# HEALTH EMERGENCY

**Issue No. 65, Summer 2008: 60th Anniversary Special**


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Aneurin Bevan explains NHS values – ***centre pages***


Plenty to defend and a lot to lose – ***page 13***

# Happy 60th birthday, NHS…

# Don't let the private sector mess it up!


WE HAVE a lot to defend in our publicly-funded, publicly-delivered National Health service.

Aneurin Bevan's bold reforms, which took full effect from July 5 1948, swept away a failed "market" in health care, comprising a near-bankrupt voluntary sector, a struggling private sector and an uneven mish-mash of ageing municipal hospitals, and a system that still required half the population, including most women, children and older people, to pay fees for every visit to the doctor.

Bevan's new system nationalised the hospitals, creating a single system, and struck a deal to include the reluctant General Practitioners. It ***superseded*** the market, offering a universal, comprehensive system of care, free to all at point of use, funded from general taxation.

It was this new system that opened up the possibility of modern medicine, a national system for training doctors, a huge expansion in the numbers of specialist doctors, and many more nurses and support staff.

Official reports (see page 13) have now confirmed campaigners' arguments that it was the further expansion of the NHS with the new funds since 2000 that has enabled the improved performance in recent years – NOT the costly and wasteful experiments in utilising for-profit private companies to provide operations and primary care, expensive management consultants, and private capital for the building of new hospitals.

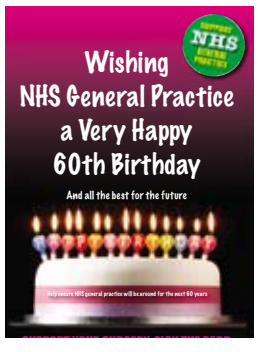
The latest so-called "reforms," involving even more privatisation, threaten to undermine the gains that have been made since 2000.

Let's celebrate and defend our NHS – and join forces to compel ministers to call a halt to the policies that are creating a new "market" in health care, and dragging us back to the dark days before 1948.

# Polyclinics? NO THANKS!

**OVER A MILLION patients signed the BMA petition in defence of NHS general practice in just three weeks from mid-May.**

**This is another stark reminder that more people trust doctors and health professionals than politicians – and proof that health ministers have failed to convince any significant part of the population of their latest policies.**




**Nonetheless in London, Primary Care Trusts have decided to press ahead with a hugely controversial – and very vague – plan to reorganise hospital and primary care services on the strength of a claimed 51% support from just over 3,700 responses – out of an electorate of 5.6 million.**

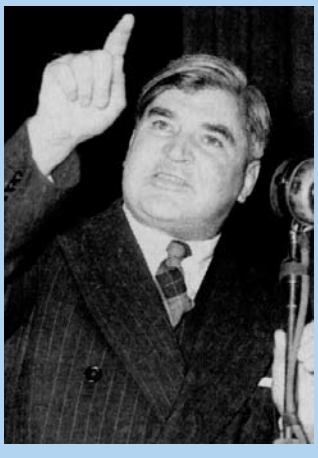
**Just 3 out of every 10,000 Londoners have indicated any support for the plans.**

**Having failed to persuade, health ministers have now taken refuge in outright lies: as Haringey (see page 2) draws up plans to axe 45 out of 60 GP surgeries, and similar plans are hatched up all over England, Alan Johnson has publicly claimed that "no current GP practices will be closed" – and accused the BMA of scaremongering!**

**He's not kidding us, or almost anyone.**

**If 'polyclinics' are such a good idea, why don't they prove it with a single well-targeted pilot project, rather than trying to force through a plan that could guarantee Labour's defeat at the next election?**

## Bevan's warning to Gordon Brown



"Doubtless defects can be found and further improvements made. What emerges, however, in the final count, is the massive contribution the British Health Service makes to the equipment of a civilized society.

"It has now become a part of the texture of our national life. No political party would survive that tried to destroy it …

"No government that attempts to destroy the Health Service can hope to command the support of the British people."

Founder of the NHS, Aneurin Bevan, writing in "In Place of Fear" 1952


**website: www.healthemergency.org.uk email: info@healthemergency.org.uk**

# Never mind the punters … London PCTs press ahead

AS WE GO to press, London's 31 PCTs have just voted to press ahead regardless with a scheme for polyclinics and hospital closures that virtually nobody in London actually supports.

Lord Darzi's widely-touted call for family doctor and other services in London and elsewhere to be centralised in a new network of "polyclinics" has triggered confusion, debate and now a massivecampaign by the British Medical Association to "Support NHS General Practice".

The original proposal for polyclinics came in Darzi's report on London's NHS last July: he suggested a network of 150 in the capital, each to cover a local population of 50,000 and employing 100 or more staff including upwards of 20 GPs and many more nurses and support staff at an estimated cost of £21m a year for each polyclinic.

Critics have pointed to serious flaws in Darzi's "technical document" which tried to show how they would work.

Despite the strong opposition of the BMA, and major reservations among Strategic Health Authority bosses a consultation based on Darzi's plans was held in London: the results, drawn up by spin doctors Ipsos Mori have now been published, claiming a wafer thin 51% of responses supporting the idea of polyclinics.

On closer examination, this 51% turns out to be fewer than 1,900 people out of just 3,700 who responded to the consultation from an electorate in London of 5.6 million.

In other words Darzi's plan is supported by just 0.03% of adult Londoners – hardly a resounding mandate for a risky and controversial policy.

Nonetheless PCTs have already drawn up plans to force over 100 GP surgeries around London to close to make way for polyclinics – including Haringey, Enfield, Ealing, Kensington & Chelsea, Camden, Lambeth and Waltham Forest.

Outside the capital, campaigners are challenging similar plans in Norwich, South Staffordshire, Bolton, Cheshire, Greater Manchester, despite evidence that the existing model of GP practices offers more choice, better access and greater quality of care than polyclinics.

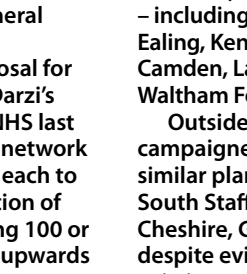
The BMA has launched a campaign to save local GP surgeries, including the monster 1 million-plus petition by patients, to put pressure on their MPs and local PCT.

With growing awareness of the link between the plans for polyclinics and the government's plans to wheel in major corporations to build and run them, and to deliver primary care services, the fight to defend and improve primary care is an important one for us all to support.

## Branson's bid gets bum's rush from punters

Congratulations to all those campaigners up and down the country who got pickets together against the Virgin Health Roadshows and made it patently obvious to the bearded wonder that his profit-seeking health centres are not wanted or needed.

Time and again the presence of trade union and other campaigners, with banners and leaflets outside the venues – and sometimes intervening effectively inside – has exposed the money-grubbing operation and encouraged those local GPs who are most committed to working with the NHS.




Unfortunately ministers remain committed to privatising primary care services to the tune of £250m a year – regardless of what patients want.

## Merton and Sutton Trades Union Council

Happy 60th Birthday NHS!

Congratulations London Health Emergency on 25 years of campaigning to defend health services


# Haringey fights to stop plans to axe 75% of GP surgeries

Haringey Primary Care Trust Board has defied public opinion and voted through a 10 year strategy involving the highly controversial creation of five polyclinics in place of neighbourhood-based services (especially local GP practices).

About 50 people took part in a protest lobby and deputation to the Haringey Primary Trust Board meeting in St Ann's Hospital on May 21. The 'Save Our Surgeries' protest was called by the Stop Haringey Health Cuts Coalition at 3 days notice as the PCT had only released the details of their 'polyclinics' plans on Friday evening, 16th May.

The PCT's new proposals were for 5 polyclinic 'hubs' with 15 GP practices 'spokes' (meaning that 45 local practices would be closed down). The PCT had not publicised their plans - which they know are unpopular and highly controversial - in any way, and it had been left up to the Coalition to alert their members as best they could.

South Tottenham resident Mario Petrou criticised the Board for misleading the public and the Council's Scrutiny Committee (which has a duty to monitor and protect Haringey's health services) about the public consultation, or lack of it.

Dave Morris, Secretary of the Stop Haringey Health Cuts Coalition, made a presentation to the Board calling for the strategy to be rejected as 'irresponsible', 'unpopular' and 'unacceptable'. As an alternative he proposed the decision be postponed to allow for public consultation, since the general public remains entirely unaware of the details of the proposals.

During the meeting members of the public present tried to address the Board with their concerns, many shouting out: 'let the public decide!'

However the Board agreed to adopt the strategy and said they would develop and refine it over the coming year, with its implementation starting in 2009.

Residents stormed out of


the meeting and vowed to continue to campaign to save Haringey's neighbourhood-based health services, especially local GP surgeries.

Campaigners argue that Haringey's 60 local GP surgeries are the cornerstone of, and gateway into, local health services, and the plans would also threaten closure of many neighbourhood-based local chemists.

The details of this highly controversial strategy were only released over the weekend, with no public announcement or consultation. The information was even concealed from two major PCT public events a few days earlier.

There was no public consultation at all : The Council's Scrutiny Cttee told the PCT that 'the consultation [last year] did not provide sufficient detail to allow the public… to fully appraise the proposals or assess the likely impact of the planned changes..'

The plans have no public support: a recent poll found that 95% of patients wanted to keep their local surgeries.

The plan is clearly a step towards privatisation: the PCT argues explicitly that " contestability (ie. competitive tendering of services against an agreed specification) is an important vehicle for securing best value," and "expect it to play an increasing part in how we seek to maximise health benefits from our commissioning spending future."

Polyclinics will NOT provide many additional services four of the five proposed polyclinics already exist as health centres, and the fifth (Wood Green) has no site identified yet. They will simply swallow up local neighbourhood-based services.

Over the last two years in Haringey fought £15-20m cuts affecting hospitals, clinics and surgeries, and services for family planning, mental health, and the elderly.

The official proposals (released only late on Friday) for our GP practices:

■ Stop Haringey Health Cuts Coalition can be contacted via the Union Office, St Ann's Hospital, N15 or at info@haringeyresidents.org tel 020 8211 0916

## Primary care up for sale

Primary care – family doctor services – is the latest growth area for profit-seeking private corporations looking to slice out profits from our National Health Service.

The Department of Health's Director of Commissioning, Mark Britnell, has confirmed that £250m a year has been earmarked for new privately-provided health centres and services.

He said: "There is a potential business here worth more than £1bn for Virgin, Assura, Boots and other private-sector providers to bid into, alongside existing G.P.s and foundation trusts."

The Government has also introduced a scheme in which private business can bid for Alternative Provider Medical Services contracts (APMS), where private companies take over whole GP practices.

Health Secretary Alan Johnson plans 250 new APMS surgeries and GPs are already

feeling the negative effect of these privatisations.

Dr Sam Everington, former deputy chair of the BMA and current European GP of the Year, lost out to private company Atos Healthcare in a bid for an APMS practice near his own award-winning practice in Bromley-by-Bow.

Other companies eager for to get their snouts in the trough include US insurance giant UnitedHealth which has just won GP contracts in Camden and elsewhere – and the newly-created Virgin Healthcare.

The NHS trade unions have come out in opposition to what clearly amounts to more privatisation of public services. UNISON said "It is deeply alarming that a private company such as Virgin will be marketing its additional services to potentially vulnerable patients when they are in need of medical care. By providing private services alongside NHS services, Virgin completely undermines the whole ethos of the NHS – a health service free at the point of need."

Local campaigns challenging this new race towards the privatisation of our most popular public service are gathering strength as people wake up to the real threat to health care.

# Darzi's five pledges could be the key to halt closures

Campaigners battling to stop the threatened closures and downsizing of district general hospitals and accident and emergency units have a surprising new weapon to wield against arrogant local health chiefs.

Gordon Brown's high profile surgeon-minister Lord Darzi has spelled out five new "tough rules for changes in the NHS" – all of which give grounds to challenge many local plans to centralise hospital and primary care services, and close down smaller hospital units.

Campaigns to defend local hospitals, which spread over much of the country in 2006, have continued – including the recent victory by campaigners fighting cutbacks at Banbury's Horton Hospital, who secured the first intervention by the so-called Independent Reconfiguration Panel to overturn a major planned cutback in maternity services.

Although some significant cuts have been forced through, the weight of local opposition has forced prolonged delays in many schemes including several in London – and the dilution or abandonment of other plans such as the reduction in A&E services in Surrey and West Sussex. The plans of several Strategic Health Authorities have again been thrown into disarray.

The delays mean that any decision to press forward with closures now could mean stirring up fresh waves of local opposition between now and the General Election, adding fresh fuel to David Cameron's efforts to claim the NHS as a Tory issue against New Labour.

Although a handful of government loyalists, backed up by a few Blairite think-tanks and tame academics have backed the call for closures and reorganisation, there has never been any evidence of wider public support, with medical opinion divided.

Now Lord Darzi's five pledges, claiming to "ensure that change is transparent and driven by the best evidence", promise that:

● "Change will always be to the benefit of patients". This potentially re-opens debate in many areas over issues of access and the potential impact on patients when local services face closure.

● "Change will be clinically driven" – this will raise fresh question over changes which have quite clearly been motivated by cash pressures, including (as in South East London) the knock-on costs of Private Finance Initiative schemes in adjoining areas.

● "All change will be locally led". There is a debate to be had over how "local" is "local" (the ten Strategic Health Authorities in England, spanning populations of millions and large geographical areas, are far from local, and in no way accountable to their catchment population).

However this raises the possibility of specific local needs being forced back on to the agenda where plans have previously attempted to impose inappropriate policies and unpopular changes.

● "You will be involved". Here too there is room for debate on what "involvement" means, but Darzi specifically states that "NHS organisations will work openly and collaboratively" – which seems to undermine those Primary Care Trusts and Strategic Health Authorities which have been seeking to force through changes without proper consultation and disclosure of relevant information.

● "You will see the difference first": this is potentially the most far-reaching pledge, since it commits NHS bosses to establishing new and improved services BEFORE existing services are withdrawn and buildings closed.

This promise alone – with its clear implication of double running costs, and the pressure to resolve many of the issues left deliberately vague by local health bosses – would be enough to bring most of the planned rationalisation of services across the country to a grinding halt.

Darzi at least is flagging up the need to put any more unpopular closures on hold until after the next General Election.

This by no means guarantees the future of the threatened hospitals, but should encourage local campaigners to step up the pressure, pile the heat on local councillors and MPs, and force health chiefs to abandon the plans that nobody really supports.

# Mixed messages from maverick minister

Perhaps Lord Darzi has actually picked up some real sense of the unpopularity of these policies in his £1m "listening" exercise, in which he has claimed to have "engaged" with over 60,000 people in set-piece review events around England.

Or maybe this unelected minister has slightly more political nouse than some of his head-banging Blairite colleagues and predecessors, who have been oblivious to the logic that having dug themselves so deep into electoral trouble the least they should do now would be stop digging.

Darzi's retreat is not limited to hospital closures: he has also tried to distance himself from the notion of large-scale "polyclinics" as a new model for primary care, despite having spelled out precisely this idea in great detail in his report last summer for NHS London.

In an interview with the *Times* Darzi has claimed his policy – advocating 150 polyclinics, each covering catchment population of around 50,000, should be set up in London – had been "misunderstood":

"The idea that I am going to herd all GPs into one large building is ludicrous … there are very good examples of federated models where you have five or six practices that have access to a diagnostic service".


*Hemel Hempstead campaigners are among the thousands up and down the country who have been fighting to save local services*

(*Times* April 1 2008)

But a reading of the 50-page "technical paper" that accompanied Darzi's "A Framework for Action" reveals that all of the outline costings and assumptions centre on the use of a single centralised building per polyclinic.

More significantly, Darzi's national review of the NHS has continued to stress the notion of large-scale 'one-stop shop' polyclinics or "health centres", and to raise the possibility that some or all of these would be built and run by the private sector, not least the ubiquitous Richard Branson's Virgin group.

Whether or not Darzi is still wedded to his polyclinic idea, it is increasingly obvious that hardly anyone else is.

A recent letter in the ***Health Service Journal*** from Patient Concern points out the unavoidable fact that there is no public lobby at all behind the proposal "Patient Concern has yet to hear from any patient who wants a polyclinic".

Even the normally docile King's Fund has joined the growing chorus of criticism exposing the flaws in the plans for polyclinics: in a new report it argues that NHS patients will get a poorer standard of care if the government persists with its plans.

The Fund says polyclinics may be more expensive, less efficient and less accessible than the traditional family doctor service.

GPs have been joined by their consultant colleagues in opposing the plans: Jonathan Fielden, chairman of the BMA consultants committee, said the government should "dump the polyclinic plan" adding that it had "no benefit and no financial gain."

None of these retreats and divisions at top level guarantees that local services will be safe from the logic of the market reforms already unleashed.

But they do open new avenues for campaigners and trade unions to challenge unpopular and damaging closures that seemed set to be forced through in the next few months.

Let's not waste the opportunity: who knows when they all may change their minds yet again, and embark on another barmy package of reforms that ensure their electoral defeat?

## Minister slams closure plan

**Health Minister Ivan Lewis has shocked NHS chiefs in the North East by publicly slamming plans to axe hospital wards for Alzheimer's sufferers in Durham, with the nearest alternative provision 40-50 miles away.**

**Apparently echoing one of Lord Darzi's new pledges, Lewis told the House of Commons, in answer to a question from local MP Kevan Jones, that it was "nonsense" to propose the reorganisation and reconfiguration of services "without being clear about the alternative provision".**

**"There should be genuine consultation, but it must be about future provision for people with dementia. It is important that the voice of relatives is heard."**

**This intervention is welcome: but will Mr Lewis force other Trusts and PCTs to reconsider half-baked schemes that have already been forced through in the teeth of well-argued popular opposition in other parts of England?**


Is your body in fact just two writeoffs welded together?

## 3 in 10,000 say "yes" to Darzi

**The gaping lack of support for Darzi's plans for primary care and polyclinics has been obvious in the very few public debates and detailed discussions that have taken place on the Darzi plans for London.**

**At the end of NHS London's ludicrous £15m charade of a "consultation" on the Darzi report, just 932 people registered support for the idea that "almost all GP practices in London should be part of a polyclinic, either networked or same-site". Slightly more (966 people) said that they "tend to agree" with the nebulous idea.**


**This endorsement from a thumping 0.033893% of the Greater London electorate, dressed up by NHS London as 51% of the 3760 responses which answered the question, was trumpeted in the *Guardian* with the headline "Public in favour of polyclinic scheme for London, says NHS".**

**By contrast the *Health Service Journal* more prudently headlined "Polyclinics 'pie in the sky,' finds capital consultation".**

**Nobody backs these plans: they should be binned, and discussions should instead be opened up with the BMA and health unions on ways to improve primary care.**

# Public services: ministers just don't give a FESC!

**FOURTEEN giant private sector corporations, including four big American health insurers and care managers – Aetna, Humana, UnitedHealth and Health Dialog Services – are now allowed to bid for contracts to help Primary Care Trusts spend their massive £75 billion NHS commissioning budgets.**

**In fact the Department of Health last year began to apply open pressure on PCTs to bring in private companies to advise them on commissioning, and warned SHAs that they would be measured on the number of PCTs that were implemented the so-called Framework for Procuring External Support for Commissioners (FESC)**

**Also included in the "approved" list of 14 firms are UK-based private companies including BUPA, Axa PPP and Tribal, along with KPMG and McKinsey.**

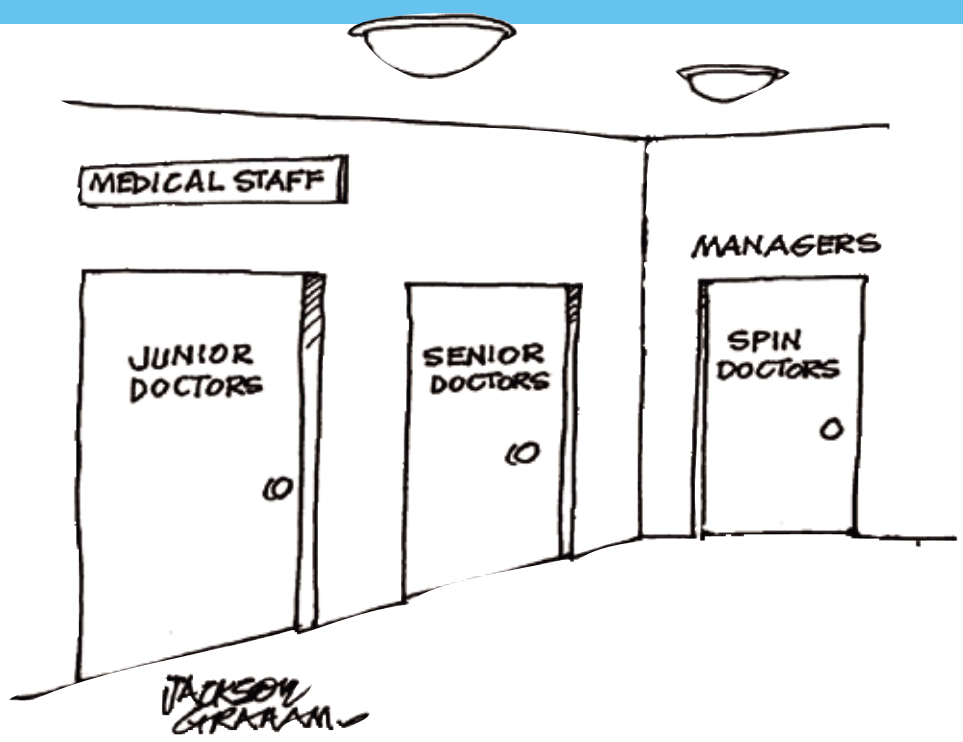
**Contracting out commissioning in this way represents a qualitative step change in privatisation, one that could open the door to US-style Health Maintenance Organisations moving in on primary care and elective services.**

**Health Minister Ivan Lewis claimed that the organizations were "already known and trusted": but one thing all 14 companies have in common is that not one of them has any experience of commissioning or providing a comprehensive and universal health care system like the NHS.**

**The US corporations are part of a ruinously expensive and inefficient and fraud-ridden system that leaves one in six of the population without health insurance.**

**This huge and qualitative leap forward in privatisation came in the same week as a devastating *Health Service Journal* investigation revealed that the NHS had forked out for 50,000 operations the previous year, by "independent sector treatment centres", that were not delivered.**

**Here the private sector is not only more expensive and delivering questionable quality care, but clearly does NOT represent patient choice.**


# New NHS "failure regime" – wheel in the private sector

There was outrage when ministers unveiled plans in early June to hand over the management of "failing" NHS Trusts to private sector managers.

The policy flies in the face of logic and the bitter experience of the limited experiments so far in the NHS.

The most notorious failure was at the Good Hope Hospital Trust in Solihull, where a 3-year contract with Secta to manage the financially challenged 550-bed hospital began amid a welter of optimistic publicity in September 2003, but was terminated 8 months early at the end of 2005 after Anne Heast, the Secta employee appointed to the chief executive role, left for another position within Secta's parent company Tribal Group. The running of the hospital was handed to the management of Birmingham Heartlands Hospital Trust.

'No way does this bonus reflect the full scale of my failure'

During the contract the company had successfully jacked up its own fees by 48 per cent in its first year, but this was clearly not performance-related pay: instead by the time Anne Heast finally cleared her desk the Trust was in dire financial straits, losing money at £1 million per month, heading for a £47 million deficit , and threatening the entire local health economy.

An Audit Commission report on the franchise agreement revealed a managerial shambles, with no financial strategy in place, and branded the franchise agreement as a costly failure:

"During the period of the franchise, the cost of the Chief Executive to the Trust was £225,000 per annum. This is approximately £60,000 to £80,000 more than would be paid for a direct appointment. In addition, in excess of £1 million has been spent on interventions during the contract period."

"The franchise arrangement, despite significant effort on behalf of the Trust and private sector company, was only partially successful and introduced significant additional costs to the Trust" (Audit Commission 2006)

Inadequate provision within the contract meant the trust itself could not terminate the contract early or enforce penalty clauses.

Shortly after the deal ended managers at the Hospital agreed on radical cost-cutting measures including a loss of beds, wards and buildings, to make potential savings of £21 million a year.

The hospital said the measures were needed to prevent a worst-case scenario deficit of £47.5 million the following year: quite a legacy from a pioneering privatisation of NHS management.

All this has been clearly lost on ministers: indeed health minister Ben Bradshaw, when asked about the Good Hope fiasco, flatly denied that the contract had been a failure.

If that episode is what ministers rate as successful, there could be some really hard times ahead for failing Trusts, and some bumper profits for incompetent and poorly-performing management consultants.

# Anger as Whittington Chair welcomes UnitedHealth apologist

Joe Liddane the new Chair of Whittington Hospital Trust, has caused controversy by inviting the chief executive of UnitedHealth, the private firm which has taken control of three of Camden's GP surgeries, to give a speech on privatisation in the NHS.

Dr Richard Smith's senior role in the giant American healthcare provider is not mentioned on invitations to the lecture.

Instead, he is billed as the former editor of the *British Medical Journal*.

His lecture will be titled "Is the NHS being privatised? What of the future for Health Care?" Allies of former hospital chairman Narendra Makanji have claimed he was ousted because he wanted to stand up for the principles of the NHS. It's clear that no such danger is likely to face Mr Liddane.

Dr Smith has been with UnitedHealth since 2004, when he quit his job at the BMJ to take over the leadership of a European wing of the company, alongside former Tony Blair advisor Simon Stevens, who is now a top director of UnitedHealth in the USA.

In March UnitedHealth undercut bids by local GPs and despite offering inferior services, were awarded contracts from Camden PCT to run three local GP practices. PCT chiefs ignored local protests to force through the deal.

# Billions of NHS cash unspent as penny-pinching cuts continue

The NHS has reported a surplus of £1.66 billion – after years of cutbacks and pressure on front-line staff.

On top of this, Foundation Trusts have piled up their own surpluses, which now total between £1.5 billion and £2 billion: but because Foundations are now outside the NHS management framework, none of these surpluses will be available to assist with local problems and issues in the NHS.

In South east London, for example, the two big Foundation Trusts (King's and Guy's-St Thomas) are sat on surpluses bigger than the annual deficits of the local NHS Trusts, but the cuts, closures and downsizing will fall entirely on the NHS Trusts.

All these figures need to be taken with a pinch of salt, since they conceal many manoeuvres and transactions designed to make the performance of individual Trusts and Primary Care Trusts seem more satisfactory: but the unspent surpluses will be little consolation to those who have lost their jobs or seen treatment and services withheld or withdrawn as NHS chiefs battled to balance the books.

The turnaround from the £500m deficit reported under Patricia Hewitt two years ago has run alongside the loss of over 20,000 jobs and a rapid and dramatic closure of beds across the board, with the first significant reduction in front-line acute hospital beds since 1994. 4,000 beds (four percent of the England total) closed in the year to March 2007, squeezing local services.


In the same period 2,000 geriatric beds were axed – almost nine percent – meaning that specialist beds for the elderly have now been reduced by more than a quarter since Tony Blair took office.

Mental health beds also fell in number by almost 7%, with almost 1,900 closed: these specialist beds have also declined by a quarter since 1997.

But it's not just beds that have been closed to save money: PCTs across the country have clamped down on the use of drugs they are not obliged to pay for, or – as in Oxfordshire – excluded operations such as elective hernias, and a growing share of podiatry services, forcing patients needing treatment to go private, move, or go without.

There has also been a reduction in central budgets and Trust-level spending on the training and on-going professional development of staff – including doctors, nursing and other professions and the training of non-clinical support staff.

Meanwhile one NHS Trust in five still faces a cash deficit, and many are still pressing through "reconfiguration", downgrading staff and reducing numbers in post to save money.

# Two faces of PFI



Now you see the NHS – now you don't, as the PFI consortium's giant crane swings over the new Peterborough hospital site

## Mid Yorks Trust bosses hope for the best

**If the finances or organisation of the new hospitals now being constructed in Wakefield and Pontefract go horribly wrong, Mid Yorkshire Trust will have only themselves to blame.**

**After nine years of furtive and secretive negotiations, half-baked "consultations" and inadequate information they are pressing ahead with a private finance initiative scheme that has more holes in it than a Tetley teabag.**

**The UNISON branch battled long and hard most of last year to extract a copy of the Full Business Case – but when the massive collection of documents was eventually grudgingly handed over it was studded with deletions of information which managers claim is 'commercial and confidential'.**

**Simply listing the omissions, with a few sketchy and formulaic arguments on why they have been omitted, required 13 pages of A4.**

**Among the many subject areas they and the PFI consortium believe are too sensitive to allow the public to know the details are:**

- **Figures on the rate of return to be generated by the consortium**
- **Numerous details on the treatment of non-clinical support staff under the TUPE (transfer of undertakings) arrangements, through which they would be seconded to work under the management of the consortium, while remaining NHS employees**
- **A whole appendix analysing the transfer of staff to the management of the consortium**
- **Details of any additional borrowing to be carried out by the consortium**

**Perhaps just as worrying as the omissions are some of the clauses and conditions that have been accepted, and the projections on bed numbers and caseload which UNISON has consistently argued are hugely over-optimistic.**

**The reduction of beds is focused on Wakefield and in Pontefract, where the combined bed loss will be almost 20%.**

**Mid Yorks Trust admits that the increased cost of the new hospitals will be an additional financial challenge on top of the current "headline financial challenge of £77m".**

**The "net revenue impact" (i.e. additional cost) of the scheme is £17.7m a year at 2006-7 prices.**

**To make it look as if the sums all balance up, the Trust assumes a large (29 percent) increase in total clinical income. But there is no guarantee at all that this money will materialise.**

**And even if fewer patients are treated, and income is reduced, the PFI rent, or 'unitary charge,' will not be reduced, but will rise each year by inflation. So all of the risk remains with the public sector, while private shareholders pocket the profits.**

## Profits For Industry


It is now eight years since the first PFI-funded hospitals opened their doors to patients and we can now see evidence of the high costs and doubtful value of financing new hospitals through PFI, and new primary care and community facilities through the equivalent system known as LIFT (Local Improvement Finance Trusts).

One spectacular failure sums up the dangers and problems of PFI. The £93m PFI-funded Queen Elizabeth Hospital in Woolwich opened in 2002: by 2005 it had been declared "technically bankrupt" as a result of the sheer size of its ballooning PFI debt.

The 'unitary charge' (effectively the lease payment by the NHS Trust for use of the PFI-funded hospital and the supply of non-clinical support services) amounted to 14.6% of the Trust's income – and the payments for the building alone, index-linked each year, would amount over 35 years to more than five times the initial cost of the project.

The inflated costs of Queen Elizabeth along with two other PFI hospitals in South East London have generated a combined "unpayable" accumulated deficit of £180 million, with Bromley Hospitals Trust alone notching up a staggering £99 million in.

Lewisham, the third PFI hospital in the area, also faces deficits, and has been running a brand new PFI-funded building with a whole top floor left empty to reduce costs – while the new build, on a fixed 30 year contract had increased the Trust's occupation costs by around 50%.

PFI contracts are notoriously inflexible, with heavy penalty payments to deter any early cancellation, regardless of the changing needs of the NHS. In the case of South East London the combined effect of the PFI-induced deficits in three Trusts has been to force proposals for the closure of services in a fourth hospital – Queen Mary's Hospital, Sidcup, a Trust which was not facing large deficits, but did not have the 'protection' of a PFI contract that would incur huge penalty charges for closure.

This meltdown in South East London is just the most recent and dramatic expression of the rumbling crisis unleashed by PFI, which has forced up the overhead costs of dozens of Trusts across the country at the very time that the government's controversial new system of "Payment by Results" has imposed a fixed tariff of payment, which assumes a far lower (5.8%) level of spending on buildings and facilities than most PFIs can achieve.

As a result the soaring costs of these new buildings – for which payments are index-linked and legally-binding for 30 or more years ahead – have begun to undermine services and force cutbacks elsewhere in local health services.

Official figures have revealed projected repayments totalling a staggering £53 billion on capital projects costed at just £8.5 billion. Since most PFI schemes show a split of roughly 2:1 between the 'availability charge' (i.e. rent) and the facilities management contract, this suggests that over and above the costs of building and maintaining the hospitals and delivery of non-clinical services, the private consortia are set to cream off a surplus of at least £23 billion for the 80 or so hospital schemes already operational or under construction.

The extent to which PFI can now be seen as "NHS investment" at all is not clear, given that the assets to be constructed do 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 therefore 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 squeeze on NHS capital meant that PFI was seen by NHS managers as "the only game in town".

Only six major NHS-funded schemes, totalling less than £300m, were given the go-ahead in the five years from 1997. And under the Tories only seven publicly-funded schemes costing more than £25m had been completed in the 17 years to 1997.

Since 1997 a massive 85% of all new capital investment in the NHS has come from the private sector.

## Hospital (and cost) goes up

**The long, long awaited new hospital for Peterborough has been scaled down in size, while the cost of the project has actually increased – all thanks to the fact that it is to be funded through the controversial Private Finance Initiative (PFI).**

**In 2005, the scheme was announced to be for a 760-bed hospital at a cost of £340 million: but then NHS chiefs began to recognise that the rental payments on the new buildings were becoming unaffordable.**

**So the scheme agreed in early 2007 by Patricia Hewitt was for just 612 beds, at a reduced cost of £282 million.**

**However the cost per bed has actually increased, from £447,000 to £460,000 – and there are still serious concerns over affordability.**

**Meanwhile the private consortium has gone out to borrow extra money on the back of the project: ABN-AMRO managed to float bonds worth £442.8 million last summer.**

**A nice little earner all round … for the private sector.**

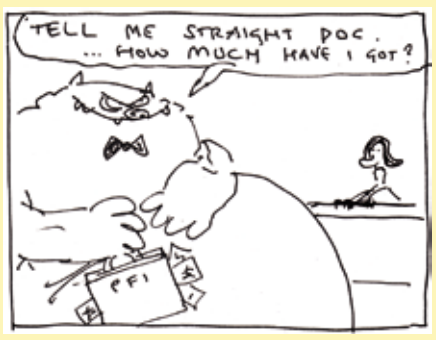
## PFI: a license to print money

**Researchers from Manchester Business School last year calculated the *extra* cost of financing new hospitals through PFI at £480m a year, from which companies can expect to pocket a rate of return well above the 15% level which the Treasury described as "too high" in 2005.**

**The researchers also questioned the longer term affordability of PFI schemes which consume upwards of 10% of a Trust's income .**

**Unlike 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.**

**In the longer run it is possible to see the process of renewal of NHS buildings through PFI, coupled with the disposal of NHS "surplus" assets, leading towards**




**a situation like that in social care, where the estimated value of assets involved was £13.3 billion in 2000, £10 billion of which were owned by the "independent sector".**

**In 2000 the estimated net book value of Health Authority and Trust assets was around £23 billion, with primary care assets valued at another £2.2 billion: but with NHS PFI projects likely to total £7 billion by 2007, inroads were being made.**

**Existing NHS assets are still being sold off, (estate worth an estimated £1.58 billion was identified as "surplus" in preparation for the NHS Plan) while little new public investment has been injected to health care facilities and buildings.**

**The NHS Plan in 2000 looked forward to a situation where by 2010 "40% of the value of the NHS estate will be less than fifteen years old" (DoH 2000:44): since virtually all new buildings were to be PFI financed, this suggests a dramatic penetration of public assets by the private sector.**

# Darzi on mental health:
## More questions than answers

**LAST JULY a relatively little-known specialist surgeon, Professor Sir Ara Darzi, published a review of London's health services, commissioned by the capital's newly-merged Strategic Health Authority, NHS London.**

**The proposals to restructure hospital services and primary care, with the establishment of a network of 150 "polyclinics" at a cost of over £3 billion per year grabbed most of the flurry of media attention: few commentators focused on the four scant pages on mental health.**

**NHS London commissioned a consultation document that was drawn up by a team of PR spin-doctors, deleting any concrete proposals.**

**This has now received the "support" of a cliamed 51% of the 3,700 Londoners who responded, and is to be implemented by London's 31 Primary Care Trusts.**

**But what it says – and doesn't say – about the future of mental health services can offer an indication of the policies that could be rolled out soon across London and elsewhere in England.**

Londoners face higher levels of mental illness than the rest of the country: while an average one in six in England suffer from some form of mental illness, the figure rises to one in five in London, with much higher concentrations in some of the capital's more deprived boroughs.

A study last year by the Greater London Assembly featured maps showing the correlation between ill-health and poverty: as Europe's largest city by far, London also contains extremes of wealth and poverty, with billionaires paying telephone numbers for prestige penthouses just a few miles from pools of unemployment, poverty and ill-health.

The Darzi report highlights the contrast in local life expectancies in a journey from Westminster to the East End on the Jubilee line – and the document currently out to consultation echoes the same point on mental health when it states:

"Mental health problems are greatest in the most deprived areas of London. The different mental health needs of migrants, offenders and the black and minority ethnic community need to be met."

It also goes on to point out that:

"Some of the most deprived areas of London also have the fewest GPs, the highest infant death rates and the shortest life expectancy. We need to consider how we can address these issues in everything that we do. … The 20 per cent of most deprived electoral wards have more than twice as many mental health inpatients as the 20 per cent least deprived."


Poor people in London are leading stressful, difficult and needlessly shortened lives: but they are often the ones who find it most difficult to access care when they need help for mental illness, and whose GPs are least likely to have the time and the resources required to deliver adequate services at primary care level.

Identifying this problem and agreeing on it may be a start, but it is not in itself a solution: yet neither the Darzi Report nor the NHS London consultation document discusses or offers answers that address these real issues and gaps in mental health care.

The initial Darzi Report offers many mentions of mental health, but the section looking at mental health services is just over four inconclusive pages out of a total of 130.

The consultation document goes on to elaborate the problem in more detail: it points out that 23% of London's mental health inpatients have the most serious level of mental illness, compared with 14% nationally.

"This higher rate of serious mental illness creates a more volatile, disturbed environment on mental health wards.

"But the need to focus resources on the most severely ill can mean people with moderate illness are less likely to be able to access services here than in other parts of the country."

London Health Emergency and the health unions have been making similar points for almost 20 years, but governments have stuck at the level of fine words. Indeed much of the National Service Framework for mental health, adopted in 1999, still has yet to be implemented in many areas.

What we need is a commitment of ring-fenced funding to address these problems: but what we see in practice is that every mental health Trust and Foundation Trust in the capital is engaged in cost-reduction programmes and economies to balance their books and demonstrate a "surplus" for the bureaucrats and bean-counters in NHS London.

Cost improvement programmes for 2007-8 total a staggering £50m in the nine of London's ten mental health Trusts that publish accessible information, the biggest cost cutting plan being the £10.2m programme at South London and Maudsley Trust.

In the midst of this, with many acute wards full or in some cases overflowing as they were in the 1990s, it seems especially bizarre for the consultation document to open up a discussion about cutting these facilities back still further, asking:

"Whether, as admissions to mental health units decrease, inpatient beds are needed in every borough"

Patients should not be given institutional care where there is an alternative: but the worst possible situation for patients is poorly resourced institutional care in overcrowded and potentially violent wards which make it impossible to deliver therapeutic care.

So we want to see a real investment in the supporting services – and a real reduction in admissions, with evidence that bed occupancy has fallen to safer and more sustainable level. only then does it make any sense to discuss how far out of their borough patients should be expected to travel for treatment.

We do however fully endorse the consultation document's call for:

"Improving the quality of inpatient care, from the environment where treatments are given to the quality and range of treatments".

## Mental health in primary care:
# Mind the gaps!

The consultation document underlines the chronic shortages of staff and services in primary care. It correctly argues that this is inadequate and restricts the treatment available:

"Too often care focuses on anti-depressant drugs. Ninety-three per cent of GPs have said they have prescribed anti-depressants because of a lack of alternatives."

However this will remain the case until there is a concerted drive to change the status quo.

We need a plan that will link up GPs with interprofessional teams of mental health specialists – nurses, therapists, doctors – and establish an adequate network of community mental health provision, with staffing levels geared to local levels of need for mental health care, ensuring workable caseloads that allow staff to establish and maintain supportive relationships with service users.

What has been lacking at PCT and Strategic Health Authority level (and the NHS nationally) is a genuine political will to break from the current situation in which mental health, like care of older patients, is each viewed as a soft and convenient target for every round of spending cuts and economies by Primary Care Trusts.

**The latest Department of Health figures show that London has lost almost 1,600 mental health beds since 1998, equivalent to almost 22%.**

**But while Darzi and the consultation document give the impression that fewer beds are needed, the figures show average occupancy levels have gone up over the same period, from 87.7% to 92.4% – and in many units occupancy levels are well above this average.**

**Bed closures in East London & City have led to extreme pressures, and the use of sofas and mattresses on floors to accommodate patients, while the Trust stacks up an apparent financial "surplus".**

Without this change of line, the consultation document's suggestions are little more than a pipe dream. For example, it spells out the worthy proposal that:

"We should set out clearer pathways to care, so that patients, carers, GPs and those who come into contact with people with mental health problems, such as police officers, know how to contact services and what to expect from them."

Yet in many cases the problem is not so much knowing what to expect: it is knowing that there is no point in expecting anything, since the services required are non-existent or desperately under-resourced and over-subscribed.

The same is even more true of the services that might be most easily delivered in a primary care context, but which are often unobtainable at a time when they would make the most difference in preventing the deterioration of a person with milder mental health problems.

The consultation blandly states that:

"Cognitive behaviour therapy and other `talking therapies' could be used extensively – but accessing these services is a problem and people in many parts of London face long waits for these services."

This might be regarded as one of the understatements of the year.

But the document goes on to suggest a policy that flies in the face of the squeeze on mental health services and budgets that has been taking place across the capital:

"More mental health workers could be employed to deliver talking therapies. Other therapies should also be explored, including exercise, reading and walking."

Mental health staff will be happy to endorse the call for an expansion of talking therapies and other services.

But after years of neglect of mental health, which have seen some innovative projects and services being axed to save pitifully small sums of cash as a result of short-sighted policy decisions by PCTs we are not convinced that a throwaway comment of this type is sufficient to force the kind of change we need.

## Mental health for older people

The consultation document's concern to improve services for older people with mental health problems will strike a particular chord with campaigners in SE London who have the recent experience of battling to save the exemplary services at the Felix Post and Eamonn Fottrell units against pressures to scale down and close them, despite the lack of any viable replacement.


The NHS London consultation document argues that:

"Older people with dementia need early access to services and a care plan that addresses their health and social care needs. We should aim to provide support for people and their carers as close to their own homes as possible but with specialist assessment and treatment units available if necessary."

We look forward to NHS London getting together with the GLA and the London boroughs to identify the funds and a system that can recruit and train the necessary staff and facilities to deliver this level of support.

Across the country there are currently 560,000 dementia sufferers, and this figure is projected to increase with the ageing population towards the million mark.

This suggests that something upwards of 100,000 London pensioners currently need support, while a huge shortfall in nursing home provision has been an enduring feature of the capital for many years.

If the Darzi process is really going to open up a new chapter in London's mental health, we need a clear and unambiguous commitment to ring-fenced resources to tackle these problems. If the discussions help shift opinion in this direction, they will be worthwhile.

# Manchester Community and Mental Health Branch

UNISON
the public service union

# Reinstate Karen Reissmann

## nurse and union rep sacked for speaking out

Karen Reissmann, UNISON activist and community nurse, was sacked by Manchester Mental Health and Social Care Trust in November 2007. She was sacked for speaking out about cuts in the NHS.

All the charges related to her trade union activity and her speaking out against government policies and local cuts.

When Karen was sacked, UNISON members in her branch were outraged and took 42 days strike action to demand her reinstatement and the right of all of us to speak out without fear.

The initial campaign in January 2007, culminating in a 2 day strike, stopped over 40 potential redundancies and down-gradings of community staff

After the strike, 7 new stewards were elected. Plans to cut staff in community teams were finally reversed in Spring 2008. In May 2008 down-grading of all community staff was reversed after union protests.

### Defend Karen – Defend Whistleblowers

The fight for Karen's reinstatement goes on. We had a successful lobby of parliament in May. Ask your MP support the Early Day motion 443 for her reinstatement. Send protests to Alan Johnson, Secretary of State for Health:
***johnsona@parliament.uk***

### What you can do

Karen's case is at an Employment Tribunal on 1st to 5th September in Manchester. Come and show moral support for a victimised activist on the first day of her hearing, from 8.30am-10.00am, Parsonage Gardens, off Deansgate.

- Join us at events over the summer like the Durham Miners Gala and the summer Melas in Manchester.
- Raise the issue at your branch meeting, and invite Karen to speak.


### Support Karen

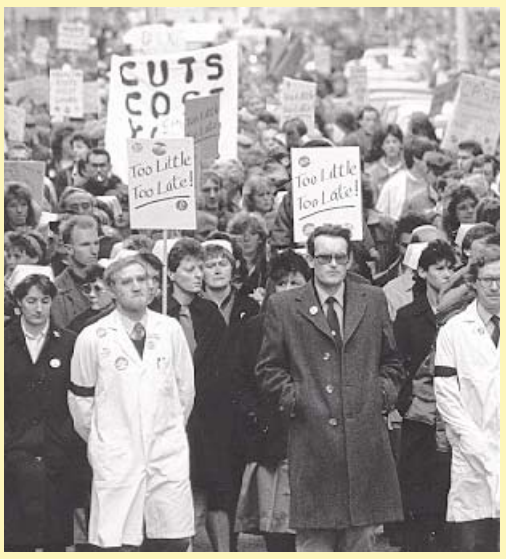
Support the NHS at 60 and the principles on which it was founded. Fight against government policies of marketisation, privatisation, commercialisation. Fight for properly funded Mental Health Services.

If you want to help the campaign for Karen's reinstatement, get in touch on 07972 120 451 or unison@zen.co.uk


UNISON Manchester Community and Mental Health branch has a proud history of opposing cuts and privatisation, and fighting for better health services.

**Many congratulations to Health Emergency on its 25th Anniversary – still at the forefront of campaigning for the NHS.**

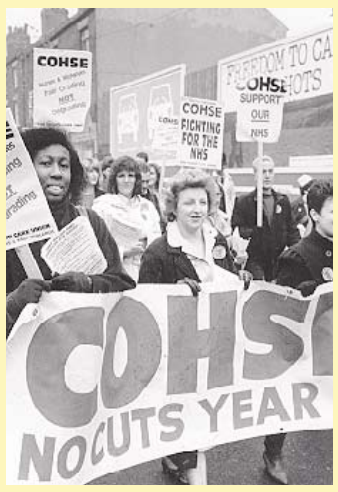
# How did we get to this? **The 30-year NHS countdown to crisis**




**1976** IMF demands British (Labour) government impose cash limits on public spending as condition for loans.

**1980** NHS cash limits made legally binding. Black Report on growing inequalities in health and public health solutions quietly sidelined by Thatcher government.

**1983** Sainsbury boss Roy Griffiths' so-called 'business-style' managerial reforms bring in NHS Chief Executives. 'Lawson cuts' in 1983 budget trigger round of hospital closures, followed by years of near or below-zero real terms spending increases: met by angry campaigns, including launch of London Health Emergency.




**1984** Competitive tendering forces privatisation of many hospital support services (cleaning, catering, porters, security, etc).

**1987** Summer election victory for Thatcher government followed by massive winter crisis – hospital cuts and closures as waiting lists lengthen.

**1988** Griffiths review of Community Care aims to privatise most long-term care of elderly, imposing means-tested charges.

**1989** NHS White Paper Working for Patients outlines plans for an "internal market" -- separation of purchasers and providers and competition between NHS providers. Legislated in 1990.

**1991** First Trusts launched, along with new system of GP 'fund-holding' which allows GPs to retain unspent surpluses

**1992** Tomlinson Report calls for large scale cutbacks in London's hospital services: resisted by angry unions, medics and Londoners

**1993** Community care reforms introduced – effectively removing most continuing care for elderly from NHS, and allocating it to (means-tested) social services.

**1994** Private Finance Initiative (PFI) introduced to NHS: brings 4-year standstill in major NHS capital projects

**1995** Health authorities adopt tighter eligibility criteria to restrict access to NHS-funded continuing care of elderly.

**1996** Waiting lists for treatment continue to rise above 1 million. New Labour embraces PFI.

**1997** New Labour government publishes White Paper The New NHS, proposing end of 'internal market' – but preserving purchaser/provider split. PFI to be used to build new hospitals.

**1998** First PFI hospital projects agreed

**1999** Primary Care Groups established, initially as sub-committees of health authorities, but offering leading role to family doctors (GPs).

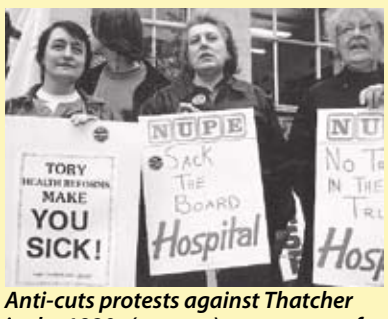
**2000** March budget proposes big increases in NHS spending. NHS Plan published . stressing role of PFI and private sector. First PFI hospitals open – with fewer beds, no spare capacity, and higher operating costs.

**2001** Cash crises in many hospitals and services before new funding takes effect: health authorities reorganised, and Primary Care Trusts replace PCGs – GPs marginalised in these new .commissioner. organisations

**2002** National level negotiations open on private ("independent") sector Treatment Centres (ISTCs) to deliver services funded by NHS

**2003** Plans for best resourced and top-performing hospitals to become "Foundation Trusts" free to retain surpluses, borrow funds and work with private sector passed by wafer-thin majority in Parliament. Foundation Trusts will compete with other NHS Trusts for contracts and for staff.

**2004** First Foundation Trusts launched; independent regulator Monitor spends over 60% of first year budget on private management consultants (McKinsey's). By 2007 FTs have accumulated surpluses of over £1billion.




*Anti-cuts protests against Thatcher in the 1980s (top two), opponents of Trusts opting out 1990 (above) and (below) Alan Milburn brandishes the NHS Plan, 2000.*

**2005** Payment by results system begins phased introduction. New plans for reorganisation and privatisation set out in "Commissioning a Patient-Led NHS" – PCTs encouraged to privatise their commissioning and services.

**2006** Strategic Health Authorities merged, as are many PCTs, to form larger, even less democratic or accountable organisations. Commons Health Committee questions value for money of ISTCs. Government figures show £8 billion worth of new hospitals will cost £53 billion under PFI

**2007** R. Channing Wheeler, senior executive from US insurance giant United Health, recruited on £300,000 annual package as NHS director of commissioning services from private sector: back in the US one in six (an estimated 50 million Americans) lack health insurance.

**2008** Wheeler's old firm picks up contracts for GP services in Camden in questionable procedure, despite vocal protests by local people. Wheeler returns to US to join other United Health bosses in answering a legal challenge, having allocated £1 billion of work to private sector. Ministers propose privatising management of "failing" hospital trusts.

*Nye Bevan visits Papworth Hospital*

# Bevan explains the principles of an NHS free at point of use

These are extracts from the fifth chapter of Aneurin Bevan's book of essays ***In Place of Fear,*** published in 1952, and now available in full on the Socialist Health Association website

PREVENTABLE pain is a blot on any society. Much sickness and often permanent disability arise from failure to take early action, and this in its turn is due to high costs and the fear of the effects of heavy bills on the family. The records show that it is the mother in the average family who suffers most from the absence of a free health service. In trying to balance her domestic budget she puts her own needs last.

Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide. But private charity and endowment, although inescapably essential at one time, cannot meet the cost of all this. If the job is to be done, the state must accept financial responsibility.

When I was engaged in formulating the main principles of the British Health Service, I had to give careful study to various proposals for financing it, and as this aspect of the scheme is a matter of anxious discussion in many other parts of the world, it may be useful if I set down the main considerations that guided my choice.

In the first place, what was to be its financial relationship with national insurance; should the health service be on an insurance basis? I decided against this.

It had always seemed to me that a personal contributory basis was peculiarly inappropriate to a national health service. There is, for example, the question of the qualifying period. That is to say, so many contributions for this benefit, and so many more for additional benefits, until enough contributions are eventually paid to qualify the contributor for the full range of benefits. In the case of health treatment this would give rise to endless anomalies, quite apart from the administrative jungle which would be created. This is already the case in countries where people insure privately for operations as distinct from hospital or vice versa.

Whatever may be said for it in private insurance, it would be out of place in a national scheme. Imagine a patient lying in hospital after an operation and ruefully reflecting that if the operation had been delayed another month he would have qualified for the operation benefit.

Limited benefits for limited contributions ignore the overriding consideration that the full range of health machinery must be there in any case, independent of the patient's right of free access to it. Where a patient claimed he could not afford treatment, an investigation would have to be made into his means, with all the personal humiliation and vexation involved.

This scarcely provides the relaxed mental condition needed for a quick and full recovery. Of course there is always the right to refuse treatment to a person who cannot afford it. You can always 'pass by on the other side'. That may be sound economics. It could not be worse morals.

Some American friends tried hard to persuade me that one way out of the alleged dilemma of providing free health treatment for people able to afford to pay for it would be to 'fix an income limit below which treatment would be free while those above, must pay.

This makes the worst of all worlds. It still involves proof, with disadvantages I have already described. In addition it is exposed to lying and cheating and all sorts of insidious nepotism.

And these are the least of its shortcomings. The really objectionable feature is the creation of a two-standard health service, one below and one above the salt. It is merely the old British Poor Law system over again. Even if the service given is the same in both categories there will always be the suspicion in the mind of the patient that it is not so, and this again is not a healthy mental state.

The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged.

Two ways of trying to meet the high cost of sickness are the group insurance and the attachment of medical benefits to the terms of employment. Group insurance is merely another way of bringing the advantages of collective action to the service of the individual.

All the insurance company does is to assess the degree of risk in any particular field, work out the premium required from a given number of individuals to cover it, add administrative cost and dividends, and then sell the result to the public. They are purveyors of the law of averages. They convert economic continuity,

which is a by-product of communal life, into a commodity, and it is then bought and sold like any other commodity.

What is really bought and sold is the group, for the elaborate actuarial tables worked out by the insurance company are nothing more than a description of the patterns of behaviour of that collectivity which is the subject of assessment for the time being.

To this the company adds nothing but its own profits. This profit is therefore wholly gratuitous because it does not derive from the creation of anything. Group insurance is the most expensive, the least scientific, and the clumsiest way of mobilizing collective security for the individual good.

The other alternative is a flat rate compulsory contribution for all, covering the full range of health treatment, or a limited part of it. There is no advantage whatever in this. It is merely a form of poll tax with all its disagreeable features. It collects the same from the rich and the poor, and this is manifestly unjust. On no showing can it be called insurance.

There is a further objection to a universal contribution, and that is its wholly unnecessary administrative cost. Why should all have contribution cards if all are assumed to be insured? This merely leads to a colossal record office, employing scores of thousands of clerks solemnly restating in the most expensive manner what the law will already have said; namely, that all citizens are in the scheme.

The means of collecting the revenues for the health service are already in the possession of most modern states, and that is the normal system of taxation.

"There are a number of potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats, both must be classified." .

*July 5 1948: Bevan with staff at Trafford Park Hospital*

This was the course which commended itself to me and it is the basis of the finance of the British Health Service. Its revenues are provided by the Exchequer in the same way as other: forms of public expenditure.

Many people still think they pay for the National Health Service by way of their contribution to the National Insurance Scheme. The confusion arose because the new service sounded so much like the old National Health Insurance, and it was launched on the same date as the National Insurance Scheme.

One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes.

No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen.

However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats, both must be classified.

What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march together.

The cost of looking after the visitor who falls ill cannot amount to more than a negligible fraction of the total cost of the Health Service. The whole agitation has a nasty taste. Instead of rejoicing at the opportunity to practice a civilised principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialised medicine.


*2007: Bevan rides again, featured on this UNISON banner*

## Nye Bevan in 1952

# Will patients inevitably rip off a free NHS?

And now comes the question so frequently asked: do not all these free facilities invite abuse?

Whenever I was asked that question I always answered:

"A prerequisite to a study of human behaviour is that human beings should first be allowed to behave."

When the Service started and the demands for spectacles, dental attention and drugs rocketed upwards the pessimists said:

"We told you so. The people cannot be trusted to use the Service prudently or intelligently. It is bad now but there is worse to come. Abuse will crowd on abuse until the whole scheme collapses."

Those first few years of the Service were anxious years for those of us who had the central responsibility.

We were anxious, not because we feared the principles of the Service were unsound, but in case they would not be given time to justify themselves. Faith as well as works is essential in the early years of a new enterprise.

The question uppermost in my mind at that time was whether a consistent pattern of behaviour would reveal itself among the millions using the Service, and how long would it take for this to emerge? Unless this happened fairly soon it would not be possible to put in reliable estimates for the Budget.

The first few estimates for the Health Service seemed to justify the critics. Expenditure exceeded the estimates by large amounts, and Mr. Churchill with his usual lack of restraint plunged into the attack. In this he showed less insight than his colleagues, who watched his antics with increasing alarm.

They knew the Service was already popular with the people. If the Service could be killed they wouldn't mind, but they would wish it done more stealthily and in such a fashion that they would not appear to have the responsibility.

Ordinary men and women were aware of what was happening. They knew from their own experience that a considerable proportion of the initial expenditure, especially on dentistry and spectacles, was the result of past neglect. When the first rush was over the demand would even out.

And so it proved. Indeed, it was proved even beyond the expectations of those of us who had most faith in the Service.

It is not generally appreciated that after only one full year's experience of the Service I was able to put in an estimate which was firm and accurate.

This was remarkable. It meant that in so short a space of time we were able to predict the pattern of behaviour of all the many millions of people who would be using the Service in a particular year.

Whatever abuses there were, they were not on the increase. From that point on, any increased expenditure on the Service would come from its planned expansion and not from unpredictable use and abuse.

We now knew the extent to which the people would use the existing facilities and what it would cost us. The ground was now firm under our feet. Such abuses as there were could be dealt with by progressive administrative pressure.

*First moves towards a new health centre: Bevan does the honours*

Read the full text and more under History at http://www.sochealth.co.uk/

# NHS boss falls well short of 60 closure target


*Angry protestors abandon political correctness in Chichester at the height of the campaigns against the Hewitt cuts of 2006*

ONE MAN with egg on his face after Lord Darzi's review and recent pronouncements is NHS chief executive David Nicholson. He took office under Patricia Hewitt in the autumn of 2006, when finance-driven cuts were taking shape across the country.

Nicholson immediately set out a hard-line agenda of downsizing and centralisation, grabbing headlines with his target of 60 hospital Trusts to be "reconfigured" before the next general election.

His brave words linked up with the pressure from organisations such as the NHS Confederation and the Blairite think-tank IPPR, which calculated on the basis of increasing the catchment populations for A&E units that up to 59 should close – including nine in London.

One difficulty in promoting this line of argument (over and above the unpopularity of the policy) was that it ignored the steady and continuous increase in numbers arriving at A&E units – and in the numbers requiring emergency admission.

But Nicholson's commitment to press forward with closures also coincided with a high tide of protest and campaigning at local level as people in normally sleepy towns of middle England recognised the threat to their hospitals and took to the streets.

A worried Labour Party chair Hazel Blears was revealed to have drawn up a "heat map" indicating where string campaigns could do Labour electoral damage – and a few months later could be seen opportunistically joining a picket in defence of her local maternity unit, while her ministerial colleagues forced through similar changes elsewhere.

The campaigns were not universally effective, but in many areas they held up planned closures and rationalisation.

By mid 2007, Lord Darzi had become the central focus of a different way of driving forward changes: his report and the subsequent consultation in London effectively paralysed the process towards closures in SE, NE and SW London.

Only in north London did the Barnet & Chase Farm Hospitals Trust press through the decision to axe the A&E at Chase Farm – in the teeth of a powerful protest campaign.

Darzi's national review of the NHS which followed his appointment as minister has now held up the process of rationalisation in many Strategic Health Authorities: some closures have been dropped or scaled back, downgrading rather than closing departments.

Some SHAs have gone further and effectively used the consultation on the Darzi review as a pretext to abandon earlier plans for cuts – and to reject proposals for polyclinics.

All this confirms that those who fight back against cuts can sometimes win more than they expect – while those who do not resist are guaranteed to lose their local services.

With Gordon Brown trailing so badly in the polls it seems that campaigns that manage to hold up closures now may save popular local services for another three or more years.


***The big victors out of David Nicholson's embarrassment have been the campaigners at Banbury's Horton Hospital (above), whose two decade-long battle to maintain local services has secured the first-ever ruling from the Independent Reconfiguration Panel that overturns a major planned cutback, and upholds the continuation of maternity services in Banbury. The threat had been of 30-mile journeys for expectant mums to Oxford's John Radcliffe Hospital.***

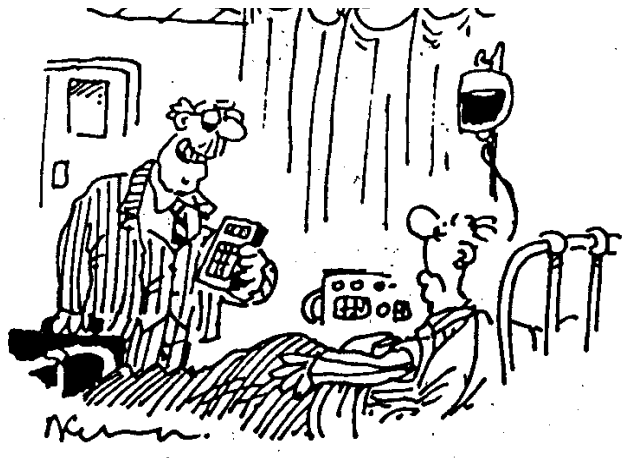
# SE London: a picture of crisis

In South East London plans to downsize and axe local hospital services in Bexley and Lewisham have been put forward by Primary Care Trusts under the misleading title "A Picture of Health".

The main hospitals facing cutbacks are Queen Mary's in Sidcup and University Hospital Lewisham – as health chiefs seek ways to rescue floundering Trusts in Bromley and Greenwich which are saddled with enormous costs from hospitals built with funds from the Private Finance Initiative (PFI).

Lewisham councillors have joined their counterparts in Bexley in opposing the plans, with the local newspapers also on board, and local campaigners are keeping up the pressure.

Advocates of the reorganisation are routinely losing the argument wherever a public debate takes place, and have failed to answer concerns that the reorganisation would leave a catchment of a million people desperately short of front-line hospital beds.



*"I'm not Dr Jekyll – I'm Mr Hyde the accountant"*

Leaked minutes from a meeting between local consultants and specialists and so-called "turnaround expert" Anthony Sumara in mid January underline the extent to which the entire exercise has been driven from the beginning by financial pressures, and expose the deception of management claims that the reconfiguration was being led by clinicians.

The minutes record that the Chair of the "Outer South East London Joint Committee", John Hart, told the meeting that local services needed to be "safe and sustainable (by which he said he meant affordable)".

He also admitted that the Joint Committee had been set up to push forward the selling of estate to help pay off debts, with particular focus on Queen Mary's, Lewisham and Bromley's Orpington Hospital.

Mr Hart made clear that if the Trusts fail to implement the decisions of the Joint Committee, their Chief Executives and Boards could be removed and replaced.

However it is interesting to note that this rather cumbersome process has been introduced in order to avoid public consultation on a merger of the four Trusts facing reorganisation.

Asked if a merger was planned, Anthony Sumara replied:

"We avoid the "m" word as this stagnates change. Merging requires a full consultation process, slowing down the entire process of re-organisation and more debts would accumulate."

Sumara went on to admit that switching services away from Queen Mary's is vital to prop up Queen Elizabeth Hospital in Woolwich and Bromley's Princess Royal University Hospital – but that none of the options would actually pay back the £180m of debts run up by local Trusts.

These issues may appear a little parochial, but similar processes are still rumbling on in many other parts of the country, backed by similar spurious arguments and dodgy figures.

## Surprise for PCTs as joint scrutiny committee fights on

**Attempts to force through a brutal rationalization of hospital services in South East London have met determined opposition – from a committee of councilors!**

**The Joint Health Overview and Scrutiny Committee (JHOSC), made up of councillors from the seven affected boroughs, have slammed proposals that include axing the Accident and Emergency and maternity units at nearby Queen Mary's Hospital, Sidcup – the district general hospital covering the borough of Bexley.**

**The councillors, from south London boroughs and Kent County Council claim the consultation was 'inadequate' and the proposals are driven by 'financial pressures'.**

**Echoing a previous report drawn up by London Health Emergency for staff unions at Queen Mary's, Bexley councillor Sharon Massey told the local press:**

**"The report unanimously objects to the consultation. The NHS has just thrust this upon us. It seems this was cooked up in a backroom and they have all decided. Nobody is buying it apart from those who decided it.**

**"No other organisation is supporting it. It is completely flawed. The whole thing is a mockery. I can't believe these are the people in charge of reorganising our NHS. It is scary."**

**The report makes 34 recommendations including a call for more detailed work and costings to be made available about the effects on the London Ambulance Service. Health chiefs from the so-called "Picture of Health" project have 28 days to respond.**

**Members of a joint committee of primary care trusts will make the final decision about the future of health services in the area in July.**

**So far they have ignored all arguments and protests.**
**But if the councillors are not satisfied with the decision, the JHOSC could refer the case to the Secretary of State for Health.**

# Keep up pressure to halt Epsom closure


**Geoff Martin**

Ten years after UNISON launched a campaign to stop the closure of key services on both the Epsom and St Helier hospital sites, there is now growing evidence that the plans to downgrade one or both of the hospitals have been pushed back.

It's too early to start counting chickens, but the latest working documents on Women's and Children's services suggest that campaigners are winning the argument – and that gives an opportunity to revitalise the campaign.

At the end of the 1990s, when the first plans to centralise Epsom and St Helier services on a single site were unveiled, some people said we were wasting our time fighting the proposals.

A decade on – and many chief executives, project officers and management consultants later – the service at Epsom and St Helier remain pretty much intact.

UNISON has worked alongside the local communities, MPs, Councillors and our other staff organisations, to make sure that changes to services have not been railroaded through against the wishes of the staff and the public.

Only a few months ago, the closure of maternity and paediatrics looked like a done deal – but now the latest working papers in the review suggest that that is not the case, and that the views of the clinicians, other staff and the general public are being given serious consideration.

We always warned that if Epsom's services were closed, those patients would not automatically head over to St Helier hospital further in to London, but they would look for their care further south.

We warned that, incomewise, the Trust would be shooting itself in the foot. Those arguments now seem to be sinking in. Of course, the other thing that has changed is the national political situation. The threat to services at Epsom and St Helier was always part of a national policy of centralising services – usually dictated by financial pressures.

With the government well and truly on the ropes, they are in no position to start driving bulldozers through our hospitals. On the BBC recently the health minister, Lord Darzi, said very clearly that no services will be changed without the support of local people and NHS staff, and without new services put in place before existing services close.

When we put thousands of people on the streets of Epsom and Sutton in protest at plans to downgrade our hospitals, we were sending out a clear message – and nobody should be in any doubt that we will mobilise again if the need arises.

We know that we are not out of the woods yet. We also know that our hospitals, particularly St Helier, need major capital investment if we are to secure services long into the future.

But we have proved a very important point. If staff and the service users stand together we have got some real power.

It still sticks in our throat that so much time, money and energy has been wasted on pursuing ill-conceived and unpopular local hospital plans which have now been abandoned to all intents and purposes.

We still think that those responsible for that wilful waste of taxpayers' money should be held to account.

What we need now is a period of stability, with every ounce of energy and every penny of our resources directed at delivering the highest quality care.

We don't think that's too much to ask.

## SWLEOC

**Back in the autumn of 2005, Epsom-St Helier Trust bosses unveiled plans to hand over the management of an NHS Treatment Centre, the South West London Orthpaedic Centre (SLEOC) to a New York-based private company.**

**Campaigners challenged the decision and lobbied the Trust Board, demanding the Finance Director explain how this would provide value for money. He was unable to answer, the plan was suspended pending a review – and SWLEOC is still operating as an NHS unit, delivering state of the art treatment almost three years later. It was singled out by Lord Darzi as an example of good practice – and stands as an example that campaigning can have a lasting impact.**

UNISON

## Epsom & St Helier Branch


- Happy Birthday NHS!
- Congratulations to London Health Emergency on 25 years of principled campaigning against cuts and privatisation
- Fight on to defend jobs and health services in Epsom and St Helier

**KEVIN O'BRIEN Secretary**
**ANNIE HOLNESS Chair**
**Union Office, Ferguson House, St Helier Hospital, Wrythe Lane, Carshalton, Surrey**

# It's official: improvements in NHS waiting times come from extra cash … and targets

# £1 billion squandered on health reforms without results, say Commissions

Tony Blair and Gordon Brown have sown dragon's teeth, but apparently harvested fleas, according to a devastating new report.

Health "reforms" – including Foundation Trusts, the use of private sector treatment centres and the system of "payment by results" – have cost up to £1 billion to introduce over five years, but appear to be having little significant effect, according to a study by the Audit Commission and Healthcare Commission.

And there are clear signs that the two Commissions have pulled their punches. The report is curiously silent about the impact of most expensive policy of the lot – the Private Finance Initiative (PFI) as a means to fund new hospitals.

The inflated costs of PFI payments, combined with the rigid system of "payment by results" are forcing many Trusts into financial crisis: yet PFI is not even mentioned in the 94-page report.

Nor does it discuss the huge problems generated by payment by results for specialist hospitals, whose larger than average costs are not properly reflected in the national tariff, and who remain dependent on transitional support to prop them up.

The report highlights the continued refusal of the present government – aping the previous attitude under the Tories – to ensure the systematic and sustained collection of data by the DH to enable analysts to monitor the impact of the reforms, and admits that information is at best sketchy:

"The lack of formal monitoring of the reforms means that we have not carried out a comprehensive examination of the reforms in every single part of the NHS."

In fact the report gathers serious data from just a few selected areas, and avoided any discussion or consultation with front-line health workers or trade unions – or indeed anyone outside of the magic circle of policy insiders.

Instead they only met NHS managers, hand-picked GPs, non-executive directors, and Foundation Trust governors, and held a series of interviews with "commissioners, providers and strategists based in London".

Nor did they speak to patients, even a carefully-screened selection. Instead:

"The views of patients were gained through analysis of the results of the DH Choice survey."

Even this narrow and exclusive group of people and sources could not persuade the two Commissions that the "reform" package was cost-effective or delivering its promised improvements.

While waiting times had been reduced, for example:

"A hospital with a shorter waiting time now than in 2005 might have responded to targets, increased capacity with additional funding, or improved service efficiency because of greater actual or potential competition from a private sector ISTC."

Some changes are discounted: Practice-Based Commissioning by GPs, for example, has proved less than popular with doctors and delivered little in the way of improvement: just one GP in six felt it had improved care.

"PBC has yet to have a significant effect on the redesign of services and the transfer of care from a secondary to a primary care setting. Where transfer is occurring, it does not appear to be as a direct result of PBC."

The much-vaunted "patient choice" policy had also failed to make much impact, although as campaigners have warned, it is enough to destabilize some local NHS Trusts:

"Unsurprisingly, given that choice is not universally provided, there is no evidence from our fieldwork that choice policy has so far had a significant impact on patient pathways or that it has led to an improvement in the quality of services offered.

"We did not find endorsement of choice as a mechanism for changing patient flows. In those trusts or units that are on the cusp of financial stability, a small activity change as a result of choice could have a significant impact on the viability of a service or of an organisation."

The vexed question of what happens when patients defy ministers and choose their local NHS hospital has also created problems:

"One Foundation Trust reported that it was working at full capacity and was struggling to bring its waiting times down to meet the 18 week referral to treatment target, while taking on all the patients that chose to be treated there.

"This had the effect of stalling Choose and Book, as the hospital could then only offer one appointment date, which is counter to booking policy."

Interestingly the report also publishes figures from a London survey which shows that the prospect of going to a private hospital for treatment was the least popular of 16 possible factors cited by patients.

Perhaps another reflection of this resistance is the problems experienced by Primary Care Trusts, which have often been struggling against the odds to press-gang reluctant patients into treatment at new private (Independent Sector) Treatment Centres (ISTCs) when their choice was to remain in the NHS:

"Some health economies reported that, despite a significant effort from PCTs, their local ISTC was still underutilised. Some PCTs cited that there was little local appetite for independent sector providers, with the majority of patients choosing to be treated at the local NHS hospital, even if it had longer waits than the ISTC."

The two Commissions echo the arguments of critics and campaigners that the total activity carried out in ISTCs is a minuscule proportion of the NHS caseload – with a best case figure of just 105,604 cases in 2007-8, equivalent to just 1.79% of the elective activity of the NHS.

The previous year ISTCs carried out just 4 percent of cataract operations, and 7 percent of hip procedures: such small levels of activity – at costs 11% above the NHS tariff – make it "difficult to draw any conclusions about the impact of ISTCs".

The report also backs up campaigners who have argued that ISTCs are merely "cream-skimming" the easiest and most profitable cases:

"Among our fieldwork sites, there was a belief that the ISTCs have cherry-picked cases and have left the potentially more complicated and expensive cases to the local NHS. … In addition, due to the lack of facilities such as intensive care, the costs of any complications resulting in a patient being readmitted as an emergency will be borne by NHS providers."

Campaigners who argued that the trappings of "democracy" in Foundation Trusts such as the election of a Board of Governors was simply a charade also find support from the Commissions' report:

"Our qualitative research did not find significant evidence that FT governors were having a clear and identifiable impact on FT development. Indeed, we identified some instance of confusion of roles between the governors and board of FTs."

Neither have Foundations used their new freedoms to innovate greatly in service, or even to borrow money – with just £100m out of £2.5 billion available having been borrowed so far. What they have done is build up massive unspent surpluses, which are now outside the control of the NHS.

A case-study of the University College London Hospitals FT's so-called "turnaround" from a large financial deficit focuses on the changes to top management, but tellingly reveals (without comment) that at the centre of the changes was an increase in clinical activity coupled with a reduction in staff.

Despite this and other evidence of the increasing workload carried by front-line staff, the report argues that new contracts for doctors and Agenda for Change for nursing and other staff were a "missed opportunity", raising costs without a proportionate increase in productivity

This latest report by the two Commissions is far from perfect: its authors and the two organizations commissioning the work do not begin as critics of the reforms. They have avoided some highly sensitive issues.

But despite these limitations the report again shows that health workers and campaigners have been proved right: the NHS improved thanks to record growth in spending, backed by targets to reduce waiting times. These were "substantially delivered without using the system reforms".

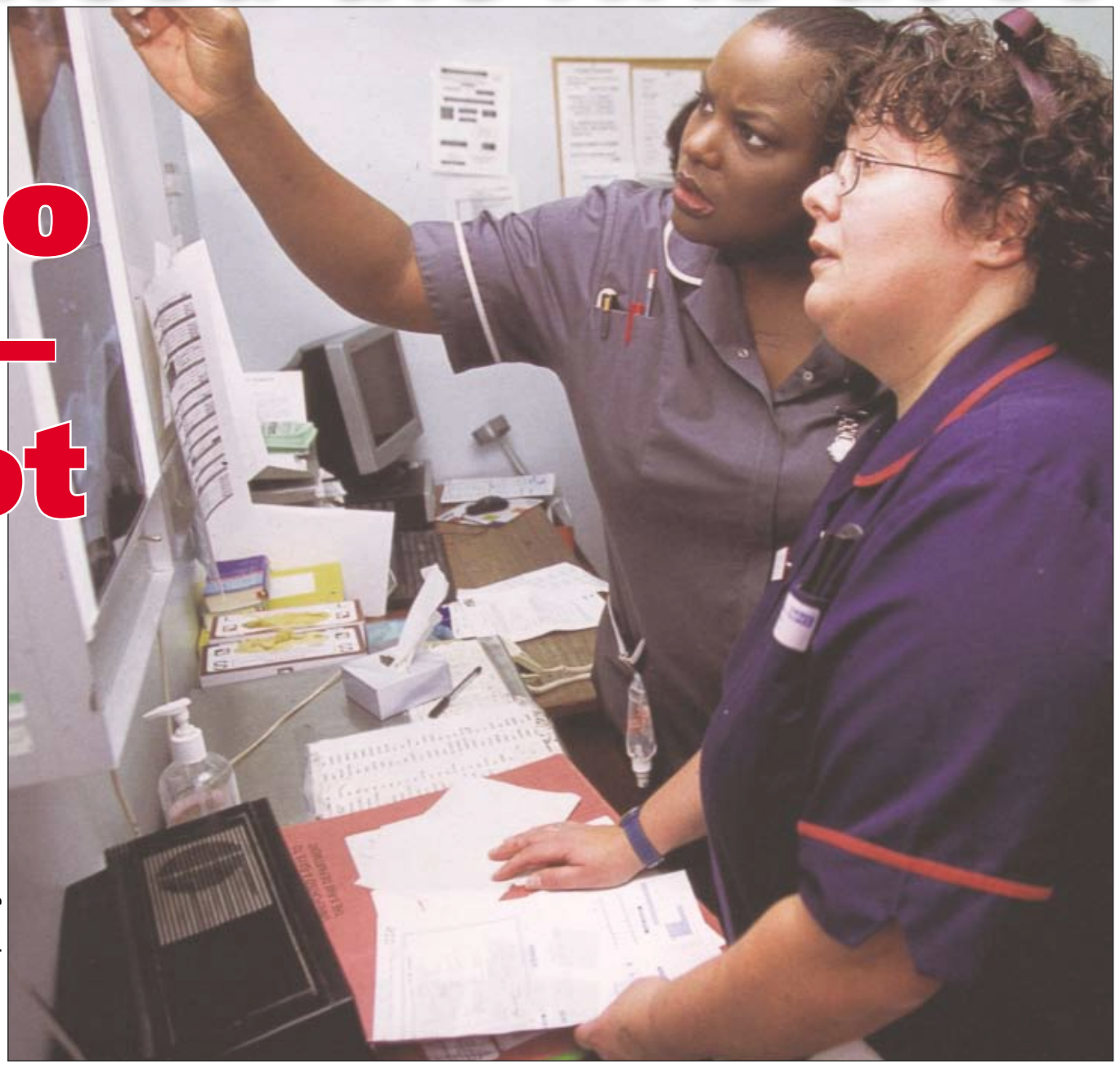


*This rash of Independent Sector Treatment Centres has simply bumped up costs and reduced efficiency in the NHS*

**The inflated costs of PFI payments, combined with the rigid system of "payment by results" are forcing many Trusts into financial crisis: yet PFI is not even mentioned in the 94-page report.**

# Balance sheet: the NHS at 60

# Still plenty to defend – and a lot to lose!



John Harris reportdigital.co.uk

The private sector involvement in the NHS in recent years is expensive and wasteful, but much of it remains very small in scale and operates at the margins of a National Health Service.

The NHS now has 1.3 million staff, including a significant increase since 2000 in numbers of nurses, hospital doctors, GPs, health professionals, and many more skilled clinical and non-clinical support staff whose effort and dedication make the system tick.

The NHS has established a national network of hospitals, health centres, clinics and community-based services, with resources allocated on the basis of maximising accessibility and meeting health needs, not on targeting the wealthy and maximising profit.

NHS primary care services – involving GPs, community, district and practice nurses and midwives, health visitors, occupational, speech and physiotherapists – have improved and provide tens of millions of consultations and treatment, free of charge. For non-emergency health issues primary care is the principal gateway for referral to specialist hospital treatment.

But there are more important strengths: NHS is the only source of 24-hour emergency services – ambulances and A&E departments – offering a comprehensive mix of care including specialist services that the private sector does not even pretend to provide.

In 2005-6 almost 18 million people attended Accident and Emergency units in England. In 2006-7 NHS hospitals admitted over 4.7 million people as emergencies for hospital treatment: no such treatment is available from the private sector.

Waiting times in A&E have been reduced: ambulance services have begun to improve.

Overall, NHS hospitals in England delivered 14.8 million episodes of treatment in 2006-7, 4.4 m of which were day cases, and 5.27m (36%) of the hospital treatment was for older people (aged over 65).

7.8 million NHS patients had surgery in England in 2006-7: against this, the few tens of thousands treated – at inflated expense – in Independent Sector Treatment Centres can be seen as a statistical irrelevance to the overall capacity of the system.

The expansion of the NHS in the last ten years has also been dramatic: in 2006-7 the NHS delivered 289,500 cataract operations – a 44% increase on its performance in 1998-9.

Numbers of heart operations have doubled in the same period, from 41,000 to over 81,000, with the main expansion being in the use of angioplasty by balloon or laser to free up blocked arteries.

**The generally small-scale network of private hospitals average just 40 beds each, and do not employ full-time doctors**

The NHS is performing 31% more hip operations now than in 1998-9, and 36% more kidney transplants. 22% more people are being diagnosed with cancer, and 18% more with ischaemic heart disease.

Another service not available from private sector health insurance or private hospitals is maternity: in 2005-6 hospitals and NHS midwife-led units gave expert help in 593,400 deliveries in England, up 1.6% on 2004-05.

A further 15,900 took place at home (2.6% of all NHS deliveries) compared to 13,700 (2.3%) in 2004-05. NHS hospitals also lead the field in the care of premature and newborn babies and in specialist care for children.

Swifter access to life-saving treatment for cancer and heart problems has helped deliver improved results in the form of falling death rates. 99.9% of people with suspected cancer are now seen by a specialist within two weeks of being referred by their GP, compared with 63% in 1997.

An estimated 60,000 lives have been saved from cancer and 175,000 from coronary heart disease since 1997: all of these key services are delivered by the NHS.

The NHS has also trained and educated nurses and midwives, health professionals and therapists, and doctors – with large NHS district general and teaching hospitals offering the basis for the development of specialist skills, and a career structure for nurses and medical staff.

Private sector hospitals do not train medical staff, but recruit from the pool of NHS-trained doctors and nurses, or poach skilled staff from overseas: and because they accept only the most minor and least complex cases private hospitals don't offer a broad enough caseload to allow them to train specialists, or conduct research.

The last 60 years have also seen very important improvements in the treatment even of those patients often seen to be on the margins of the NHS – the elderly, and people with mental illness.

Old, poorly resourced workhouse-style wards for the elderly have increasingly been superseded, and community-based services have shown a glimpse of the possibilities if adequate resources are made available and the gulf between health and social care can be bridged.


Mental health services, too, are predominantly provided by the NHS, but again significant strides have been taken to break down the model of institutionalised care, and develop new and creative methods of treatment and support for service users in smaller units and in the community.

As in mental health, the NHS and public sector have also led virtually all of the ground-breaking research into new techniques, new anaesthetics, drugs and surgical methods in the UK: it was the NHS which pioneered the notion of separating emergency care from non-emergencies and streaming the less complex routine operations through dedicated Treatment Centres – an area of care subsequently hijacked by private sector providers and now increasingly monopolised by profit-seeking multinational corporations.

NHS district and teaching hospitals are all much larger and offer a much more comprehensive range of services than the generally small-scale network of private hospitals which average just 40 beds each, and concentrate only on the least complex and most profitable types of treatment.

Unlike private hospitals, NHS hospitals are staffed 24-hours a day by consultants and doctors as well as specialist nurses and experienced support staff: and NHS hospitals maintain a network of almost 3,500 critical care beds – high dependency and Intensive Care – for patients suffering potentially life-threatening conditions.

That's why when private hospitals face any emergency situation in which an operation goes wrong, or a patient faces complications … they rush them to the nearest NHS hospital.

It is important to keep hold of these very strong pluses in the development of the NHS as a basis for any serious critique of the inroads of market-style "reforms" and the private sector.

There is still plenty worth defending in the NHS, and still large areas of NHS services which the private sector has no intention of taking over.

■ (Adapted from John Lister's new book ***The NHS After 60: for patients or profits?*** – see page 15.)

## Ham notes market failure

**The body of opinion questioning the evidence behind the government's pell-mell dash towards market-style reforms of the NHS, based on the "purchaser-provider split" and the concept of "commissioning" services, has been boosted by the one-time Blair government advisor and Birmingham University academic Chris Ham.**

**In a "high level overview" report commissioned by West Midlands health bosses*, Professor Ham concludes that:**

**"Experience and available evidence from Europe, New Zealand and the US indicates that in no system is commissioning done consistently well. …**

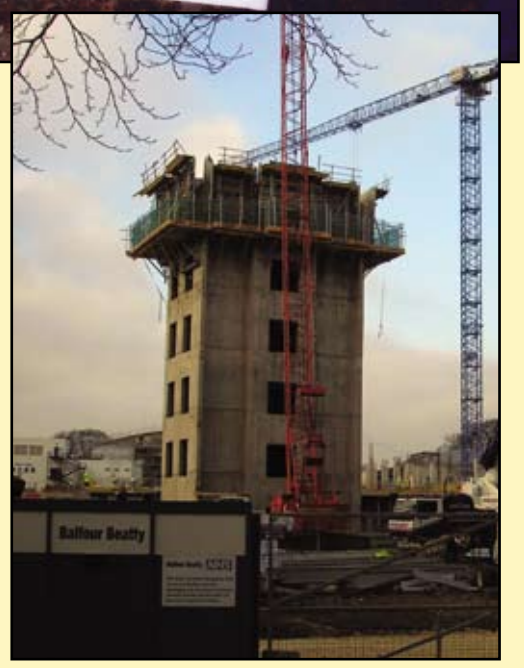
**"Put simply, the challenge in making systems based on a separation of purchaser and provider roles work effectively, reflected in the experience and evidence summarized here, may mean that integration offers a more promising way forward."**


'You've got affordable cancer'

*** Ham C (2008) *Health Care Commissioning in the International Context: Lessons from Experience and Evidence*, University of Birmingham Health Services Management Centre, www.hsmc.bham.ac.uk**

UNISON

Anniversary greetings from Wakefield and Pontefract Hospitals UNISON Branch


- Open the books: No ‘trade secrets!
- Abolish commercial confidentiality in the NHS.
- For a health service that is fully publicly funded, owned and managed

UNISON

# South London and Maudsley Branch

Fighting for mental health services


UNISON Union eyes

Number 23 Spring 2008 UNISON SLaM Branch

UNISON has its say on Healthcare for London: A Framework for Action

SHAPING THE FUTURE OF YOUR JOBS AND SERVICES

Big changes in the future pattern of health services in London are up for discussion. NHS London has launched a report *Healthcare for London: A Framework for Action* which is the most fundamental review in decades.

UNISON here at SLAM believes that it's essential that we all understand exactly what these changes are all about and that we have our say.

Is this just another finance-led attempt to hack services around to fit budgets or is it a serious attempt to model a health system for a modern capital city?

Will mental health at last get the profile and resources it deserves, or will we once again get shoved to the back of the queue in the scramble for funds?

What will happen with the commissioning role? Will there be genuine engagement with patients and staff to shape the future, or will the system be bogged down in bureaucracy and fragmentation between different agencies?

Will the inequalities in access to health services which have been a feature for so long be seriously tackled or will we be left with the same gaps between the haves and have nots?

These are just some of the points that need discussion and which require firm answers at the end of this process.

To help you get a full understanding of the big changes that are underway UNISON and South London and Maudsley NHS Foundation Trust invite you to participate in a discussion on the proposals for mental health services arising out of Lord Darzi's report – *A Framework for Action* – and the ongoing review by the mental health working group.

It will be in the Wolfson Lecture Theatre on February 28.

London is by far the largest city in Europe and faces many unique problems, including far higher incidence of severe mental illness than the England average. Pressure on services continues to grow, along with financial pressures on London's mental health trust and foundation trusts.

SlaM and the SlaM branch of UNISON want to ensure that mental health features prominently in the debate about the future of London's NHS.

That's why we have jointly called a major event to raise awareness of the mental health dimension to the London-wide consultation, which runs until March 7 2008, based on Lord Darzi's report.

The discussion will also help inform the UNISON SlaM formal response to the consultation.

On the centre pages you will find an analysis of the mental health issues raised by the Darzi report and the back page you will find a poster advertising the consultation event. Please display the poster in your ward or department and make every effort to attend.

Big plans for the capital's health care: Lord Darzi

Join UNISON today: form on page 7

UNISON SOUTH LONDON and MAUDSLEY Branch Annual General Meeting

20TH February 2008 2.15pm Boardroom Bethlem Hospital

All members are urged to attend – these are times of great change for mental health staff. Come along and play your part in shaping the future of your trade union.

Ministers warn of more NHS pay restraint

All the signs coming out of the Government are that we can expect another three years of pay restraint.

What that means is more pay awards that fail to meet real inflationary pressures – particularly here in London and the South East where the cost of living for health care staff is squeezing salaries hard.

We can also expect to see more staged pay increases which claw back the odd percentage point on the pay bill to help prop up the underfunding of services.

Gordon Brown needs to heed the words of warning from UNISON and the other trade unions.

Making public sector workers pay the price for the looming economic crisis will bite deep into the Labour Party's core vote and he would be well advised to back off.

To find out more about UNISON's campaigns on pay and conditions – and for an update on current pay scales – take a look at www.unison.org.uk

# Happy 60th Birthday NHS!

A campaigner's critical history of the NHS

# From Nye Bevan's principles … to surplus-centred care

***The NHS After 60: For patients or profits? by John Lister, Information Director of London Health Emergency. 340 pages. Published by Middlesex University Press, £25***

RICHARD BAGLEY finds out how the NHS got to the state it's in today, and what can be expected if the cuts are allowed to continue.



**"This is a very significant book, meticulously researched, and intensely readable. It warns us all about what is on the agenda – the steady privatisation of the National Health Service. Everyone should read this book, and we must get together to ensure that the privatisation that it warns of does not happen" – Tony Benn**

PREPARE to get angry. In his excellent new book, John Lister charts the illogical and disastrous policies that have propelled the NHS to the edge of a precipice.

In Wales and Scotland, as Lister points out, there are signs that politicians have woken from their slumber and are reversing some of the market-driven excesses of the past few decades. In England, alas, there is no sign of any let-up.

Lister is an academic who lectures in health policy, but who may be more familiar to activists through his campaigning work at London Health Emergency since 1984.

He uses his considerable knowledge to assess the flawed genesis of the NHS in 1948, when a Labour government brought primary care and a patchy hotch-potch of municipal, voluntary and private hospitals under the remit of the state. For the first time, the entire British population had access to free health care.

Yet Lister underlines the imperfect nature of its birth and the impact of years of underfunding that left the NHS ripe for hostile intervention.

While he points out that the bulk of his book looks at policies brought in by new Labour in the wake of the Tories' first steps towards privatisation and marketisation, his study of our health service's genesis is instructive.

That the NHS could function at all, despite politicians cutting the health budget to among the lowest in the developed world, stood as testimony to its efficiency and the sterling efforts of its committed staff.

Yet it was to be the change in emphasis from a health service funded according to need - which is, of course, finite - to one with a tragically low budget fixed at Whitehall that would choke this shining example of idealism and bring it to its knees.

Some of the most disturbing sections of Lister's book chart the impact of budget cuts on mental health and geriatric services.

The mentally ill and elderly have become collateral damage despite warm words on community care, that have not been matched by funding.

The private sector has eagerly filled the breach at the expense of some of society's most vulnerable people.

What's more, Lister details how the politicians, both Tory and now new Labour, made ready to wield their special brand of surgical knife on hospital acute care and GP services.

They planned to cynically exploit their own underfunding to drive through market reforms based on a failed US model, laying the groundwork for a massive expansion of private health care provision for no reason other than ideology.

While new Labour's arrival may have heralded a boost in funds, it came at a great price.

The hugely inefficient private finance schemes continued and were accompanied by perpetual "change" and enforced competition that has sucked billions out of the front-line services that define a health service from the point of view of us mere mortals.

Avoiding overly academic language, Lister generally succeeds in sharpening a picture so complex that most of the media have buried their heads in the sand, bemused.

He leaves you wondering, dumbfounded, whether the sanity of the weak-minded politicians at the top should be questioned.

Lister argues for a new model for health care that strips out the false competition and fat cats and empowers employees and communities in their stead.

While there may have been no truly golden age for the NHS, there was a dark age before. Lister warns that, unless we rally to its defence, we will soon return to it.

This book is an essential educational tool to understand what is happening at your local hospital and in your local surgery. Read it and scream. Then take action.

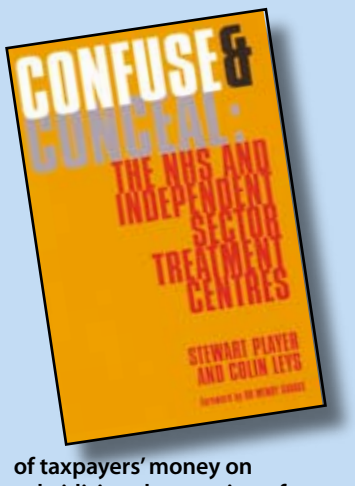
**■ Reproduced with thanks from the *Morning Star*.**

**■ Copies of *The NHS After 60* are available to Health Emergency readers at a special 20% discount (£20 rather than the full price of £25) via the website www.healthemergency.org.**

**"John Lister has written a book which everyone interested or active in health care needs to read. There should be a world of difference between the NHS economy serving public need, and the business economy serving private greed. This book will help you to re-establish that difference" – Julian Tudor Hart**

## Lifting the lid on a genuine NHS conspiracy

John Lister reviews *Confuse and Conceal: The NHS and Independent Sector Treatment Centres*, by Stewart Player and Colin Leys, Merlin Press, £10.95




AMONG the many factors that have undermined faith in Gordon Brown's government, growing public doubts over its management of the NHS have been a substantial factor – and this new and valuable volume goes to the heart of one of the most damaging policy initiatives arising from Alan Milburn's 2000 NHS Plan.

With little or no local or national public consultation or debate, and – as this new study shows – virtually no significant Parliamentary or other scrutiny, ministers have committed themselves to squandering £5.6 billion of taxpayers' money on subsidising the creation of a brand new, for-profit private sector delivering elective (non-emergency) operations and diagnostic tests at inflated prices to the NHS.

Independent Sector Treatment Centres (ISTCs) – even on the best case reading of available information – deliver no more than one percent of the total NHS caseload for elective treatment and diagnostics.

However the new financial structure required to allow them to carve out a slice of the NHS budget is now destabilising NHS hospitals and services, and the establishment of this new private sector is the hidden factor forcing the pace of 'rationalisation' – with plans for the centralisation and closure of district hospital services.

Authors Stewart Player and Colin Leys use an impressive array of official documents and reports to show that despite the huge levels of spending, and the recruitment of a staggering 190 bureaucrats (182 of them from the private sector) to the Department of Health's new "Commercial Directorate", little or no information on these new centres has been published or subjected to any serious form of scrutiny.

Time and again, the authors show, ministers have refused to publish data to show the capacity of the (ISTCs), refused to publish any financial data required to show whether the contracts they have negotiated represent value for money, and failed to demonstrate that their performance matches the NHS or conforms with the targets they have been set.

The Commons Health Committee, which should be the body holding ministers to account on such issues, has allowed itself to be kept in the dark, and failed to ask the key questions which could tease out the logic of the government's policy and highlight the dangers and implications for the NHS and for patients.

Nobody ever asked Labour ministers to set up ISTCs: in some areas strong campaigns have been waged against them. This book will provide vital ammunition for campaigners fighting on to Keep Our NHS Public.

The book can be obtained at a reduced price of £10 if ordered via the Keep Our NHS Public website *www.keepournhspublic.com*

## Brown launches fraudulent "consultation"

# It's time for free social care

Gordon Brown's announcement of a new consultation on Social Care helps to underline the growing sense of crisis in the services that are supposed to care for growing numbers of frail older people.

As NHS geriatric beds are scaled down. 70% of councils are now restricting services to those with "critical" or "substantial" care needs.

The new market-style NHS looks to discharge older patients more swiftly, and hopes to keep more of them out of hospital: but in January the Commission for Social Care Inspection published a grim report noting that while the eligibility criteria for social care have been tightened by cash-strapped councils seeking to exclude all but the most desperately frail from access to services.


The report shows that while numbers of 75+ pensioners have increased by almost 3% since 2003, numbers using social care services have fallen by 3%. 25% fewer households were accessing home care in 2006 than in 1997.

The most recent adult social care figures are indeed a picture of decline, showing a 3.6% drop in day care attendances, an 11.3% drop in meals services, falling numbers receiving home care, and reduced numbers of places in residential and nursing homes.

Couple this with the privatisation of most home care services, and the continued rundown of specialist elderly care beds in NHS hospitals (more than a quarter – almost 9,000 – have closed since 1997) and we have a formula for distress among many frail older people. Their families are being squeezed out from services that should support them, while rising numbers of (mainly elderly) medical emergencies are being admitted to inappropriate hospital beds.

The chair of the Commission Dame Denise Platt told Public Finance magazine that "People who only five years ago qualified for council-arranged help are today excluded and left to fend for themselves".

Minister Ivan Lewis has promised a review of the eligibility criteria – which have themselves become a bit of a misnomer, since they primarily serve to determine who is NOT eligible to receive services.

But ministers seem primarily concerned to advance their own agenda of increasing the use of cash payments to individuals and their carers to purchase their own package of care.

This neatly lets social services and the NHS off the hook, leaving many families with no viable choices and vulnerable to substandard, largely unregulated private providers.

And even a thorough revision of the eligibility criteria could only solve the problem if it is accompanied by a substantial increase in the funding available to social services to provide or procure the care that is so desperately needed.

The premise of Brown's consultation appears to be that free social care is excluded in advance as an option: and many of the suggestions seem to revolve around means to persuade or press-gang elderly people into paying for their own care, in place of the "cradle to grave" philosophy of the 1948 NHS.

By contrast Counsel And Care has calculated that a levy of just 2.5% on every estate worth over £10,000 after death could finance free care for all. Which would you prefer?

## 1983-2008: 25 years of LHE

# Join with us to defend the NHS!


**THIS special issue of Health Emergency marks a double anniversary: the 60th year of the NHS – and, in the autumn, the 25th anniversary of London Health Emergency.**

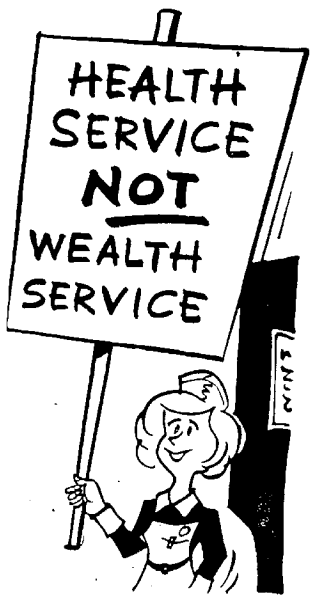
**We are delighted that so many trade union branches and local campaigners remain affiliated to LHE and that their combined affiliations and supporting adverts have made this 16-page special issue possible.**

**We have worked hard over the years to maintain a consistent and principled stand in defence of the NHS and its core values, and against cash-driven cuts and all forms of privatisation.**

**And while many organisations were happy to support us in this while the Tory government was seen as the main enemy, it has been harder to maintain momentum and support when the driving force for market-style policies has been the Labour government of Blair and Brown.**

**However we have remained firm in our approach, welcoming the positive moves such as the increased funding for the NHS, while criticising those policies which undermine patient care and staff morale and threaten to open up our most popular public service to private profiteers.**

**That's why much of the campaigning work of London Health Emergency in the last couple of years has centred on establishing a new broader campaign linking the issues of cuts and privatisation – Keep Our NHS Public.**




**That campaign launched in September 2005 and in more than 20 towns and cities local activists and campaigners have attempted to build local Keep Our NHS Public branches as broad-based campaigns that can stop and roll back the juggernaut of government policies. Meanwhile it is vital that we continue to resource LHE, which has provided key campaigning work and research skills to Keep Our NHS Public.**

**LHE has also stepped up its systematic work using the local and national press and media to ensure that the NHS remains high on the political agenda, and that journalists looking to cover health stories can always access a hard-hitting quote defending the principles of our NHS.**

**Solid support from many UNISON branches and regions and from Amicus/Unite and other health union branches has been the key to LHE's survival as a campaign for over 20 years since the GLC (which first funded us) was abolished.**

**We now receive NO grant funding from local government, or core support from any organisation – every pound we spend on campaigning has to be raised through commissioned work and from donations.**

**If you have not yet done so, please make sure your branch and region affiliates to LHE for 2008 – and where possible add a donation to help the campaigning work that cannot be funded any other way.**

**Affiliation is just £25 per year, with a lower rate of £15 for the smallest organisations and pensioners' groups.**

**Affiliates get copies of our campaign newspaper *Health Emergency,* which we produce as resources allow – and a discount rate on any LHE consultancy services, such as publicity and research work.**

## Affiliate now to Health Emergency!

London Health Emergency, launched in 1983, works with local campaigns and health union branches and regions all over England, Wales and Scotland.

The campaigning resources of ***Health Emergency*** depend upon affiliations and donations from organisations and individuals.

■ If you have not already done so, please affiliate your organisation for 2008: the annual fee is still the same as 1983 – £25 for larger organisations (over 500 members).

■ If you have affiliated, please consider a donation.

■ Affiliates receive bundles (35 copies) of each issue of ***Health Emergency*** and other mailings.

■ Additional copies of ***Health Emergency*** are available: bundles of 75 for £20 per year, and 150 for £40.

■ **Send to LHE at BCM London Health Emergency, London WC1N 3XX**

■ **You can call JOHN LISTER on 07774-264112.**

■ **or email *info@healthemergency.org.uk***

**PLEASE AFFILIATE our organisation to Health Emergency.**

I enclose £15 ❑ £25 ❑ £……

I also enclose £10 ❑ £20 ❑ for extra copies of the paper, and a donation of £…… Value of cheque £ ……

NAME .....

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ORGANISATION .....

Position held .....

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## Health Emergency publicity services

**We produce professional-looking tabloid branch and regional newspapers, and can also research and draft detailed responses to reconfiguration, cuts, closures and privatisation. For more details give John Lister a call on 07774 264112.**


Campaigns and information

London Health Emergency website

**www.healthemergency.org.uk**

Keep Our NHS Public

**www.keepournhspublic.com**

Published by London Health Emergency, BCM London Health Emergency, London WC1N 3XX . Printed by Scottish County Press Ltd, Bonnyrigg Midlothian EH19 3LW