – of £139m in 1997-8 and £348m in 1998-9. [8]

The real figures are also disguised by the inclusion of PFI money under the general heading of "health capital investment" – of which it now makes up around a quarter of the claimed total [9]. However the extent to which PFI can be seen as "NHS investment" at all is not clear, given that the assets to be constructed will not belong to the NHS.

Instead the (inflated) cost of paying for the hospital projects financed through PFI will be met from NHS revenue budgets over the next 25-30 years. The "investment" is not a public sector capital asset, but a long-term public sector revenue liability.

Despite the claims by the DoH that PFI is simply "one of the weapons in our armoury of procurement tools", the pool of NHS capital is inadequate to offer Trusts a real choice of whether or not to seek private finance. This squeeze, tighter than ever since 1992, has meant that PFI has become seen by NHS managers as "the only game in town".

Only six major NHS-funded schemes, totalling less than £300m, have been given the go-ahead since 1997. This followed a long lean spell for NHS investment under the Tories: from 1980 to 1997, only seven publicly-funded schemes costing more than £25m were completed. [10]

By contrast, the Labour government has so far given the go-ahead to 38 PFI-funded NHS schemes totalling almost £4 billion, and aims to increase this to £7 billion by 2010.

A massive 85% of all new capital investment in the NHS is now coming from the private sector.[11]

Up go the girders: and with PFI, up go the profits for each new hospital – replacing NHS assets with private

Critics have argued that any short term benefits of PFI are outweighed by the long term costs. By 2007 the annual cost to the NHS of PFI payments involved in leasing these privately-owned, profit-making hospitals, and buying ancillary services from private contractors, will be in the region of £2.1 billion[12] – almost exactly the value of the entire NHS total gross capital expenditure last year.

Unlike the current capital charges, the payments to PFI consortia represent a net flow of cash and capital OUT OF the NHS and into the coffers of banks, building firms and their shareholders.

Together with capital charges, the total bill for leasing hospital premises from PFI consortia and capital charges levies by the government on Trust assets will add up to £4.5 billion a year. [13] This will become a first charge on the revenue of NHS Trusts – and thus squeeze the remaining budgets to finance patient care.

The PFI-funded £228m replacement for the Norfolk & Norwich Hospital is on a greenfield site on the edge of the city, and will cost £33.5m a year for 30 years.

In the longer run it is possible to see the process of renewal of NHS buildings through PFI leading towards a situation like that in social care, where the estimated value of assets involved is £13.3 billion, £10 billion of which are owned by the "independent sector".[14]

Of course such a process has a long way to go: the current estimated net book value of Health Authorities and Trusts is around £23 billion, with primary care assets valued at £2.2 billion. The estimated cost of replacement is over £75 billion.

But with NHS PFI projects likely to total £7 billion by 2007, inroads are being made, while existing NHS assets are still being sold off, (estate worth an estimated £1.58 billion has been identified as "surplus") while little new public investment is being injected to health care facilities and buildings.

The Department of Health's Investment Strategy points out that "One of the legacies of the under investment throughout the nineties is the sharp increases in backlog maintenance levels over the latter half of the 1990s. Between 1995-96 and 1998-99 backlog maintenance increased by around 40%. In 1998-99 it was £3.4 billion."

But this scale of backlog maintenance and the lack of NHS capital funding are used as the most potent arguments by Trusts seeking to justify embarking on costly and controversial new-build PFI schemes rather than refurbishing and redeveloping existing NHS assets.

The NHS has also fallen way behind European health services in levels of investment at every level – in medical staff, in hospital beds, and in modern diagnostic equipment.

The Investment Plan admits that the UK currently has just 7 CT scanners per million population compared with 20 in Germany and Italy and 15 in the Netherlands. And our hospitals have just 4 MRI scanners per million population, compared to Germany's 10 6 in Italy and 8 in the Netherlands. [15]

But the Strategy does not point out that our NHS also has fewer acute hospital beds per head of population than any OECD country other than Turkey. Only Turkey, Korea and Mexico have fewer physicians per head, and we are sixth from the bottom in numbers of practising nurses per head. [16]

A policy of investment for the future would focus on building, modernising and refurbishing a network of hospitals that would enhance the existing NHS asset base, rather than turning the country's most popular public service from a cash-strapped landlord into a cash-starved tenant in property rented from the private sector.

If PFI is allowed to remain the "only game in town" for the financing of the remaining hospital programme, Labour will not only fall short of the radicalism and public service commitment shown by Enoch Powell and the Tories in 1962, it will have substantially reduced and privatised the legacy of assets passed down from Nye Bevan in the formation of the NHS in 1948.

1 The NHS Plan, July 2000
2 Ministry of Health (1962) A Hospital Plan for England and Wales. HMSO.
3 Webster, C The Health Servics since the war, (1996) Vol 2 p99
4 HM Treasury, Budget 2001, Chapter C, Table C24)
5 "NHS's 1.6 per cent budget boost", DoH Press Release, Nov 28 1995.
6 The Government's Expenditure Plans 1998-1999, Fig 2.7.
7 Health Minister John Denham, Commons written answer, February 2 2000.
8 Gaffney D. Pollock A.M. Price D. and Shaoul J. "NHS capital expenditure and the Private Finance Initiative – expansion or contraction?" BMJ 1999 319; 48-51 (July 3).
9 The Government's Expenditure Plans 2000-01, Chapter 4, Fig 4.1.
10 Gaffney et al 1999
11 The Economics of the Private Finance Initiative in the NHS, by former Treasury advisor Jon Sussex, Office of Health Economics, April 2001
12 Will primary care trusts lead to US-style health care? Allyson Pollock, BMJ 322, 21 April 2001.
13 Ibid.
14 Departmental Investment Strategy, department of Health Nov 2000.
15 Departmental Investment Strategy, department of Health Nov 2000, p 14
16 OECD 'Health At A Glance', 2001.

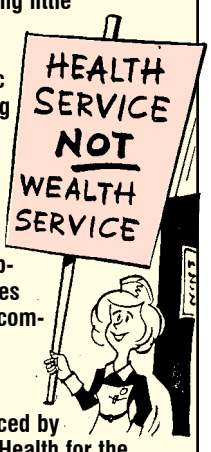
Publicly-funded NHS schemes: on budget and on time!

MINISTERS have claimed that financing new hospitals and NHS facilities using the controversial Private Finance Initiative represents value for money, despite costing more than publicly-funded alternatives – partly because, as they claim, PFI delivers projects "on time and to budget".

The implicit claim, (as stated in the PricewaterhouseCoopers report recently cited by Prime Minister Tony Blair) is that:

"traditional public sector procurement still suffers from delay, cost overrun and compromise on initially planned requirements."

Yet the government has gone over so enthusiastically to PFI as the means of funding 85% of NHS capital investment, that few public sector projects of any size have been agreed in the last five years, giving little base on which to assess the efficiency of the public sector in monitoring capital schemes.



Alan Milburn recently told the Commons Health Committee that only four major publicly funded schemes were under way – compared with 64 PFI schemes "on the stocks".

Yet figures produced by the Department of Health for the Health Committee reveal that of 24 publicly-funded NHS projects ranging in cost between £9.4m and £62m under way in 2001-02, with a total value of £510m, only two were expected to exceed budget … by a total of just £2.3m (less than a quarter of one percent of the total investment), and only five schemes are expecting a delay of 1month or more.

More significant, according to DoH forecasts, two NHS-funded schemes, in Blackpool and Bury, are expecting to come in BELOW the projected cost – something that NO PFI scheme will ever do.

The price of PFI: Kidderminster Hospital axed to pay for new Worcester hospital

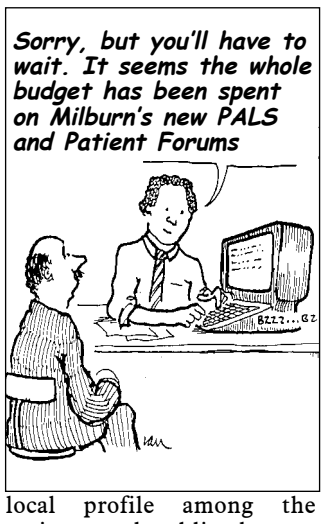
£200m bill to axe CHCs

Scrapping the Community Health Councils, which since 1974 have in many areas been the only means by which patients and local campaigners could challenge the policies of unelected health authorities and Trusts, is likely to cost the government an extra £200m a year, according to the Health Service Journal.

Financing the network of local CHCs, which are often the last remnants of local accountability after a confusing proliferation of mergers and reorganisations, costs the NHS just £23m a year.

But the new, bafflingly complex system which ministers want to bring in instead, replacing the expertise and popular base of the best CHCs with a Trust-based Patient Advocacy and Liaison Service (PALS), Patient Forums, coupled with "independent advocacy", and local government scrutiny committees, will generate a combined bill of £221m for 2003-4.

While this is likely to soak up all of the claimed savings from the reorganisation of health authorities under the government's bizarre "Shifting the Balance" policy, it will result in a series of organisations of questionable independence, and with little or no local profile among the patients and public that are supposed to be represented.



The PALS system itself, which will operate from offices within each Trust, and replace the present statutory role of the CHCs as the watchdogs pursuing patients' complaints, will cost a massive £56m a year to run – more than double the current cost of CHCs.

Not even a trolley for Doctor Foster

Early in January Gloucestershire Royal Hospital ran out of beds for emergencies, leaving eight patients to be treated in ambulances outside, in freezing temperatures.

The crisis was the latest symptom of capacity problems in Gloucester, and one of the solutions has been to ferry patients to beds in Standish Hospital a few miles away – which local health chiefs have been trying to close down for over nine years.

A hard fought campaign has challenged the closure of an attractive and popular local hospital to cram more services onto the Gloucester Royal site.

One of the paramedics, pointing out that without the extra beds GRH would have been in trouble, asked local reporters "what happens when Standish is closed down?"

That's exactly what LHE and campaigners have been demanding to know since the closure plan was floated in 1993.

Stalingrad O'Neill

Campaigners against the Birmingham PFI scheme have highlighted its cost and loss of beds

Price hike for Brum PFI

BIRMINGHAM's controversial new PFI hospital appears to have gone up again in price even, as the Trust gets the go ahead to invite private bids.

The latest estimated price is £306m, an increase of over 5% from the last quoted figure of £291m.

Arguments continue over whether the new hospital will have sufficient beds. While there is a nominal increase in bed numbers overall, a large number of these will be "intermediate" beds on site, and another 100 "intermediate" beds are to be sited elsewhere "in the community" and run by GPs. The number of front-line acute beds will fall by 207 (20%).

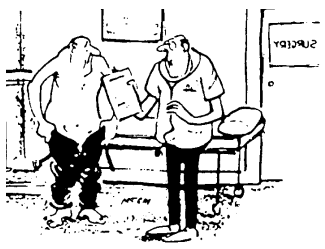
The local CHC points out that up to a third of local GPs are likely to be retiring before the new hospital opens in 2008, and there is therefore little chance of medical staffing for the "community" beds.

Under pressure: London round-up

Hillingdon

Hillingdon Hospital Trust is one of the big London losers in the latest waiting list figures. Its total waiting has almost doubled from 1366 to 2477 in the 12 months to December, while numbers waiting 6-11 months have more than doubled to 364.

Hillingdon HA reported in November that "Delayed transfers of care for health authority patients are at a higher threshold (66 acute beds) than at the same point last year and resources are limited." Delayed transfers affect 16% of acute beds.



"Given the present health care costs, Mr Frampton, I'm afraid you can't afford to go on living"

Camden & Islington

Camden & Islington's inpatient waiting list went up to 6160 in December, "13% above the planned figure and 900 above the start position for the year." The major variances are at UCLH [451 above] and the Royal Free [438 above].

Outpatients waiting over 13 weeks rose by 804 in December to 4,933 – 76% above the planned total and 1607 above the total at the start of the financial year. 26 week-plus waiters are 106% above plan.

East London

East London & City HA has warned that 50% of GP premises are still below minimum standards.

Barking & Havering

Health Authority (Jan31) reports that acute sector activity after nine months of the year was 7.8% higher than planned, while waiting lists (over 11,000) are 10.4% above target. Outpatient 13 week waits are also more than double the target level.

Whipps Cross

Redbridge and Waltham Forest HA's Local Capacity Planning Group has recognised that Whipps Cross Hospital will be unable to cope with "unprecedented emergency demands" and "constraints in social care" without additional beds. Unfortunately, despite a limited injection of cash last year, "a substantial funding gap remains."

SLAM

South London & Maudsley (SLAM) mental health Trust is projecting a year end deficit of £1m, largely due to:

- Acute overspill into the private sector in Lambeth
- Staffing over establishment on acute wards in Lambeth and Southwark
- Pressures on services for older people
- Cost pressures from new drugs.

The current projected overspend on placements for mentally disordered offenders is £5.6m.The health authority notes the above inflation increase in the cost of private sector forensic placements "Cost increases in the private sector are averaging around 12% at the present time".

■ The minutes of Lambeth Southwark and Lewisham HA reveal that there were 470 assaults on SLAM staff in the first quarter of the year.

Barnet

Barnet & Chase Farm Trust claimed to be making a recovery from the problems which brought its no-star rating, when it was thrown back into crisis.

A backlog of 2,700 requests for ultrasound scans was found, and Trust boss Liz Heyer resigned … leaving the way open for the Trust to be one of four to be "franchised" to managers from other NHS Trusts.

They still have a long way to go. Outpatient waits are getting worse: at the last count 4928 patients were waiting over 13 weeks for an outpatient appointment – 80% above the target of 2732 – while numbers waiting over 26 weeks are more than three times the target of 292.

£40m hole in Edinburgh PFI scheme

Serious flaws have been revealed in the business case for the £184m Edinburgh Royal Infirmary – even as the first part of the privately-financed hospital opened for business.

The Trust, which is already cutting 135 jobs will need to raise almost £40m in savings over the next five years to support the new hospital.

An accountant from PricewaterhouseCoopers brought in to scrutinise the deal has told the Trust that the assumptions underlying the PFI deal – that a privately financed option would be better value than public funding – were "hopelessly optimistic". The Trust needs to find £900,000 next year, £9.4m the following year, and £14.8m for two more years to make up the difference.

Trust chief exec James Barbour denied there was a problem: "£14.8 million is the additional cost of running the new buildings," he said.

We could have told him that!

Bristol bemused

Residents of North Bristol have been confronted with one of the flimsiest-ever consultation documents – a 4-page A5 leaflet which floats the idea of a single new hospital to replace the existing hospitals at Frenchay and Southmead.

Although it contained precious few facts and no figures, the consultation got off to an even worse start when door to door deliveries of the leaflet failed to reach key areas.

To compound the confusion, Trust bosses insisted in public meetings that they had not yet formulated a definite plan – and it was all up for grabs.

John Courcouf

London Health Emergency steering committee members and campaigners in many parts of London will be saddened to hear of the death of doughty Waltham Forest health activist John Courcouf, who passed away peacefully on February 14, aged 91.

A veteran of the Battle of Cable Street, John was a tenacious fighter for the NHS and a thorn in the side of self-serving bureaucrats and politicians until a few weeks before his death.

He was a loyal and extremely active supporter of London Health Emergency from its formation with GLC support in 1983, through all the tough times in which we have had to fight for funding and defy pressure from those who prefer to see no independent voice for London's health services.

His energy, and attention to detail meant that John would often alert LHE, local campaigners and the media to local issues buried deep in health authority and Trust board papers, and kept him at the centre of a succession of campaigns around Whipps Cross Hospital, and health authorities in Waltham Forest and Redbridge.

LHE's Information Director John Lister said: "John was a real inspiration to campaigners, and never gave up. He would travel across London to collect copies of Health Emergency, and send us cuttings, comments and cartoons. We always wanted more like him, to help us put the pressure on NHS managers throughout the capital. He will be very sadly missed."

John's family have requested that donations in his memory be sent to LHE. We thank them for continuing the support he gave so strongly. Cheques should be sent to us at Unit 6, Ivebury Court, 325 Latimer Rd, London W10 6RA.

Wakefield UNISON says 'no' to merger

UNISON Pinderfields and Pontefract Hospitals Branch has slammed a health authority proposal to merge Dewsbury Health Care NHS Trust (acute services) with Pinderfields and Pontefract Hospitals NHS Trust.

The merger plan has emerged as a by-product of the launch of a Primary Care Trust for North Kirklees, and the development of a specialist mental health services Trust, which will leave the remainder of the Dewsbury Trust "too small to maintain high quality services by itself."

The document – which doesn't even offer the semblance of a business plan for a merger of a Trust with £136m assets and an annual turnover of £207m – says nothing about the jobs of hundreds of health workers' jobs, and there is no assurance of no redundancies among clinical or other support staff.

UNISON concludes that: "Too many promises of improvements to come have been broken by the Pinderfields and Pontefract Trust. We cannot and will not support finance-driven initiatives which appear to promise the earth, but ultimately deliver nothing."

Nursing home chiefs holding elderly clients to ransom

Fighting back: Wandsworth home care staff strike against privatisation

Elderly clients in nursing homes have been trapped in the middle of a stand-off between profit-seeking proprietors and cash-strapped councils.

Some have seen the funding (of up to £110 per person per week) from the government, intended to reimburse them for the costs of their "nursing" care, pocketed by cynical nursing home chiefs desperate to force up their own profit margins.

Age Concern has attacked the botched, complex and inadequate scheme for free nursing care as a "shambles", while UNISON has launched a campaign to press the case for all continuing care services for older patients to be free of charge.

But in what has become a classic example of "market failure" some frail older patients are finding themselves turned away by home owners demanding increased fees from local authorities – or facing eviction and transfer against their will as homes are closed down because they don't make enough money.

In Stockport a group of care homes with over 1,000 beds has been threatening to turn away council-funded clients unless it gets a 9% increase in fees, while another provider has threatened to close down its 70 occupied beds.

In nearby Trafford 500 places in care homes have closed in the last three years, including a 23-place nursing home which closed just ten days before Christmas. Manchester faces the loss of 130 care home beds in a reorganisation by the company which took over the city's residential homes in 1991: it will slim down the remaining 16 homes to just 7. And there have been warnings that nursing homes in Wales could face abrupt closures because many of them are running at a loss.

According to analysts Laing & Buisson, the market in long term care for the elderly is worth a massive £5.6 billion a year to the private sector.

Meanwhile, as important areas of the country (including London) face a dire and worsening shortage of nursing home places, and government figures produced by National Statistics show the need for a 65% expansion of care home places over the next 30 years, ministers insist that the only solution is for councils to offer the private sector more money in an effort to bribe them into providing places.

Some of the homes still running are reportedly making economies at the expense of residents, with cuts in staffing levels, poorer quality food and heating levels reduced.

According to analysts Laing & Buisson, 12,600 beds for the elderly in care homes disappeared last year – the fifth successive year in which bed numbers had fallen.

This level of reduction represents 6% of care home places – but is the equivalent of well over 10% of available general and acute beds in NHS hospitals: with many NHS Trusts already struggling to meet targets for the discharge of older patients, this level of closures can only increase the pressure on front-line hospital beds.

Why have the nursing home owners been pulling out of what appeared in the 1980s to be an endlessly expanding market? Because profit margins have been squeezed by a combination of increasing costs and tight limits on the social service budgets which account for 75% of care homes' income.

Social service directors estimate that there is a national shortfall totalling £1 billion between the government allocation of funding and the costs of providing services: and while the greatest pressure has come for councils to increase spending on children's services, the most common area for economies seems to have been in care of older clients. Councils are facing a £200m overspend this year.

This has increased problems in cities like Birmingham, where nursing home places lie empty and % of NHS beds filled with patients awaiting discharge, for lack of social service funding.

While the council cash pot is empty, the pressure on nursing home bosses has been increasing.

Nursing and residential homes have long been notorious for the low wages and poor conditions they offer most of their staff, and they were hit hard by the introduction and increase in the minimum wage, followed by the Working Time Directive and other requirements to treat staff better.

With costs rising and fee increases pegged back to just 2% by councils, nursing home owners have also been tempted by soaring house prices to cash in their property assets and convert their buildings into luxury flats.

Homes have been closing: even BUPA, which has lower costs than its smaller rivals, closed down three fully occupied homes in Leeds last year after the council refused a fee increase.

Scottish Care, the body representing 800 private and residential nursing homes has been involved in a trial of strength with the Council of Scottish Local Authorities, demanding a £50 per week increase in fees per client, and threatening to turn away council-funded referrals if this was not forthcoming by February 11.

In the event Scottish Care bottled out of the confrontation and appears to have settled for a smaller increase, leaving many of its members close to bankruptcy.

Meanwhile the desperate lack of funds for elderly care at NHS and council level has led York University academic Alan Maynard to warn that the government's trumpeted National Service Framework for older patients will be nothing more than an "empty wheeze".

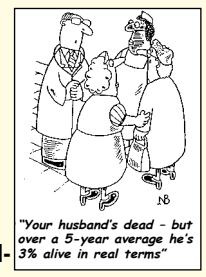
Selling off the elderly

Public provision of residential care beds has plummeted over the last 20 years from 134,000 in 1980 to just 56,000 in 2000, with more being closed or privatised all the time.

By contrast the number of beds in privately owned residential homes has soared more than four-fold over the same period from 40,200 to 185,400. According to Department of Health figures private sector residential accommodation was valued at £10 billion in 1999, compared with public sector provision of just £4bn.

Government policy since the 1980s has squeezed spending and investment on public sector care, while favouring the expansion of private sector homes. Social services were effectively paid a bounty for every elderly person switched to a private sector care home, as well as escaping any obligations to invest in and modernise ageing council-run properties.

The latest variant of this pressure to privatise has come in the form of the national Care Standards Act (2000), stipulating minimum standards for residential and nursing accommodation, and setting a timetable for them to be achieved. The cost of this has been widely cited by councils as the deciding factor in them handing over buildings and services to private sector providers.



So serious has the problem become that new government guidelines have set out to dilute and delay the implementation of the new standards.

A survey last year by RAGE (Residents Action Group for the Elderly) found that up to 12,000 beds were affected by a new wave of plans involving disinvestments, privatisation or closure, with more still to come. (RAGEnational.com)

RAGE points out that under community care legislation, local authorities are required to define the costs of care on the basis of patients' needs, not the availability of resources.

The failure to do this explains councils putting an unrealistic ceiling on their payments to private care homes, forcing more of them into closure – or crisis measures including the widespread imposition of "top-up" fees on individual clients.

The RAGE report exposes the "dutch auction" on budgets for long-term care, in which councils such as Birmingham have drawn up misleading cost comparisons with other councils which have already pulled out of provision of elderly care, or reduced costs by slashing the terms and conditions of their care staff.

Rationing hits social services

A report by 21 organisations campaigning on care for the elderly has warned that up to a million older people are not getting the care and support they need from the NHS and social services.

With the cash squeeze affecting many social services departments, and forcing them to tighten their eligibility criteria to offer care only to the frailest of the elderly, many with less severe needs are receiving little or no help at all.

The report, compiled by the Social Policy Ageing and Information Network questions whether the extra £300m made available over three years by the government to ease "bed-blocking" and delays in access to support would be sufficient to solve the problems. It would be targeted only at the most visible and embarrassing "tip of the iceberg", while half a million people still living at home needed regular visits and help with daily tasks including bathing and getting dressed.

One area epitomising many of the problems is Oxfordshire, where social services face a £4m (4%) overspend, and the leader of the County Council Keith Mitchell called in January for social workers to put financial awareness ahead of other professional concerns – and begin rationing care. He told the *Oxford Times*:

"It has to come back to rationing the services that are available. It is right that managers should have up to date and reliable information. It will enable them to exercise the rationing process fairly.

I fear they will have to say 'no' more often."

Home help services are once more on the chopping block, with criteria being raised to exclude more clients and cut spending by £1m. Meanwhile hospital beds in the county remain blocked for lack of sufficient nursing home places, and lack of funding for additional placements.

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