HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.61 * Summer 2005

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Call for new alliance to Save Our NHS

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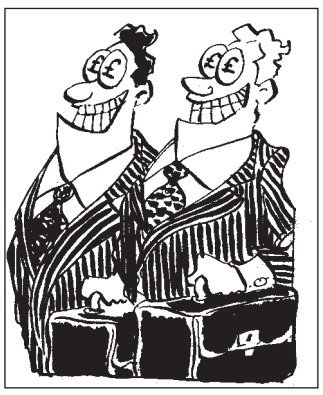
Say no to first sale of NHS hospitals

Above: the shape of things to come? SWLEOC as it may appear when its management is privatised next April

The prospect of Michael Howard as PM was revolting: but the re-election of Tony Blair for a third term of "unremittingly New Labour" policies has already produced a new lurch towards the privatisation of clinical services in the National Health Service – a policy even Thatcher never attempted.

The first NHS units to be hived off to the private sector will be the brand new, publicly-funded £16m South West London Elective Orthopaedic Centre (SWLEOC), based at Epsom General Hospital, and Ravenscourt Park Hospital, another orthopaedic centre in NW London, leased from the private sector in 2002.

The Epsom & St Helier hospitals NHS Trust has told staff that



an advert has been placed in the official EU Journal inviting private companies to bid to take over the management of SWLEOC from Spring 2006: but the decision was taken at national level, and Hammersmith Hospitals Trust which manages Ravenscourt Park was not even consulted about the proposal.

This privatisation of modern NHS facilities flows directly from the New Labour policy of promoting private sector provision of routine operations in preference to expanding NHS capacity.

But a report by YouGov in the middle of June found that 87% of the public oppose private companies taking over public services.

Blair's "modernisation" drive is constructing a new, competitive market system in health care, effectively reducing the NHS to a European-style health fund, purchasing care from a range of public and private sector providers – and stacking the odds in favour of the private sector.

Just three days after taking office pledging to act as a "listening Health Secretary", Patricia Hewitt announced a further massive expansion of spending in private sector Treatment Centres, with £3 billion extra spending over the next five years to buy 1.7 million more operations.

This will effectively double the NHS use of private hospitals: but NHS hospitals like SWLEOC have been forbidden to compete for this work.

NHS-owned Treatment Centres offering modern facilities and swift treatment have been stuck with unused beds and mounting financial problems.

Meanwhile contracts signed by the government have diverted NHS patients and funds into new rival private sector units.

SWLEOC is reportedly £4m in the red, and Ravenscourt Park £12.5m.

License to poach NHS staff

Private sector treatment centres are to be given a 'license to poach' NHS staff, as Patricia Hewitt relaxes one of the very few safeguards which worked to protect the NHS.

The government insistence that treatment centres had to recruit staff from elsewhere, and not employ anyone who had worked for the NHS in the previous six months, resulted in the nonsense of specialist ophthalmology staff being flown in from South Africa to deliver cataract operations in Oxfordshire, while the NHS Eye Hospital faces a devastating loss of revenue.

The BMA. which represents doctors in private practice as well as NHS staff, has gone further and demanded greater "integration" of NHS and private providers.

This would create additional income streams for moonlighting NHS consultants – and also possibly soften the BMA's critical, if rather belated, response to the government's reforms.

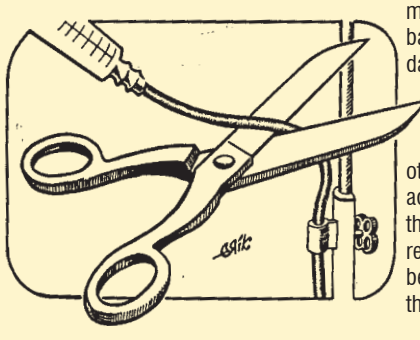
8,000 NHS jobs face the axe

UPWARDS of 8,000 jobs are likely to be axed in English Trusts and PCTs as SHAs battle to clear deficits which now total more than £750m, according to the *Health Service Journal* (July 14).

Strategic Health Authority chiefs have even hatched out a bizarre plan by which eleven of the SHAs with the smallest overall financial shortfall would lend money to bail out the six SHAs regarded as financial basket-cases with 'no hope' of clearing debts this financial year.

A middle group of 11 SHAs will need to make "significant savings" to balance their books by March 2006, when the government's controversial "payment by results" regime will throw the system back into the melting pot.

The Department of Health has reportedly brokered the scheme under which SHAs which are currently in the black would offer loans totalling £200m on terms



which ensure interest payments of at least 10 percent per year – more than many credit cards.

The six hopeless cases that would borrow the cash are NW London, Norfolk, Suffolk and Cambridgeshire, Bedfordshire & Hertfordshire, Surrey & Sussex, Hampshire & Isle of Wight and Cheshire & Merseyside.

This wacky carve-up leaves some of the SHAs with the biggest individual problem Trusts in the middle group, where cutbacks are the order of the day, and where the estimated 8,000 jobs are predicted to go.

Obviously Trusts within the other 14 SHAs will also be adding their contribution to the cuts, closures and redundancies that are set to be a feature of the NHS into the autumn and winter.

What is clear is that for a lot less than the £3 billion she has just allocated to purchasing elective treatment from the private sector, Patricia Hewitt could have wiped out the cumulative debts that are dragging down Trusts and services across England, and expanded NHS services to meet the government's targets.

She has chosen not to do so: only a real fight against each cutback and closure will make her change her mind.

● Foundation Trust regulator 'privatised' - p4: ● PFI hit by soaring costs - p8

Scottish ministers get thumbs down for foundation trusts

A report for the Scottish health minister has concluded that Foundation Trusts in England, far from a model to be emulated, represent a fragmentation of the NHS "like pre-Machiavellian Italy with warring city states".

Professor David Kerr of Oxford University warned that the system would not work in Scotland, where hospitals are a long distance apart, meaning that only those patients with access to private transport would be able to exercise any "choice" between rival Foundations.

Competition between Foundations in a market style system would also cut across the cooperation which was needed to raise the overall quality of care and achieve the basics of National Service Frameworks, he argues.

Training hit as University axed

One unheralded closure that ministers have pushed through without opposition has been the closure of the NHS University, the initiative that was to improve the training of NHS and social care staff.

230 staff members were made redundant at the end of June as the University, a flagship proposal in Labour's 2001 Election Manifesto, which was opened by Health Minister John Hutton in December 2003, with its closure announced eleven months later, and the closure completed within 18 months.

Briefly ...

Robot wards

Two £50,000 robots will take the place of doctors going from bed to bed at St Mary's Hospital, Paddington, giving patients remote communication with the doctor who performed their surgery, or other specialists.

At less than half the cost of an average GP salary, with no union, and no problems with fatigue, it is hardly surprising that this seems like the dream workforce for a team of ministers who behave remarkably like robots themselves.

Cut price Welsh prescriptions

The Welsh Assembly Government has pressed ahead with reductions in prescription charges as it prioritises GP services and primary care in its effort to cut the pressure on hospitals.

Prescriptions in Wales now cost just £4 per item compared with £6.50 in England: the downside is that desperately over-stretched Welsh hospitals have far longer waiting lists than their English equivalents, and of course it costs £4.60 to get to Wales across the Severn Bridge.

Long job

To transfer GPs' computerised notes onto a new NHS electronic system could take 18 years unless there is a marked acceleration of current rates of progress, according to a leaked report in the *HSJ* (April 28).

Cottage industry

Devon could see one of the first-ever hospitals built as a private sector scheme delivering clinical services to a PCT.

Private sector interest has been strong in a new cottage hospital for North Devon PCT which would include not only demolishing and rebuilding the existing hospital in Lynton, but also the provision of primary, diagnostic and intermediate services and pharmacy, complete with staff.

Worried walk-in

Private walk-in centres delivering "primary care" to the worried well are still going ahead at railway stations, at a cost of £25 million over three years, despite the obvious lack of any coordination with existing primary care providers in the target areas.

NHS indirect

Worried well people fed up with waiting hours for an answer from NHS Direct, but not sick enough to merit a 999 call or out-of-hours GP visit may be offered yet another variety of telephone helpline according to the latest Department of Health thinking.

A new number would give an immediate answer, but hopefully avoid burdening the 999 service with trivial calls that don't require an ambulance.

There are currently at least 1,000 numbers in London alone which patients could use to make contact with various levels of service.

Paying customers replaced by NHS patients in private hospital bonanza

AS private hospital bosses brace themselves for a bonanza of income from the taxpayer, NHS patients are likely to make up half of the total private sector admissions by 2010.

Up to 150,000 people a year who would have attended as private patients could be drawn back to the NHS because of shortened waiting times, but numbers of NHS patients treated in private hospitals are likely to rocket four-fold from 140,000 a year to 643,000 a year, according to a report for the Healthcare Commission.

Private patients currently account for 85% of private hospital activity: this would be slashed to 55% as the NHS patients take their place.

People with private medical insurance are expected to account for just 43% of private hospital activity, compared with 66% at present.

One of the factors driving NHS patients to choose private hospitals in place of their local general hospital is their claimed lower infection rates in the ongoing press hysteria over MRSA.

Of course private hospitals are all vastly smaller than their NHS equivalents, and offer only elective treatment largely to wealthy people who are not otherwise ill.

Smaller hospitals with no long-stay patients bring fewer visitors, and therefore less risk of infections imported from outside.

Private hospitals have also resisted any pressure to save money through contracting out cleaning services.

■ 81% of the 3,800 private sector psychiatric beds are paid for by the NHS or public sector, and it is a booming area, expected to grow by 30% over the next five years, according to analysts Laing & Buisson.

Here, too, the private sector is profiting from the lack of capacity within the NHS, which has continued the rapid closure of mental health beds that began in the early 1989s.

Almost 10% of NHS mental illness beds (2,800) closed between 1997-2004.

■ Current spending on private sector treatment has already risen eight-fold since 1997, from just £200m a year under the Tories to £1.6 billion this year under Tony Blair.

On current plans the NHS is set to spend £4.5 billion a year on services from the private sector including almost £2 billion a year on elective hospital treatment, as well as psychiatric services, nursing home care, learning disability services, PFI hospitals and IT services.

Anger over role of ward 'entertainment advisors'

A previous issue of *Health Emergency* highlighted the profitable activity of Patientline the company which supplies bedside consoles supplying telephone, radio, and TV services in many NHS hospitals.

We pointed to the constant flow of mind-numbing advertising that is flashed onto the monitors from early till late unless patients resort to a complex manoeuvre to disable the display.

Now a row has erupted over the numbers of staff being employed by a rival company, Premier TeleSolutions, to promote the use of their consoles, which also offer bemused patients internet links and video games.

Six 'entertainment advisors', paid at £5.50 per hour, have been set patrolling the wards of the West Suffolk Hospital in Bury St Edmunds, ready to pounce on any patient showing interest and "demonstrate and explain how to use the systems".

Hospital staff earlier this year were complaining at drastic shortages of cleaning staff on the wards, but while the Trust runs a deficit it seems there is plenty of surplus cash sloshing round from the fees forked out for cards to activate the TeleSolutions machinery.

Monster crunch

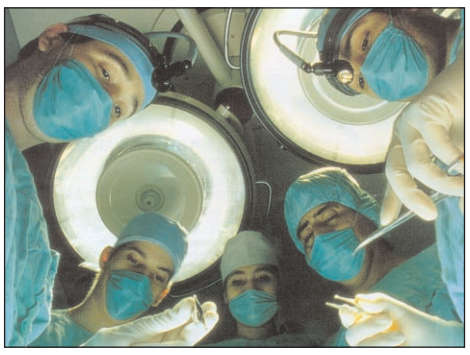
Among the many soaring deficits that have come to light at the beginning of the new financial year, the biggest Trust deficit appears to be the £30 million-plus hole in the finances of the Surrey & Sussex Healthcare Trust.

Auditors have warned that without an additional injection of government funding the Trust will effectively be bankrupt, failing its statutory duty to break even over the three years to March 2006.

So desperate was the financial plight at the end of the 2004-5 financial year that the Trust board considered delaying March staff salaries to April and withholding PAYE tax and national insurance payments to make the deficit seem smaller: a full payment of debts outstanding would have left it £36m in the red.

The Trust was placed under the control of a firm of financial trouble-shooters in February.

Acting chief executive Anthony McKeever, from Quo Health, told the *Health Service Journal* that since the Trust had no chance of breaking even by next year without extra funding, he would be looking at measures including selling off property, a loan or one-off support to hold down the deficit.



Which ones can they make redundant?

Leeds trust slashes jobs

Leeds Teaching Hospitals Trust has been one of the early job-cutters, with plans to axe up to 640 jobs by the end of the financial year to cut back a projected £12m deficit.

Last autumn the Trust cut more than £2m from radiology budgets, and the latest round of cuts has brought the resignation of the clinical director of radiology Tony Chapman.

Early this year the trust closed 200 beds and four operating theatres to save money: more cuts are still to come.

SHAs, Trusts and PCTs face soaring deficits

With the election results out of the way, the real scale of the financial crisis that is facing England's NHS Trusts and Primary Care Trusts has begun to emerge.

Even Health Secretary Patricia Hewitt is reportedly astonished at the size of some of the deficits, but instead of listening to the reasons, has immediately ordered Trusts to take whatever action is necessary to balance the books – and not to expect any additional injection of government funding.

As the NHS braced itself to publish figures showing more Trusts running bigger debts than ever before, Hewitt told managers at the NHS Confederation's conference in Birmingham that more reform to the system was not an optional extra but "your highest priority".

Managers were failing to tap in to "major productivity gains to be had from the extra investment already in the system," insisted Hewitt.

She went on to demonstrate how little she had learned in just over a month in the job when she argued that the key to improved productivity was reducing average length of stay for hospital in-patients, ignoring the fact that many hospitals are struggling to discharge patients because of a lack of adequate support from other agencies – PCTs, community services and social services, all of which are faced by heavy financial pressures.

A survey of top NHS managers by the NHS Confederation found that two thirds of them do not believe their organisations can meet all of the government's targets for improving services with their current levels of funding.

Four out of five believed that unless funding levels continued to increase at the rate they have been in the last few years, patient care would decline after 2008, when the current NHS Plan allocations come to an end.

A third of the managers responding felt that the quality of care would not be improved by offering patients more choice on where to get their non-emergency surgery.

Health workers may be groaning under the non-stop barrage of reforms but Patricia Hewitt believes that the instability her government's policies have created are good for the NHS.

In a June 14 interview with the *Financial Times's* Nick Timmins, she admitted that too many NHS staff feel that "change upon change has been done to them, rather than with them", but spelled out the scenario:

"It's not only inevitable, but essential that payment by results and these other elements create instability and change for the NHS. That is precisely what they are designed to do."

"Yes there is a real risk of a unit closing because it simply can't deliver the quality of care and the value for money that all of us as patients and taxpayers want."

The changes would be rammed through in the next two or three years, in the hopes that voters would have forgotten by the next big polling day:

"It's much better to take the pain and change now … in the first year or two after a general election, than to do it in the year or two running up to the next election."

The logic of Hewitt's position is simple: any hospital that fails to balance its books must also have failed to attract sufficient patients – and that patients have therefore exercised their choice.

Since patient choice is the main mantra of NHS policy, those hospitals which are not chosen will be allowed to close.

"I am not going to force patients to choose services they don't want," she told NHS employers.

But she has made no such promise to patients whose first choice would be to use services at their local NHS hospital, but who face being dispatched for private sector treatment to meet new targets for Primary Care Trusts.

Nor do her strong words take account of the complexity of services delivered by NHS hospitals compared with the narrow range of elective specialities offered by cherry-picking private companies.

Only the NHS provides emergency services, and there is no sign at all that the private sector wishes to compete for this costly and risky section of the "market".

Bankrupting district general hospitals or forcing the closure of NHS hospital departments could trigger the closure of A&E units, and leave people without vital local services.

Jess Hurd (www.reportdigital.co.uk)

East London protest in 2001: it's time to dust off the placards again

Will Hewitt get cold feet on cuts?

In an apparent change of tack, Hewitt told the *Health Service Journal* on June 16 that while she had her foot 'flat down on the accelerator' of reform, it would be "ridiculous" to imagine that hospitals will close all over the country as a result of her policies.

And she argued on BBC radio's Today programme on June 24 the there was "no question" of putting hospitals delivering A&E services in jeopardy "because the A&E service is absolutely essential".

A week later the *HSJ* reported appeals from a health authority chief executive and from Bill Moyes, the chair of Monitor, the Foundation Trust regulator, for the government to write off the debts of some of the struggling Trusts.

Many Trusts have debts so large that Moyes would not be able to rubber stamp their applications for Foundation status by the target date of 2008. He went on to point out that many Trusts which appeared to have broken even had in fact concealed deficits by in-year borrowing ("brokerage") which simply stores up long-term problems.

However Hewitt appears to be holding firm, apparently encouraged by the absence of headline coverage and local resistance to cuts and closures. It's up to campaigners to change her mind.

South Tees strips out jobs

South Tees NHS Trust has plunged deep into the red, with a deficit of £25m, revealed in March comprising a £13m overspend and a £12m loan to be repaid to the local SHA.

More recent projections suggest the deficit has grown to £32m.

A vacancy freeze was imposed which hoped to save £9m in the current financial year, while implausibly claiming that it would not affect patient care.

Managers have tactfully avoided any reference to the costs of their giant PFI hospital taking shape step by step alongside their deficit.

Free to swing axe

Hampstead's Royal Free Hospital is rumoured to be preparing for wholesale redundancies in a bid to stem a cash haemorrhage after it plunged more than £13m into the red.

Brighton rocked by cash crisis

Brighton and Sussex University Hospitals Trust has stacked up a deficit of £32 million, more than 10 percent of its budget, after carrying forward a debt of almost £8m from last year.

Trust bosses will be looking at bed closures and redundancies, compounded by a change of strategy by Brighton's PCT which has slashed the hospital spend by £6m a year.

The Brighton trust also faces a massive £15m a year cut in its orthopaedic budget when a private treatment centre begins to hoover up 85 percent of elective NHS patients and funds next year, leaving only complex surgery and emergencies in the NHS.

Plans to cut spending could involve an end to in-patient services at Brighton General Hospital.

Briefly …

Zero to hero?

Patricia Hewitt has chosen the chief executive of a zero-starred Trust, Royal Surrey County Hospital, as one of her seconded policy advisors.

Matthew Swindells will wind up working alongside a hand-picked group of Hewitt's old cronies from her days at the Department of Trade and Industry and the Blairite-leaning think-tank the Institute for Public Policy and Research.

SHA soft landing

Strategic Health Authorities have taken over the role previously occupied by Regions and the universities as the safety net for failed executives who miss out on appointment as government advisors.

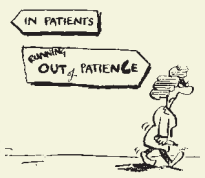
Paul Haigh, Chief Executive of Kensington & Chelsea PCT, which ran up a staggering £14.5m in debts without realising it, has been shunted sideways into a job with the financially challenged NW London SHA, where the debts should make him feel well at home.

The PCT's chair Terry Bamford at least had the decency to resign after the £9m "black hole" discovered in the PCT's finances, including bills from more than a year earlier.

Queuing to leave

40 percent of overseas nurses are eager to leave Britain, according to a survey of 400 nursing staff in May.

A month earlier figures from the Royal College of Nursing showed that more than 13 percent of London nurses quit the NHS last year: some were lured into the private sector, some retired and others left to have children, but the rate of decline is a serious problem, while there is also evidence that fewer nurses are coming to Britain to work.



If 40 percent were to leave, it would reduce qualified nurse numbers in the capital by 8,000.

Postcode IVF

The much-vaunted right to IVF treatment announced by the government on the recommendation of the National Institute for Clinical Excellence has brought a renewed postcode lottery in which different PCTs offer widely different packages of treatment, and almost all NHS patients face long delays.

The All Party Parliamentary Group on Infertility has found that in some areas the delays are long enough to mean that women will be too old to meet the top age limit of 39.

Some PCTs offer to pay for two and even three cycles of IVF treatment, while others have cut back and some only ever offered one. Waiting times are as long as two years.

PCTs are set target to send NHS patients privately

By the end of this year, Primary Care Trusts which hold the purse strings for health services will have to send at least 10 percent of their NHS elective (waiting list) operations to private hospitals.

Hewitt has now set course to increase this still further, towards a longer-term target of 15%, but has insisted that there would be "no arbitrary limits" on the share of the market that private providers could capture.

The tax-funded expansion of the private sector will have a severe knock-on impact on existing NHS Trusts. They will:

*** Lose the funding for many routine waiting list operations, and have to find ways to deliver other services with reduced budgets.**

*** Lose crucial nursing and medical staff, who will increasingly be poached by growing private treatment centres, leaving front-line NHS services struggling to cope.**

*** Have to cancel their own plans to expand services to meet government targets for reduced waiting times**

*** Lose valuable opportunities to train doctors and specialist nursing staff in routine treatments. Some hospitals face the possible loss of their accreditation to teach doctors and nurses, with severe consequences for future skill shortages in the NHS.**

*** Face a more complex and costly caseload of patients, people the private sector has no interest in attracting. The removal of much routine "bread and butter" work from the NHS will force up the unit costs of the services that remain, and undermine the viability of many Trusts that are currently struggling with large deficits.**

To make matters even worse, next year Trusts will face the introduction of "payment by results", a market system which will bring back competition, and seriously disrupt the finances of many major hospitals.

Hewitt is spending billions of taxpayers' money on these policies, which have been denounced not only by health unions such as UNISON, but also by the BMA and the Royal College of Surgeons.

And Hewitt has warned that any "failing" NHS hospitals – those that lose out in this new, unfair competition with the private sector – will be closed down.

Private sector makes room for profitable NHS patients

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Up to 150,000 people a year who would have attended as private patients could be drawn back to the NHS because of shortened waiting times, but numbers of NHS patients treated in private hospitals are likely to rocket fourfold from 140,000 a year to 643,000 a year, according to a report for the Healthcare Commission.

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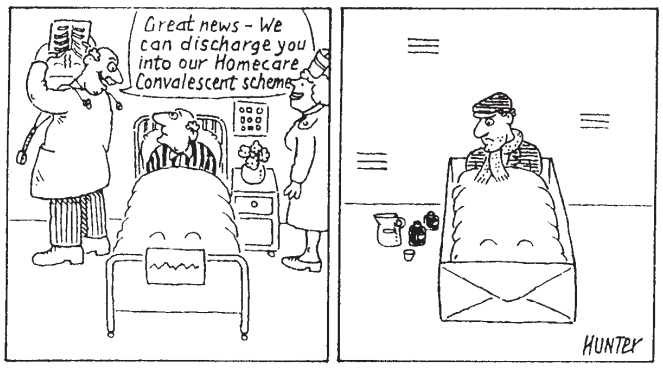
Of course private hospitals are all vastly smaller than their NHS equivalents, and offer only elective treatment largely to wealthy people who are not otherwise ill. Smaller hospitals with no long-stay patients bring fewer visitors, and therefore less risk of infections imported from outside.

Private hospitals have also resisted any pressure to save money through contracting out cleaning services: almost all have in-house cleaning, while the NHS has had suffered the brunt of cowboy contract firms.



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Mental health: standing room only

Pressures are running high in mental health services as PCTs attempt to foist some of the spending cuts onto the least visible sector of the NHS.

Figures in April's *Health Service Journal*, surveying a sample of 30 Trusts, showed that the numbers of mental health trusts running bed occupancy at above 100 percent was higher than those running below 100 percent.

A Sainsbury Centre survey of 330 wards in 50 mental health Trusts found that one in four had lost staff to community services, while nearly half had no lead consultant psychiatrist.

Many wards were unable to offer a full range of therapeutic activities for lack of appropriate professional staff.

Another audit of 265 mental health facilities, by the Royal College of Psychiatrists, has revealed "startlingly high" levels of violence against staff and among patients.

Four out of every five nurses said that they had experienced violent behaviour while working on their ward, while nearly half of all patients and a third of visitors had witnessed violent incidents.

● Mental health beds rented from the PFI-financed South Manchester University Hospital are costing £5m a year – almost 10 percent of the Mental Health Trust's income – with the costs effectively a surcharge which is "crippling the mental health economy".

Pensions face new threat

The 'payment by results' financial reforms were not the only measures postponed to avert pre-election disaster.

Another conspicuous retreat was on the hugely unpopular plans to slash NHS pension entitlements, increasing the retirement age for any NHS staff who reach 60 after 2013, and for all new staff joining from 2006.

Under threat of coordinated strike action from public sector unions (led by local government staff who faced changes this year) Blair personally intervened to postpone this onslaught until after the votes were counted.

But immediately after the election David Blunkett was put in charge of pensions, making it clear that the government would be back in the autumn determined to get its way.

However the impact of the threatened pensions strike gives a clue to the most effective response: coordinated and militant action to challenge job cuts, closures and privatisation may be the only way to save pension rights and save the NHS as a public service and defend standards of care for patients.

Foundation Trusts

Scandal as 'independent regulator' is privatised

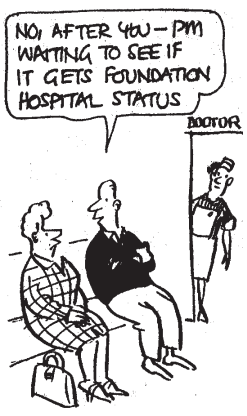
The Queen's Speech left room for the New Labour government to bring forward controversial measures to widen the powers of Foundation Trusts including more generous borrowing limits, and expand private provision of "primary care" (GP) services.

Foundations are already openly lobbying for a higher limit on their right to borrow from the private sector, which was imposed at Gordon Brown's insistence.

Perhaps more significantly, the Foundations are also attempting to overturn the cap that prevents them increasing the volume of private treatment they deliver as a share of their total turnover, allowing them to bring in as many paying patients as they can.

And their trade group, the Foundation Trust Network, have called for a system that would allow them to set up outlets selling their specialist services in other NHS Trusts – along the lines of the franchising system of beauty boutique counters in Debenhams.

As the signs grow that the Foundations are getting more cocky in their pursuit of a healthcare market, Gordon Brown is understandably concerned that they could run up big debts if borrowing restraints are relaxed: this happened in New Zealand, where the equivalent to Foundations, Crown Health Enterprises, were allowed unrestricted borrowing from the private sector in the early 1990s. They ran up massive debts before being brought back under government control. The bills are still being paid off.



Concerns over the future direction of Foundation Trusts will be heightened by recent reports in the Health Service Journal revealing that Monitor, the 'independent regulator' charged with overseeing Foundation Trusts, has itself been largely privatised.

Two thirds of Monitor's £15.5m first year budget has been spent on hiring private management consultants from the USA, flying in American whizz-kids from McKinsey consulting – including Chelsea Clinton.

The USA has the most expensive, least inclusive, most privatised and most bureaucratic health care system in the world, spending $1 out of every $3 of health spending on administration – $400 billion a year. What lessons does Ms Hewitt think McKinsey have got to teach the NHS?

Monitor's chair, Bill Moyes, has proposed that a single regulatory body should vet the running of the NHS – along the lines of Ofcom. PCTs should be merged into fewer, larger organisations, and they as well as Strategic Health Authorities should no longer have their own boards, suggests Mr Moyes, effectively removing any element of external involvement in the policy-making process.

While Trusts, PCTs and health authorities have always been appointed bodies, the requirement to include non-executive board members from the wider community (although most of them are rent-a-suit bigwigs from the business community) created some notion of public involvement.

The removal of these non-execs would presumably also end any requirement to hold business meetings in public or to publish board papers – and open the way for even more money to be spent on high-cost American management consultants to tell us how the NHS should be run.

Rocky foundations...

Pay up for chairs?

*** Foundation Trust chairs and non-executive directors should have a thumping great pay increase, according to a new Foundation Trust Network set up by the bosses organisation the NHS Confederation.**

Chairs should get as much as £60,000 a year – almost three times the £22,000 currently paid to Trust chairs – while non-executives should be paid up to £14,000 – a £10,000 boost for the invisible and largely mute army of obedient hand-raisers and vol-auvent consumers who make up the numbers on Trust Boards to so little obvious effect.

Trust chairs are currently expected to make themselves available for up to three and a half days a week, and it is not clear if the Network is proposing any increase in hours to justify a monster increase for a largely token role.

The first "super chair" in a Foundation Trust was installed at the insistence of Monitor, and was paid a cool £60,000 for six months' work.

Nice enough, if you can get it.

Rhetoric exposed

* A six-month Bath University study of Foundation Trusts has concluded that ministers' claims that they would increase local control and accountability are nothing but rhetoric.

Governing boards, themselves unrepresentative of local communities, are in any case excluded from the key management decisions, which are taken by unelected chief executives and trust chairs.

Elective governors are effectively diverted into mundane issues such as car parking, and denied a voice on real strategic questions. Where trust elections took place, those voting tended to be generally white men aged over 65, hardly representative of local communities.

In May a King's Fund report also pointed to the fact that governors were struggling to make any impact on Foundation Trusts.

Two tiers of Foundation Trusts

*** The notion that Foundation status would only be available to top flight Trusts that meet all of the criteria took a battering when it was revealed that Bradford Hospitals Trust had sneaked through with an over-optimistic balance sheet.**

But in April Lancashire Teaching Hospitals Trust was given the go-ahead to lift of as a Foundation by the "independent regulator", Monitor, despite carrying £3m in debts.

The deficits were incurred after the Trust secured its 3-star status, but it appears that the criteria are applied tactically, and a £3m deficit is seen as "financially viable and sustainable" in Lancashire, whereas a £4m shortfall in Bradford triggered a heavy-handed intervention by Monitor.

It's a 2-tier system alright, but not as many expected.

Trusts braced for PBR shock

Cash crises leave NHS reeling

Spending on the NHS this year, at £67 billion, is running at twice the level that Gordon Brown inherited from the Tories in 1997.

Waiting lists have been drastically reduced, along with waiting times, and the equivalent of more than 270,000 additional doctors, nurses and support staff have been added to the payroll. But this autumn and winter promise to echo to headlines of cuts, closures and a large wave of redundancies across English hospitals and PCTs.

The strangely relaxed attitude of the Department of Health at the beginning of the yar to the spectacle of dozens of Trusts and many Primary Care Trusts (PCTs) failing by miles to hit their financial targets, could be directly explained by the imminence of the Election.

Some finance chiefs are now complaining that their warnings of problems getting worse were downplayed or dismissed in the months up to May 5, resulting in even bigger problems still to be confronted.

For exactly the same reason ministers staged a tactical withdrawal on their plans to force through the new "Payment By Results" (PBR) system which was planned to be the method of financing 70% of NHS treatment from April 1 – but which threatens to push dozens of hospital Trusts and even more specialist departments over the edge, triggering wholesale cuts and closures, from April 2006.

"Give it to us straight. How long have we got?"

Hospitals which are struggling to cope with demand will lose income if they treat fewer patients than planned, and only paid for the work they do: well-resourced hospitals which successfully "poach" patients from other Trusts can pocket the difference.

Consequences

Some now doubt that the full policy will ever be rolled out for fear of the consequences in terms of the closure of busy local hospitals.

Although PBR rules out competition on the basis of price, with the phased introduction of Department of Health reference prices for specific treatments, competition for contracts is set to be fiercer than ever once the PBR system is phased in.

Ministers clearly want to build up sufficient capacity in the private sector to generate a real fear that failing NHS Trusts will be allowed close down, with services delivered from alternative private providers.

The PBR system also helps New Labour turn health care back into a commodity, breaking down the barriers between the public and private sectors, and thus switch more work to private sector providers.

Their plan is no longer for an "internal" market – but simply a market system, in which NHS Trusts have to compete not only against other NHS Trusts, but also against private hospitals which have a much more selective – and thus much less complex and costly – caseload, with no emergencies.

Bizarrely, NHS hospitals, under the cosh to deliver endless year-on-year "efficiency savings" have now been told they will be allowed to spend taxpayers' money advertising to attract patients.

'Patient choice'

And the pace of this competition has been forced by putting the responsibility not on to Primary Care Trusts, but on to individual patients, who will be offered a progressively wider "choice" of where to have their treatment.

By the end of 2005 Primary Care Trusts will be obliged to offer almost all patients a "choice" of providers – including at least one private hospital – from the time they are first referred: but eventually (from 2008) Blair has pledged that any patient will be allowed to choose any hospital which can deliver treatment at the NHS reference cost.

Early in 2005 the government invited private tenders to deliver a further 250,000 operations a year, worth an estimated £500 million annually: in addition another £400m worth of X-rays, scans, blood tests and pathology tests will be hived off to the private sector.

These moves will almost double the number of private sector operations to be purchased by the NHS, pushing the government's total spend in the "independent sector" up towards £1.5 billion – two thirds of the total £2.3 billion turnover of the private medical industry in 2003.

Ministers now insist that 'patient choice' is a more fundamental principle than maintaining local access to NHS hospital services, following a line from Tony Blair: "Choice is not a betrayal of our principles. It IS our principles"

What this scenario does not address is the wide range of emergency and other services which are currently available only from NHS hospitals, and which the private sector has shown no interest in providing.

NHS Trusts will have to close services which attract too few patients, and the NHS Bank has been told to stand by and offer "support to services in transition, where exit or recovery is needed".

UNISON's campaign for cleaner hospitals got ministers on the run earlier this year. Now cynical right wing papers are using poor hygiene and MRSA in NHS hospitals – the results of competitive tendering and privatisation – to urge patients to choose private health providers.

Stop the rot – start the fight!

Save Our NHS!

The first steps towards building a new national coalition that will fight to Save Our NHS, sounding the alarm and mounting a challenge to every cut, closure and privatisation, were taken on July 12 in central London.

A small but significant gathering of consultants, academics, an MP, trade union officers, and campaigners met to discuss the basis of a new wide-ranging coalition of forces that will oppose the government's 'reforms'. Everyone agreed that the matter is now urgent.

There is no sign that the public know about or support these "stealth reforms" (a recent poll showed 89 percent against private provision of NHS care).

The meeting outlined plans for a new, broad, national and local campaign that will collect information, raise media interest and public awareness, and encourage campaigners, health workers and concerned citizens to take a stand and fight back.

All those present agreed that a new campaign, a coalition for the NHS, must now be built, to link up all those at national and local level who oppose these changes in the NHS, and want to defend its core principles and prevent it from disintegration and commercialisation.

A launch statement is being finalised that will call on concerned organisations and individuals at all levels to sign up, and join together in challenging the marketisation of health care and its new structures, systems, and for-profit providers:

"Every private contract, every cutback, closure and erosion of public sector provision of health care must now be subject to scrutiny and challenge."

Look out for more information on www.SaveOurNHS.com

LHE appeal for campaign funds

As this issue of Health Emergency confirms, the NHS faces an unprecedented barrage of cuts, closures and privatisation, one which cries out for a firm and active response at local level.

That's why we are launching a special campaign appeal for the resources that will enable LHE to play a full part in encouraging the development both of campaigning work at local level across the country, and at national level the building of a new, broad organisation fighting to Save Our NHS.

The need for action is urgent.

The newly reelected government has five years ahead of it. Ministers have shown that they listen to nobody, but have declared a mission to "modernise" … by bringing back the competition and market system which Tony Blair promised to sweep away in 1997.

To make matters worse, ministers are determined to establish a higher level of private sector involvement in health care than the Tory government ever attempted to introduce.

As billions are siphoned out of the NHS to line the pockets of private sector shareholders, across the country cuts packages are being drawn up by PCTs, Trusts and Strategic Health Authorities, and some closures of beds and operating theatres and job losses have already been announced.

Even though the NHS remains the most popular and universal of public services, there has so far been little local resistance to cuts, and no sign of systematic campaigning against the privatisation of elective services and primary care.

But with the reservoir of public support so far untapped, sustained campaigning could force back some of the attacks and force ministers to recognise the political cost of half-baked policies that are smashing up the National Health Service

Break the silence

Sustained, high-profile activity could begin to push the crisis in our NHS into local and national press headlines, and break the media silence which has left many of these policies being pushed through with little or no public awareness or debate.

John Harris www.reportdigital.co.uk

We need active, local campaigns to fight back

London Health Emergency made its name in the 1980s as the organisation that offered practical and campaigning advice, information, resources and publicity support to local campaigns against cuts and closures – and subsequent campaigns against privatisation and PFI.

Over 20 years later we want again to be part of building a real fight to save our NHS.

We are appealing to affiliates who agree that a fight is needed to make a donation, as large as you can afford, to enable LHE to play its full part in the new Save Our NHS coalition that is to be launched in a few weeks, to produce campaign leaflets, posters, stickers, pamphlets and to send speakers to support local campaigns.

We are also urging local organisations that want to fight back to take the first steps to organise hard-hitting public campaigns that can draw together angry communities, win support from local trades councils and union activists.

Pile on the pressure by pumping out press releases, lobbying Trust Boards, PCTs, MPs, councillors and council scrutiny committees – and why not explore the possibility of industrial action to defend threatened services and jobs?

A combination of local and national campaigning, hard information and popular support can still force ministers to retreat and to drop some of their most damaging policies.

We still have an NHS to defend – so let's defend it.

Give us the tools, and we will help you do the job!

■ Rush all donations to:

Campaign appeal, Health Emergency, 213 Church Rd, Hayes, Middlesex UB3 2LG.

Donate now!

❑ I/my organisation wants to support Health Emergency's campaigning work in 2005. I/we enclose a donation of **£ .....**

❑ Please send ..... additional copies of *Health Emergency* (@ £10 per 100 copies).

❑ Please notify us of forthcoming leaflets and publications

NAME .....

Organisation .....

..... **Position held** .....

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..... **Post Code** .....

email .....

Surreal world of NHS accounting

North West London Strategic Health Authority wound up last year with a sector-wide deficit of £55.8 million, £33.4m of which was down to Trusts and £28.4m to PCTs: the SHA itself actually underspent by £6m.

But there is no light at the end of the tunnel: the projected deficit for this year is even worse, at almost £60m, half of which stems from two hospital Trusts, Hammersmith Hospitals (£18m) and NW London Hospitals (£14m).

But according to the SHA Financial plan:

"The achievement of in-year financial balance in the plans is based on the premise that the sector is able to deliver £189m of savings, of which 50% are either unidentified or not sufficiently robust to ensure in-year balance.

"… Therefore the accompanying commentary to the Department of Health gave an SHA view of a forecast deficit of £94.9m for 2005/06. The total level of savings required to achieve this position was £151m of which £99m are identified and £52m would require further action in year."

Significantly the Trusts are looking to slash £25 million from spending on NHS staff, with another £3.5m from agency and bank staff.

£7m of this is to be cut at Hammersmith Hospitals and £2.8m at NW London Hospitals, with another £3.5m of NHS staff cuts in West London Mental Health Trust and £2.2m from West Middlesex.

The savings plan involves cuts as high as 8.5% of the total income of some organisations.

However a closer look at the plans shows that almost £90m of savings in PCTs and Trusts are yet to be identified: the biggest of these are a staggering £13m at NW London Hospitals, £10.2m at Kensington & Chelsea PCT, £9.1m at Hillingdon PCT, £7.8m at Harrow PCT, £6.7m at Hounslow PCT and £6.5m at the Royal Brompton & Harefield Trust.

There's nothing like planning ahead: and this is nothing like planning ahead!

■ In North Central London the wording is more subtle, but the air of unreality is as palpable.

The Sector "broke even in 2004/5" on the basis of 'non-recurrent measures' which contributed an extra £60m.

Barnet and Chase Farm Trust, down as a break-even, in fact received a hefty bung of £11.2m to prop them up. The Royal Free, North Middlesex and Royal National Orthopaedic all came in with thumping deficits.

Now PCTs face private sector influx

Ministers are planning to create a ring-fenced allocation from PCT budgets to be spent exclusively on 'innovative programmes' from the private sector in primary and community services.

A closed meeting between senior Whitehall officials and private investors heard assurances that the government was determined to overcome "institutional inertia" within the NHS and open up a long-term market for private providers.

"We have created a market place – it's up to you now to put together the teams that can provide PCTs with the high quality value for money services they want in their communities," investors were told.

The theory is that in this "new era of healthcare provision" the private sector still needs sweeteners and incentives to persuade them into investing in the NHS market – and that these will come at the expense of mainstream NHS budgets.

Vanishing beds

■ Tony Blair's government has cut specialist elderly care beds by over 10 percent since 1997 (2,800 closed) while almost 13 percent of mental health beds have closed in the same period.

By contrast the latest figures show an increase of less than 2 percent in NHS acute beds – although many of these are now closing as this year's cuts are drawn up.

New threat to Charing Cross

Charing Cross Hospital, in Fulham, West London, which defied a death sentence after it was recommended for closure in the 1992 Tomlinson Report, is again faced with the threat of closure.

The financially-challenged Hammersmith Hospitals Trust is looking at plans to "rationalise" services and concentrate new facilities on the Hammersmith Hospital site.

The 627-bed Charing Cross is 32 years old, but in need of substantial maintenance: it recently struck a £1.5m deal with BUPA to expand its private bed capacity, investing some of the Trust's scarce resources to offer privileged treatment to wealthy cancer sufferers.

The defence of the hospital against the 1990s closure threat focused heavily on its geographical location, which means that local people would face severe delays and access problems if services switched to the Hammersmith in White City.

£50m Oxon nightmare

Oxfordshire Trusts and PCTs face combined deficits totalling over £50 million for the current financial year, with South Oxfordshire PCT topping the list with a staggering £25m deficit.

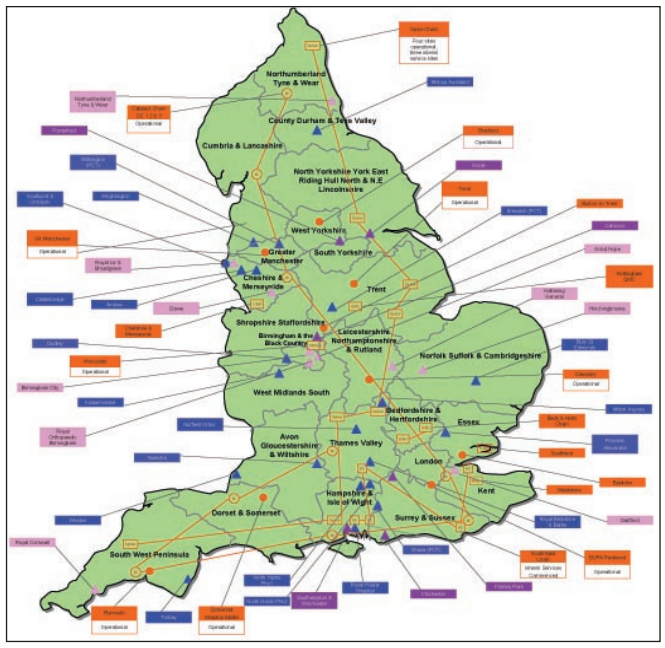
37 beds in six of the PCT's community hospitals are to close – but there is still no word on how the vast bulk of this huge shortfall will be recouped.

North Oxfordshire PCT has been offered a £4m handout towards its shortfall of £10m, but is looking at handing over community hospitals in Bicester and Chipping Norton, complete with staff, to private management.

The third PCT, Oxford City is planning to cut the skill mix of its nursing staff, and hoping to cut emergency admissions by 15 percent to cut costs by £3m.

Oxford Radcliffe Hospitals Trust, which claims to have cut £20m from spending last year faces another £11.7m cuts which "may require the Trust to reduce service capacity".

Further cuts are hitting ambulance services and mental health.



Department of Health website shows a national epidemic of treatment centres: how many NHS units will now go private?

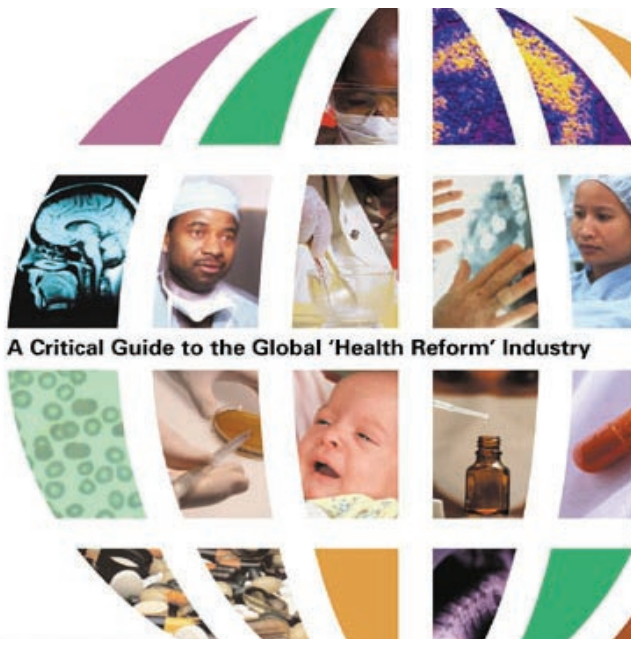
£100m private bonanza

A private treatment centre is to be built on the King George Hospital site in Ilford, with a link corridor to the NHS hospital. It is expected to receive14 percent of local elective operations from the surrounding area of Barking & Dagenham, Havering, Redbridge and Waltham Forest from 2006.

This means that 9,000-plus cases will be transferred from the cash-strapped Barking Havering & Redbridge Trust, at a cost of £102m over five years, despite concerns that the Trust will lose income and wind up saddled with up to £4m a year of additional costs.

Challenging the market in health care

Global agencies are driving health reforms the wrong way



***Health Policy Reform: Driving the Wrong Way? A critical guide to the health reform industry*, by John Lister, Middlesex University Press. 360 pages, £25**

Jess Hurd (www.reportdigital.co.uk)

G8 protestors don't support their government's line of market-style health care

As the G8 leaders weep crocodile tears for Africa, global agencies continue to press the poorest countries to adopt 'reforms' to their health care systems which have been shown to fail, and proven to discriminate against the poor.

Now a new world-wide study, *Health Policy Reform: Driving the Wrong Way?* argues that while the World Bank has been pressing for poor countries to minimise spending on hospital care, and for their governments to fund only the most minimal package of primary care, immunisation and health education, it has been the country that has most flouted these guidelines – Cuba – which has delivered the most spectacular success.

The 'reform' agenda promoted by the World Bank, USAID and the host of consultancies and NGOs they sponsor does not even attempt to address the grotesque global inequalities of health spending, in which the USA, with just 5 percent of the world's population spends 40 percent of the world's health budgets, and Japan, with roughly the same population, spends 270 times more on health than Nigeria.

The burden of disease is unequally divided the other way round, with the lion's share landing on the poorest, but the main health policy reform agenda is more concerned to spread market models and impose fees for treatment than to address the desperate need for expanded and accessible treatment in the poorest countries to tackle infectious and parasitic diseases and the HIV/AIDS epidemic.

Expensive and ineffective

As a result, policies which have shown themselves to be expensive, ineffective and exclusionary in the wealthiest countries are being exported to even less favourable terrain, backed up by the threat that a failure to comply could mean the loss of credit ratings, loans or other assistance.

USAID is an arm of the US State Department which poses as a donor organisation: the World Bank claims to be a development organisation, spending upwards of $100 million a year on research.

Both organisations are guided by adherence to neo-liberal ideology, which makes them fundamentalist missionaries promoting private sector involvement, competition, user fees and market mechanisms in emerging health care systems, and minimising public funding for health care.

They are part of a burgeoning 'industry' in health care reform that has been spawned by the huge economic, social and political weight of health care as a global industry, with turnover in excess of $3 trillion – 8 percent of the world's gross domestic product – and a workforce upwards of 35 million worldwide, plus millions more in linked services and occupations.

Reform 'industry'

Around the world, in countries rich and poor, the health reform 'industry' has thrown up profitable private sector consultancies, and commissioned work from an elite of academics, mainly in the US and UK.

They have generated an identifiable "menu" of reforms which are being advocated and implemented the world over – despite the lack of any serious evidence that they can deliver the promised improvements in health care systems.

The reforms are not driven by pressures to cut costs, constrain demand for services, improve efficiency, or hold down public spending. Indeed far from offering economies or efficiencies, many of the new "market-style" reforms serve to increase costs both to government and to individual service users, and have a questionable impact on overall efficiency of health care systems. Their aim is ideological: to remodel health care along market lines.

Among the most common of these measures are

- decentralisation;
- the separation of purchaser from provider;
- the use of contracts to allocate resources and monitor service provision;
- increased provider autonomy (such as Foundation Trusts) and cultivation of "entrepreneurial" approach";
- the purchase of publicly-funded services from private sector providers;
- new systems for the payment of health care providers;
- the creation of competition between providers (and in some countries between purchasers, such as rival insurance funds);
- privatisation;
- the use of private sector capital (PFI/PPP);
- and a focus on 'patient choice' and on consumerism in place of planning and accountability.

A varied combination of one or more of these standard reforms can be seen to be under way or under discussion in Britain and most developed countries: but many of them are also incorporated into proposals for some of the world's poorest countries.

Health Policy Reform: Driving the Wrong Way? traces the history and origins of market-style reforms and their impact on health care systems around the world.

Agencies

The first part of the book explores the context, itemises the main market-style reforms, explores their motivation and contradictions, and scrutinises the main global agencies that have helped promote the reform agenda.

It identifies ways in which the progressive rhetoric of reform – phrases and terms such as accessibility, sustainability, public health, efficiency, decentralisation and equity – has been hijacked by neo-liberal reformers for whom this entire vocabulary has a very different meaning.

The second part consists of over 40 country studies, covering all five inhabited continents, contrasting for example the divergent path of development which brought the relative affordability and inclusiveness of Canada's tax-funded "single payer" Medicare system with the chaos and profligacy of the US system.

This not only leaves 61 million Americans uninsured or underinsured, but also squanders a staggering $400 billion a year on administrative costs alone (this is around four times the combined health budgets of the 62 lowest-spending countries in the world, including India and China).

An extended study of Kenya sums up the negative impact on most sub-Saharan Africa countries of debt and World Bank policies which wrecked post-independence health services, imposed user fees which drove away the poorest, and has prevented the development of an adequate infrastructure of primary care or hospital services.

By contrast the book also notes the World Bank's belated change of line on Cuba, whose pace-setting, publicly-owned health care system, tax-funded and delivering a combination of primary care high-tech hospital care and public health measures free of charge to all, had been almost completely ignored in Bank reports until the end of 2003.

Since the 1959 revolution, and even after the fall of the Berlin Wall and the end of Soviet support, blockaded Cuba has not only developed its own highly successful research and drug industry, but also, drawing the lesson from Che Guevara, trained a vast progressive army of Cuban doctors as well as medical students from developing countries.

While the poorest countries that caved in to World Bank guidance are still counting the cost in ill-health and low life expectancy, Cuba has lower infant mortality than Washington DC.

But the focus is not entirely on the "Third World": author John Lister, has for 21 years been the principal researcher for London Health Emergency.

There are studies of the reform process in both Western and Eastern Europe, and the longest section of the book addresses the breakneck pace of the "modernising" reforms being rammed through in Britain by New Labour.

England has effectively been the world's test bench for experimental policies in the last 15 years or more: and now Blair in his third term is further increasing the pace of privatisation and heading towards a full-scale market system from next April.

Those health workers, campaigners and concerned citizens who resent their status as guinea pigs in Mr Blair's free market laboratory will find the book a useful source of ammunition in challenging the unsupported assumptions and costly contradictions of the reform process close to home.

BOOKSHELF

Catching Europe's workers by the Bolkesteins

Tony Blair's government has made clear that it will throw its weight behind reactionary proposals that aim further to undermine the elements of social solidarity which have survived longer in the EU than the UK.

One immediate example of this has been Jack Straw's declaration of the government's determination to press ahead with the controversial 'Bolkestein directive', which would allow open competition and the marketisation of almost all services throughout the EU, including health care and health insurance.

The directive, drawn up by a Dutch right-winger Frits Bolkestein when he was an EU commissioner, has been as eagerly supported by big business and free-market fundamentalists as it has been opposed by the trade unionists and supporters of public services who are aware of its existence.

75,000 trade unionists from across the EU marched through Brussels in protest at this legislation in March. The European TUC has warned that it could "speed up deregulation, seriously erode workers' rights and protection, and damage the supply of essential services to European citizens".

Straw has promised that the UK presidency will "seek a better balance between public health, environmental protection and competitiveness": no prizes for guessing which of these three is a New Labour priority – and which two will take a back seat.

Will soaring costs scupper PFI deals?

There are mounting rumours that ministers are about to call time on a number of large-scale hospital projects to be funded through the Private Finance Initiative.

Patricia Hewitt and top DoH officials have warned of the danger of investing in costly "monuments" which will quickly outgrow their usefulness.

So far only the ill-starred Paddington Health Campus has been put out of its misery by an increasingly irritated Strategic Health Authority, with an unbridgeable affordability gap in excess of £40 million a year.

As *Health Emergency* has noted in previous reports, the soaring cost of PFI schemes, running well beyond the bounds of affordability, have raised questions of whether Trusts could implement the latest schemes and stay viable, especially when the NHS institutes fixed reference costs and payment by results from next year.

When the first wave of PFI hospitals were signed off in the late 1990s the average capital cost of a new hospital was £75m: this has since spiralled into the stratosphere, with a number of schemes now above, or close to, £1 billion, and several more in excess of £400 million.

The costs are staggering. Annual payments on a £420m scheme in Central Manchester came out at £51m per year, index-linked, over 38 years, £30m of which was the 'availability charge' for the building itself.

The combined costs of PFI payments, residual NHS interest charges and facilities management was to total £64m a year – almost 20 per cent of the Trust's total revenue.

The latest figures for the super soaraway Barts and London project suggest a total capital cost of at least £1.89 billion – almost £500m of which is comprised of interest and fees. The annual payment starts off at £115m a year, index-linked, with £67m of this being the rent ('availability charge').

This means that the taxpayer will have forked out well over £5 billion for the two hospitals in the next 40 years, while the Skanska Innisfree consortium picks up guaranteed profits from legally-binding payments which currently equate to 23 percent of the Trust's annual turnover.

This type of increased overhead costs – and restricted capacity – have already helped to force most of the operational PFI hospital Trusts deep into deficit.

They face restricted options for economies, since all support services are incorporated into legally-binding, index-linked, contractual payments to the PFI consortium, and Trusts retain discretion only over clinical budgets.

Hence the nonsense of Greenwich's £120m Queen Elizabeth (PFI) hospital running with wards closed, as Trust bosses wrestle with a £10m deficit.

With the prospect of a new system of Payment by Results that will offer only a fixed tariff for each item of treatment, PFI hospitals from next April will be at a huge disadvantage, with bloated, fixed overhead costs, and inadequate capacity.

Where new PFI hospitals do proceed, they are likely to drain vital resources from community health care and mental health budgets, leaving a lop-sided pattern of care for a generation to come.

These economic facts of life were clearly a factor in the belated decision to axe the flagging Paddington Health Campus project – and seem likely to bring the demise of several more lumbering giants.

PFI for the NHS remains a high-cost, high-risk way of building facilities which unlike previous NHS buildings, are not public assets but liabilities weighing down on the local health economy.

(Left) Dudley's new PFI-funded Russells Hall Hospital has just opened for business, with the usual problems – no air conditioning, heavy doors, privatised support services. But the £1 billion scheme to replace Paddington's St Mary's (above) has collapsed.

Liverpool tops league – in PFI costs!

Costs appear to be running out of control in the plans for a new mega-hospital to be shared by the Royal and Alder Hey hospitals – latest estimated cost £835m and rising.

Leicester

University Hospitals of Leicestershire Trust has also put another, far higher price tag on the ever-more expensive PFI hospital project which started out at a projected £150m.

By the end of March this year this had risen more than five-fold – to a staggering £761m, while the numbers of beds in the scheme are now being whittled back down.

Although the Trust has chosen a preferred PFI partner, Equion, no final deal has yet been signed and all the smart money from local punters will be on another massive upward hike in price before the Full Business case is published.

In February 2001, managers drew gasps of astonishment when the projected cost of the plan hit £286m: by today's standards that is a bargain that should have been snapped up.

Birmingham

Birmingham and the Black Country SHA has come up with a plan to privatise 15 percent of elective operations and axe 20 percent of NHS hospital beds (over 1400) by 2008.

Campaigners who also pointed to a growing gap between availability of GPs and planned expansion of primary care were told that a 40 percent increase in primary care activity did not mean employing 40 percent more staff, since it revolved around "new ways of prescribing, new ways of tracking patients and intervening".

Who wants to bet against the prospect that new ways of explaining another failed policy are also on the cards in the midlands as another half-baked plan takes shape?

■ The new 1231-bed University Hospital in Birmingham, with a capital cost of £543m, will cost the Trust £50m a year, index-linked, over 40 years, even though it is the first PFI deal that does not include "soft" facilities management.

The scheme includes an assumption that the equivalent of 76 fewer beds would be required because of "best practice efficiencies", despite the failure of such projections in other PFI hospitals.

Edinburgh Royal PFI rip-off

The PFI consortium behind the £180m Edinburgh Royal Infirmary has come back to demand a late increase in payments to cover its annual contract to deliver support services.

Despite repeated claims by ministers that PFI deals offer a 'fixed price', enabling Trusts to plan their outgoings, Consort Healthcare in May demanded local health chiefs stump up an additional £1.1m a year, invoking a clause in the contract which allows them to seek an adjustment of fee levels.

Misery for staff and patients, but highly profitable

Norfolk & Norwich PFI brings profit windfall

Octagon, the consortium that financed and built the £220m Norfolk & Norwich Hospital refinanced the deal two years ago, and scooped a bonus £115m – almost half the initial cost – in windfall gains.

Just £34m of this was shared with the Trust, and that to be paid in the form of a £1.7m cut in the annual fees for use of the building and support services. The remaining £81m has no doubt been wisely invested in yachts, claret and caviare by Octagon's gleeful shareholders.

Walsall campaign lifts off

A campaign to defend Walsall's Goscote Hospital, which faces rundown and closure as part of the proposed merger of the Walsall and Wolverhampton hospital trusts, has launched with a 50-strong public meeting on July 21.

Plans include a PFI-funded redevelopment of Walsall's Manor Hospital, incorporating the acute bed capacity currently at Goscote, while half the hospital's beds would be axed and replaced by "community" provision.

The public meeting, which included local UNISON officer Tracey Wood and four former Mayors of Walsall, agreed unanimously to launch a broad campaign against the merger and the closure of Goscote Hospital.

■ Further details: Pete Smith 01922 491925.

No confidence

Doctors and the staff side unions at Pennine Acute Hospitals Trust have voted to endorse motions of no confidence in the Trust board. The 211-34 vote by doctors backed an 8-point statement cataloguing management failures.

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