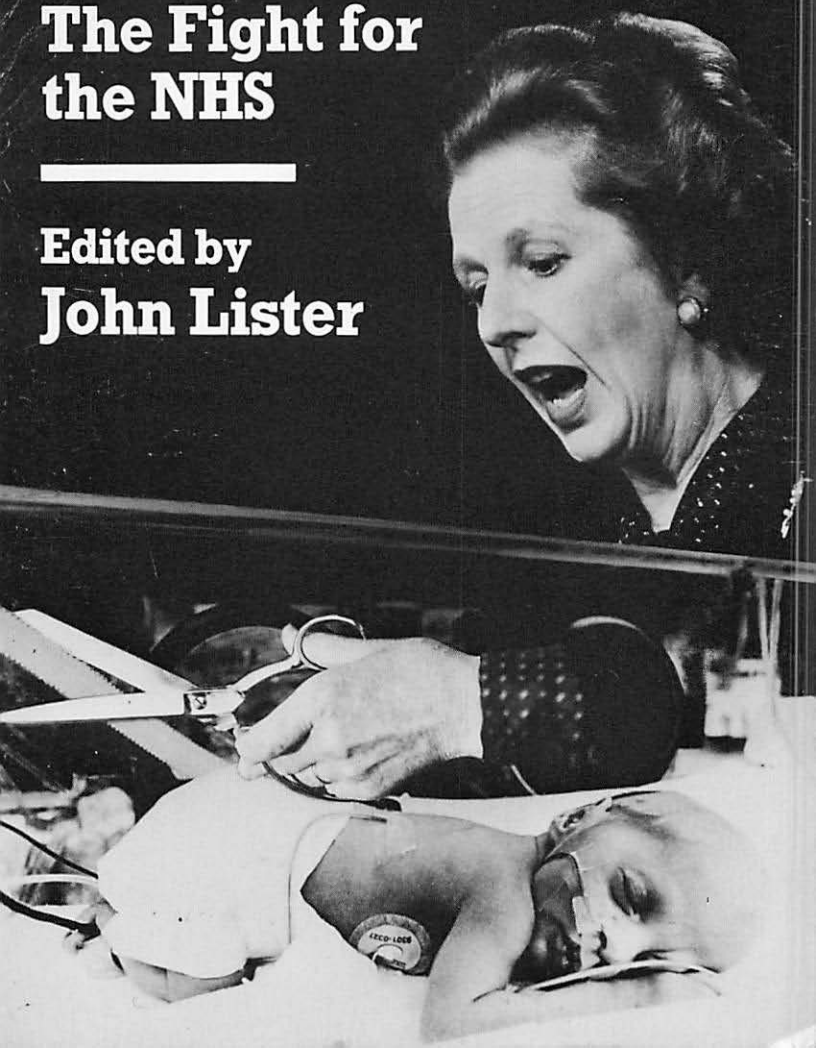
CUTTING the LIFELINE

The Fight for the NHS

Edited by
John Lister



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London Health Emergency

Foreword by Frank Dobson MP
Shadow Leader of the House of Commons

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Contents

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JRL April 2, 1988

Foreword

by Frank Dobson MP (Shadow Leader of the House of Commons)

Sweet fine old gal,
For worlds I wouldn't lose her,
She's a dear good old gal,
And that's what made me choose 'er
She's stuck with me through thick and thin,
When luck was out, when luck was in,
Ah! Wot a wife to me she's been,
An' wot a Pal!
We've been together for forty years,
An' it don't seem a day too much . . .
There ain't a lady livin' in the land
As I'd swap for my dear old Dutch.

My Old Dutch, by Albert Chevalier

The words of Albert Chevalier provide a fitting 40th anniversary theme for the National Health Service. For the NHS was a union of idealism and practicality, based on everyone in health making a pledge to help everyone in sickness. The target was to ensure that the best health services should be available to all and that money should no longer be the passport to better or quicker treatment. And it *worked*. It is actually *more* popular in practice than it was when it was just an idea.

The National Health Service brought great practical freedoms to patients. Freedom from pain and suffering; freedom from having to make sacrifices to pay for treatment; freedom from the fear of not being able to pay; freedom from the humiliation of relying on charity.

It also brought freedom to health workers: freedom

from having to spend time billing people; freedom from the embarrassment of trying to collect money from people who couldn't pay; freedom from having to assess what treatment a person could afford; freedom from the paperwork that goes with a pay-while-in pain health service.

For all its problems, the National Health Service remains immensely popular, remarkably cheap and far more efficient than any alternative. That, of course, is why Mrs Thatcher and her government dislike it so. It gives the lie to all the old golf-club bar myths to which the present Tory Party subscribes. As we applaud the 40th anniversary of the founding of the NHS, we should be considering what more needs to be done to enable our health service to respond to changing needs and social attitudes, to the opportunities provided by scientific and technical developments and by the desire to make the system more 'user friendly'. We also need to make it simply a better service to work in.

Instead we are threatened by an assault on the basic idea of the National Health Service. Proposals that were rejected as ridiculous, out-of-date or unfair at the time the health service was being thought out are being wrapped up in tinsel and peddled as something new. Most of the ideas being put forward are either American answers to problems we haven't got, or are grotesquely bureaucratic and expensive 'commercial' schemes, or are intended to make sure the better off can buy better and quicker treatment. They are trying to portray the NHS as a bold social experiment which went wrong. But it has only gone wrong from the point of view of those who *wanted* it to fail in the first place. In fact this experiment in democratic socialism has been an overwhelming success – cheap, efficient and popular.

Whilst we celebrate the first 40 years of the National Health Service, we must rededicate ourselves to the task of making sure it is not destroyed, and that we hand on to our children an even better service than the one our parents handed on to us.

Introduction
Health – a political issue

This book is not an academic study or a theoretical discussion on health care in general. In the 40th Anniversary year of the National Health Service, it looks at its origins, its strengths and weaknesses, from the standpoint of the fight to defend and extend the NHS today.

There has always been a need to struggle for the concept of a comprehensive health service: and that struggle has always been highly political, since the causes of ill-health are primarily social conditions rather than individual misfortune. Any serious health policy has always required a two-pronged approach – combining steps to improve living standards, eliminate poverty, poor housing, occupational hazards and other preventable dangers to health, with provision of a back-up personal 'repair service' for those who do fall ill. Conspicuously it is the first, preventative, 'public health' measures which always prove the most controversial, since they involve implicit recognition that health is not only political, but a class issue.

Perhaps the only contribution to health issues made by Margaret Thatcher and her government has been to bring the NHS firmly back into the political arena after almost 40 years of phony 'consensus'.

Her approach echoes that of Winston Churchill's Tory Party, which waged a hysterical campaign in opposition to the establishment of the National Health Service in 1946-48. Ignoring the huge popular support for Labour's National Health Service Bill, Conservative MPs obediently trooped through the lobbies to vote against it at its Second and Third readings, and again voted against its

implementation as late as February 1948.

Since then we have seen many governments give inadequate attention or resources to the NHS. We have seen others – through policy decisions or under the impact of economic pressures – make cuts in health spending. But only now, 40 years after the NHS was founded, do we see a Tory government, led in the Churchillian style, hell-bent on undermining, breaking up and eventually destroying the NHS as a comprehensive, tax-funded service free to all at time of use.

Applying the motto of 'don't get sore, get even', Thatcher has set out to avenge the Tory defeat in 1946, and roll back the clock to the pre-NHS two-tier system of private medicine for those with money, and a rock-bottom charity and state system for those without.

There have always been weaknesses in the NHS. It began with minimal resources, but it was set the impossible mission of eliminating sickness in a society where a myriad reflections of class divisions have constantly generated and replenished a reservoir of ill-health. However the hostility towards the NHS from the hard-line Tory right has always been hostility to its *strengths*. They have always rejected its socialist aspirations, especially the fact that from day one of the NHS, the treatment received was to be not on the basis of ability to pay, but on the medical need of the patient, rich or poor.

The NHS, functioning within the capitalist framework, shared many of the contradictions of the post-war nationalised industries – coal, rail and other utilities: like them it represented social ownership but not social control. The NHS, too, took over a haphazard collection of assets, neglected to the point of virtual collapse by the old owners and in dire need of investment. Like the nationalised industries, the NHS kept much of the old management intact, and attempted to run as an island of social responsibility and planning in an anarchic, profit-seeking capitalist economy. For 40 years the NHS has been shamelessly milked for profits by private drug monopolies, suppliers and contractors, starved of investment to modernise, and is now even being stripped of its assets as

land and buildings are flogged off to make ends meet.

Unlike other nationalised industries, the NHS began by *eliminating all charges*. While customers still retained a commercial, cash relationship with British Railways or the Coal Board, the NHS was funded from taxation (which in theory fell most heavily on the wealthy), and offered patients as much treatment as they needed, without fee. Thatcherism, as today's radical Toryism, despises this, and detests the very notion of collective provision for the sick, the disabled and the elderly, which it sees as examples of the 'socialism' Thatcher herself has pledged to eradicate. She now openly argues that 'there is no such thing as society' – only individuals and their families.

To destroy this best-loved and most widely used of all the public services, she has had to undermine confidence in the system which many believed represented a post-war all-party consensus. This has meant attacking a health service which by any international standard is highly efficient, its low-paid but dedicated staff delivering superb value for the grossly inadequate share of national wealth invested in it. It is one of the ironies of the Thatcher offensive against the NHS that it is having the most savage effect on the most efficient hospitals – those that have best suceeded in maximising the use of hospital beds and focussing their resources on patient care. The calls from NHS management around the country for doctors to *reduce* their caseload and perform *less* operations to save money spells out the cranky logic of the radical right, which knows it must first break up the existing popular system before anyone will seriously contemplate their wildly unpopular 'alternative'.

In response to opinion polls showing huge support for a transfusion of new cash to the NHS, Thatcher has offered only traumatic amputations and unwanted injections of right wing Tory ideology. While the NHS suffers a haemorrhage of nurses and other under-paid staff, the Thatcher government provides only a further tax tonic to the rich. When doctors indignantly expressed a second opinion, and joined the outcry, Thatcher hit back with a secretive top-level 'review', threatening to do to the NHS what this

government has already done to the steel and mining industries – or, as Thatcher warned on television:

> Just as we considered education, just as we considered a community charge, just as we considered what to do with housing, we are now considering the Health Service. And when we're ready – and it'll be far quicker, I believe, than any Royal Commission – we shall come forward with our proposals for consultation. And should they meet with what people want, then translate them into legislation.
>
> (Speaking on *Panorama*, BBC1, 25.1.88)

Thatcher's team of NHS Ministers – Moore, Newton and Currie – has apparently been selected with the sole intention of insulting and infuriating health workers and patients. Not having put any of their new 'radical' plans to the electorate last June, they know they have no mandate and no popular support for any of their potentially far-reaching 'solutions' to the NHS crisis. Unfortunately they have an impregnable Parliamentary majority: despite occasional back-bench whingeing, most Tory MPs are so clearly out of step with the views of even Tory voters (over 80% of whom favour more government spending on the NHS).

This means that only by the most massive campaign of resistance, linking health workers with other unions and the wider public at local and national level, can we hope to prevent major damage being inflicted on the very fabric of the NHS before the next General Election. This book is intended to assist and encourage health workers, patients and others embarking on such campaigns at local and national level.

1 *The road to the NHS*

Victorian values, Dickensian conditions

As the savage and unpopular new social security 'reforms' confirm, the affection of Margaret Thatcher and the Tory right for 'Victorian Values' is no pretence. They are genuinely attracted to the hypocritical, prudish morality, the austere 'self-help'-and-workhouse mentality, and the arrogant imperialist attitudes of nineteenth century capitalism. But a look at the conditions of life for the working class in those unbridled times serves as a stark warning of the possible consequences for millions of people if the government succeeds in turning back the clock of progress, further widening the class divide, and demolishing the gains of the welfare state.

The 'golden age' of unfettered capitalist expansion and industrialisation meant years of untrammelled misery for the urban working class, bringing chronic ill-health on a scale worse than in many parts of today's so-called 'Third World'. In the runaway pace and cut-throat competition of the Industrial Revolution few employers had the slightest concern for the care and maintenance of the key component of their productive process – the workforce whose sweated labour provided the source of profit. Like machines, they were worked to capacity and discarded without thought when worked out. Soaring death rates from 1816 onwards, raging epidemics, and the appalling physical condition of millions of Britons were largely ignored by the ruling classes. Only a relative handful of more far-sighted capitalists recognised the necessity for

some form of restrictive legislation – the various Factory Acts and protective laws from the 1830s onwards – to curb the length of the working day, gradually raise the age of child labour, and create conditions in which the work-force could maintain and renew itself.

The same period, in the aftermath of political agitation for the first Reform Bill and a huge cholera epidemic of 1831-32, saw the first steps towards state health provision when the Poor Law Amendment Act called on parish workhouses to set up sick wards where inmates could be kept when they fell ill. These wards quickly filled up with the sick and invalid poor, and by 1848 were full to capacity. The conditions in which they had to function is described by Friedrich Engels in his documented account *The Condition of the Working Class in England* (1844):

> When one remembers under what conditions the working people live, when one thinks how crowded their dwellings are, how every nook and corner swarms with human beings, how sick and well sleep in the same room, in the same bed, the only wonder is that a contagious disease like this (typhus) fever does not spread yet farther. And when one reflects how little medical assistance the sick have at command, how many are without any medical advice whatsoever, and ignorant of the most ordinary precautionary measures, the mortality seems actually small.
>
> Dr Alison, who has made a careful study of this disease, attributes it directly to the want and the wretched condition of the poor . . . He asserts that privations and the insufficient satisfaction of vital needs are what prepare the frame for contagion and make the epidemic wide-spread and terrible. He proves that a period of privation, a commercial crisis or a bad harvest, has each time produced the typhus epidemic in Ireland as in Scotland, and that the fury of the plague has fallen almost exclusively on the working class.

The class divide

Official reports confirmed that while the employers and

aristocracy drew comfortable incomes from the toil of others, the new fast-growing British industrial towns were a far cry from the prim, cosy image of Victorian prosperity cultivated by today's 'radical right'. Even malaria was endemic as mosquitos thrived on stagnant pools of water and sewage in the ill-drained streets and alleys built by grasping capitalism.

The death toll was horrendous. The report on the Sanitary Condition of the Working Class found that in Liverpool in 1840 the average life expectancy of the upper classes was only 35, of the middle business classes only 22, and of the manual working class a mere 15 years. These figures reflect enormous infant mortality rates, which show a similar class bias. 20% of upper class children died before their fifth birthday, compared to 32% of middle class children: but almost *three fifths* – 57% – of working class children died before five years of age.

The death rates arose from poverty: but the lack of medical care or treatment compounded the problems and intensified the suffering for those who survived as well as those who died, as Engels pointed out:

> Another source of physical mischief to the working class lies in the impossibility of employing skilled physicians in cases of illness. It is true that a number of charitable institutions strive to supply this want, that the infirmary in Manchester, for instance, receives or gives advice and medicine to 22,000 patients annually. But what is that in a city in which, according to Gaskell's calculation, three fourths of the population need medical aid every year? English doctors charge high fees and working men are not in a position to pay them. They can therefore do nothing, or are compelled to call in cheap charlatans, and use quack remedies, which do more harm than good.

By 1861 hospitals and wards had expanded to provide 11,000 hospital beds and 55,000 workhouse beds. In 1867 local authorities were compelled by law to provide institutional care for the insane and for sufferers from TB, smallpox, and fevers.

This treatment of disease ignored the deeper health problems afflicting the working class: in the 1870s, studies showed that a sample of 11 to 12-year-old boys from public schools were on average *five inches* taller than working class boys the same age – and that a height difference of at least three inches remained through to adulthood. As one observer later commented:

> In the Manchester district 11,000 men offered themselves for war service between the outbreak of hostilities in October 1899 and July 1900. Of this number 8,000 were found to be physically unfit to carry a rifle and stand the fatigues of discipline. Of the 3,000 who were accepted only 1,200 attained the moderate standard of muscular power and chest measurement required by the military authorities. In other words, two out of every three men willing to bear arms in the Manchester district are virtually invalids. (Arnold White, *Efficiency and Empire*)

In 1917, when the army was again looking for recruits, less than a third of the volunteers were in satisfactory health, 10% were deemed totally unfit, 22% suffered from 'partial disabilities' and 41.5% from 'marked disabilities'.

Despite the ill-health forced upon the working class by poverty and poor living conditions, medical science had actually begun to make considerable advances, offering new ways to reduce suffering. Anaesthetics, antiseptic techniques, and with them more advanced surgery, including operations on the brain, chest and abdomen made great strides forward after 1870. By 1917 army surgeons were pioneering blood transfusions and patching up a wide variety of terribly wounded casualties. As early as 1913 immunisation had become possible against diphtheria – though the absence of any agency to carry it out meant that it took another 27 years to introduce this simple preventive measure: 3,000 children a year continued to die needlessly of diphtheria.

The Liberal answer: National Health Insurance

The working class had developed its own version of the

Victorian 'self-help' ideology, by making its own collective arrangements for some form of health care. The (largely male, craft-based) trade unions in the 1860s and 1870s had established limited flat rate insurance and mutual benefit schemes to finance medical cover, (mostly restricted to GP services), for their members – but not for wives, children or other dependants. Unions also organised for and assisted fund-raising appeals to build local hospitals. However, the final decades of the century brought a new, rapid growth of unionisation among unskilled and semi-skilled manual workers with the rise of the great general unions and big strikes by dockers, transport workers, gas workers and others previously ignored by the craft unions. Women, too, were among the new layers of downtrodden fighting for a voice. The militant struggles helped expose the anti-union, capitalist politics of the Liberal Party which had until then enjoyed a virtual political monopoly over the emerging trade union movement. This in turn led in the early 1900s to the first timid steps by frightened union leaders towards a break from the Liberals and the formation of a Labour Party to represent the unions in Parliament.

One of the differences between the radical 'new unionism' and the more conservative craft unions was the recognition that low- paid workers could not afford dues large enough to finance the kind of insurance and benefit schemes established by their skilled counterparts.

Demands for some form of universal state medical insurance began to arise from the growing workers movement. At the same time the British Medical Association – many of whose GP members were relatively poorly paid – began to lobby for a system of health insurance. In 1911 Lloyd George introduced the National Health Insurance Act, which instituted compulsory medical insurance for lower-paid workers (earning less than £2 per week) and sections of the middle class. The newly-created 'Panel System' was to last (extended and modified) until 1948; it entitled those employed who paid their weekly stamp to free medical care from GPs, free prescriptions funded by the state, free treatment for TB, and sickness benefits.

By 1913, 15 million workers were covered by the scheme – just one third of the population: though workers were to remain insured even after retirement, their unemployed dependants were not covered. There was no provision for childbirth or for children: and hospital treatment was excluded from the scheme. Though the BMA tried unsuccessfully to oppose aspects of the new scheme, many doctors did very nicely from it. They were able to pick up almost double the fees per patient they had received from the unions and mutual benefit societies under the 'club' system, and many gained an expanded list of patients.

The friendly societies, unions and insurance companies continued to collect subscriptions as part of the National Health Insurance scheme, which was administered by a lumbering Insurance Committee including representatives from the old systems. In effect the state took responsibility for and extended the existing network, rather than introducing any radical new changes.

At the end of the war came a new Ministry of Health: but its role and power was strictly limited. More ambitious plans and proposals were devised but quietly dropped.

The 1930s began with new means tests for dole payments – heaping humiliation upon misery for the millions unemployed – and they ended in the horrors of a new war. Poverty, hunger, slum housing and the countless agonies of deprivation took their physical and mental toll on a generation of youth, on adults and the elderly, with little respite offered by the rudimentary health services. There was a rise in preventable deaths in childbirth, and a savage loss of children's lives, including 2,000 each year from whooping cough. In 1937, only 12% of 1,638 children examined in County Durham were free from rickets. Between 30,000 and 40,000 young adults a year died of TB, especially among the working class. The health divide was clearly still a class divide: in 1935, 42 infants per thousand died in the relatively prosperous South East, compared to over double that figure (92) in Sunderland and almost three times as many (114) in Jarrow. Comparable figures for Glamorgan were 63 and Scotland 77.

An independent Report on the British Health Services in

1937 appealed to the wallets of the employers when it underlined the economic costs of appalling ill-health – over 30 million working weeks lost each year through illness, even at a time when to take days off sick could mean instant dismissal. It again exposed the class divide: ill-health fell most heavily upon low-income families (TB was twice as prevalent among the poor as in the more prosperous classes).

The outbreak of the Second World War brought a shake-up in the ramshackle hospital system, and the establishment of the Emergency Medical Service. The Minister of Health took powers over the local authority hospitals and the increasingly debt-ridden voluntary hospitals. A national immunisation campaign was launched in 1940 which helped virtually eradicate diphtheria; bed capacity was expanded by 50%.

The Beveridge proposals

Even the Tory Party began to turn towards some form of state-funded service to placate those pressing for reform. The 1942 Beveridge Report began from the assumption that a comprehensive health care system – available to anyone, at home or in hospital – was needed. The government in 1943 declared it accepted the need for a comprehensive health scheme – but its two plans ran into insuperable problems. The landslide Labour election victory of 1945, brought a new Health Minister, Aneurin Bevan, to take on the task of piloting a new National Health Service Bill through Parliament.

Bevan's novel solution was to nationalise all of the hospitals, establishing a structure of 14 Regional Hospital Boards, overseeing local Hospital Management Committees. The nationalisation was immediately and stridently opposed by the Tories. Former Health Minister Willink complained that:

> This fancy of the Minister, this idiosyncrasy of the Minister – because no one ever thought of it before him – will destroy so much in this country that we value.

Forty years on, elements of the Tory party have still not accepted the nationalisation of the hospitals: indeed Norman Tebbit began 1988 by combining his attack on low-paid nurses 'moonlighting' with a much more fundamental challenge:

> Is the present structure of a nationalised hospital service the best way of getting the best and the most patient care out of each pound we spend? Could more provisions be privatised?
>
> (*Guardian*, 16.1.88)

Labour's answer: the NHS

> I believe it is repugnant to a civilised community for hospitals to have to rely upon private charity. I believe we ought to have left hospital flag days behind. I have always felt a shudder of repulsion when I have seen nurses and sisters who ought to be at their work, and students who ought to be at their work, going about the streets collecting money for the hospitals.
>
> (Aneurin Bevan, *Hansard* April 30, 1946)

So little consensus was there between Tory opponents and Labour supporters of the National Health Service Bill in 1946 that even Bevan's elementary statement of commitment to adequate tax funding for the service was seized upon and attacked by Conservative leaders.

The Tory amendment to the Bill singled out for criticism the fact that it

> gravely menaces all charitable foundations by diverting to purposes other than those intended by the donors the trust funds of the voluntary hospitals.

Staunch defence of the prerogative of the wealthy to dictate the shape of local health services by donating (or not) to hospital developments proved a mainstay of the Tory counter-attack. Their amendment to the Third Reading of the Bill again claimed that it 'discouraged voluntary effort and association ... ' and 'appropriates trust funds and benefactions in contempt of the wishes of donors and

subscribers.' Bevan was accused of wantonly 'wrecking' the voluntary hospital system. He retorted that:

> The only voluntary part of the hospital service destroyed by the Bill is the necessity to sell flags and to collect money. Honourable Members opposite, as they represent the party of property, always imagine that the only voluntary act which has any sanctity behind it is the writing of a cheque.

In today's NHS crisis, 40 years on, the proliferation of fund-raising appeals to bail out hospital development programmes or even sustain vital cancer wards is once again a focal point of contention. The Tories may have been roundly defeated on the issue in 1946, but they are now coming back to wreak vengeance.

Whipping up the doctors

Other aspects of the Tory attack on the Bill were also to have lasting repercussions. Bevan was angrily (and falsely) accused of preparing the way for a full-time salaried service for the medical profession, which was seen as anathema by the well-to-do reactionaries of the BMA. In reality, despite the fact that a salaried service was Labour Party policy and a long-held dream of the Socialist Medical Association, Bevan never attempted to establish it. His early, prickly meetings with the BMA had persuaded him to drop any suggestion of a salaried service for GPs; instead he sought a compromise formula in which they would remain 'independent contractors' receiving a basic salary topped up by capitation fees.

However, his nationalisation of the hospitals certainly did open the door for an expansion in salaried posts for hospital doctors. In part this was designed to persuade them to take up posts in hospitals outside the traditional centres of medical excellence which otherwise would have found it almost impossible to attract consultants (of over 3,000 voluntary and municipal hospitals in 1946, half had less than 50 beds, and only 350 had over 200 beds. Of 30 teaching hospitals, 13 were in London, 7 in England, 9 in Scotland and one in Wales).

Bevan's moves to end the buying and selling of GP practices were accompanied by the welcome sweetener of a generous £66m compensation, which had been agreed in discussions with the profession. He also allowed room in NHS hospitals for both private practice and also private beds. These issues have proven a bone of contention ever since.

The BMA team had always regarded the Welsh socialist with fear and suspicion. 'We might have been going to meet Adolf Hitler . . . We were quite surprised to discover he talked English,' Dr Roland Cockshut, one of the BMA delegation later told Bevan's biographer Michael Foot. Egged on by the Tory press and Tory politicians, the BMA leadership began stridently to denounce the Bill:

> I have examined the Bill and it looks to me uncommonly like the first step, and a big one, towards National Socialism as practised in Germany. The medical service there was early put under the dictatorship of a 'Medical Fuehrer'. This Bill will establish the Minister of Health in that capacity.

So wrote Dr Alfred Cox in the *British Medical Journal*. In fact the bedrock of the opposition centred on the status of GPs. Bevan's plans for the hospitals were widely recognised as offering increased opportunities for consultants and a new career structure (indeed the numbers of hospital doctors have increased three-fold since 1948).

Cynical Tory leaders stoked the flames, and the BMA was encouraged to engage in a desperate exercise in brinkmanship; in July 1946, even while the Third Reading of the Bill was overcoming Tory opposition in Parliament, the BMA voted to break off negotiations on the new service.

By then, some hospital doctors, including some of the Royal Colleges, and other influential forces were beginning to swing in favour of the Bill. A majority of medical students proclaimed themselves willing to work in the new service and approved the new basic salary – especially after Bevan announced a new salary and fee scale higher than any pre-war rate paid to doctors.

None of this could shift the obdurate opposition of reactionary BMA leaders, who stuck firm, demanding that basic elements of the legislation be revised, including 'the state ownership of hospitals, the embargo on the buying and selling of practices, all direction of general practitioners, and the salary element in general practitioners' remunerations.' In January 1948 the BMA held a plebiscite on the new Act – which showed a 9-1 majority against it, including over 17,000 GPs.

Bevan remained adamant that the new service would start as decided – in July 1948. He predicted that most doctors would participate and that almost the whole population would quickly enrol. He arranged for a further parliamentary debate on February 9 to endorse the Act – where once again the Tory Party voted against it. Bevan spelled out the situation:

> These negotiations have been a long series of concessions from us, and not one from the medical profession – not a single one. Indeed, one member of the Negotiating Committee boasted that during these negotiations they had not yielded a single inch.
>
> Consider what we have done. Consider the long record of concessions we have made. First of all, in the hospital services we have accorded paid bed blocks to specialists, where they are able to charge private fees. We have accorded, in addition to those fees for those beds which will have a ceiling, a limited number of beds in the hospitals where there is no ceiling at all. I agree at once that these are very serious things, and that, unless properly controlled, we can have a two-tier system in which it will be thought that members of the general public will be having worse treatment than those who are able to pay. That is a very grave danger, and it is a very serious and substantial concession made to the medical profession. We have also conceded that general practitioners and specialists can have private patients. That was repugnant to many of my honourable Friends. They hated it, because they said at once that we can have, if we are not careful, a revival of the old Poor Law system, under which the man who does not pay does not get the same

> treatment as the man who does.
>
> This kind of propaganda contains the possibility of developing that atmosphere. I would warn honourable Members opposite that it is not only the British working class, the lower income groups, which stands to benefit by a free health service. Consider very seriously the tradition of the professional classes. Consider the social class which is called the 'middle class'. Their entrance into the scheme, and their having a free doctor and a free hospital service, is emancipation for many of them. There is nothing that destroys the family budget of the professional worker more than heavy hospital bills and doctors' bills. There is no doubt about that at all, and if honourable Members do not know it, they are really living in another world.
>
> I know of middle class families who are mortgaging their future and their children's future because of heavy surgeons' bills and doctors' bills. Therefore it is absolutely vital, not only for the physical good health of the community, but in the interests of all social groups, that they should all be put in the system on 5 July and that there should not be some in and some out of the scheme.

The points about the middle class were to be proven ironically accurate in a way not intended by Bevan: the Black Report of 1980 revealed the extent to which the middle classes rather than the working class had reaped the benefits of the NHS – widening the health divide.

Bevan's stand, however, had overwhelming public support, with a Gallup poll showing 69% in favour of the planned National Health Service and only 13% against. Having isolated the BMA and Tory opposition, he moved in April to divide the doctors by offering a new package of concessions in the form of new amendments to the Act. He announced he would legislate to *forbid* a full-time salaried service for GPs, and offer GPs the chance to opt out of the £300 basic salary if they chose after 3 years. He had taken enough steam out of the BMA campaign, and though almost 26,000 doctors still voted against the Act in May 1948, by the end of that month many were signing up to

work for the NHS, with 26% of English GPs, 37% of Welsh GPs and 36% of Scottish GPs already in.

The NHS wins huge support

The launch of the NHS saw 75% of the population on the list. By September 1948 this had reached 93% (39.5 million people) and soon after the figure hit 97% (41.2 million).

18,000 GPs had signed up, and wrote 187 million prescriptions in the first year; 8.5 million patients received dental treatment, and 5.25 million were prescribed spectacles. The new service immediately came under a huge strain as it grappled with a vast backlog of unmet need for medical attention.

In its first year the NHS cost £402m compared to an estmated £180m. Ophthalmic services cost *22 times* the expected £1m budget, while dental services cost £34m compared to a provisional estimate of £10m.

For millions of women, for children, for the unemployed and the elderly and disabled, the forgotten people of previous schemes over the decades, the new system which required no means test, no weekly stamp, no qualifying period, and no prior enrolment on a 'panel', offered for the first time a remedy for ailments and discomfort. Hand in hand with other significant improvements in living standards – the biggest of which was a decline in unemployment – the new National Health Service helped bring dramatic falls in infant mortality and deaths in childbirth.

Women also had good reason to celebrate a system which at last allowed them to solve long-standing health problems. As Welsh GP Julian Tudor Hart put it:

> A huge backlog of gynaecological surgery was shifted in the 1950s, the accumulated discomfort and misery of the neglected pre-war generations of working class mothers.

2 *NHS growing pains: 1948-1979*

Problems from birth

The new National Health Service has always been enormously popular and was a historic stride forward. But it fell far short of the ambitions of many socialists, and began life dogged with debilitating weaknesses. It was unplanned, uncentralised, undemocratic and under-resourced. Dominated by doctors, and increasingly by the hospital services, its priorities emphasised intervention rather than prevention, and acute care rather than the chronically ill. From the outset the less glamorous fields of mental health, mental handicap and geriatrics were marginalised and community services – most of which were still run by local authorities – were steadily downgraded.

Bevan's early concessions to the doctors had led to a continual parasitic involvement of private practice, enabling private medicine to re-emerge from almost total eclipse in 1948 to mount a fresh expansion in the 1970s and 1980s. The elitism and male domination of the medical profession left its mark on the pattern of services, which saw a vast army of low-paid mainly women workers (including ever more black workers) under the management of white men, while especially low priority has always been attached to preventive measures affecting women.

From the outset the new structures minimised the possibilities of radical change. Bevan's argument had been that since the NHS was to be centrally funded, he as minister had to be answerable in Parliament for local policy; and

therefore the regional and local bodies should be appointed rather than elected, and responsible to him. In part his policy also reflected pressure from the BMA, who feared any element of control by local authorities (or anyone other than fellow doctors). He was also keen to enforce national standards and control spending. Unfortunately the new mechanism did nothing to raise standards, while spending remained pitifully inadequate.

Bevan's view was contested within the cabinet by Herbert Morrison, who argued for handing control to local government, arguing with grim prophesy that the new boards would be 'mere creatures of the Ministry of Health, with little vitality of their own.' The only way they could be given vitality would be if they were 'left free to spend Exchequer money without the Minister's approval and to pursue policies which at any rate in detail may not be the Minister's, but for which he would presumably be answerable.'

Bevan himself had scathingly exposed the myth of 'local responsibility' in the old voluntary hospitals – whose boards of governors ('a patchwork quilt of local paternalism') were neither elected nor accountable to anyone but themselves. Yet many of the nominees on the new NHS Boards were simply switching from the old bodies to the new. Forty years' miserable experience of various appointed structures within the NHS, and vain efforts of campaigners to raise local problems with Ministers through the Commons machinery have not shown any real sign of accountability.

A ramshackle network

The new Boards and Committees were not only inaccessible and undemocratic, but they inherited a network of hospitals and GP surgeries that had grown up in almost completely anarchic fashion before the war. Out of almost 3,500 voluntary and local authority hospitals, comprising 150,000 beds, almost half were over 50 years old, and 20% were built before 1861. 80% of GP surgeries in working class areas and 50% of those in middle class areas were 50

years old or more. Many of the buildings were in a shocking state of neglect.

Even if there had been a plan – which there wasn't – there were no resources provided, especially by the subsequent Tory government, to fill the gaps by building new hospitals. The 1950s were to see the slowest growth in hospital building for over 100 years. Only 40 health centres were to be built in the first 20 years of the NHS – and only one new general hospital before the 1960s.

The 14 new Regional Health Boards each centred on a university with a medical school. London was carved into four regions, each reaching far out to the midlands and the coast. Teaching hospitals however were separately administered by Boards of Governors, while other hospitals or groups of hospitals were run by 388 Hospital Management Committees. From the start this divided the hospital service into rival interest groups.

To make matters more clumsy, community services were under a completely separate chain of command through local health authorities. This hived off maternal and child welfare, health visiting, home nursing, vaccination and immunisation, mental illness, and mental handicap. Local authorities were also responsible for ambulance services. This early obstacle to an integrated health service, and the 'second class status' of the community services have never been overcome, leaving them the least resourced and first victims of every cutback.

The third independent wing of the service was the Family Practitioner Service, staffed by an army of GP 'contractors', and directed by their own Executive Councils.

Under-resourced

Each section of the NHS was responsible to the Ministry, but none to the local electorate and consumers of the service, or in any way to health workers other than the senior doctors who were included in the appointed committees.

The new system took over the patterns of provision and the dictatorial control by doctors that had preserved such

deep class divisions in health: indeed these divisions actually widened. The more affluent and self-confident middle classes most readily took advantage of the new system, while an increasing layer of low-paid impoverished working class families often missed out on their new entitlement to treatment even while their health was eroded by poor housing, and inadequate state benefits.

The immediate pressure on NHS resources and the narrow 'curative' bias of the doctors discouraged any serious scientific investigation into the actual level of need for services, or wider preventive measures that could begin to *reduce* that level of need.

The NHS has ever since reeled under unexpectedly heavy demand for treatment, with its resources expanding only retrospectively, depending on waiting lists as the (rather unreliable) indicator of adequate resources. Even in its first year of operation, cuts were made in hospital budgets as the service groaned under the strain of coping with patients emerging from silent unknown suffering to seek the care they had longed for.

Another early weakness was that the Act left a loophole for patients to be charged for some aspects of the service. Bevan himself resigned from the cabinet when the Labour government took advantage of this to introduce charges for spectacles and teeth in 1951. The Tories were even more ready to wade in, slapping on a prescription charge of a shilling (5p) a form to raise £20m a year from the sick. Five years later this was bumped up to a shilling an item, and in 1961 this was doubled to two shillings (10p). The Wilson government of 1964 scrapped this charge – only to reintroduce it in 1968.

The bias of the new NHS towards cure rather than prevention was compounded by the entrenched division in management and planning between the community services, GP services and hospitals. Even the administrative boundaries of each sector was different, as was the source of funding.

The power of the doctors in the new health service was reinforced by the concessions made by Bevan. Doctors could nominate representatives to all the governing and

advisory bodies, and use their influence on them to ensure that no more lowly ranks of health workers got any look-in on decision-making. Their veto on the salaried service led on to the introduction of the secretive, elitist and extremely costly system of Merit Awards for the inner-circle of consultants. This has been shown to discriminate strongly against women and black consultants. Yet in 1950 an SMA article calculated that a switch from part-time to full-time salaried contracts for consultants would have saved £12m a year.

However, the most jealously guarded 'professional' privilege was the 'right to moonlight' – the continuation of private practice, including pay beds in the main NHS hospitals. The concentration of research work in the big hospitals, and the new – if inadequate – availablity of funds and equipment for innovative work helped foster a new and more influential layer of senior consultants. Their development of new techniques in high technology medicine have shaped many hospital services in the last two decades, if anything worsening the neglect of the chronically ill and disabled in favour of ever-greater attention to high-profile 'life saving' acute services. The share of expenditure taken by the hospital sector rose consistently from the 1950s to the 1980s, when cash limits reined it back compared to the demand-led Family Practitioner Service.

Tory policies stunt NHS growth

From 1951 a 13-year period of Tory rule began with stagnation in health spending. The Tories had 'accepted' the NHS only grudgingly, and were determined to spend as little as possible: but they recognised its popularity and tried to dress up their minimal increases in funding to look much larger, using massaged and one-sided statistics. A report published in 1956 debunked these, showing that in a growing economy the NHS had actually received a *declining* share of the Gross National Product (reduced from 3.75% in 1949 to 3.25% in 1953-4), and that spending in real terms had only gone up by £11m in the five years

1949-54. The report, which had been commissioned by the government in 1953 in the hopes of showing the NHS to be costly and bureaucratic, instead pronounced it cost-effective.

The war had brought a new impetus to medical techniques, and new potent drugs had been tried and proven. Half the NHS drugs budget in the 1950s was accounted for by new sulphonamides and antibiotics, while tranquilisers were becoming more widely used. There were new drugs available for diabetes and high blood pressure, and the end of the 1950s saw further development in chemotherapy and radiotherapy for cancer treatment and drugs to relieve the mentally ill. There were new surgical methods, too, and in the 1960s kidney dialysis became available. There were new breakthroughs in pathology testing, diagnostic X-ray techniques and the care of premature babies.

Any dynamic system of health care is going to generate pressure to expand as it widens its expertise and creates new chances to heal and to cure. While some of the new techniques have proved expensive to research and to carry out, other modern techniques have helped *reduce* costs. Patients now recover much more quickly after modern operations, some of which have been reduced to day cases; and the use of new instruments, drugs, lasers and lithotripters have simplified much previously complex surgery, also reducing the duration of a patient's stay in hospital – and thus saving money.

Preventive medicine has made advances too, though limited by the abysmally low level of resources available to it. Despite the Tory rhetoric warning of the 'bottomless pit' of NHS spending because more people are being kept alive, most lives are being prolonged not by transplants or other trendy hi-tech 'frontier medicine', but by the beneficial effects of improved living standards: at any given time, the numbers needing treatment are finite and manageable – given a political will to devote resources to health.

New buildings at a cost

It was not until 1962 that Tory health minister Enoch

Powell unveiled *A Hospital Plan for England and Wales*, which spelled out proposals for new hospital building to meet the growing needs of the NHS. Powell's plan was backed up by a long-overdue programme of capital investment in hospital building, which peaked at £393m in 1972 before the Heath government and economic crisis slammed on the brakes.

The plan aimed to utilise this new money to build 90 new hospitals and modernise others, and at the same time increase 'efficiency' by reducing overall numbers of beds for most categories of patients. The reductions included a 15% cut in target acute bed provision (from 3.9 per thousand to 3.3) and a huge 45% cut in mental health beds (from 3.3 to 1.8 per thousand). As usual these cuts in targets were divorced from any new resources or facilities for care in the community. Only maternity beds were to be increased, following a critical report on maternity services in 1959.

The need for new buildings arose not only from the appalling condition of the ageing hospital stock, but also from the need to distribute beds in more rational fashion in line with the growth in population. However, the building programme had barely begun before it was scaled down in the mid 1960s. There were also a succession of planning fiascos, including the Royal Free Hospital tower block which opened in 1973 at a cost of £20m before anyone realised that the plans had not included a morgue! Worse, the whole building was widely seen as out of date before it was opened; and continual rundown of maintenance quickly caused problems. By 1981 a *Times Health Supplement* investigation showed many of the newer hospitals already in need of repair. The Royal Free and Charing Cross Hospitals were both to feature in kitchen hygiene scandals by the mid 1980s.

Later designs focussed more on phased developments, which sound more sensible but leave endless scope for later cancellation of whole phases according to financial pressures. Only six new hospitals were built between 1955 and 1965: between 1966 and 1975 another 71 were started, and some completed. But from the mid 1970s the onset of

economic crisis had begun to restrict new building.

1959 had also seen a new Mental Health Act which reduced the grounds for compulsory admission to psychiatric hospitals. Attention was increasingly on the possibility of using the new generation of psychotropic drugs to treat mental illness 'in the community'. In 1961 Powell had predicted that half the psychiatric hospitals would close in ten years. However this process was not to go so fast or so smoothly: though the influx of new long stay patients was reduced, the mentally ill suffered perhaps the most of any group from the separation between NHS community services, local government social services and the hospital sector. The conservative self-interest of the psychiatrists who wanted to keep patients in hospitals was more easily overcome than the lack of any developed local services to support discharged patients – a problem which has intensified as 'community care' plans have developed in the 1970s and (worsened by cash limits and ratecapping) in the 1980s.

GP services developed in their own freewheeling way; despite the fact that theirs is the most used section of the NHS (81% of all NHS patients are dealt with wholly by GPs, compared to only 3% admitted to hospitals) nobody was in a position to control the ways in which these 'independent contractors' performed their work. GPs had in many cases jealously guarded their individualistic methods of work, while local authorities had had neither the cash nor the resolve to build new health centres. By 1979, 15% of GPs in England were still running single-handed practices, 43% worked in small partnerships of two or three, and only 42% in partnerships of four or more. However the 1960s did speed up the building of health centres: 100 opened between 1963-69, and another 170 by the end of 1971. By 1977 there were 731 health centres, accounting for 17% of GPs.

The 1970s

Heath's new 'radical right'

The Tory Party had never happily come to terms with a

National Health Service which by being free at time of use had largely wiped out the big private insurance market prior to 1948. Numbers covered by private schemes had slumped from over 10 million before the war to 120,000 by 1950, and the resentment of Tory politicians at the relatively equitable tax base of NHS funding occasionally broke through their bland pretence of 'consensus' on the Welfare State.

During the 1964–70 Labour government, Tory Shadow Health Minister Bernard Braine had openly suggested restoring the private sector:

> We could ensure that more is spent on medical care by introducing charges which could be covered in part . . . or wholly by health insurance . . . or we could encourage the growth of private medical schemes . . . we might even look at the possibility of levying a hotel charge for a hospital stay.
>
> (*International Medical Tribune*, 26.10.67)

This new, more aggressively 'radical' right Tory line of the late 60s, reflected in Enoch Powell's racist rabble-rousing speeches of the same period, and also in the Heath leadership's 'Selsdon Manifesto' (offering short shrift to 'lame duck' industries) represented a definite if rather more tentative precursor of the Thatcherite policy since 1979. Under Heath's government Thatcher herself gained her first real taste of notoriety as 'Maggie Thatcher – Milk Snatcher' for her attacks on school children's free milk. Heath's focus was on reducing all public expenditure that benefitted the working class in order to maximise tax cuts that would most benefit the rich. Chancellor Anthony Barber lost no time in presenting a mini-budget which included:

- A doubling of prescription charges;
- Increased charges for spectacles;
- Dental charges increased to half the cost of treatment.
- Income tax cut by 6d (2.5p) on the basic rate, giving the average industrial worker with two

children an extra £7 a year, but top industrialist Lord Stokes of British Leyland an extra £20 per week.

In November 1973 the Barber mini-budget cut £1.35 billion from social spending, including £111m from the NHS. The Commons Public Expenditure Committee declared: 'It is the opinion of our committee that no government has ever provided sufficient money to allow the health service to function and to react to growing needs effectively'.

Sir Keith 'reorganises' the NHS

By the mid 1970s the NHS had begun to look much more like today's service. Lengthy debates on restructuring the Regional Boards and Hospital Management Committees had begun under Labour in the late 1960s. Two Ministries were merged to produce the Department of Health and Social Security in 1970, but it was the first Tory Secretary of State, Sir Keith Joseph, who with minimal debate or discussion forced through the NHS Reorganisation Act which laid the basis for a new structure in April 1974 (just after Labour had again been reelected).

Joseph's objective was the usual Tory desire to exert tight control over spending, establishing firmer lines of 'accountability' *upwards* from local hospitals to the Department (though of course not *downwards* from the health authorities to local patients or health workers). There were ritualistic nods towards democracy through the establishment of Community Health Councils as (largely toothless) watchdog bodies scrutinising the activities of appointed health authorities.

The new structure seemed intended to produce a more integrated service, with the boundaries of 90 new Area Health Authorities (AHAs) largely identical to local authority boundaries. The new AHAs were responsible for community, domiciliary and preventive services as well as liaison with the still separate Family Practitioner Service. The combination of weak community and powerful hospital services under single management was like putting David (minus sling) into bed with Goliath.

In theory the new system was also supposed to promote links between the NHS and local social services, which were still run by local government. However, though Joint Consultative Committees were set up between councils and AHAs, in the absence of financial resources or common control real integration would only be a pipe-dream. The non-elected, tax-funded AHAs shared only common boundaries with the elected, rate-funded councils. The 90 AHAs ranged in size of catchment area from 250,000 to 1 million. Their chairs were to be appointed by the Secretary of State, and paid a part-time salary. There was no reason to assume that this would change much from the 1960s, when 11 out of the 15 Regional Boards were chaired by company directors or senior business figures; and on Hospital Management Committees a really representative sample of opinion included:

> 4 Lord Lieutenants, 20 deputy Lieutenants, 146 JPs, 12 peers or baronets, 5 wives, widows or offspring of peers, 1 ex-Lord mayor, 8 retired admirals or generals. Of a sample of 92 of the HMCs, one quarter of the chairmen were company directors and not a single one as far as was known was a wage earner.
>
> (John Robson, *International Journal of Health Services*, no 3 1973)

Joseph's reorganisation alienated many existing NHS administrators, increased admin staff by 17,000, and cost at least £9m to carry out. In reality, behind the facade of the new-fangled health authorities, more power was being given to the full-time Area Teams of Officers and the local District Management Teams, who took all of the day-to-day management decisions, and drew up all of the proposals and documents for AHAs, according to the cash available from the Regional Health Authorities (RHAs).

The Tory reorganisation never worked, and was roundly criticised by a Royal Commission set up by Labour's Barbara Castle in 1976 (but which did not report until after the Thatcher victory in 1979). It attacked the Joseph plan for incorporating too many tiers of manage-

ment and too many administrators; for failing to make quick decisions, and wasting NHS resources – so much for the self-styled Party of business methods and efficiency!

The RAWP fiasco

Three years later there were to be much bigger cutbacks. In 1976-7, under pressure from the International Monetary Fund, the Labour government introduced a new system of financing health authorities by setting maximum spending figures for Hospital and Community Service budgets *in advance* as a fixed 'cash limit', and compelling AHAs to remain within this limit. Only Family Practitioner Services were exempted from this restriction, which began to bite at the same time as spending cuts imposed on IMF instructions.

An equally important watershed was the Wilson government's attempt to remedy the huge regional inequalities in the provision of health services which had widened since 1948. This was done not through a nationally co-ordinated plan to develop and expand the NHS, but through manipulation of cash funding to RHAs. A Resources Allocation Working Party (RAWP) was set up and reported in 1975 and 1976.

The inequalities were inescapably real: they had grown out of the anarchic network of hospitals that had been nationalised in 1946. The relatively prosperous South East, as a concentration of the power and pressure of the consultant lobby and of the affluent middle classes, had done predictably rather well, and the status of its teaching hospitals had enabled them to secure a continuing expansion. However regions to the North had lost out heavily in relative terms, with much lower health spending per capita of population, and less advanced facilities available. One result was that patients often had to travel long distances – sometimes hundreds of miles to a London teaching hospital – to get certain specialist treatment.

The RAWP proposals worked out new 'target' levels of resources for each region. These were based on statistical

projections of the numbers of people to be served, adjusted for varying proportions of each age and sex, the average death rates for each age and sex grouping, and the expected levels of need for various hospital, ambulance and other services. The RAWP strategy was to ensure that the regions furthest below these spending 'targets' should receive additional resources, while those furthest above them should receive relatively smaller growth.

The most immediate problem arising from RAWP was caused by the package of public spending cuts carried out in 1976. This immediately ruled out any process of levelling up, and instead meant that RAWP would be an exercise in levelling *downwards* by landing the largest cuts on the 'over-provided' South East regions, while providing inadequate extra resources to make much improvement in the 'under-provided' regions.

The RAWP follies

From the very beginning, RAWP drew up its 'targets' from a very conservative standpoint. There was no suggestion, for example, of trying to fill in the gaps in the service by a coordinated plan to build extra teaching hospitals as new 'centres of excellence' in the under-provided regions; nor of building the necessary new specialist units closer to the populations least well served. Instead it looked to abstract cash targets that would hold back services in the better-provided areas, while giving a larger cash share to the others.

The powerful consultants' lobby which had ensured a continual growth in the big teaching hospitals and carved out influential empires around their new specialities, took up the cudgels to defend their interests against the new spending cuts, while consultants in the more deprived regions spotted a chance to build up similar empires. The effect was once more to widen the class divide in health, since the extra resources were still largely funnelled into the more glamorous acute services, while the cuts instead fell onto community services and the smaller hospitals, which tend to provide local people with health care in

teaching districts. Under the hammer came geriatric beds, mental health and other non-acute specialities, while the high-flying cardiac, cancer and kidney units managed to survive with less damage.

However, there were even more long-term problems with the whole concept of RAWP, which was in reality only *half* a plan, since it aimed to measure out resources without any serious attention to actual levels of need or demand for services. (Even waiting lists – one rough and ready way of assessing unmet need for health care – were ignored). Nor, for all its focus on 'target' levels of resources did RAWP make any effort to lay down basic minimum standards or targets for provision of health services – leaving the bizarre spectacle of authorities subject to intricately calculated and rigorously enforced cash limits, but free to neglect whole areas of health care if they choose.

In fact RAWP ignored *all* social factors outside the immediate sphere of NHS spending: it paid no attention to such aspects of deprivation as unemployment, poverty, poor housing or the racial pressures on inner-city ethnic minorities; and by focussing simply at regional level it ignored pockets of misery even in the 'over-provided' South East. Because its calculations of ill-health were based simply on mortality rates, the RAWP criteria also ignored long-term and debilitating ailments (such as bronchitis or arthritis) which may not kill, but contribute to demands on local services.

As a dressed-up 'per capita' quota system, RAWP also fell very heavily upon London, where 1970s projections suggested the population would continue to drop. The glib RAWP statistics drew from this the conclusion that there would be less need of NHS services in the capital. In fact both sets of figures have been shown to be doubtful. Some of the areas forecast to lose largest numbers – and therefore lose most NHS revenue – are in fact now *growing* in population (partly as the housing crisis and soaring property prices force the division of inner-city houses into flats). In any event, even with a reduced overall population, demand for health services in the capital has conti-

nued to increase, while chronically poor GP services mean much of this demand falls on the hospital sector. Government figures year by year have boasted of the rising numbers of Londoners treated as inpatients and outpatients – yet RAWP cuts mean there is less and less cash allocated to treat them.

London is a particularly good example of the folly of generalised statistics, since within the general decline of its population, there has been a marked proportional increase in numbers of elderly people – who are much more demanding of NHS resources. And within the generalised prosperity of which we read so much, there are whole areas of chronic and grinding poverty, in which thousands are homeless and thousands more in unsuitable, overcrowded accomodation.

London also loses out extremely heavily under the RAWP formula for teaching hospitals, which fails to reckon with the fact that they serve a much wider catchment area than the District they are in, and that many of the cases referred from outside Districts to teaching hospitals tend to be more complex and costly to treat than routine cases who will normally be treated nearer home. Also, since RAWP lays down no standards, and deals with resources rather than services, it does nothing to challenge the dominance of teaching hospital hierarchies within health districts.

The alternative to RAWP

In opposing RAWP, campaigners like London Health Emergency have accepted the need to combat regional inequalities. They have argued however for a major increase in NHS funding, to level upwards, and for a serious attempt at planning to meet the actual level of need for health services. This requires some systematic work to produce a survey or 'Health Census' that will include the 'hidden' waiting lists of patients still waiting for outpatient appointments, the scale of 'hidden' community care provided unpaid by women in the home, caring for relatives, and the scale of the resources needed to provide real community care for the mentally ill and mentally handicapped

(most of whom are already 'in the community').

Instead, RAWP, though motivated no doubt by worthy intentions, was and has remained a fiasco. In 1976, according to estimates from health economist Robert Maxwell, the cost of levelling *up* the under-target NHS regions would have been only 0.2% of GNP: instead the cock-eyed attempt at Robin Hood tactics has added to the misery of London's inner city poor while doing little to improve the other regions.

Closing hospitals

Another modern feature of the 1970s was the wave of hospital closures, speeded along by RAWP and the IMF cuts, but also related to reduced targets for acute bed provision. A 1977 document *The Way Forward: Priorities in the Health and Social Services* called for a 17% reduction in target provision of acute hospital beds from 3.4 per 1,000 population to 2.8, and a substantial cut in the share of NHS spending allotted to acute and maternity services.

The pace of 'rationalisation' began to accelerate. Between January 1976 and October 1978 AHAs in England and Wales decided on 217 hospital closures and changes of use. 143 of these went ahead, while CHCs objected to 37 closures. By 1979 the NHS had lost 484 (mainly smaller) hospitals in the 20 years from 1959, while treating an increased number of patients (up from 90.2 patients per 1,000 population to 120.4 in 1979). Plans drawn up included the loss of 31% of London's hospital beds between 1975 and 1986, with £110m sliced off spending through reallocation and cuts, and over 24,000 NHS jobs to be axed. With trade unions and local community organisations alarmed at the loss of their hospitals, the scene was set for an eruption of active health campaigning that brought the NHS to the forefront of local political life in a way not seen even in the pay battles of the early 1970s. Though few of the battles to save threatened hospitals were victorious, some did score lasting successes, including the marathon 3-year 'work-in' to save the Elizabeth Garrett Anderson Hospital, so far still open in Bloomsbury.

The *Priorities* report also suggested small increases in resources for the elderly, the mentally ill, mental handicap, paediatrics and primary care, and increased target bed quotas for the elderly (never achieved). In fact many of the smaller hospitals under the axe in the closure plans were geriatric hospitals. Far from receiving improved 'priority' care, many elderly patients found themselves rudely and suddenly uprooted and bundled into large impersonal wards in general hospitals. Once there, they swiftly began to be regarded by consultants as a nuisance, 'blocking beds' for acute patients. The pressure was mounting for ousting elderly long-stay patients from hospitals altogether, and there was a rising tide of government propaganda praising the supposed advantages of 'community care', despite the absence of social services and NHS structures to support the frail elderly in the community.

The fight over pay-beds

By 1974, the private sector had taken advantage of the difficulties of the NHS to rebuild its base of middle class subscribers to over 2 million – though still only a shadow of pre-war strength. In contrast, the 1948 total of 7,188 pay-beds in NHS hospitals had dwindled by 1970 to 5,125, and by 1974 to 4,574, treating an insignificant number of patients compared to the growing NHS caseload.

However, a series of eye-opening revelations on the extent to which these pay-beds were siphoning off NHS resources and increasing NHS waiting lists gave the issue a new lease of life in 1971, with the Labour Party once more in opposition.

The Labour leadership took this up as a handy weapon to popularise the NHS issue – and wrote into their Manifesto for both 1974 General Elections a pledge to ensure 'total separation of private practice from the Health Service.'

Predictably, the BMA and right wing press were outraged at this attack on 'clinical freedom'. One Dr H. Fidler, Chair of the BMA's Private Practice committee later summed up the view that: 'If we lose this freedom . . .

the medical profession is finished. Even worse, this country is finished.'

Spontaneous action by health workers helped to stoke up tension on the issue. As early as March 1973 Portsmouth health workers had taken the lead in boycotting work for private patients in the hospital's 30 pay beds.

The BMA hit back – with its own package of 'sanctions'. These were most energetically applied by the consultants least committed to NHS work, and therefore they had little obvious effect. It soon became clear that few junior doctors and fewer GPs were prepared to give active support to the sanctions. Holding hospitals to ransom in pursuit of the 'right' to fleece a popular National Health Service to the tune of at least £7m a year, and to defend the relics of a two-tier system of care was not the way to win public support.

Yet even while the union boycott action spread across London and reached over 100 hospitals in Yorkshire and the north, Barbara Castle declared 'While I can understand the feelings of the staff, I cannot condone the action they are taking.'

In the event, Castle set up in 1976 a new quango body, the Health Services Board, which was given the task of agreeing with the private sector the pace at which pay beds would be phased out – to be replaced by beds in private hospitals. In this way 1,600 pay-beds were eliminated between 1977 and 1979; however, the Labour government had missed a golden opportunity to complete one of the unresolved tasks which had been urged on Labour leaders by socialists since 1948.

3 *Thatcher and the Tory offensive*

Widening the class divide

The 1970s began and ended with the election of Tory governments committed to reduce the share of national wealth allotted to public spending, and to restrain the growth of the NHS. Both succeeded. The decade also began and ended with stark reminders of the unbridged and widening class divide in health.

In an influential article in the *Lancet* in 1971, Julian Tudor Hart described what he called the 'Inverse Care Law' by which health resources are least available to those who most need them:

> In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas: and hospital doctors shoulder heavier case-loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up as the Inverse Care Law: that the availability of good medical care tends to vary inversely with the need of the population served.
>
> If the NHS had continued to adhere to its original principles, with construction of health centres a first priority in industrial areas all financed from taxation rather than direct flat-rate contribution, free at the time of use, and fully inclusive of all personal health services, including family planning, the operation of

> the Inverse Care Law would have been modified much more than it has been; but even the service as it is has been effective in redistributing care, considering the powerful social forces operating against this.
>
> If our health services had evolved as a free market, or even on a fee-for-item-of-service basis prepaid by private insurance, the law would have operated much more completely than it does; our situation might approximate to that in the United States, with the added disadvantage of smaller national wealth.
>
> The force that creates and maintains the Inverse Care Law is the operation of the market, and its cultural and ideological superstructure which has permeated the thought and directed the ambitions of our profession during all of its modern history. The more health services are removed from the force of the market, the more successful we can be in redistributing care away from its 'natural' distribution in a market economy; but this will be a redistribution, an intervention to correct a fault natural to our form of society, and therefore incompletely successful and politically unstable, in the absence of more fundamental change.
>
> (*The Lancet*, 27.2.71)

By the middle of the decade there had been more attempts to prove statistically the theory which Tudor Hart and other doctors knew to be true. In 1977 the Labour government commissioned a working group on Inequalities in Health, chaired by Sir Douglas Black. A speech by Secretary of State David Ennals to the Socialist Medical Association summed up the indicators of inequality which had persuaded him to take such a step:

> To take the extreme example, in 1971 the death rate for adult men in Social Class V (unskilled workers) was nearly twice that of adult men in Social Class I (professional workers) even when account had been taken of the different age structure of the two classes. When you look at death rates for specific diseases the gap is even wider.
>
> For example, for tuberculosis the death rate in Social Class V was ten times that for Social Class I;

for bronchitis it was five times as high and for lung and stomach cancer three times as high . . .

Maternal mortality – down a long way from the figures of 40 years ago – shows the same pattern; the death rate was twice as high for wives of men in Social Class V as for those in Social Class I.

At age 5 Social Class I children are about an inch taller than Social Class V children.

30 years of growth

The first 30 years of the NHS had seen it expand unevenly, with little overall plan, and often struggling to compensate for the ill-health generated by poverty, and social problems – sometimes exacerbated by government policies.

In 1980 the NHS reached its highest-ever share of Gross National Product – 6.1%, with an annual budget of £11.875 billion, or £212 per head for every person in the UK (compared to £9 per head in 1948). 89% of NHS revenue was from taxation, 9% from the National Insurance Stamp and only 2% from charges and other sources. Despite inadequate capital or investment and appallingly low pay for NHS staff, efficiency had continued to improve, with a steady increase in numbers of patients treated in each bed and reduced average lengths of stay in hospital. Staff numbers had more than doubled since 1948 to 822,390 in England (with Wales and Scotland bringing the total to near the million mark).

Staffing costs by 1981 were 70% of total NHS spending. Nursing staff had increased from 137,000 to 297,684 (36% of the NHS workforce), and there was a large increase in numbers of technical and paramedical workers as well as a 3-fold rise in numbers of consultants and hospital doctors. The hospital sector had steadily increased its share of total NHS spending from 54.9% to 62.7%.

One pattern had remained constant: preventive work in the mid 1970s received only 0.38% of NHS spending, while health education received a miserable 0.1%: there still is no occupational health service.

Though numbers of community nurses had increased

since from 9,529 to 32,162 in the 30 years from 1949, they were outnumbered 10-1 by hospital nurses, and facing a daunting increase in workload from the growing elderly population and a continued lack of proper liaison with local authority social services. By 1980 the Commons select committee on Social Services was warning of the evident drift of government policy towards dumping the elderly onto the 'community'.

The 'Bermuda Triangle' of community care – bounded on three sides by health authorities, local authorities and voluntary organisations, but into which tens of thousands of elderly, mentally ill and mentally handicapped people have for years been slipping without trace – was clearly in evidence even before the Thatcher government embarked on its radical mission of 'reforming' the NHS. The inherent weakness of the three-way split in health services at the very birth of the NHS had helped to undercut its effectiveness and created a loophole that would be ruthlessly widened by a new monetarist government 30 years later.

The Thatcher onslaught begins

Ignoring the class divide

The efforts of Secretary of State Patrick Jenkin to suppress the embarrassing findings of the Black Report in 1980 summed up the new 'radical' Tory approach to the economy as a whole and the public services in particular – to *promote* rather than combat inequality, and ignore all evidence of the misery this causes. Mr Jenkin expressed his own evident distaste for the facts in his off-hand 'Foreword' to the 263 tatty duplicated typescript copies of the Black Report his Department grudgingly produced on August Bank Holiday weekend:

> It will come as a disappointment to many that over long periods since the inception of the NHS there is generally little sign of health inequalities in Britain actually diminishing and, in some case, they may be increasing. It will be seen that the Group has reached the view that the causes of health inequalities are so

> deep-rooted that only a major and wide-ranging programme of public expenditure is capable of altering the pattern. I must make it clear that additional expenditure on the scale which could result from the report's recommendations – the amount involved could be upwards of £2 billion a year – is quite unrealistic in present or any foreseeable economic circumstances, quite apart from any judgement that may be formed of the effectiveness of such expenditure in dealing with the problems identified.

The Black Report had certainly trodden on some Tory corns, stressing as it did that 30 years of the NHS had left the health of manual workers and their families lagging even further behind the professional and middle classes; they tended to die younger and suffer worse health at all ages.

For every baby boy from the professional classes that died before his first birthday, two died in the skilled working class and *four* died among unskilled manual workers.

By 1976, infant mortality under the NHS had fallen by 45% for the professional class, 49% for the 'managerial' middle class, but only 34% for the unskilled manual working class. Nearly twice as many wives of unskilled workers died in childbirth as wives of professional and managerial workers.

The Black Report looked more widely at the problem than simply at the NHS and health services. It found that the children of unskilled workers were ten times more likely to die from fire, fall, or drowning, and seven times more likely to be knocked down and killed by cars than their professional class counterparts.

Unskilled men actually stood a *greater* chance of early death from a number of common causes in 1969 than they had ten years earlier, and the difference in death rates widened in the years 1950 to 1970. In 68 out of 92 causes of death, rates were higher for semi and unskilled workers than for the middle classes.

Manual workers were also less likely to use community health and preventive services than the middle class, who

make most call on Family Planning and cervical screening services. The Black Report also provided figures to prove Tudor Hart's 'Inverse Care Law' – showing that hospital and community health spending was lowest in the regions with the highest proportion of unskilled and semi- skilled manual workers. A working class person would also be less well served and less healthy in a working class area than a socially mixed area.

Poverty creates ill-health

The Report probed the underlying causes of ill-health in terms of levels of poverty and housing, and emphasised the *increase* in poverty in the preceding years. Numbers living below or marginally above supplementary benefit levels had almost doubled from 7.74 million in 1960 (14.2%) to 14 million (26.6%) in 1977. A third of these were employed workers or in wage-earning families, while 40% were pensioners.

It also looked at the issue of nutrition, especially in childhood (pointing to the beneficial impact on children's health of the food policy during the Second World War); and focussed on the perils of cigarette smoking which leads to around 50,000 premature deaths a year, and is most popular among the manual working class.

Among the recommendations which Patrick Jenkin dismissed so contemptuously were a series of measures to relieve poverty, including an increase in child benefit and the maternity grant; payment of an infant care allowance to mothers of under-5s and a comprehensive disablement allowance. On nutrition it suggested free school meals for all children. And it also proposed free nursery facilities, especially in the most deprived areas, and an expansion of sheltered housing for the elderly and disabled. It was costed in 1979 at a total of £1.5 billion a year (little more than half the cost then of the married man's tax allowance) – but it would have been an excellent investment, producing longer-term cash savings by reducing demand for NHS treatment.

Instead, the Black Report and its recommendations were

brushed arrogantly aside by the Thatcher government, intent as it was on policies that would intensify the level and increase the numbers in poverty – thus boosting the demand for health services.

In the first four years of Thatcherism, the Child Poverty Action Group figures show numbers living in poverty increased 47% from 11.57m (22% of the population) to 16.38m (31%). Included in this was a 72% increase in the numbers of children living on or below poverty levels. While real salaries for the top fifth of wage earners went up 22% in the eight years from 1979, the bottom 10% of families saw their incomes *fall* by upwards of 15%, and 1986 alone saw the numbers of low-paid increase by 400,000. Homelessness increased from 57,000 families in 1979 to 94,000 in 1985, while the proportion of the British workforce paid at or below the Council of Europe's 'decency threshold' has increased from 36% to 42% – some 8.8 million workers.

Prescriptions up again – and again!

The Tory attitude to the NHS and the low-paid was also spelled out in the rapid increase in prescription charges after the 1979 Election, with a 125% leap to 45p within six months of taking office. In April 1980 the charge went up another 55% to 70p, and by December 1980, when the price hit £1, patients had suffered a five-fold increase in just 18 months of Tory rule. A succession of increases each year from 1982 has brought the charge to £2.60 in April 1988 – no less than a thirteen-fold increase in just nine years. Yet still the charge raises only a token amount: with 75% of patients exempt, the total recouped from those unlucky enough to pay is only around 8% of the £2bn-plus annual drug bill.

Hardest hit once again are low-income workers who must pay the full fee for prescriptions. Pharmacists point to an increasing number of patients unable to afford several items on a prescription form and forced to choose one or more to do without. They also published a list of over 120 commonly used drugs and preparations now cheaper to

buy 'over the counter' than on NHS prescription.

The token gesture of forcing patients – irrespective of their ability to pay – to stump up cash for their treatment is the driving motive behind this Tory insistence on prescription charges. The 8% increase in 1988 will raise only an estimated £10m in the next financial year. Yet no similar increase is being given by the government to the cash limits of the hospital service, which also faces the same soaring drug prices which Health Minister Tony Newton blamed as the reason for the prescriptions increase.

Another reorganisation

While they pumped up the prescription charges, Tory ministers in 1979 were also planning a new reorganisation of the NHS, set out in a document under the misleading title of *Patients First*. This scrapped the Area Health Authorities, abandoning any pretence of common health and council boundaries, and snapping the always fragile links with local government at the very moment when government strategy was more focussed than ever before on shuffling off as many patients as possible to 'the community'.

In place of the AHAs, Regions would oversee 192 District Health Authorities (DHAs) in England, where there would also be 9 Special Health Authorities. The Tories also suggested ditching the Community Health Councils, but they soon retreated from this once the scale of opposition became clear.

These proposals, which led to the 1982 reorganisation, were of course embellished with rhetoric about 'accountability'. Yet this once again meant the accountability of the DHAs to the Ministry and its cash limits, not to local people. Patrick Jenkin used the rhetoric even more misleadingly when he suggested that the new structure would offer genuine local control: 'I believe it is wrong to treat the NHS as though it were or could be a single giant integrated system,' (however the Thatcher years have seen increasing efforts by Sainsbury's Sir Roy Griffiths and others to turn the NHS into one big 'business-style' corpo-

ration!). 'Rather we must try to see it as a whole series of local health services serving local communities and managed by local people.'

In fact, the new DHAs were smaller and no more representative of local people than the disbanded AHAs. Members were still *appointed* – some (a reduced proportion) from local authorities, and some appointed by the Region. A small number of token (right wing) Labour chairs were still selected, especially in areas where cuts were in the offing. There was to be a 'trade union seat', though the trade unionist would be chosen not by the labour movement but by the RHA, and even this concession lasted only until some Regions started to veto trade union nominees – effectively abolishing several union seats.

In any case the scope for serious decision-making by DHAs was always very slender, since they are entirely dependent for their information on the full-time district management, and have no say over the total sums of cash at their disposal. Their only legal obligation is to comply with government cash limits, though (unlike councillors), they run no personal risk other than removal from the health authority if they defy these limits and overspend to protect services. In fact the whole history of health authorities is remarkable for their almost universal and docile acceptance of *every* government instruction to cut spending even at the expense of devastating local services. Only a handful have even tried to rebel.

Few of the health authorities needed any urging to toe the Government line, since they tended to be stuffed with Tory Party stalwarts and fellow-travellers. A 1984 survey by Michael Meacher, Labour's spokesperson on Social Services, showed that:

- 60% of DHA Chairs were Conservative Party supporters or members – only 9% were Labour;
- In 1982, 5 prominent members of the Labour Party who sat on RHAs were dismissed by the Secretary of State;
- Appointments to West Midlands RHA brought

the total of Tory councillors to 4, while the only Labour one was not reappointed;

- The number of women on DHAs averaged around 25% – despite the fact that women are 52% of the population.

Many were surprised to find the figure of known Tory DHA chairs was as low as 60%: but 40 DHAs had not replied, and this together with the 30% of unknown allegiances could well account for this discrepancy.

During the same period, research carried out by London Health Emergency into the composition of the Thames Regional Health Authorities exposed a completely unrepresentative cross-section of double-barrelled squires, retired army officers and company directors. A popular column 'Top R(H)AT' published in *Health Emergency* featured a number of unsung heroes and heroines, including in SW Thames:

> *Gerald James Mortimer, CBE, MBE, F Eng, FRSA, CBIM, Hon FIMM, etc*
> A former Surrey county councillor and former chairman of the East Surrey Conservative Association, Gerry is also a retired major. He is a consultant to Consolidated Gold Fields Ltd., who have a turnover of £125 million and 10,000 employees, with subsidiaries all over the world, including Gerry's old haunt of South Africa. President of the Old Caterhamians (a Surrey version of Old Etonians) in 1970, he is now a member of London's exclusive Carlton Club, a rich Tory politicians' meeting place.'
>
> *A.H.C. Broadbent*
> Not from the political wing of the Tory Party; you could say he comes from the industrial wing. He uses the address of his company, J. Henry Schroder Wagg & Co. Ltd., rather than his Richmond home. Who are Schroder Wagg? Massive merchant bankers, whose interests stretch from Europe to Canada and then to Rio, Argentina, Singapore and Tokyo, with sister companies in Switzerland, Bermuda, Grand Cayman and Lebanon. With

people like this running our health service, we know that we are in safe hands.

A similar bunch could be found in North West Thames, including:

Sir Malby Sturges Crofton Bt, BA.
The 5th baronet (originally created in 1661) learnt to represent the people of London by going to a typical London school, Eton, and from there to Trinity College, Cambridge. Debrett's *Handbook of Distinguished People in the British Isles* reveals that his address listed in the RHA handbook is but a small town house compared to the family home – Longford House, County Sligo, Eire. A former stockbroker, Sir Malby is now a partner with Fenn & Crosthwaite. He has the honour of being both a local councillor for Kensington & Chelsea and GLC member for Ealing North, which must give him plenty of time to concentrate on RHA matters.

The column also listed six more top Tory councillors and a local Conservative Association chairman who sat on NW Thames RHA. A similar picture emerged in NE and SE Thames.

Antics in the Chair

The role of DHA Chairs has proved no less crucial to the implementation of government policies, and these too have included some colourful characters. East Surrey's former Chair, Paul Alderson, a Croydon dentist, was banned as a Wimbledon tennis umpire in 1987 for attempting to tout his complimentary Centre Court tickets. He has been forced to resign after the Inland Revenue successfully pursued a bankruptcy petition against him for alleged tax arrears of £29,000.

Bananas paved the slippery path to ruin for another former Surrey DHA Chair, this time Mr Patrick Salmon from SW Surrey. In 1983, despite his only income being his Chair's honorarium, Mr Salmon managed to borrow £100,000 from a bank, which he invested in the import of bananas from Central America. But things began to slide

out of control when the bananas were not allowed into Britain and were 'towed away down the Solent'. Undeterred, the ever-eager Mr Salmon then borrowed *another* £35,000 from business friends, which he handed in cash to a Mr Julian Williams 3 in order to take part in an unofficial (and unsuccessful) gold deal. This was followed by another £20,000 which Mr Salmon drew later in 1984 from his own bank account. Having chucked good money after bad bananas, his total debts at the time of his bankruptcy hearing had reached £275,000, of which he was owed £122,000 that he was unlikely ever to receive back. Mr Salmon, like his fellow DHA Chairs, had been personally appointed by the Social Services Secretary.

Time and again DHA Chairs appointed in this way have used their casting vote or blatantly bureaucratic methods to push through cuts packages and ward closures in areas including Brent, Ealing, Pontefract and most recently Salford, where a group of three Labour councillors stormed out of a February 1988 DHA meeting in protest at such tactics.

Tower Hamlets health campaigners have also protested at the actions of DHA Chair Frances Cumberlege for acting as a 'government stooge'. At the peak of a local campaign against major cutbacks and bed closures in the District, Mr Cumberlege issued a brazenly political secret memo to local unit managers insisting that 'The District must be seen to be on the side of the region and the Secretary of State'. The memo ended by saying Mr Cumberlege could be contacted in Peterborough or 'at his club in London'.

Cumberlege, who had also instructed managers not to join an official DHA deputation to press Secretary of State John Moore for more cash, had been acting on the instructions of NE Thames RHA Chair David Berriman. The deputation, which included the two Tower Hamlets MPs, Professor Williams from the Medical College, Liberal councillor John Nudds, and CHC Chair Elsie Gilding, was 4 therefore even more enraged when they arrived at John Moore's office to find him already closeted with Berriman and Cumberlege!

Under new management

Government emphasis on the 'accountability' of DHAs *upwards* to the Department has dovetailed in with the further reorganisation of authorities to include a new tier of 800 General Managers who were appointed at unit, district and regional level in 1984-6. This new arrangement, suggested by Sainsbury boss Sir Roy Griffiths, is headed by a new NHS Management Board, initially chaired by Mr Victor Paige. *Health Emergency* commented on his appointment:

> Mr Paige previously chaired the Port of London Authority and was Deputy Chair of the National Freight Consortium. Despite his confession that he knows virtually nothing about the NHS he'll be getting £70,000 a year for his efforts. On hearing of his appointment, Paige was quick to boast of his long-standing subscription to private health insurance and said he had no intention of cancelling his BUPA policy: 'Like most people I am covered by private medical insurance,' he blurted out – only to be corrected by an embarrassed DHSS. A mere 8% of the population has private medical insurance. . . . The appointment of Victor Paige is a clear indication of the Government's intention to step up its 'rationalisation' of the NHS along business lines.

In the event Paige was not up to the task, and resigned after 18 inconclusive months, but the Tory commitment to 'business methods' remained unshaken. After gratefully declining an offer from Mr Ian MacGregor to do for the NHS what he had just done to the mining industry, Norman Fowler appointed Mr Len Peach, a top figure from the notoriously anti-union IBM corporation to the post of Chief Executive. As might be expected, Mr Peach's idea of accountability is a vertical structure in which managers are accountable to the Department – and health authorities are for the most part irrelevant. He set out his views at some length in January 1988 in a key article in the *Health Service Journal*. He praised in particular the new NHS system of

'accountability of individual managers' as assessed and reflected in their pay packets by the 'Individual Performance Review (IPR)' system. (IPR offers personal bonus payments of up to 10% for managers who meet performance targets: since these targets include enforcing cash limits, managers can be turned into 'bounty-hunters', winning extra pay for closing wards or treating less patients.) Significantly out of the various general managers who have left before ending their initial 3-year contracts, only *one*, clearly upset by huge cutbacks in Reading, has resigned rather than continue to hack back services.

Mr Peach also praised the secretive procedures that occur inside the closed doors of the NHS Management Board, and the closet cabals of regional health chiefs that debate between themselves issues that affect the lives of millions. He insists that there really *is* a serious discussion – even if we are not allowed to hear it:

> . . . Our exchanges are conducted in private. While it may not do much for our street credibility, we all believe it is the way to do business.
>
> *Health Service Journal*. 14.1.88

It clearly *is* the way bosses do business: but is it the right way to run a health service? Mr Peach seems really irritated that ordinary folk should even try to poke their noses in:

> I am occasionally surprised and worried at the ignorance displayed at local level about what it happening at district and region levels. If people do not know what is going on and are not involved, they fill the vacuum with misconceptions and rumours, generating problems that consume vast amounts of management time.

Of course it is the very system Mr Peach so praises which creates these problems as management struggle like crazy to keep information away from health authority members, from health workers and their unions, from doctors, from the press and from the general public. All too often it is not 'misconceptions' which throw management into a flat spin but the leak of genuine information on the scale of local cutbacks under discussion.

Enforcing silence

In fact there has been an ever more obsessive secrecy imposed upon health policy matters in the Thatcher years, and the trend is to less and less public accountability and less access to information. An article in the *British Medical Journal* by Assistant Editor Richard Smith last December summed up a few of the more obvious recent examples, including:

- Changes in the contracts of DHSS-funded researchers designed to inhibit publication of results that do not support government policy, and delaying publications that do not fit ministerial tastes;
- Attempts to 'silence' a Worcester consultant who had urged patients to complain at delays in hip replacement operations caused by spending cuts;
- Attempts by the Chair of the Health Education Council in March 1987 to block publication of *The Health Divide*, an up-dated follow-up to the Black Report – underlining the link between poverty and ill-health. (The Health Education Council has since been disbanded and replaced by a much more tightly-controlled Health Education Authority);
- Attempts to silence the Chairs of inner London DHAs who with the Kings Fund had produced a damning report *Back to Back Planning*, outlining the scale of bed losses and chaos in the capital's health services arising from RAWP cuts;
- Attempts by NW Herts DHA to silence then COHSE Secretary Doug Landman for speaking to the press over conditions at Hill End psychiatric hospital. (Doug and new Branch Secretary Jane Barclay-Taylor have both since been *sacked* for the same 'offence');
- The surreptitious publication of sensitive NHS statistics (including waiting list figures) late on Friday afternoons to avoid press coverage;
- DHSS pressure to force publicity departments of three Thames regions to alter press releases because their originals were not 'positive' enough;

- Attempts to 'silence' Birmingham Children's Hospital heart specialist Dr Eric Silove, who had complained to the media over the impact of bed cuts and staff shortages on urgent operations.

In addition to this list, there have been widespread complaints against various 'gagging memos' issued by local management. One case was in Brent, another in Tower Hamlets, where Community Unit general manager Jeff Prosser last November threatened to take 'disciplinary proceedings' against any member of staff who spoke to MPs, councillors, health authority members or newspapers about the effects of cuts. Equally transparent were the efforts of managers in Bath to silence community health physician Dr Gillian Cardy, who was suspended for speaking to the press about the planned cuts in Family Planning services. In a move described as 'the logic of the madhouse' by the local BMA, managers objected to her making the obvious point that a massive £140,000 cut in Family Planning and Well Woman clinics would cause a rise in unwanted pregnancies. Managers also complained that after she had been ordered not to speak to the press she then told journalists that she was not allowed to talk to them! Only after a BMA meeting of over 120 doctors had backed calls for her reinstatement did management eventually back down.

Health and efficiency?

The new management methods wheeled in on Sir Roy Griffiths' Sainsbury trolleys are plainly neither democratic nor open. But are they *efficient*? We have been regaled with endless talk of efficiency in the NHS. It is interpreted at different times in different ways, but not one of them starts from the patient's eye view, which is to seek a system which maximises the care and attention he or she receives as an individual while in hospital. Conspicuously, the most avid advocates of 'efficiency' in the NHS also tend to be the types who opt for more labour-intensive 'First Class' facilities when they travel, eat out or (as with Mr Moore, who lashed out £195 a night rather than stay in an NHS

bed) spend time themselves in hospital.

▷ Ministers trot out lists of figures for the increasing numbers of patients who pass through our hospitals as in-patients or out-patients each year. Unfortunately these figures are an abstraction. A patient carried out of a hospital in a coffin is counted as a 'discharge', just the same as the restored patient who jogs home in a track-suit: a patient readmitted with complications after a rushed and premature discharge from hospital is registered *again* as a 'new' patient in the statistics – allowing the *inefficiency* of treatment to appear as increased 'efficiency'. It is rather as if Sir Roy simply counted queues of customers at Sainsbury's without checking whether they are all buying more goods, or simply lining up with complaints and returned merchandise, demanding their money back.

▷ There are overall staffing 'ceiling' figures, linked to the claim that within the NHS workforce less staff are now employed to do ancillary work while proportionally more resources go to 'front line' nursing and patient care. Yet as many patients know all too well, scaling down the hours of work of domestics – or handing over domestic services to cheapskate private firms – simply increases the pressure on *nursing* staff, often landing them with unwanted (and unpaid) cleaning jobs, diverting them from essential patient care. The 'efficiency' in ancillary work is bought at the expense of *inefficiency* among nurses, and exploitation of the remaining, even lower-paid ancillary workers. It is as if Sainsbury's forced their check-out clerks to clean the floors in addition to taking the money: the stores would swiftly become dirty, while customers would wait longer to pay and feel less well looked after.

▷ Neither the figures on numbers of patients treated nor those on numbers of staff employed pay any attention to the level of *need* for health services or the size of waiting lists. To measure the 'efficiency' of any enterprise a basic starting point should be its ability to meet the given demand for services. The present attempts to measure the 'efficiency' of an NHS with waiting lists of over 700,000 are more akin to those of an East European supermarket with its fixed quotas of supplies, its queues and empty

shelves than the business approach of Sainsbury's or Marks and Spencer, where managers aim to merchandise to match potential sales.

▷ This last analogy shows another major problem in seeking to compare the NHS with a retail or industrial 'business'. In Sainsbury's or Marks and Spencer's, every sale generates *profit*, and every extra sale *more* profit: the objective is through advertising and quality of service to *maximise* the potential market for the firm's goods – and then to satisfy that market. If supplies run short, they can be re-ordered with minimal delay: managers who sell out of basic supplies (or of perishable goods too early in the day) are criticised for missing sales, and seek to order enough. None of this applies in the NHS, where every patient treated represents a *cost* against a limited, pre-determined budget. The more patients treated, the more it costs: but cash limits mean no more resources are available, no matter how extreme the demand. Services are arbitrarily limited in advance, hence there is no attempt to measure – let alone expand – the potential market.

The sad fact is that the top decision-making bodies of the NHS are dominated by a government which, unlike any private enterprise, is hell-bent on driving even more 'customers' away from the NHS to its private 'competitors'. Could Sainsbury's function efficiently under such adverse circumstances?

▷ In any case it is doubtful whether health care is the kind of service where 'efficiency' can usefully be measured by the 'burger bar' standard – where a minimal workforce carries a maximum workload for minimal pay. Neither Sainsbury's nor Marks and Spencer's (both noted for their efficiency) would dream of working that way.

Nobody would seriously suggest, for example, that it would be any more efficient for teachers to take in classes of 60 instead of 30. Though their 'productivity' would double in crude statistical terms, the *quality* of education provided would be more than halved. Similarly; the argument that *less* NHS staff in proportion to *more* patients moving faster through *less* beds in *less* hospitals is necessarily 'more efficient' starts off from the criterion of account-

ancy rather than effective patient care. Bed cuts have also brought the crazy inefficiency of highly-paid doctors wasting hours on the phone seeking beds for emergency admissions.

▷ Health campaigners, patients and health unions would all like to see a more efficient, effective health service in modern buildings providing the best possible treatment free on demand to those who need it when they need it. We would all like it to be a service where the queues are eliminated, and where staff once again have time to give support and reassurance to patients instead of working under constant, nerve-grinding pressure. But this kind of efficiency does not come from arbitrary cash limits, a miserably low-paid over-stretched workforce, and a hollow facade of big business-style management concealing a crumbling stock of hospital buildings facing an estimated £4 billion maintenance backlog. Sir Roy would not try to run his grocery stores like that: why should he suggest it as a way to run a health service?

Think tanks in the streets

For decades, extreme Tories have wanted to drive a substantial private wedge into the tax-funded NHS. But only in the grim climate of the 1980s, the Thatcher years, have they felt bold enough to step up the fight. A controversial Think Tank report advocating 'radical right' policies was leaked to the press in 1982: but then Thatcher was not ready to move. A more influential document was the 1984 *Omega Report*, drawn up by the Thatcherite Adam Smith Institute in the self-confident afterglow of the 1983 Election victory.

Looking for areas suitable for private expansion inside the NHS, the *Report* insists upon the term 'hotel costs' to describe the costs of keeping a patient in a hospital bed. It suggests that a 10% saving in this cost could support '51,000 extra nurses, or 17,600 extra doctors'. It goes on to list a wide range of other services which it regards as 'candidates for potential savings', looking far wider than the three services – domestic, laundry and catering – that

had already been put out to tender by DHAs. Portering, administration, security, maintenance and pest control are all seen as ripe targets.

Then come the proposals for wholesale privatisation of the NHS. DHAs, says the *Omega Report*, should be run as 'independent commercial enterprises' (one of the options reportedly now under consideration in the Thatcher 're-view'). NHS buildings and facilities which are unused or under-used through lack of funds should be sold or leased to private health care firms (this too is already happening). Impoverished NHS hospitals could in turn hire facilities from the wealthy private sector (there is already a boom in private operations being carried out for NHS hospitals).

Expanded private check-up clinics, offering X-rays and other tests, could help close down hospital outpatient facilities and give a 'boost' to the income of GPs, suggests the Report. Ambulance services could be cut back, privatised, and even replaced by 'public transport(!), taxis or cars provided by neighbours or relatives.'

But it is in the arena of *charges* that the *Omega Report* spells out most clearly the bleak prospects ahead if the Rabid Right have their way. It suggests charges for GP visits; for (privatised) Family Planning services; and for non-urgent ambulance journeys. There should be charges for 'non-essential' hotel services – such as beds! – in hospitals, at around £5 a day in 1981 prices (giving an average fee of £50 per visit to hospital, 'the equivalent of a TV licence'). Though there might be means-tested exceptions to these charges, they should be only for the very poorest, since 'The temptation to exempt too many groups will defeat the whole object of the exercise – for example some 31 million people are entitled to free prescriptions.'

The report suggests a 'health card' or 'Medicard' be used as the means of exemption. This notion of 'credit', coupled with the introduction of scales of charges would enable even the poorest to choose to use their 'Medicard' as part-payment for private treatment, and encourage the provision of different standards of comfort and care in hospitals, depending on how much each patient chose to pay. Meals would of course cost extra. People without exemp-

tion would be encouraged to buy stamps each week to cover their new health service fees – like the present TV licence stamps (or National Insurance stamps?). There could be tax rebates as incentives for those wealthy enough to opt out of NHS cover and buy their own comprehensive health insurance.

Eventually, the *Omega Report* dreams, health insurance could be made as obligatory as car insurance (except of course people can choose *not* to buy a car!). In this 'brave new world', redundant NHS hospitals and institutions could be taken over by private practice. The clock could be set back 50 years or more, almost as if the NHS had never existed. The more time goes by under Thatcher, the more the *Omega Report* appears not the ravings of a crackpot team but a blueprint for a deadly serious political attack.

At the end of 1984, two Tory MPs went public with calls for a system of charges for NHS treatment. Edward Leigh MP, writing in *Conservative Newsline* in September suggested that 'Full charges should be established for all except OAPs, children and the chronically sick,' apparently not knowing that those categories account for a majority of NHS in-patients. Meanwhile, Mid-Sussex MP Timothy Renton went one better, suggesting a profit-making system.

By 1986, the right wing's plans had widened out in other directions. A booklet published by Sir Keith Joseph's Centre for Policy Studies, written by a former general manager of BUPA, gave a few more ideas on what some would like to see. *NHS: The Road to recovery* by Hugh Elwell argued for new ways of bringing 'the citizen into close touch with the health service,' and giving him/her 'a more effective voice'. Back would come payment of a 'modest fee' for visiting a GP, and hospital patients should pay 'a modest hotel fee – a minimum of £15 a night and a maximum of £75 for their stay,' while 'growth of insurance schemes should be encouraged.' It would be back to the 1930s with a vengeance, with charity funding once again a mainstay of the service:

> Labour MPs especially have decried as 'nurses with

> begging bowls' this form of charitable contribution to the NHS, but views seem to be changing with the demonstrable effectiveness of the hospice movement. Though much money would be raised through fetes or flag days, substantial amounts could come from annual donations allowable against tax by the donor. Charitable contributions might seem like a drop in the ocean against the £18bn NHS annual budget (!), but many thousands of pounds (!) have been raised for local units like this.

Nevertheless, Mr Elwell had to admit that under his system:

> As the strain increases on NHS funding, it is hard to see where greater resources are to come from unless there is a payment by the hospital patient when using the service. A board and lodging charge would provide the unit with additional funds and would make the patient an active participant (!) in the way the service was provided.

There, in a nutshell, is the right wing notion of accountability, offering patients the kind of 'participation' enjoyed by a customer in Sainsbury's – the right to complain afterwards. The pamphlet proved too embarrassing for Tory ministers to endorse at the time, and was quietly pushed out of the limelight as the decks were cleared for another General Election. But since June 1987, the concept of a tin-shaking, flag-selling NHS has been gathering supporters among despairing NHS managers as well as ministers.

Once that Election was in the bag, the dyke was breached, and a torrent of cranky right wing ideas on 'alternative' funding have poured forth in the tabloids and even the serious press. One set of proposals from an 'Investigative Seminar' organised by the far-right Carlton Club in November 1987 explicitly began with the admission that 'against a background of inadequate Central Government Funding, the Health Authorities throughout Britain are technically bankrupt, with aggregate debts approaching £1,000m.' Among its concluding suggestions are:

- Privatising even more NHS services including Intensive Care Units, Pathology services; ambulances, secretarial work, housekeeping and building project management
- *Dismantling* 'the appallingly involved Employment packages/salaries and wages structure currently dictated by an out-of-date Whitley Council'
- *Disbanding* 'old fashioned' trade unions (COHSE, NUPE, ASTMS, etc, etc)
- *'Retitling'* the NHS 'to show that its first 40 years was the 'end of the beginning', and that from 1988 onwards a whole new concept of *funding* and services (with a major accent on fitness) will take us into 2000 AD.'
- *Extending* the 'principles of charging' and creating 'a costed service'
- *Creating* together with the private sector 'a National Health Insurance Scheme'
- *Increasing* the use of joint ventures between the NHS and Private Sector, 'creating an integrated and inter-related market'
- *Dismantling* Regional Health Authorities, 'concentrating all Funding and Administration at DHA level,' with the right of individual hospitals to 'opt out', 'thereby instilling into the system a competitive element'; (a proposal to abolish RHAs was recently defeated in a half-empty House of Commons by only 17 votes)
- *Tax relief* on private medical insurance premiums

(Tax relief on private medical insurance payments would cost the Exchequer at least £150m a year, not a penny of which would go into the NHS.)

The Barmy Right know that there are only two basic sources of 'private money' for the NHS.

One is *your* money – as a patient paying new charges for treatment that is presently free, or as a subscriber (willing or not) to additional private medical insurance over and above your taxes and National Insurance contributions.

The other is *company* money, invested in various schemes with a view to reaping a *profit* out of aspects of health care. However, almost any injection of company money will also involve more patients paying charges for treatment: so in the last analysis there is only *one* source of new 'private money' – and that is *your* purse or wallet.

Charity funding of course is another, less direct way in which the generosity of individuals and their commitment to the NHS is exploited to fill in the gaps in government funding. However this, too, comes down to persuading *you*, the punter in the street, to pay more as an individual, while the government (in the name of the anonymous fit, healthy and young 'taxpayer') seeks to pay less on behalf of us all collectively. A number of schemes have been pushed forward by the Rabid Right to conceal this harsh reality. Among the more frequent are;

▷ *Voucher Schemes*, which dress up charges for treatment and a new two-tier system as an exercise in 'consumer choice'. The schemes would all cost an arm and a leg to administer, requiring a vast new parasitic army of cashiers, administrators and debt collectors, while the nursing crisis lurches from bad to worse.

▷ *'Hotel charges'* mean paying for each day and night spent in a hospital bed. The term 'hotel' is used to suggest idle luxury, but few would want to take up Edwina Currie's suggestion and spend their holiday money on hospital treatment rather than their fortnight in Torremolinos (and many peole cannot afford even one holiday). An obvious problem with 'hotel charges' is that they would need to be means-tested, since a majority of in-patients are pensioners or children. Those caught for the full charge would have to pay a hefty sum to cover the massive numbers of exemptions. This would be wildly unpopular and expensive to run.

▷ *'Creating an internal market'* and competition within the NHS is a trendy notion that means next to nothing unless NHS resources are substantially increased. Without additional cash, for example, many major hospitals especially in London will need to *reduce* their caseload. What comfort would it be for elderly and severely ill patients to

hear of 'competitive' NHS hospitals with vacant beds in Liverpool or Devon? Worse, if London's hospitals somehow *did* succeed in competing and increased their 'market share' in relation to other regions, they would in effect begin *reversing* the limited steps to equalised resources that have occurred as a result of RAWP. Prestigious London teaching hospitals could in theory squeeze smaller provincial hospitals out of business, reverting to the worst inequalities of the system before the NHS.

▷ *Separating out a 'health stamp'* seems like a pointless organisational change which would produce no extra cash for the NHS, until we realise it would reduce income tax but send National Insurance contributions through the roof. This plan has been advocated by Leon Brittan and others. They like it because many low paid workers (who barely pay income tax, but do pay National Insurance) would be hit extremely hard. To round off the scheme, Brittan and pals advocate that the filthy rich be given the chance to 'opt out' of the state plan altogether, which would leave only the poorest and least healthy to use and pay for the remains of the NHS.

▷ *'Greater co-operation with the private sector'* is yet another deception, since the whole burden of training nurses, medical and technical staff, the whole burden of providing emergency services and care of the chronic sick lands on the NHS and local authorities. This leaves the private firms free to offer their increased 'co-operation' in the most lucrative waiting list operations.

▷ *The Lottery*: Why not run a state lottery, raising millions for the NHS? No less than 121 (not exclusively Tory) MPs actually voted in February to support a private members' Bill proposing an NHS Lottery – with 164 against. Yet this too would require a whole administrative machinery to print and sell tickets, count and collect the money, calculate and pay 'winners' and promote the whole enterprise. It is sometimes hard to realise that the ultra-right advocates of this type of policy are the same people who suggested sacking thousands of ancillary workers to focus health spending on front-line nursing: apparently they prefer to hire unnecessary fund-raisers than to pay

hard-working cleaners. If this type of funding is such a good idea, let the government start a lottery for Trident, or a raffle to fund the police force.

The shape of things to come?

Already there are increasingly frequent glimpses of the type of health care we could expect if some of these schemes ever bear fruit in government action. Vital research work on ovarian cancer, for example, which kills 4,000 women each year, apparently depends upon patients selling raffle tickets to raise money. Margaret Woddis from Leyton in East London took part in an ovarian cancer screening programme at the London Hospital, Whitechapel. Yet she was appalled to receive a follow-up letter on health authority notepaper, asking her personally, and other patients to help keep the project alive. It said:

> The first phase of the . . . project has yielded extremely valuable and exciting results . . . There is now a real possibility that we can dramatically improve the outlook for the 4,000 women a year who die from ovarian cancer in this country.

However, there was a snag. The letter went on to state that since the project is 'funded by charitable donations', patients could lend a hand:

> By helping us to raise sufficient money to complete the project *by selling tickets for our 1988 raffle*. If every woman who has already attended the clinic sells tickets for us, the future of the project will be assured.

Of course hidden in this appeal is the tacit threat that if some of the women concerned do *not*, for whatever reason, sell their raffle tickets, they could be partly responsible for the project being wound up – and 4,000 women a year continuing to die.

Another glimpse into the possible future of an NHS which pursues Mr Moore's suggestions of 'income generation' comes in the intriguing report of a police raid last autumn on Sicily's biggest hospital, which according to a

report in *The Times* found 'a private chicken farm in the cancer ward, dozens of cats in the corridors, a fig plantation in the intensive care unit and piles of discarded syringes used by heroin addicts.'

> The arrested hospital workers argued that the bending of the rules was part of a self-help plan to make up for health service cuts. One employee said that he had introduced almost 30 cats to keep down rats and mice. Another worker explained that the chickens were supposed to provide fresh eggs for the patients. The fig plants were part of a scheme to provide vitamins. 'It was all a question of market forces adjusting to difficult times,' one doctor said.
>
> (*The Times*, 22.9.87)

4 *The victims*

Does the Community care?

Women bear the brunt

In 1982, the Equal Opportunities Commission warned that:

> The expectation that women will provide the necessary care within the family whatever the cost to herself still underpins the reality of community care. Cuts in health and social services and cash benefits intensify the demands placed on carers, they mean there are less physical resources to aid them, less alternatives to relieve them, and less money to support them. Savings in public expenditure increase the cost to the carer in terms of her social life, her employment prospects and ultimately her physical and mental well-being. These costs are borne individually and do not figure in any public expenditure account. The price paid is the restriction placed on women's opportunities.
>
> *Who Cares for the Carers?*

In 1985, a top regional health authority official admitted that the government's plans to transfer patients from hospitals to community care were completely impractical. David Pace, Treasurer of SW Thames RHA told a conference of the Royal College of Physicians that hospital services and community care could not both be properly financed under existing cash limits – and;

> People are going to have to face the fact that they are going to have to work for nothing . . . We should be talking about people giving up part of their leisure time to look after people in the community.

There are no prizes for spotting that the 'people' being called upon to work for nothing and give up their leisure to look after other 'people' are *women*, being lumbered with even more domestic toil. Of course not only the carers, but the majority of elderly patients are women, who have been the main victims of the whole community care fraud. A vivid example was the Oxfordshire RHA plan for community care devised in 1982-3. As *Health Emergency* warned in 1984:

> Oxfordshire RHA plan to reduce institutional care on the assumption that people will get support services in their own homes. But those support services – social workers, home helps, meals on wheels, etc – and housing arrangements are scandalously inadequate at present for the elderly. Purpose-built sheltered accomodation is available for only a few . . . Many elderly people live in homes that are cold and damp, need modernising, adapting and insulating. Who will pay for this? . . . As for community care, Oxford already has 300 families waiting for home helps, and employs only half the number laid down by the DHSS norms. £55,000 – plus a charge to pay from home helps – has just been lopped off the meals on wheels budget. 120 villages are without meals on wheels. Numbers of social workers coordinating services for the elderly have been cut and plans for day care centres have been scrapped. Subsidies for lunch clubs, help with telephone rentals, laundry services, chiropody services and transport have all been cut. When health authorities turn elderly patients away from hospitals and close them down they know how little support there is outside – and that their families will be expected to look after them. This means daughters or daughters-in-law will have to give up their jobs to take care of elderly dependents . . .

As the Oxford example shows, the squeeze has not been just on the NHS but simultaneously on local government services. In 1984 the Association of Metropolitan Authorities warned:

> The suspension or abandonment of planned NHS projects, particularly for the elderly, will have major consequences for local authorities. There is some evidence that health authorities are attempting to use Joint Finance Funds to protect their own main-line services.

Crisis for the elderly

Meanwhile the looming crisis in care for the elderly grew more severe with the news that not one RHA in the country was planning to provide the target bed quotas for the elderly suggested by the DHSS in 1976. Despite an 'age explosion', with an increase of 1 million in numbers of elderly people over 75, RHA plans looked to per capita numbers of geriatric beds 25% *less* than 1976 guidelines, with day places a massive 50% below DHSS recommended target provision. In replying to a questionnaire from Shadow Social Service Secretary Michael Meacher, two thirds of regions made no reference at all to support for carers looking after elderly patients at home. In fact some 25,000 hospital beds for the elderly and the mentally ill have been closed since 1976, while only 9,000 day care places have been established. An estimated 1.25 million women care for disabled or elderly relatives at home – over 100,000 of these have been caring for over 10 years, and surveys suggest two thirds of them may themselves be in poor health. Yet a recent survey showed that 83% of carers received *no assistance whatever* from community nurses, health visitors, GPs or even members of their own family.

Under the rhetoric of community care a dramatic load-shedding operation has been carried through by the NHS, especially with elderly and psychiatric patients, more and more of whom are being dumped outside of the NHS. In the 10 years to 1984 the bed occupancy time per geriatric patient has almost *halved* – though not as the result of any medical breakthrough. At the same time there has been a dramatic increase in the number of residents in homes for the elderly from 130,000 in 1974 to 250,000 today. A

similar picture emerges for psychiatric patients over the same period: the number of psychiatric beds fell, average stay per patient almost halved – but the number of places in homes and hostels for the mentally handicapped and disabled has *doubled*. The total of these residential places in homes and hostels now rivals the number of NHS beds. In the case of homes for the elderly, the expansion has all taken place in the private sector; there seems to have been no increase at all in local authority homes.

The return of the means test

Why has this switch taken place? Firstly because outside the NHS all care is means-tested. This fact has not been lost on Sir Roy Griffiths whose recent report on Community Care eyes up the potential for extra cash from this source. The statistics from the DHSS, local authorities and the Audit Commission show that already:

▷ Some 50% – even as many as 65% – of the patients in private homes are *paying their own fees*, which in most cases means they have had to sell their own homes to raise the money;

▷ Local authorities 'claw back' 36% of the costs of their homes for the elderly. Much of this money must come from the same source. If a patient leaves his or her home for non-NHS residential care, the house is counted as a capital asset for means-testing. The total of all these fees and claw-backs must be around £1bn each year.

Health care responsibilities (and costs) are thus shunted from the NHS to the local authorities and the DHSS through social security benefits. The advantage to the government is that by forcing thousands of elderly patients into the limbo of community care they can squeeze from them their life savings as a compulsory donation to the costs of their residential care, milking them and their families to the tune of hundreds of millions of pounds each year.

A Brent social worker, in the aftermath of the closure of the Neasden geriatric hospital summed up the situation in *Health Emergency*:

> In Brent at the present time, Community Care can be likened to groups of nurses, health visitors, social workers and community workers sailing along in a boat that is rapidly developing holes and is sinking. As these workers, totally demoralised, desperately try to shore up the sinking vessel, so more gashes, cuts and holes appear, and the task seems more and more hopeless. The recipients of care suffer, and expect, poorer and poorer services. Community care is to be provided at best on a shoestring and at worst with no extra funding at all. It is to take place against a backcloth of a community itself being destroyed by unemployment and massive cuts in health, education, social services and voluntary organisations. . . . The policy changes have been agreed on paper: but in reality on-going support for workers in the field is non-existent.

The enthusiasm of Ministers and top management for community care schemes is reminiscent of the enthusiasm of some architects for tower blocks, and businessmen for Youth Training Schemes: they are happy enough as long as it is for *somebody else*, or somebody else's relatives: there is no way they ever intend to receive the treatment they are so happily meting out to others.

Lives in danger

Meanwhile the constant pressure to cut hospital spending can imperil the very lives of women in long-stay hospital care. Many of the closures of geriatric wards and hospitals have been traumatic upheavals for patients, followed by a sharp – and predictable – increase in patient deaths. An example of this was revealed in the summer of 1987, when grim warnings of deaths if a 17-bed ward for elderly women was closed in Bexley Hospital were proved tragically correct. Four consultants had warned against the sudden, cost-cutting closure of the ward for the elderly mentally ill. But Bexley health authority voted to ignore the medical advice in the hope of saving £125,000 by the move: seven patients out of the 17 died soon after the transfer, compared to only two of a comparable 18-bed

ward who had not been moved. Consultant Dr Mike Cohen told the *Bexleyheath Times*:

> One has to say that some of the women would have died in any case, but we did say there was the likelihood of increased deaths, and this has been shown. The decision to move the patients was not taken for clinical reasons, but purely to raise money.

Similar grim testimony to the impact of unnecessary cuts and closures on the very lives of elderly patients has also emerged from Woodilee Hospital in Scotland, Neasden and New End Hospitals in London and Thornton View Hospital in Bradford.

The mentally ill

The plight of psychiatric patients discharged to the tender care of the community has been a steadily mounting scandal. The NHS assumes that people passing into the community are on their way to social service care: social services assume the opposite. In between the two, people 'disappear'. Of course they do not really disappear: ask them, ask the carers. The National Schizophrenia Fellowship has called community care 'The gap where a service ought to be.' The NSF estimates that 2,500 mentally ill people are being transferred to the 'community' each year.

NSF figures show that nationally out of 224,000 people suffering from chronic or relapsing schizophrenia, only 17,000 are in hospital care, and 3,000 in local authority, private or voluntary homes – while the whereabouts of no less than 204,000 are 'unknown'. The picture is only too clear: 90% of sufferers are cared for by relatives – or not at all.

Little appears to have changed since 1985, when an all-party select committee of MPs made their highly critical appraisal of community care schemes with particular reference to the mentally ill and mentally handicapped. The committee was highly sceptical of the viability of government plans, and stressed that community care, if properly provided in such a way as to benefit patients is *more expens-*

ive than present services, and therefore requires *increased funding*, which was not on offer from the government:

> A decent community-based service for mentally ill or mentally handicapped people cannot be provided at the same overall cost as present services. The proposition that community care could be cost-neutral is untenable. Even if the present policies of reducing hospital care and building up alternative services were amended, there would in any event be considerable additional costs for mental disability services. There are growing numbers of mentally disabled people living in the community with older parents; some provision will have to be made for them. The Victorian hospitals in which thousands of mentally ill or handicapped people still live, in visibly inadequate conditions, will either have to continue to be shored up, at growing capital and revenue expense, or demolished and replaced by more appropriate housing, at even greater expense.
>
> If the hospitals were to be maintained, it is also inevitable that in most hospitals staffing ratios and the proportion of trained staff would have to be improved. (. . .) proceeding with a policy of community care on a cost-neutral assumption is not simply naive: it is positively inhuman. Community care on the cheap would prove worse in many respects than the pattern of services to date. (. . .) There is ample evidence of the decanting of patients from mental illness hospitals in years past without sufficient development of services for them. This has produced a population of chronically mentally ill people with nowhere to go.

However life in an NHS psychiatric hospital is no bed of roses either, and as spending cuts bite home, there are increasing signs of Victorian values in the old work-house ethic of some managements. In the autumn of 1984, for example, it was announced that psychiatric patients at St Cadoc's hospital in South Wales were to have their hot evening meal replaced with soup and sandwiches to save money. *Health Emergency* queried whether 'the next cut would be to remove the soup'. The same year, North

Manchester's Springfield psychiatric unit cut patients' wages for bed-making and other duties almost in half, from £7 to £4 per week, an hourly rate of 19p. In the summer of 1986 came similar news showing that the true spirit of Scrooge lives on in parts of the NHS, as *Health Emergency* reported:

> 'Let them eat cake!' said Queen Marie Antoinette when the Paris mob could not afford bread. But today's hospital patients stand equally little chance of luxury fare. At the Maudsley Hospital, stingy managers have cut the amount of jam in kids' sandwiches, restricted supplies of tomato sauce, and cut rations of cake and biscuits in an apparent entry for the 'Scrooge 86' cost-cutting award. Even biscuit manufacturers were astounded at the news and delivered a couple of free boxes to make up for the miserly attitude of the management.
>
> Meanwhile at the Friern Hospital, cooked breakfasts are to be replaced by continental breakfasts, in efforts to prune back spending at the expense of disadvantaged patients.

Women and the NHS crisis

Maternity services

Though women are the most frequent users of all NHS services, they suffer from the sexism of a male-dominated medical profession in which only 1% of surgeons and 12% of gynaecologists are women. Despite the fact that they comprise 30% of medical students, only 22% of practising doctors are women. This pattern is reflected in the low priority attached to services for women.

Maternity services were slow to develop in the NHS: as late as 1958 a third of babies were being born at home, with 20% in GP units and the remainder in hospitals where maternity beds were in short supply. Alarmingly high incidence of complications in childbirth, many of these leading to the death of mother or baby led to a 1959 report recommending tighter criteria for home births. The consultants enthusiastically seized upon this, and propaganda

for hospital deliveries bombarded women from all sides. By the 1970s only tiny numbers of determined women were defying medical pressure and insisting on having their babies at home. The subsequent outcry against ever-growing and excessive medical intervention, and campaigns for a return to forms of 'natural childbirth' (or at least for some form of choice to be offered to women) were urged on by the awakening women's liberation movement.

They objected to the way one of women's most natural and healthy functions had been transformed by a largely male hierarchy of specialists into an alienated, hi-tech process which often – through frequent resort to 'induction' methods – appeared geared to producing births at times of day best suited to doctors, and – through epidural anaesthetics and large numbers of caesarian operations – deprived women of much of the sensation and experience of childbirth. This pressure appears to have had some effect; levels of intervention and numbers of induced births abated, though the unresolved potential conflict between women and the male-dominated profession rumbles on. The recent conflict over methods of delivery between leading obstetrician Wendy Savage and the notorious sexist hierarchy at the London Hospital was simply a visible reminder of this problem.

The almost obsessive preoccupation of hospital management with speeding 'throughput' of women in maternity beds has also contributed to a renewed crisis of maternity care in the 1980s. This is one very special form of care in which a 'waiting list' is obviously impractical – and a shortfall of beds can prove disastrous. London's birth rate is rising, yet 28 maternity units have closed in the capital since 1974, and 16% of maternity beds have been axed since 1980. Cash-strapped maternity units have been imposing rigid catchment areas to limit the numbers they admit. By the summer of 1987, pressure of work had reached the point where in three London districts women were moved *while in labour* to other hospitals because all the beds were occupied in the units where they had booked to have their babies.

Pressure on units to discharge women ever more swiftly after giving birth can also cause serious problems for their full recovery, especially when women are sent back home without support to an over-crowded house or flat where they may already have young children, and come under pressure from their partner to resume domestic chores. To make matters worse, low pay has helped create a shortage of midwives in many areas, with many maternity units in London 20% short-staffed.

Family planning: a soft target

Family Planning services are also under fire as community services bear the brunt of many cuts packages. Family Planning has always seemed a relatively 'soft' target for cuts, since health authorities argue the same service can be provided by GPs instead – thus pushing the bills onto the open-ended Family Practitioner Service budget.

A recent report confirms that the autumn of 1987 brought a new toll of cutbacks in Family Planning clinics. While the heaviest impact of this will fall again on women, men, too are affected. In 1984 a report from the Birth Control Trust and Family Planning Association complained that cuts and cash limits were hampering the clinics, with the effect that many were simply turning men away, while others would issue condoms only to wives. Most clinics told the survey they could not afford to offer condoms. It is estimated that 80-200,000 unwanted pregnancies a year could be avoided by involving men in family planning responsibilities. Yet while 2.8 million couples rely upon them (compared to 3.5 million women using the Pill in 1984) only 6.6% of condoms were provided free.

This policy reflects male priorities. The Pill has been linked with forms of cancer and other complications, (especially for women who smoke); yet it is provided free, while the second most widely used method of contraception, the condom, which reduces male sensations but also helps reduce incidence of cervical cancer, venereal disease, herpes, AIDS and other sexually-transmitted diseases among women, has to be purchased. Meanwhile many

male GPs remain ignorant on how to fit women with a diaphragm or coil.

Much worse scandals affecting women have come from some of the mechanical inter-uterine contraceptive devices such as the notorious Dalkon Shield which have caused agonising discomfort, serious complications and even death for those unfortunate enough to be fitted with them.

The feminist magazine *Spare Rib* ably underlined the evident cavalier disregard for women's health among the (male) researchers when these devices are developed. A satirical article *Breakthrough in Male Contraception – A Joke* discussed in teeth-clenching detail a new 'intrapenile device' which:

> is inserted through the head of the penis and pushed into the scrotum with a plunger-like instrument. Occasionally there is perforation of the scrotum but this is disregarded since it is known that the male has few nerve endings in this area of his body . . .
>
> Dr (Sophie) Merkin declared the Umbrelly to be statistically safe for the human male. She reported that of the 763 graduate students tested with the device only two died of scrotal infection, and only twenty experienced swelling to the tissues. Three developed cancer of the testicles, and thirteen were too depressed to have an erection. She stated that common complaints ranged from cramping and bleeding to acute abdominal pain. She emphasised that these symptoms were merely indications that the man's body had not yet adjusted to the device. Hopefully the symptoms would disappear with a year . . .
>
> (April 1980: Penguin *Spare Rib Reader*)

No laughing matter was the fact that devices – and later drugs such as the injectable contraceptive Depo Provera, first available in 1963 – with equally pernicious side-effects were being widely prescribed for women by GPs apparently ignorant or indifferent to the suffering they would cause.

Abortion, the law and the doctors

For those women who faced unwanted pregnancy before 1967, restrictive legislation, coupled with restrictive private practice, made it difficult to obtain an abortion. Legal abortion was only permitted in exceptional circumstances, when the woman's mental or physical health was 'seriously endangered'. Of course this definition rested – as so many other medical decisions – on the discretion of the doctor, and could often be influenced by putting sufficient money on the table. In 1966 around 20,000 legal abortions were carried out – half of them in the private sector: wealthy women however could also go for their abortions to clinics in Switzerland or Sweden.

Tens of thousands, especially working class women, were driven to seek illegal abortions: estimates of actual numbers ranged from 15,000 a year to 100,000. After sustained campaigning from the Abortion Law Reform Association (ALRA), Liberal MP David Steel, with low-key tacit support from the then Labour government, steered through a private member's Bill which became the 1967 Abortion Act. But the new law did not go the whole hog and repeal the 1861 Offences Against the Person Act which had illegalised abortion: instead it simply created a series of exceptional circumstances permitting abortion – conditional, once again, on the consent of two doctors. This fell a long, long way short of giving women the 'right to choose'; but it did at least open the way for a massive expansion in legal abortions, which increased from 35,000 in 1967 to 95,000 in 1971.

Even this new figure did not reflect the true level of demand for abortion services: reactionary doctors, often with the support of nursing staff influenced by Catholic dogma, have continued to use the restrictions of the Act and their monopoly grip on decision-making to prevent women from obtaining abortions. Whole areas of the country (such as Birmingham) have become notorious for the difficulty of obtaining abortions on the NHS. A booming private and charitable sector – which impose charges on women for abortion services – has continued to play a

key role, performing at least half, and now a majority of legal abortions.

The onset of NHS cuts in the mid 1970s brought a more surreptitious attack on abortion services as obstetric and gynae beds have been closed, and staffing levels reduced: more and more health authorities have begun to 'farm out' abortion work to the private sector. On top of this, reactionary politicians eager to impose their 'right to choose' against abortion on millions of women have waged no less than fifteen Parliamentary attacks on the 1967 Act itself. Ironically, the most recent and most likely of these attacks to succeed is the Bill proposed by Liberal David Alton, undermining the important advances of David Steel's original measure. The women's movement, most vocally the National Abortion Campaign, often with substantial trade union support, have been forced to defend the limited but significant gains of the Act, while waiting for the chance to complete the liberalisation of abortion laws to give women a genuine 'right to choose'.

To prevent, or not to prevent?

A tell-tale sign of government priorities in the 1980s has been that while Ministers have got tough and tried to press-gang every health authority into privatising ancillary services (at the expense of thousands of low-paid women's jobs), it has barely lifted a finger to compel them to introduce systematic screening for cervical cancer. To have set up a fully-fledged computerised system that would call and recall women for cervical smear tests would have cost only £17 million in 1985 (out of a £17 *billion* NHS budget). In exchange it could save the lives of up to 1,000 women each year – avoiding not only the needless trauma, and agonies of the women concerned, but also the need for intensive treatment and terminal care for those unfortunate enough to die from it.

Instead of implementing the necessary scheme, ministers tried for years to conceal the 1982 recommendations of the Committee for Gynaecological Cytology which would have established a national computer register with regular

screening for the women most at risk. Health authorities were left to do their own thing, with some model work being done (and saving lives) in parts of Scotland, while in England local policies ranged from call and recall every three years to no scheme at all. Some health chiefs actually resisted moves to persuade more women to seek cervical smears – on the grounds that inadequate path labs were already over-burdened and facing backlogs of months, and that this would get worse if more women demanded tests! Despite a succession of public scandals which piled added pressure onto the government, many districts still have not set up a computerised register or the automated call and recall system for women over 20, which would almost certainly halve the 2,000 a year death toll from this curable condition. Worse, the latest government suggestions for privatisation include pathology services: the standards of private path labs have already been shown to be extremely low, and women's health could be further at risk from the false diagnosis of a positive smear test.

Despite a more energetic Tory pretence of concern, there is a strong danger of a similarly careless approach to the prevention of breast cancer, as a result of inadequate resources to implement a new screening programme. Early in 1987 Norman Fowler announced he was accepting the full proposals of the Forrest report on prevention of this most common cancer in women, which kills 15,000 each year, and allocating £6m to set up the first 14 screening units. Over 3 years the programme would cost £50m, including £31m for new equipment to screen the 5 million women aged 50-64 who are most at risk. The idea was to offer every woman in this age range an X-ray check every 3 years. But the economics of the scheme allowed for only 120 of the specialist screening units across the whole country – less than one per health district. The Society of Radiographers has questioned whether there will be enough trained staff to operate these units if the present miserable rates of pay are not improved.

However this is not the only problem. The Forrest costings are based on each unit processing 12,000 attendances each year – requiring a target population of

471,000. In many parts of the country several districts together could only just total that many: only one London District (Barking) is that big. So in the hunt for 'efficiency', women are to be obliged to travel often long and awkward distances for their X-rays, remembering that in any case many will need to be persuaded to attend, and fewer women than men have the use of a car. This penny-pinching and leisurely approach to a screening programme which could save 1,600-2,000 lives a year does nothing to show women's health is being taken seriously.

Well Women?

90% of young women believe they should have a choice of seeing a male or female doctor: but in 1985 only three health authorities could offer such a choice. Indeed, even as increasing numbers of women are recognising the value of Well Woman clinics, health authorities have begun cutting and closing them to save money, while others have been using the title to set up clinics which are run not by women but by male doctors and staff. Such clinics often amount to a cut in existing Family Planning and cytology facilities.

Many women complain that some male GPs dismiss their problems as 'trivial'. These problems can include vaginal discharge, period pains and menopausal problems which are often considered to be things women have to put up with because they are women. A Well Woman centre is one way of trying to change this.

Meanwhile the pathetically tiny health education budget (0.38% of NHS spending, now totally swamped in the last few years by the unprecedented anti-AIDS campaign) has helped widen the 'health divide' between younger, more middle class women who are better placed to take advantage of modern advice on diet, smoking, and other aspects of their own health, and older working class women. Many working class women live in stressful and deprived circumstances, but find themselves time and again fobbed off by impatient and inconsiderate GPs who hand them routine palliative doses of tranquilisers or anti-depressants which can themselves become addictive and add to misery and distress.

Racism – a blight on the NHS

Passports before health care

Racism in a variety of forms has hit Britain's black communities at every level as users and workers in the NHS. And – as on many other issues – things have got worse rather than better since 1979.

One overtly racist move which understandably enraged many black people was the Thatcher government's decision in 1982 to impose hospital charges on overseas patients, with regulations requiring a patient to prove that s/he is 'normally resident' in the UK before receiving free treatment. The scheme quickly vindicated its many opponents who had argued that it was not only racist in motivation but bureaucratic in practice – more costly to administer than the charges it would raise. A mere £374,459 was collected in its first six months, compared to government forecasts of £6m a year. 157 out of 192 health authorities raised less than £100, with only £167 from London's 840-bed Royal Free Hospital and £71 from the Royal Liverpool Hospital.

Wider problems faced by black patients have also been worsened by spending cuts, and publicised by campaigners in recent years. Complaints from black and ethnic minority patients included the lack of interpreting, literature in languages other than English, attention to special diet, and outright racist attitudes: 'The doctor was surprised I was married. He smiled at me and said "I thought you coloured girls didn't believe in marriage."'

People from black and ethic minorities face racism and discrimination like this at all levels within British society. They are also generally concentrated in lower-paid occupations and experience further inequalities in housing and education: this makes them more vulnerable to the ill-health generated by poverty and deprivation. All this is compounded if, when they seek health treatment, they suffer from the racist prejudices and hostility of NHS staff: it can seriously affect the standard of care and help they receive, discourage them from making full use of their right to treatment, and hamper their recovery.

Training for multi-racial society

The training of professional NHS staff, especially doctors (who themselves often come from the more privileged layers of the white middle class), rarely takes into account the reality of a multi-racial society. Lack of appropriate training means that few professionals fully understand the cultures and situations of black and ethnic minority communities. All of these problems are exacerbated by the generalised lack of NHS resources, forcing continual unacceptable choices onto management and staff, and pressurising staff as well as patients.

Particular groups of patients suffer additional problems. Black women, for example are diagnosed as schizophrenic *four times* as often as white women, but seldom diagnosed as depressed. In the view of the (mostly white) psychiatric profession, black people unlike whites tend to 'go crazy' rather than get depressed. Psychiatry is one of the strongest bastions of the old, racist colonial attitudes traditionally shown by Britain towards the black peoples of the 'Empire' in the West Indies, Africa and Asia. White psychiatrists remain largely ignorant or indifferent to the cultural and social heritage of their black patients, their traditions and family customs. Dr Aggrey Burke, Britain's only leading black psychiatrist, argued in 1985 that this had led to black people who are not mad in any sense of the word being confined to institutions:

> Madness means different things to different people, to different communities. People are driven 'mad' for different reasons. In seeking a solution we must understand the nature of the predicament black people here find themselves in. When you have a situation where one in every two black families will have a member of the family who has been in trouble with the police, or a situation where 70% of black men are unemployed, suffering bad housing and racism, you have a kind of perpetual disgrace situation which can quickly lead to people suffering mental illness.
>
> *The Voice*, 8.12.85

The closure of psychiatric hospital beds without any satisfactory provision of community care opens up fresh dangers to black patients, as Cynthia Franklin of the Afro Caribbean Voluntary Help Association points out:

> You will have all of these people needing help on the streets since they will be returned to their area of origin. The government have made no attempt to re-educate people about what mental illness is all about, so if groups like us can't cope with the numbers, these people will be wandering about the streets, being picked up by the police. Very soon the police will begin to believe that not only are we all bad, we are also all mad. We will all get tainted with the same brush. All because of a lack of political will to provide resources to care for these people.
>
> (*ibid*)

Special problems

There are other special problems affecting groups of black patients. One Afro-Caribbean baby in every ten thousand is affected by the genetically-carried sickle cell disease. Yet the NHS has no national system of screening for the disease, even though it can be easily diagnosed from a simple blood test, and other genetically-carried blood disorders are monitored (every new-born baby's heel is routinely pricked for a blood sample to screen for the extremely rare condition known as PKU). It is hard to avoid the conclusion that if the victims were white rather than black, the disease (which causes a range of symptoms including fatigue, severe pains and anaemia) might not be seen as such a low priority. Many sufferers require regular blood transfusions, while children with the disease are especially prone to infections. The Runneymede Trust has argued for years that a national screening service is 'long overdue'.

Black women have also been the most at risk from careless doctors prescribing the controversial injectable contraceptive Depo Provera. In 1986, the *Oxford Courier* newspaper reported that at least four non-English speaking Asian women had been injected with the drug without

being warned of its often fearsome side effects. None of the women had been told that the contraceptive effects of the drug lasted for three months; nor that its side effects can include heavy bleeding and depression; nor were they warned that the drug has left some women infertile for up to 18 months. Depo Provera had already been banned in the USA, and has been marketed mainly in Third World countries; but despite strenuous efforts by women's heath campaigners it remains available in Britain – where, as the Oxford example shows, the main recipients have been black women.

The NHS as a racist employer

The NHS however is not just a service: for many thousands of black people it is also an *employer* – and a far from benevolent one at that. A glimpse into the values of the top NHS hierarchy was offered in the summer of 1986, when a public outcry against the outrageous racist comments of a DHA Chair, John Minter of NE Essex, forced him to resign. Minter had scrawled racist remarks, describing three Asian senior registrars applying for a consultancy in psychogeriatrics as 'unqualified wogs', on a sheet of paper which was subsequently photocopied and distributed to department heads. The photocopying was later described as an 'administrative error'!

Mr Minter explained that he had intended the comments to be seen by only a few colleagues – who he clearly expected would either share or tolerate his racist outburst. These colleagues, unlike Mr Minter, did not resign. *Health Emergency* asked:

> So who are these racists? How else do they give vent to their prejudices against black people? How many more racists lurk in equivalent posts in the medical and administrative hierarchy of the NHS. And since Mr Minter, like every other DHA Chair, is a direct government appointee, what is the government doing to uphold the recently publicised call from (Health Minister) Mr Barney Hayhoe for moves to stamp out racism?

Another glimpse of the same problem came in Trent region, where the regional medical officer, Professor James Scott, was accused of racism for his comments on how to solve the shortage of junior medical staff, in which he declared: 'Secondly, I would be opposed to relaxing immigration from Asia; we have already appointed too many second class doctors to permanent posts. On the other hand, I think we could and should do a great deal more to attract well-qualified doctors from the EEC for training (and permanent posts if so wished).' Professor Scott, of course, like Mr Minter, vigorously denied that his attitude was racist. Not many black people were convinced.

The following summer, West Lambeth DHA's Equal Opportunities Committee chair Stephen Bubb resigned in disgust at the DHA's refusal to sack a racist doctor, who was merely given a warning for making a remark to a patient about 'black people swinging from trees.'

That doctor's outburst will come as little surprise to observers of medical attitudes over the years. In 1984 the BMA showed its hand when it responded to the news that 1,000 doctors were unemployed. Their answer was to call on the government to keep out doctors from Commonwealth countries. *Health Emergency* asked:

'What will the BMA go for next to protect their own overfilled wallets and hierarchic privilege: compulsory repatriation?'

The BMA policy prevailed, however, and the Tory government obliged in 1985 with new moves to bar overseas doctors and dentists from their previous unrestricted right to enter Britain. Once again there was one law for the rich and one for the poor. Only the most wealthy (those with £150,000 with which to back a practice) or those taking up appointments with a work permit would still be allowed to come, though overseas medical students already in Britain were exempted. This new clampdown helped highlight the fact that though overseas doctors play a major role in the NHS, because of the racism of white consultants, they tend to be concentrated in the most taxing and least glamorous specialities, especially geriatrics. It was no surprise, therefore, when in early 1987 the Com-

mission for Racial Equality reported on the continuing racial divide within the NHS, pointing out that despite the thousands of black workers at every level – ancillary, nursing, professional and medical staff – in the NHS not one senior NHS manager came from an ethnic minority. Only a handful of unit managers and a smaller, tokenistic sprinkling of regional health authority members are black. A CRE survey of doctors in the Mersey region showed that out of equal numbers of white British and overseas doctors, merit awards went to 133 white Britons and only 10 overseas doctors. In the North West region, not one black doctor qualified for an 'A' category merit award – despite representing 20% of the total. Nationally, only one overseas doctor in 12 receives a merit award, while Britain's 15,000 overseas doctors find themselves confined to unpopular and lower-grade posts, find it harder to get a job and win promotion.

It's not only doctors who suffer racist employment practices. All grades are affected: of 27 London districts surveyed in 1985, only 12 had adopted a formal equal opportunities policy, and only 3 had done anything to implement it. Examples of ineffectual policies abound, including Brent DHA (where a supervisor was allowed to remain in post after distributing racist leaflets in a hospital canteen), and more recently Newham, where February 1988 saw management pay £500 to a Jamaican-born nurse who had worked for the authority for 13 years but was racially abused when she queried her pay-slip. West Lambeth is the only DHA so far to have completed a monitoring exercise on all jobs on the basis of race and sex. Yet West Lambeth's Nightingale school of nursing was found guilty of racial discrimination against a black applicant for a tutor's job.

Discrimination is also rife in the nursing profession, and likely to become worse with the moves towards revamping nurses' training in line with 'Project 2000'. This will effectively devalue the skills and experience of thousands of black State Enrolled Nurses, and create major academic obstacles to black women wishing to enter nursing. Even once qualified there are racial problems for black nurses

seeking promotion. A study of three hospitals in the North West showed that some 96.25% of white nurses were promoted to sister/charge nurse posts within 18 months, compared to only 45% of black nurses.

> Only 1.2% of white nurses had to wait two years for promotion, while 35% of black nurses had to wait for periods ranging from two to over six years.
>
> Protasia Torkington, *Nursing Times* 17.6.87

The fight against all forms of racism in the NHS clearly has a long way to go.

5 *The unions*

Whitleyism

Despite the abysmally low pay of health workers, it was to be 24 years from the foundation of the NHS to its first official pay strike. The formation of the NHS was linked to the establishment of the Whitley Council system of pay negotiation, in which the unions and 'professional bodies' were given seats together on the 'staff side', while management took the other half of the seats on each council. The Whitley councils only have the power to *make recommendations* on pay and conditions to the Government, which retains the whip hand in deciding whether or not to pay up.

Whitleyism embodied automatic recognition and certain basic rights for union organisation: but it produced little in the way of benefits for union members. Union seats on the 'staff side' are allocated without any regard to the actual numbers of staff each union represents: on the ancillary council, for example, NUPE, with over *half* the ancillary workforce has four seats, as does COHSE which represents most of the rest, while the TGWU and GMB, each representing a relative handful (and much more marginally concerned with NHS matters) each also have four seats. Matters are worse on the nurses' and midwives' council, where the trade unions are automatically outnumbered by the 'professional associations' including nurse management bodies, who take 15 out of 29 'staff side' seats.

The Whitley system was first devised by an industrialist, J.H. Whitley, as a measure to break the back of the militant

shop stewards' movement during the First World War by imposing industry-wide, centralised pay bargaining and shifting all negotiations from the workplace to national committees composed of remote full-time officials. It was opposed by stewards at that time, and thrown out wherever the unions were well-enough organised to resist it. The fight for control over workplace pay and conditions which fostered the growth of militant shop floor organisation throughout manufacturing industry in the post-war period was excluded in the NHS by Whitley: there was not even any regional negotiating machinery.

However, the emergence of militant trade unionism in the NHS in the 1970s eventually broke down the pretence of a consensus with management: intimidation and increasing victimisations of union activists revealed the real face of management, and forced the unions to put themselves on a more warlike footing.

The relative peace was rudely shattered by angry unofficial strikes by ancillary staff at the Royal Free and other London hospitals in 1970, and by the aggressive wage-cutting policies of the Heath government.

In the autumn of 1972 came the first widespread explosion over pay, triggered by unofficial strike action from ancillaries in Bristol against the Tory government's 'Pay Pause'. This was followed by the another unofficial one-day stoppage called by the rank and file London Alliance of Stewards for Health (LASH) on November 27. Their demand was for all-out strike action to win an £8 per week increase, a 35-hour week and 4 weeks' holiday. Union leaders called a national one-day strike on December 17, and were clearly surprised by the scale of the militant response when 180,000 heeded the call and took action. There were big demonstrations in London, the North West, Newcastle, Sheffield, Wales, the Midlands and Scotland. Nor did the militancy simply subside after the stoppages: led on again by the Bristol workers, who staged four days of strike action in January 1972 before being pushed back to work, the movement continued into the new year. The unions eventually embarked in March upon

a national campaign of selective action in up to 750 hospitals, ranging from one-day stoppages, to overtime bans, work-to-rule action and all-out strikes.

On March 1, 27,000 ancillary workers were on strike, and 80% of the remaining 230,000 were operating industrial sanctions in pursuit of their £4 a week claim. The eventual settlement produced little extra cash, but the struggle had registered the arrival of hospital unions on the industrial scene. That autumn, ambulance workers took action to confront the Tory phase 3 pay controls.

The nurses arrive on the scene

By 1974, nurses had begun to make the break from the passive 'professional' ideology that had helped hold down their wages for decades. The RCN, which began as a professional association for the nice young ladies who aspired to the Florence Nightingale model, has never been a useful champion of nurses' pay. In 1939, when the Athlone Committee met to discuss nursing conditions, the RCN gave evidence recommending *against* higher salaries to student nurses, on the grounds that it might attract 'unsuitable' applicants. The elitism of the RCN has continued to the present day: even now, nursing auxiliaries are not allowed to join, and the RCN propaganda against the February 1988 nurses' strikes insisted upon disregarding thousands of striking student and auxiliary nurses in drawing up their own ludicrously low alleged tally of 'nurses' involved.

The RCN response to the militancy of the 1970s was to develop its own 'stewards' system (the 'stewards' often being senior nurses or management figures), designed to keep control of their membership in each hospital and thus enforce their no-strike policy. They also mounted a largely ineffectual 'Raise the Roof' pay campaign based on lobbying and petitioning, as a diversion from any industrial action. The RCN's credibility took a dive when they tried to accept the initial March 1974 pay offer, only to be forced to go along with the tide of trade union opposition that eventually produced a bigger increase.

Despite the RCN's efforts, the mood was angry: the nurses had fallen foul of Tory pay restraint legislation, which was still being enforced by the newly-elected Labour government. The March pay offer, rejected by the unions, brought angry demonstrations, token strikes, canteen boycotts and restrictions on admissions. The nurses also linked up with fellow health 'professionals', the radiographers, who staged a huge 3,000-strong march (out of 8,000 radiographers) and ASTMS-organised radiographers held strikes at the Royal Free and in the North East.

The pressure of the industrial campaign on the Wilson government forced a face-saving inquiry, headed by Lord Halsbury, which found nurses to be a 'special case', and awarded pay increases averaging 30% (but with some grades receiving as little as 6%).

After Halsbury, union attention switched to the growing threat of cuts and closures in NHS hospitals as the Labour government sank ever deeper into economic crisis. Dennis Healey as Chancellor had inherited a £1.2 billion package of public spending cuts from the Heath government; but he also imposed additional cuts of £1bn in April 1975, another £3bn in March 1976, and a further £1bn in July 1976. The public sector unions – now a growing voice in the TUC – were under severe pressure to mount a fightback.

On November 17 1976 a massive TUC demonstration (80,000 on a working day) marched through London to lobby Parliament against the policies of a Labour government. The next two years were to see militant local struggles including hospital occupations and protest strikes in various parts of the country against hospital closures and cuts in service.

The 'Winter of Discontent'

Wages remained an underlying grievance, and by the autumn of 1978 pressure was building up throughout the workers' movement after Healey had attempted to impose a 5% limit on pay increases – the fourth successive round of pay-cutting wage controls. The policy was defeated at

both TUC and Labour conferences, and challenged by a wave of strikes headed by the Ford workers, but swiftly followed by bakers, provincial journalists and lorry drivers. This was the beginning of the 'Winter of Discontent'.

The big public sector unions covering health and local government had already launched their 'Low Pay Campaign', aimed at securing a 40% increase to a minimum wage of £60 for a 35-hour week. They eventually called for a joint one-day strike and lobby of Parliament on January 22, which produced a huge response. All over the country branches of NUPE, COHSE, TGWU and GMWU voted unanimously for stoppages. Shortly before the big demonstration, Prime Minister Callaghan tried to head off the strike, by conceding that low-paid workers (on less than £70 per week) would receive not 5% but a minimum increase of £3.50 (8%).

In the event, January 22 proved to be the biggest co-ordinated strike since 1926, with over a million taking strike action, and thousands joining picket lines outside hospitals, ambulance stations, schools, colleges and other workplaces. 60,000 joined the march on the House of Commons.

As localised strikes began to dig in, rank and file health workers began to sense their own power as they allocated staff for emergency cover, made arrangements with tanker drivers to monitor supplies of oil, and asserted a growing control over their hospitals. Ambulance crews staged unofficial strikes affecting two thirds of London stations and services in Manchester, Somerset and Aberdeen. Yet the 'selective' strategy was causing problems, leaving some sections isolated and forcing some militant sections back to work while they were ready to stay out.

The government increased its pay offer to 9%, leaving the unions divided, with TGWU and GMWU in favour of acceptance, NUPE against and COHSE initially undecided, though later plumping to accept. Action continued into April, but by then the campaign had run into the political crisis of the Labour government and the prospect of an early General Election.

Union leaders pressed for acceptance of the 9% as an interim settlement coupled with a Comparability Commission to investigate NHS pay. Nurses were offered £2.50 above the general increase, but no concessions on hours or holidays. Eventually Professor Clegg's Comparability Commission awarded extra cash to ambulance crews but not to ancillaries, who again slid down the pay league.

Fighting the Thatcher offensive

By the time of the next, and biggest, wages fight in 1982, NHS pay was again a national disgrace. Between 1975 and 1981 average earnings had risen nationally by 133%, while nurses had had increases of only 118% (a real *reduction* of 3.5% compared with inflation). Ancillary staff had received even smaller increases of only 97% in the same period. Three quarters of ancillaries and half of all full-time nurses were earning *less* than the official government poverty line of £82 per week (the point at which Family Income Supplement became available).

Yet the Thatcher government decided to single out the health workers for further pay cuts. With inflation running at 12% and settlements elsewhere all topping 7%, they offered hospital staff a miserable 4% increase. Angered by this, and encouraged by the novel factor of a common (April 1) settlement date for all the grades of NHS staff, healthworkers were goaded into the fight: even the RCN seemed willing to campaign – though not to strike.

However, the official union tactics were a repeat of previous recipes that had been tried – and failed. There still was not much of a cohesive or united shop stewards movement to link the various unions even at workplace level, and petty rivalries still featured in many hospitals. Areas which had managed best to overcome these problems set the pace in the dispute. In Manchester a half-day strike was called before any official action had begun. In Edinburgh, workers united in indefinite strike action which only ended because they were left isolated.

The unions opted to run the dispute through the hitherto obscure TUC Health Services Committee, made up of

representatives from all the many TUC affiliates which cover the NHS – even including the Prison Officers Association. Its composition was such that smaller unions and those representing only tiny numbers of NHS staff could outvote the major health unions. It set a dynamic pace by calling for *one-hour* token stoppages on April 14.

It was COHSE which initiated the first form of sustained action when it declared official support for a work to rule from April 26. NUPE supported this three weeks later, but NUPE leaders proved unwilling to implement their own conference resolution calling for indefinite strike action. This had recognised the futility of two-hour stoppages and one-day strikes and resolved 'to call for an all-out indefinite stoppage, commencing June 4th, *involving all health service unions*, with accident and emergency cover.'

The phrase 'involving all health service unions' was the snag: it was clear that some of the NHS unions would not support any such action. Surprising support was forthcoming from a TGWU health service delegate conference which voted for all-out action on May 11. However an emergency resolution to COHSE conference, leaving out the 'other unions' phrase, was strongly attacked by General Secretary Albert Spanswick, and defeated.

The Health Service Committee called for a 1-day stoppage on May 19, and two-hour strikes each week. This was followed by 1-day strikes on June 4 and 8, June 23, and then a 3-day stoppage for July 19-21 and a 5-day strike on August 9-13.

'All out for 12%?'

With their leaders committed to a series of partial and protest actions, 'All out for 12%' became the slogan of many union activists, intensifying with each announcement of a new one-day stoppage. The support for the health workers was enormous and the situation favourable. During the course of the NHS dispute, both the NUR and ASLEF took strike action, as did the water workers and the Post Office Engineers. Yet the TUC appeared determined to keep each struggle isolated: when it instruc-

ted ASLEF leaders to call off their strike on a Sunday, the NHS workers were due out on a new stoppage on the Monday!

Despite this, the links were made – by the health workers themselves. Nurses, domestics and porters went out to miners, steel workers, textile workers and others asking for support and organising the sympathy strikes; NALGO and CPSA members, too, responded strongly. The most significant solidarity came from the Fleet Street electricians, led by Sean Geraghty. When they announced that they would strike in support of the health workers, the press barons took out an injunction under the Tory anti-union laws. Though Albert Spanswick asked the electricians to call off their action, the EETPU branch stood firm and picketed out all the newspapers on Fleet Street; and when Geraghty was hauled into court, health workers came from all over the country to demonstrate in his support. He received only a derisory fine which, although a damaging precedent, represented a limited victory for the unions against the Tory laws.

Under pressure to do more, the TUC called a national day of action on September 22 – which turned out to be a genuine one-day general strike. 75% of coal mines, many docks, Fleet Street newspapers, Town Halls, car plants, schools, shipyards, steel plants, busworkers, firefighters, post and telecom workers, airports, ferries, television stations, road haulage, civil servants, glass makers and manufacturing workers were all involved in varying degrees of stoppages: the Welsh CBI claimed only that '50% of major firms' had worked normally. Local demonstrations included 12,000 in Dundee, 10,000 in Sheffield, 8,000 in Glasgow, 7,000 in Leeds, 4,000 in Hull, and 2,000 in Belfast. A massive demonstration of 150,000 in London took almost 5 hours to finish. Norman Fowler declared that the day was 'irrelevant to working Britain': millions of workers knew otherwise.

Many activists believed that a call for stronger action immediately after September 22 could have won a big response and changed the course and tempo of the dispute. Instead the TUC announced a series of regional 'days of

action'. At the end of October the Health Services Committee decided to ballot members of each union separately on the question of all-out strike action, but on November 9 a 'new offer' was produced which was actually *worse* than the previous offer: it gave only an extra half percent to nurses, but tied the unions to a two-year deal. After much confusion, the dispute ground to a halt on December 15, after the Health Services Committee outvoted objections from both NUPE and COHSE, and opted to accept the deal.

Competitive tendering changes the landscape

Norman Fowler was not slow to rub home his victory. Just two months after the end of the strike the DHSS issued a circular entitled *NHS support services – Contracting out*. It singled out domestic, laundry and catering services, key sectors of NHS trade union strength, as prime targets. While implementing this crude union-busting tactic against the ancillaries, the Tories also set up a separate Pay Review Body for nurses, in a determined effort to drive a wedge between them and other NHS staff.

The Review Body, similar to the Whitley council structure, took the pay issue out of the arena of trade union action, allowing the RCN to play a prominent role: like the Whitley structure, it conceded a few seemingly generous settlements, making itself relatively attractive to unions which felt in a weak position. But its recommendations are not binding on the government, and year after year the Review Body awards have been interfered with (paid in stages or under-funded), while nurses have again begun falling back in comparative pay.

The imposition of competitive tendering, beginning in earnest in 1984, and heralded by the Barking Hospital strike (against cuts in pay and hours imposed by private contractors Crothalls), was to prove a watershed in NHS trade unionism. Though the Barking strike was correctly described by NUPE General Secretary Rodney Bickerstaffe by analogy with the Miners' Strike as 'our Cortonwood', NUPE was not the only NHS manual

union lacking either a strategy or Scargill-like tenacious leadership when it came to fighting privatisation.

The Barking women strikers were feted at the 1984 NUPE conference, and saw a resolution unanimously carried calling for nationwide supporting strike action to prevent their struggle being isolated. But in the grim months that followed, as they maintained their 24-hour picket on the Hospital, the women were not to receive that support. A London 'Day of Action' in solidarity with their strike was built largely by rank and file activists, and though it showed a substantial groundswell of support, with action in many London hospitals, it was not developed further.

The strike began to be used as a propaganda tool by the unions to warn other workers of the consequences of privatisation, rather than efforts being focussed on winning it. By the time of the 1985 NUPE conference, the women who had braved the rigours of a whole year on strike and battled as best they could for trade union principles were clearly seen as an embarrassment by some officials – almost the equivalent of Banquo's ghost, reminding delegates of the resolution passed unanimously the previous year – and then ignored.

The Barking women were not freaks: many ancillary workers shared their commitment to the NHS, and their willingness to fight. But the government's strategy was to privatise district-by-district, hospital-by-hospital, and the unions' campaign against privatisation was for the most part low-key and patchy, giving the potential militancy little chance for this to show through. Similar problems of isolation befell other ancillary workers who took strike action against privatisation or competitive tendering: a marathon strike took place against contractors OCS at Addenbrookes Hospital (Cambridge) and a 6-month strike to keep ICC out of Scarsdale Hospital, Chesterfield, while women at London's Hammersmith Hospital battled three months without success against huge cuts in jobs and wages contained in a management 'in-house' tender.

That there *was* an alternative to isolation and defeat was shown by the huge campaign of rolling strike action

waged jointly by NUPE and COHSE in the North East, which eventually compelled Sunderland DHA to declare that it would not privatise further services unless instructed by the DHSS. Solid strike action by Oxford COHSE members also beat back competitive tendering at Littlemore Hospital. Scottish health unions, too, seem to have learned the bitter lessons of the Barking situation better than their British counterparts, with the launching of a pre-emptive campaign against competitive tendering *before* it is implemented by Scottish Health Boards.

The damage done to hospital unions by competitive tendering has tipped the balance of strength in the NHS workforce. Every previous major campaign until 1987-88 had been led in the first instance by ancillary staff in the manual unions: the Tory onslaught has eroded the base of precisely these sections, by pushing down wages, abolishing bonus payments, slashing full-time jobs and effectively casualising thousands of posts. Despite high unemployment, ancillary staff turnover levels are now higher than ever before, making trade union organisation extremely difficult. And many ancillary services have been handed over to private contractors, meaning that staff no longer even work directly for the NHS, even though they still work in hospitals.

Problems of solidarity

All this makes solidarity action, and even joint action over ancillary pay, much more difficult: indeed it could easily fall foul of Tory laws against 'secondary' trade union action, confronting ancillaries with the threat of court action as well as the possibility of the sack from vicious private firms if they take strike action. It is this weakening of the ancillary sector – with the loss of some 40,000 NHS jobs – more than the strengthening of nurses' organisation which has catapulted the nurses to the forefront of the latest agitation over NHS cuts.

Once again in 1988 the healthworkers have entered into struggle against the government: and once again all of the problems of achieving a level of industrial action sufficient

to win are coming to the fore. As these lines are written in mid March there has already been a 70,000-strong national TUC demonstration (March 5), various local and regional 'days of action' and COHSE's March 14 national day of action. Protest stoppages, workplace meetings and demonstrations have taken place in hundreds of hospitals across the country. Tens of thousands of health workers have shown themselves ready to fight for the NHS as have tens of thousands more trade unionists – council workers, bus workers, rail workers, miners, car workers and others – who have taken or offered action in their support.

Chancellor Lawson's arrogant Budget gave the Tories' response to all the lobbies, petitions and well-mannered appeals for extra spending on the NHS: but it also ended the first phase of the fight, which had focussed on demanding a share of the vast pre-Budget Treasury surplus for the NHS. Any union leaders who now believe that the Tory line can be changed by more one-off token actions may be fooling themselves – but are unlikely to fool their members.

To win this fight, more sustained action must be taken – and that will affect services. This will also end the deceptive 'honeymoon' period of press support (which has always depended on the health workers confining themselves to ineffective action). Only by raising the tempo and temperature of the fight can the dire threat to the NHS be overcome.

Also heating up the situation are the new round of spending cuts beginning the 1988/9 financial year. At the sharp end, nurses and health workers face the crisis on the wards. At London's Maudsley psychiatric hospital, a serious staffing crisis in March forced the COHSE Branch to contemplate a ban on overtime to press their demands for more staff.

'Management have broken their promises to alleviate the situation. They are still admitting patients to wards which can't cope with them. Members are saying we can't carry on papering over the cracks,' said Branch secretary Ian Morton.

'An overtime ban would lead to bed closures, but it

seems the only way to put on pressure. One ward has already begun a ban on overtime, regardless of what else anyone says, and we have to back that action.'

Nurses' unpaid overtime is estimated nationally at the equivalent of £150m a year. Yet their commitment to the patients is an obstacle to taking all-out strike action – an obstacle cynically exploited by government, management and the RCN. A systematic national nurses' work-to-rule, and a ban on overtime and agency working could offer a way forward in many hospitals, allowing each local branch to decide a pace and level of struggle they can keep up, in what threatens to be a long-running battle to save the NHS.

The basic dilemma of health trade unions has not changed or diminished: it is almost impossible to take industrial action without affecting patients: yet it is the defence of the patients which remains the driving force in the fight. Few other sections of workers suffer such pangs of conscience over taking industrial action: but the struggle for the NHS will not be sufficiently taken up by other unions unless health workers are seen to defend themselves.

Whatever tactics are employed, there is no doubt that the union role is central, and the longer this fight is delayed, the worse the conditions for winning will become. Health workers must take care that their proper concern for the immediate well-being of *today's* patients does not become a weapon used to prevent them taking industrial action to protect *tomorrow's* health service for us all.

Women, black workers, and the unions

Though the large majority of health workers are women, and most health unions have now established women's officers or similar posts, relatively few full-time union officials are women, fewer still are black, and negotiations tend to be dominated by white men. At branch and divisional level, too, white men dominate the structures of health unions, just as they do elsewhere in the labour movement. It is common at workplace level to find whole

sections composed almost entirely of women workers but with male shop stewards. Men are also disproportionately represented among active attenders at most union branch meetings: this in turn helps shape agendas, routines and procedures in ways that deter women and black members from involvement.

These problems are not the fault of individuals: they arise from real material pressures. Many working women shoulder domestic responsibility for the care of children, dependent relatives and often a male partner who does little or no housework. Union branch meetings in particular tend to be held out of normal working hours, often offering no facilities for childcare or payment for babysitting fees, forcing women to make complex arrangements to free themselves for an evening meeting. Even if children have been taken care of, a frosty or hostile response from a male partner who is not involved in union matters and fixed on the idea that 'a woman's place is in the home' can make even attending a meeting a major trial of strength.

Unless she goes with one or more friends or workmates, a woman attending a branch meeting for the first time can easily feel intimidated by the atmosphere of a largely male gathering working to obscure procedures, using unfamiliar jargon and referring to details and information not known to most health workers. Many women lack the confidence or patience to cut through this and to voice their concerns and demands, becoming regularly involved in trade union activities. Perhaps the most remarkable fact is that hundreds and thousands of women *do* become shop stewards and branch secretaries, and literally thousands of determined women have played an absolutely central role in all of the major struggles of the health unions.

All of these problems confront black women, but black members also face additional difficulties in the unions. Unable – often because of discrimination – to find better-paid work, many black workers wind up in the lowest-paid NHS jobs – working in ancillary grades or the more junior posts. The worsening of ancillary pay and conditions that has come with competitive tendering has also brought a very rapid turnover of staff, making unionisa-

tion extremely difficult: the most long-standing members of staff tend to be those in the more stable, relatively privileged supervisory or charge-hand jobs, or at least those still working full-time. These are very often white workers within an otherwise largely black workforce. When these people run for shop steward or other union positions they begin with an immediate advantage, since they are better-known, more secure in their employment and therefore more confident to take a high union profile than more junior or less long-standing black workers.

Union agendas tend to reflect the influences of leading stewards and branch officers, so many of the black workers who do decide to attend their branch meetings can find themselves in an almost all-white gathering, in which again much of the jargon and procedure is unfamiliar: some may also face language problems in raising their concerns and demands in such meetings. In these ways, despite the worthy Equal Opportunities propaganda and formal anti-racist policies of all the main health unions, the material attacks on the NHS help to compound inherent problems of racism within some local union bodies and make it difficult for many black workers to take leading positions in union branches.

That women and black workers have often broken through against these odds to play a prominent and leading role is no argument for complacency. Union bodies need to discuss ways in which their meetings, activities and full-time official posts can be made more accessible to women and black people, increasing the participation of the majority of their membership and strengthening the unions for the battles to come.

6 *Today's crisis in the making*

The big squeeze: turning the screw

Each of the subtle or more open Tory schemes to 'reform' the NHS depend for their effect on the financial squeeze applied from the top through government spending policies. While the rhetoric centres on the idea of 'choice' for the consumer, the first step has been to *eliminate* most people's first choice, which is to have their treatment without delay in an NHS hospital, adequately funded through taxation. Once swollen waiting lists and restricted services have begun to *deny* people this option can they be press-ganged towards less satisfactory 'choices'. This is clearly happening to more and more people. The sorry story of Mrs Edna Healey, wife of the former Labour Chancellor who had a private hip operation, was shamelessly exploited by the tabloid press during the June 1987 Election: yet it is itself a damning indictment of the state of the NHS, which forces thousands of patients to 'choose' between waiting years in agony or go against their better judgement and conscience, and spend their savings or borrow from relatives in order to obtain quicker relief privately.

There is clear evidence that the Tory squeeze is having some success in frog-marching formerly sceptical people towards private medical care and even insurance schemes. The *Financial Times* reported in February:

> Private Patients Plan, one of the big three provident insurers, reports a 45 per cent increase in public inquiries at its Eastbourne clearing office during

> January, compared with the same period last year. 'It has to be put down to fear basically,' says the company. 'People are worried about the National Health Service.'
>
> Western Provident Association, another of the three, which provides cover for 500,000 people, says inquiries have doubled in the last few weeks. British United Provident Association, the country's leading health insurer, says there is a surge of interest every time there is a furore over the NHS.
>
> Some of the increase in interest in private health insurance predates the highly-publicised crisis over NHS funding. There was a spurt of growth in private health insurance between 1979 and 1981 but this then slowed. Last year, however, PPP added 64,000 subscribers to its books, a record 12.5 percent increase compared with 9 percent the previous year. Counting family members, this added about 250,000 individuals to its million-strong customer base.
>
> (*Financial Times*, 10.2.88)

However, some private sector firms seem to feel that Thatcher is over-doing the pressure. The head of the British division of the profit-making American Medical International (which has 10% of the British private market and 1,130 beds) has been among the voices most strongly arguing for increased funding to the NHS. In a significant interview with *Independent* Health Correspondent Nicholas Timmins, he explained that:

> The private sector will never be able to provide all that the NHS does. Although we already do 25 per cent of all elective operations, *there is just not the business interest* (i.e. profit!) *in investing in the huge expansion of plant needed to take over large amounts of the health service's work.* Without the NHS we would all be in trouble.

He echoed calls for action to save the NHS:

> The service has been underfunded for 40 years. Seventy percent of hospitals are pre-war, and the evidence from Europe is that the UK needs to spend at least 25 percent more a year on its care, plus a

> massive investment in new plant. We are not talking about the odd £70m or £200m, but about perhaps £20bn over three, four or five years over what we are spending now.
>
> *Independent*, 17.12.87

These pleas, and those from anxious Tory backbenchers have fallen on deaf government ears. Ministers have applied the squeeze – and tightened it. The February 1988 report of the Commons Social Services Committee (which contains a majority of Tory MPs) has reinforced the case of those campaigners who have argued that a massive increase in spending is needed to make good cuts since 1979. The report explains and argues in detail how it is that while apparently spending ever-increasing sums of cash, the Government has still been *cutting* NHS resources in real terms when measured against increased pressures and growing demand for services. It argues:

> On these figures, which are derived exclusively from the Government's own figures, the cumulative underfunding to the end of 1986-7 was £1.496 billion *(£175m more than had been estimated)* By the end of 1987-88, assuming inflation of 8.1%, the figure is likely to be almost £1.9 billion at 1987-88 prices. In each of the last three years, the annual difference between the 'target' expenditure and actual resources available to health authorities as a whole has been £400 million at current prices.'
>
> *Resourcing the National Health Service*, pxiii

Stepping up the pace

The pace and extent of the financial squeeze have both intensified: but Thatcher's policy from the start has been to reduce public spending, and to cut NHS spending as a share of GNP. They could not do this at once. Taking office in the immediate aftermath of the 'Winter of Discontent', the new Thatcher government was not inclined to seek an immediate confrontation over the NHS. Instead they singled out the steel workers, provoked them into a confrontation, and sat out a 13- week strike to set the

brutal tone of their approach to industrial relations.

As an interim measure, Thatcher agreed to accept the outcome of the Clegg commission on pay comparability that had been set up by the outgoing Labour government to head off further industrial action in the NHS. This formed the basis of relatively generous pay awards in 1980 (though we should remember the old adage that 'even 80% of bugger all is bugger all!'). The increases came after several years of severely limited rises: and they had a lasting effect on NHS spending. Six years later the Social Services Committee explained that the cost of these 1980 pay awards alone accounted for 37% of the increase in total NHS spending between 1979 and 1986. Yet at the same time the impact of the government's monetarist policies had triggered a massive wave of inflation, which topped 20% during the summer of 1980, bringing a runaway increase in costs for the whole NHS, and cutting away most of the apparent 29% increase in gross spending in 1980-81.

For the hospital services, the Commons Committee estimates that real spending went up by only 0.9% in 1980-81; 2% in 1981-2; 0.8% in 1982-3; zero in 1983-4; shrank by 0.1% in 1984-5; increased only 0.2% in 1985-6, and only 0.3% in 1986-7. This means that in only one of these six years did hospital spending increase by the 2% which even Tory ministers have admitted is needed to keep pace with the extra expenses of caring for ever more elderly people, as well as the demands of new technology and the costs of 7 community care schemes. If the budget for hospital services had risen in line with the increased spending on the Family Practitioner Service (which is not cash limited), its spending would have been 21% higher in 1986-7 – an increase of £2 billion.

Instead, the 'Lawson cuts' of July 1983 began to turn the screws on an already troubled health service, triggering a new round of hospital and ward closures. Under these conditions of financial pressure, the RHAs were told to draw up fresh 10-year Strategic Plans, while the armlock was put on DHAs to put three hospital ancillary services

(domestic, laundry and catering) out to competitive tender. Even before this new onslaught on ancillary workers, 13,000 NHS jobs had been axed in the 18 months to March 1984. In London, the generalised financial pressures facing the NHS were sharpened by the imposition of further cuts under the RAWP formula; the 10-year plans for the four Thames regions were blueprints for reduced services and declining budgets in the capital, with cuts totalling £135m over ten years. The percentage cutbacks hitting London districts were 9.36% in SE Thames, 12.4% in SW Thames and 12.9% in NW Thames, with NE Thames cutting five districts by an average of 10.76%

The effect was shattering. In the four years 1982-86, London lost a total of 7,989 hospital beds, including 4,563 acute beds (15.7% of the 1982 total). In the seven years 1979-86, the total was 6,500 acute beds closed – a 21% reduction since Thatcher took office. 1987 saw a total of over 1,400 more beds 'temporarily' or permanently closed in the capital alone, while London's waiting list had by March 1987 risen to 22% above its level during the health workers' pay dispute of 1982.

In 1987, DHA Chairs and the Kings Fund got together a researched survey of the gathering crisis facing the capital's hospital services in the booklet *Back to Back Planning*, which warned:

> Regional plans for inner London Districts require a reduction of £109m (12.9%) in the period 1983/4-1993/4; this is the equivalent to the combined annual cost of St Thomas's, St Bartholomew's and the Royal Free Hospitals;
> This in turn involves a reduction of between 7% and 31% in each District's spending on local acute services, and overall a reduction of 1,487 (15.7%) local acute beds;
> These reductions were anticipated to accompany a 15% decline in the number of hospital admissions in inner London by 1993/4;
> BUT a review of changes which have occurred since 1983 reveals that:
> The number of hospital admissions has not declined,

but has in fact *increased by 2.5%* (reflecting a national pattern);
1,100 local acute beds, representing 74% of the planned 10- year bed reductions, have been closed in the first two years of the strategic period (also reflecting a more general trend);
These reductions have yielded £30.9m, representing only *34.5%* of the planned 10-year reduction on local acute service spending.
Thus in the first two years of the planning period, one third of the planned revenue saving has been saved, but three-quarters of the beds targetted for reduction over the ten year period have already had to be closed . . . We are bound to ask what this means for health services in London during the remainder of the planning period: will services have to be reduced much further to meet the revenue targets?

The shock-waves spread

However, it has not been simply RAWP-losing London and the South East that have been hit by the NHS cash squeeze. In 1986 and especially 1987 the problems spread across the country, with a rising tide of closures hitting firstly the big cities (Newcastle, Manchester, Birmingham, Liverpool) but also smaller centres like Oxford and Cambridge (which shoulder the cost of teaching hospitals).

By the autumn of 1987, the giant West Midlands region was facing a predicted £30m shortfall for the financial year, and had frozen 49 building projects totalling £256m as well as making drastic cuts in local districts. Kidney and cancer patients were being turned away from Birmingham's Queen Elizabeth Hospital, where 146 beds had been closed to cut admissions by 10%: doctors were told to treat 1,200 less patients in a letter from General Manager Patrck O'Connell which said: 'If money was irrelevant, we would be congratulated for increased efficiency. Unfortunately, the money problem will not go away . . . ' While the crisis at Birmingham's Children's Hospital grabbed the autumn headlines, Coventry, Worcester and Solihull were among the other West Midlands DHAs hit by the cash shortages,

as well as Shropshire, where the desperate economy measures imposed in the effort to open a new General Hospital in Telford brought the threat of closure to five popular community hospitals in local market towns, triggering a massive, angry resistance.

Yorkshire region, seeking to cut £9m, was also enforcing cuts, with Pontefract DHA making two rounds of cuts totalling £1.6m involving hospital closures, loss of beds and 1,300 cancelled operations: equally drastic cuts hit Wakefield and Doncaster, while in Leeds angry health workers, protesting at plans to axe a hospital and several wards and cancel 1,000 operations, gave Edwina Currie the bum's rush when she visited St James' Hospital.

In the Northern region, Newcastle health authority opted to close the Fleming Memorial Children's Hospital as well as 46 surgical and 25% of ITU beds at the Royal Victoria Infirmary and 22 gynae beds at Newcastle General, while the axe hovered menacingly over a renal ward, haemophilia wards and even more medical and surgical beds as they faced a £5m overspend.

There were all the signs of disaster in the North West region, with heavy closures under way in South and North Manchester and cuts in almost every district. Since then, Central Manchester in January announced it was £5.6m in the red, unable to pay bills or wages, and seeking 150 redundancies; it also caused a storm by closing a third of its 15 intensive care cots at St Mary's Hospital to save money. Salford and South Manchester have been forced to plan massive new cuts and closures; and Burnley DHA has set a national 'first' with its proposal to close all the acute services at Rossendale general hospital, to save up to £1m, as the district faces cuts of up to £3m in 1988-89. The NW and Mersey regions together now face a shortfall of £25m.

A huge £3m cuts package is also under consideration by South Derbyshire DHA, which covers Edwina Currie's constituency. Four maternity units, an orthopaedic hospital, and geriatric, medical and brand new postnatal wards at Derby's City Hospital are all under threat.

The South West region was last autumn predicting a shortfall of £10m by April, while Welsh authorities were at

least £6m in the red (St Tydfil's Hospital in Merthyr hit national headlines by closing a new geriatric ward opened less than a year previously by the Queen Mother, who was not amused). The crisis has also reached into Scotland, and the six counties of Northern Ireland, where the Eastern Health Board revealed a £7.6m shortfall in funding for 1988-89 which could mean closure of 100 beds and a casualty unit.

The plight of even RAWP-gaining districts was underlined in recent evidence to the Commons social services committee from Grimsby DHA's general manager David Jackson, who outlined some of the local cuts and closures planned to meet a shortfall of £1.7m in 1988-9, despite sucessive rounds of 'cost improvements' and cuts.

Squeezing NHS standards

The financial squeeze has had other effects as well as forcing obvious cuts in service. Forced to trim every last penny they can from budgets, health authorities have – sometimes against their initial better judgement – been pressurised into putting much of their domestic, laundry and catering services out to competitive tender. This amounts to cuts in service by the back-door, since the principal 'saving' made in the winning contracts is almost without exception a cut in staff levels and hours worked. This may (especially in catering) mean an outright reduction in services available – with the axing of night-time services, for example; or, more often, it will simply mean a drop in *standards* of hygiene and patient care.

Competitive tendering is another example of the 'double standard' at work in the actions of the government and their big business advisors. Health authorities are being pressurised by ministers to sign agreements with contractors on a basis no self-respecting supermarket boss would consider: if it were Roy Griffiths' shops and not NHS hospitals at stake, most private firms would have been sent packing long ago.

Hospital management have attempted other ways of meeting their target of 'saving' 1% of their budget each

year through 'cost improvement programmes'. Yet a consistent pattern emerges: for all the easy rhetoric about 'stamping out waste', almost every one of the itemised savings from 'cost improvement programmes' is accounted for by 'staff savings' – basically cuts in *wages*. Low-paid women workers are the ones being forced to sacrifice and lose *their* meagre bonus payments, to meet the 'performance targets' and thus provide fat personal bonuses for General Managers on £35,000-plus salaries. And as ancillary staff turnover increases, and vacancies become ever harder to fill, the person at the receiving end of this so-called 'efficiency drive', the patient, loses out.

Squeezing out women's jobs

Most of the 39,000 ancillary jobs that have been cut have been women's jobs: and most of those still directly or indirectly employed on worsened pay and reduced hours are also women, scraping the most miserable living for an increased work effort.

Most of the country's 500,000 nurses are also women, and they too face an increase in work effort on all levels – a real factor in the 'nursing crisis'.

▷ Nurses' pay continues to fall behind other comparable jobs in local government and in private industry. To make matters worse, women in nursing earn on average nearly £30 a week less than male nurses. Even when overtime, bonus and shift payments are discounted, the differential is £160 per week for men to £140 for women. Only women on senior grades 6 to 8 average out better paid than men.

▷ The exodus of 30,000 nurses a year, and the problems of attracting new recruits are leaving ever more wards short-handed, piling pressure on those who have not yet left.

▷ More rapid 'throughput' of patients, using each bed more intensively (sometimes even 'hot-bedding', getting a longer-stay patient to vacate his/her bed during the day time so that it can be used for a day case) also maximises the pressure on nurses, who find themselves constantly

dealing with seriously ill patients instead of the previous mix.

▷ The more rapid discharge of patients – some clearly before they are ready to leave, and without adequate support waiting for them at home from social services or family – has meant increased panic readmissions, and lowered nursing morale.

▷ Competitive tendering has 'saved money' by lowering ancillary staffing levels, but the work tends to get landed onto nurses.

▷ Moves (encouraged by the Royal College of Nursing) to further enhance the elitist conception of nursing by eliminating the State Enrolled Nurse grade, and excluding nursing auxiliaries from 'hands on' patient care seem certain to worsen the chronic staff shortages already facing nurses. The more academic approach and ever-higher demands for educational qualifications even to enter nurse training will also deter and keep out thousands of possible recruits, especially young black women. Some auxiliaries are already being made 'redundant' as a result of these changes, even while nursing staff are appallingly shorthanded.

Already the nurse shortage is reaching crisis proportions. In February 1988 Harriet Harman MP published results of a questionnaire answered by 120 health authorities, 60% of whom were short of psychiatric nurses, 48% short of theatre nurses and 36% short of intensive care and coronary care nurses. Yet the cash crisis also meant that 26 of these districts expected to have to freeze nursing vacancies to balance the books – again at the expense of the patients.

Similar patterns of staff shortages worsened by low pay affect most of the skilled grades of NHS staff, many of them women workers, including radiographers, physiotherapists, speech therapists and laboratory technicians, all of whose salaries are broadly similar to nursing staff.

7 *The fightback*

The first struggles

The wave of 'IMF' hospital closures in the late 1970s was met by an upsurge of local health campaigns, and in many areas, especially parts of London, these have more or less continued ever since. The campaigners notched up only a few outright victories: even the survival of Bloomsbury's Elizabeth Garrett Anderson Hospital (reportedly after the Queen intervened personally with Margaret Thatcher to oppose the closure) was linked in with some charity funding, though it is now reopened and one of the more presentable faces of today's NHS. Like the EGA, however, other hospital occupations and campaigns against cutbacks succeeded in many cases in delaying cuts, sometimes mitigating the scope of closures, and occasionally forcing a retreat by beleagured management and health authorities.

The renewed campaigns which sprang to life to combat the 'Lawson cuts' of 1983 also succeeded in winning some resounding victories, saving Hayes Cottage and Northwood & Pinner Hospitals (through occupations) and winning some important extra time for patients before closures were enforced (the Thornton View occupation in Bradford kept that geriatric hospital functioning for 18 months after the original closure date). This period also saw the development of the 'Health Emergency' network of local campaigns in London, drawing on early assistance from the GLC, and then the establishment of London Health Emergency as a liaison body in early 1984. Several

Health Emergency campaigns managed to keep going even after the local cuts they were fighting had been implemented, and outlived the GLC, creating an ongoing fight against all aspects of Tory attacks on the NHS.

The anti-cuts struggle ebbed somewhat in 1984–5. This was the result of some demoralisation after a number of defeats (in particular the swift use by management of High Court writs and bailiffs to smash occupations at St Leonards and South London Hospital for Women). At that time, with competitive tendering being used to impose cuts, few health campaigners felt motivated or confident in fighting privatisation. Yet health workers did fight back: this was the period of the Barking strike and other tenacious struggles by women prepared to fight in defence of NHS standards against private contractors. Unfortunately they were left largely isolated, while many on the left of the Labour movement busied themselves with the Miners' strike and, as usual, ignored the healthworkers.

A new wave of struggles

However things began to turn with the successful occupation in Oxford to defend the threatened Rivermead Hospital, and a new wave of cutbacks in 1986–7 triggered a fresh round of activity, and showed that victories could be won against the odds. Militant struggles by COHSE members at the Maudsley psychiatric hospital beat back a number of planned cuts in services.

1986 also saw nurses emerging as a powerful force in their own right. Mass meetings and lobbies by hundreds of nurses squashed attempts by Hounslow health authority to change shift patterns and eliminate the 'overlap' period in which most practical teaching of student nurses takes place, while relieving staffing levels on overstretched wards. The end of the same year saw the development of the highly successful campaign to Save West London Hospital (SWEL), which made use of local authority support but primarily rested on a strong involvement of local health unions, other union bodies and community organisations in building a victorious fight against Riverside

DHA's closure plans. The successful defence of this one hospital has helped lay the basis for the Campaign in Defence of Riverside's hospitals (CAMDOR) – a wider campaign now to defend *four* Riverside hospitals against closure as part of management's latest money-saving plans.

1987 brought a further rise in the tempo of resistance, as more and more districts outside London began to be heavily hit by cuts and cash crises, while campaigners sensed opportunity in the imminence of the General Election. Early in the year, Norman Fowler announced extra handouts of cash for the NHS, including funding to relieve the effects of RAWP in the electorally crucial South East. He also handed out token amounts around the country as a 'waiting list initiative' designed to create the impression that the long lists would soon be reduced in size. *Health Emergency* commented: 'We don't think we would be exaggerating to say that if London Health Emergency, local campaigners and health unions had not been so persistent and energetic is opposing the cutbacks, this money would not have been forthcoming.'

Fowler's allocations meant that all but six of London's 30 health districts received pre-election bonus handouts: but the sums were tiny, and all the sums were for one year only. However *Health Emergency* predicted that: 'In some districts, such as Riverside, the extra money may be sufficient to stave off embarrassing new hospital closures until after the next election.'

The 1987 election

By this point, Thatcher had decided on an early summer election, and pressure was obviously being applied behind the scenes to health authorities, urging them to hold back on announcements of further cuts and closures or revealing the scale of their financial problems until after the votes had been counted. Instead the headlines were grabbed by Thatcher's apparently generous 9% pay award to nurses, while the fact that only part of this was government-funded, leaving health authorities to foot much of the bill,

(a major factor in the eventual autumn crisis) was carefully hushed up.

Despite all the efforts to present a facade of a booming NHS, (not least in Barnet DHA, covering Mrs Thatcher's own Finchley constituency, where a laundered and massaged set of statistics was issued as a 'briefing' to candidates) symptoms of the growing crisis kept emerging even during the campaign itself. The clearest warning came in May from Colin Reeves, financial director of NW Thames RHA which covers 8 London districts and 6 shire county health authorities. In a confidential 'overview' document which he tried to keep under wraps until after polling day, Mr Reeves pointed out that real NHS spending had been cut back every year since 1981 – a total reduction of 8.9%, and drew the conclusion that 'The future could well be extremely difficult, with closures possibly having to take place to keep within cash limits unless there is a significant injection of resources from the DHSS.'

Mr Reeves correctly argued that the next round of cuts could not even pretend to be improvements in health services, since the only option for further large economies was to hit the biggest single item of cost: the numbers of patients treated.

Though the government continued to deny there was any problem with the NHS right through the Election campaign, the post-Election period quickly brought desperate plans from Riverside and Bloomsbury health authorities to dress up huge reductions in bed numbers (and therefore numbers of patients treated) in the guise of new hospital developments. There was also an onset of tin-shaking charity appeals, led by the destitute City & Hackney health authority seeking cash for Barts Hospital, and soon afterwards the Great Ormond Street 'Wishing Well' appeal.

An autumn hurricane of cuts stripped hospitals of wards and services the length and breadth of the country, including the high-profile crisis of Birmingham Children's Hospital and the equally appalling cuts in cancer beds in the same city's Queen Elizabeth Hospital. The fightback stepped up, with a new crop of local campaigns and pres-

sure groups, while the Tory-dominated media that had given little space to the NHS prior to the Election began to find room for it afterwards.

The autumn fightback

In early October, junior doctors played a key role in mobilising a huge demonstration and lobby by thousands of Tower Hamlets nurses, clerical and other staff, and community groups against a cuts package – and succeeded in preventing closure of the Mile 9 End casualty unit.

The late autumn also saw big anti-cuts lobbies and protests in other London Districts, including Hounslow & Spelthorne, Brent, Paddington & N. Kensington, and Haringey (where huge cuts of 120 acute beds went alongside closure of a 2-year old operating theatre). More publicised by media hacks eager to promote the no-strike Royal College of Nursing were the activities in West Lambeth's St Thomas' Hospital, where nurses and junior doctors fighting the closure of 137 beds joined forces in lobbies, a 'bed push' across the river to Parliament and (significantly for the RCN) the calling of mass work-time meetings of nurse representatives involving up to 300 nurses and forcing cancellation of ward rounds. November 13 saw a one-day strike against cuts by health workers in Riverside, which linked up nurses, ancillaries and technical staff.

The same month brought victory to 600 nurses at the Royal Edinburgh psychiatric hospital who had staged a 7-week overtime ban and work to rule demanding extra staffing on the wards. It was the threat of a ballot for indefinite strike action which finally tipped the scales in favour of the unions COHSE and NUPE which had held several 'days of action' in the course of the fight. The agreement secured 60 extra qualified staff to raise levels to 692 full-time staff for the 923-bed hospital. 'it was all about patient care,' said Jim McLaughlin, chair of the COHSE branch. 'Our quarrel was not so much with local management as with the inadequate funding from the Health Board.'

Across the country the pace was hotting up, with demonstrations, angry lobbies, public meetings and other action in Yorkshire, the North West the Thames Valley and even sleepy Gloucestershire. A December survey by the Association of CHCs for England and Wales showed that out of 113 replies, 80 districts were cutting revenue or capital spending for 1987/8. Of 56 DHAs cutting patient services, 16 were planning to close an entire unit, and 40 were closing one or more wards or a significant number of beds. 14 were cutting other services – especially community care.

Galvanising the doctors

One effect of the spread of the crisis has been to galvanise a new and welcome movement of doctors, including top consultants, and even the BMA fighting for the first time openly in *defence* of the NHS against cuts and closures. Of course courageous individual doctors have always been prepared to speak out: but Thatcher's unwitting achievement since 1980 has been to swing substantial numbers into active opposition to cuts. Consultants at Birmingham Children's Hospital defied management pressure and continued to denounce the effects of cuts and cash shortages; cancer specialists in Birmingham and at Hounslow's West Middlesex Hospital also 'went public' condemning cuts that are endangering lives. Isolated protests by Guildford GPs and by consultants in Bexley (who took advertisements in the local press to apologise for the impact of spending cuts) were followed up by similar initiatives from doctors in Reading and Pontefract, a petition of 200 Birmingham consultants (who have since formed an ongoing campaign, now copied in Manchester), an anti-cuts advert in the *Oxford Mail* signed by all bar four of the county's 300-plus local GPs, and a combined effort in Redbridge where 30 consultants and 140 GPs subscribed to a newspaper advert.

Responding to this new mood of militancy in a previously complacent profession, London Health Emergency lent support to an initiative by Hospital Alert for a

nationwide petition of hospital doctors, which in less than six weeks produced over 1,200 signatures from 160 hospitals in England, Scotland and Wales, including 20 professors and over 550 consultants. The petition was circulated by the Hospital Consultants and Specialists Association, the Medical Practitioners' Union and the NHS Consultants' Association: many forms were taken round by local medical committees, and came back with covering notes welcoming the initiative. The petition was eventually handed in on December 15 to 10, Downing Street by a group of consultants and professors, accompanied by back-bench Tory MP Nicholas Winterton: a packed press conference to launch it featured five consultants, including Dr James Birley, President of the Royal College of Psychiatrists, and Mr Nigel Harris, an orthopaedic surgeon from St Mary's Hospital, Paddington, who had only six months earlier been appearing on Tory election platforms, and who now publicly accused Tory ministers of having been 'deceitful'.

This angry mood among the medics even percolated to the topmost levels. A few days before the December 15 petition was presented came an unprecedented joint statement from Britain's three top doctors – Mr George Pinker (President of the Royal College of Gynaecologists, and the Queen's doctor); Mr Ian Todd (President of the Royal College of Surgeons); and Sir Raymond Hoffenberg (Chair of the Royal College of Physicians). These men declared their concern that: 'Acute hospital services have almost reached breaking point. Morale is depressingly low. We call on the government to do something now to save our Health Service . . . once the envy of the world.'

The three then went to meet Health Secretary John Moore. They were apparently convinced by him that extra cash would be forthcoming. Hence their angry reaction when a little later the Government's new public expenditure White Paper offered no extra money at all for 1988/9. Sir Raymond lashed out at what he called the government's 'Elastoplast policy' of seeking to patch up the NHS. George Pinker compared the Tories' one-off £100m handout to the NHS in December to 'taking a dead man from

the ground and telling him he will be going under again on March 31.'

Mr Pinker was right: the extra cash was inadequate, but it was the first of three important victories won within a month by campaigners and health workers, and this helped create the confident mood for nurses strikes across the country on February 3 and the Scottish TUC action on February 24.

Caught by surprise?

There is little doubt that the depth and momentum of the fightback against NHS cuts caught the Thatcher cabinet by surprise. Other equally vicious attacks – not least on Social Security payments (to take effect on April 11) and on the education system – have sailed through parliament barely noticed, rubber stamped by the giant Tory majority.

Caught off guard, the Tories at first found themselves pursuing contradictory policies. On the one hand they tried to appeal to the more conservative nurses, hinting at pay rises in the pipeline through a 'restructuring' exercise: yet at the same time Ministers inflamed anger to new peaks by suggesting that the costs of restructuring nurses pay be largely covered by slashing the present 'Special Duty Payments' for night shift and other duties. This could cut some nurses' pay by up to £40 per week.

With even some of Thatcher's own backbenchers calling for an extra £2.5 billion to restore the NHS – pointing out that this was the equivalent of just 2p on the basic rate of income tax, the situation remained at boiling point over the Christmas holiday period, hogging news headlines into the New Year, when the well-publicised 24-hour protest strike by 37 night nurses in Manchester opened a new phase in the struggle.

The nurses, organised by NUPE, walked out in protest at the attacks on Special Duty Payments (SDPs). Their action became national news and had immediate effects:

- Within days, health minister Tony Newton had been forced to withdraw the plan to cut the SDPs;

• Also within days, nurses in London hospitals, in Scotland and other parts of the country began organising to follow the Manchester example and take strike action – this time to show their disgust at the cuts in the NHS.

In London, where an evening trade union rally (sponsored by COHSE ASTMS/MSF and NALGO) had already been called and widely publicised by London Health Emergency for February 3, strike decisions tended to focus on that date. Some hospitals varied the timing. Nurses at the Maudsley Hospital began their 24-hour strike on February 2, while in Ealing, West London, a very successful day of action backed by local busworkers took place on February 4.

This movement for strike action was a genuine brushfire spread of rank and file anger; many of the nurses who demanded meetings of previously inactive union branches, made militant speeches, and helped carry votes for strike action, had themselves only just become active in their unions. While many local union officials responded well to this new upsurge, others at higher levels appeared suspicious and even hostile, seeking to put the lid on a movement they did not expect and could not easily control.

However the London example spread to other parts of the country, with February 3 the most common date for action at hospitals in Yorkshire and the Midlands. Being a rank-and-file movement, the results were patchy: some hospitals did nothing; some saw only a few activists take action. In many areas council workers took supporting action, and in Yorkshire, miners from Frickley colliery walked out to back the nurses.

It seems that as many as 10,000 nurses and healthworkers, including ancillary staff, 1,500 technicians and thousands of clerical workers were involved in some form of protest action on February 3, with over 40 London hospitals affected. The evening rally organised by London Health Emergency saw an enthusiastic packed hall of 1,000 militant trade unionists, including hundreds of uniformed nurses.

Other regions held back, with the North West opting to follow a regional TUC 'day of action' later in the month

(which was supported by strike action from 2,000 Vauxhall carworkers) and Wales holding protests on March 1. By far the most advanced was Scotland, where the Scottish TUC called a 24-hour Day of Action, to involve industrial as well as NHS unions, on February 24; local hospitals also staged their own, smaller scale, activities.

The TUC, under pressure to do something, called a national demonstration in defence of the NHS for March 5 – but did little to publicise it. Indeed, while the union rank and file have been demanding action, union chiefs have been divided on how to proceed. TUC policy has until now been largely dominated by the line of 'new realism', avoiding confrontation with the Tories, and courting respectability in the eyes of 'public opinion'. Perhaps the most crass version of this was the TUC chosen platform of speakers for the rally at the end of its huge 70,000- strong March 5 demonstration, which included not a single trade union or Labour Party leader, but instead featured 'agony aunt' Claire Rayner, pensioners' leader Jack Jones and Anti Apartheid bishop Trevor Huddlestone. So far, the TUC have shied away from following the Scottish example and ignored calls to organise a day of strike action in defence of the NHS: indeed COHSE chiefs were reportedly reprimanded for issuing their call for their own members to take action on March 14.

No peace in sight

However there is no sign that those fighting for the NHS will be placated or subdued. Thatcher appears to have decided to 'take on' the healthworkers just as her government 'took on' the steelworkers, the miners, and other sections of the working class. The March 15 'giveaway' Budget, a bonanza for the rich, was also a calculated two-finger insult to the health workers. Among the issues that will keep anger at boiling point in 1988:

- April starts the 1988 NHS pay review. Initial Tory proposals suggested no more than a 3% basic increase in nurses' pay. In London, nurses are already bitter at management's offer of only £51 *per year* increase in their £950

'London weighting' payments, against a union claim for an extra £1,000! Any move by Thatcher to 'divide and rule', seeking to buy off the nurses with a larger increase, could now be seen as a retreat and encourage militancy in other sections.

- Also in April, health authorities across the country begin a new round of closures and service reductions to meet their reduced cash limits.
- This summer could also see publication of Thatcher's 'review' of the NHS, in which its very existence as a comprehensive, tax-funded system free at point of use could be thrown into question. Even limited introduction 'internal market' ideas could cause complete havoc in today's cash-starved NHS.

Opinion polls before the budget showed a massive 81% of Tory voters favour spending more tax money on the NHS (compared to 91% of the whole electorate). This is no surprise: with only 9% of the British population covered by any form of private medical insurance, the other 91% – including most Tory voters – have a vested interest in defending the NHS. This is why the nurses and other healthworkers who have been picketing, protesting and petitioning feel such a weight of support behind them. The defence of the NHS, unlike the Miners' strike, does not polarise society, but unites all but a tiny handful in opposition to Thatcher's policy.

To take advantage of this, a national campaign is needed to unite the potential forces that must fight for the NHS, linking the health unions with the wider labour movement. It is vital to draw in the support of the wide spectrum of community organisations (groups of pensioners, tenants, hospital patients, black community organisations, women's groups, even health charities) which should be mobilising to defend the NHS.

One 'local' organisation that has tried to build support along these lines is the local government-funded London Health Emergency, whose tabloid newspaper distributes a print run of 16,000 through over 220 affiliated local trade union, labour movement and community groups – including many outside London. In January, LHE hosted a

national meeting of 150 activists from over 70 campaigns and organisations to take the first steps towards a National Health Emergency network.

Despite its limitations, this is still by far the most advanced national initiative towards the kind of concerted campaign that is needed.

As Thatcher sharpens the knife for major surgery on the NHS, the fightback against these attacks could yet be the catalyst that unites the workers' movement in mass action to confront her increasingly dictatorial government.

8 *An answer to the NHS crisis*

Much of the book so far has been examining the problems of the NHS, the threats that confront it, and the struggles to defend existing services against Tory cuts. It is part of the problem facing health campaigners today that any wider-ranging discussion on the type of service we would like to see has been effectively relegated to the realms of academic abstraction. Few campaigners believe we can do much better than defend what we already have.

However, it is important to note that as Thatcher's review seeks to roll back the wheel of history, further reducing the proportion of national wealth spent on health services while maximising the involvement of the private, commercial sector, there *is* an alternative approach, which would build on the principle of collective, social provision of health care that were embodied in the formation of the NHS. It is particularly important to fight against any renewed imposition of charges or means-testing for health care.

Previous chapters have argued against the conventional Tory myth that demand for health care is necessarily 'infinite', and tried to show how capitalism itself (and especially Thatcherite policies of deepening poverty and widening class divisions) actually *increase* demand for health services by generating avoidable illness. A systematic approach to health services would follow the alternative logic of the Black Report, and seek to *reduce levels of illness*, by eradicating poverty, poor housing and inadequate diet at the same time as improving health education, developing preventive medicine and primary care, and

establishing an occupational health service as an essential complement to improved NHS services.

Alongside steps to minimise the creation of new 'patients' a serious health policy would set out to *measure* the real levels of need for the various forms of health care and treatment both for acute specialties and for the more chronic conditions of the mentally ill, mentally handicapped and the elderly – many of whom need not hospital or institutional care but effective support in the community. A proper costing of these services must include provision for substantial pay increases for all grades of health workers to enable the NHS to recruit and retain a stable, skilled workforce.

We also need a detailed national inventory of the hospital and other building stock available to the NHS, together with details of its physical condition. This would enable an overall estimate to be made of the need for new building, upgrading and repairs to achieve minimum acceptable standards of hygiene, accessibility and comfort for patients and staff. Once the actual level of demand for services and the required amount of capital investment and additional staffing costs are known, it becomes relatively simple to calculate the resources needed to offer patients a legal *right* to treatment, and ensure that every health authority is financed to provide at least a basic minimum level of services.

With these legal rights and obligations laid down as a safety net, the way would be open for the regular *election* of health authorities, comprising local representatives of health workers, the electorate, and patients and user groups. These new, accountable bodies should be given control of an integrated service comprising hospitals, community services, community care, family practitioner services and an occupational health service.

This type of properly-resourced NHS, with management held accountable to elected authorities – and under legal obligation to provide services rather than merely balance the books – would once again begin to squeeze out costly and inefficient private competition. Private medicine should be completely separated from NHS

premises, ending all of the unofficial, under-cover subsidies; and part-time consultant contracts should be ended, promoting junior doctors to fill any posts left vacant if consultants resign in protest.

Of course extra money won't solve everything: but it would solve many of the problems of the NHS. Just as it is necessary to invest to generate wealth, we must invest to protect our health. A crash programme of backlog maintenance, and speeding up new building programmes would create valuable new jobs for the unemployed and liberate fresh NHS resources. Ending the contracts of all private cleaning, catering and laundry firms, and returning these services 'in-house' with a restoration of previous staffing levels and bonus payments would bring dramatic improvements in hygiene and patient care, relieve poverty among NHS ancillary staff and create useful new jobs.

Pumping this kind of increased investment into buildings and staffing would help restore nursing morale: and additional measures, including provision of creches and flexible contracts offering part-time working with full employment rights to experienced and trained nurses who have left to have children, would help to tempt them back and resolve the nursing crisis.

Systematic investment in community care facilities for the mentally ill and mentally handicapped would not only improve their quality of life and that of their families, but also enable many to find or return to useful employment, regain their dignity and care for themselves. It is typical of short-sighted 'devil-take-the-hindmost' Thatcherism that it condemns tens of thousands of such individuals to an institutionalised scrapheap rather than allow them to realise their own potential and contribute to society.

Of course the implicit values of such a plan for health services are socialist: but the policies themselves could in theory be implemented even within a capitalist framework. Indeed they are the most efficient way of delivering health care – and Nigel Lawson's 1988 Budget showed that spare billions could be found to pay for such policies – except that he prefers to hand this cash to the wealthy in tax cuts.

However, a thoroughgoing *socialist* approach would provide not only the framework for a comprehensive service, but also liberate the *resources* for it, through the nationalisation of the major drug firms, monopoly suppliers, banks and finance houses. A socialist plan would also facilitate the coordination of research programmes between the NHS, the universities and the drug industry, thus ensuring increased resources for research on issues such as AIDS and cancer.

The financial resources are available: and the gains and lessons of 40 years of the NHS offer a valuable starting point for a model system of health care. Yet Thatcher prefers to cut the lifeline to millions of men, women and children who depend on the NHS. If the labour movement, health campaigners, patients and relatives do not take up the fight now to defend our hospitals, the very notion of health care free at the point of use and available to all on the basis of medical need could be destroyed before our very eyes.

If, as Thatcher claims, 'There is no alternative' under capitalism to more devastating NHS cutbacks and the creeping privatisation of our most popular collective service, then logic would suggest that perhaps it is capitalism and the capitalists that are the problem. It is time for a nationwide political campaign for an adequately-funded NHS that sets out with the determination that if Thatcher says 'no', then Thatcher must go!

9 *The secretaries bite back!*

by Lynne Robson (Chair, NALGO National Health Committee)

Of all NHS staff, those on the administrative and clerical side are probably the most forgotten. Others, for good or ill, have a high profile, but the white collar staff are remembered only when it is expedient to knock 'the bureaucrats' and complain that the money used to pay them could be more usefully spent on more beds or improving nurses' pay. In this way the work of thousands of mainly female staff is ignored and misunderstood.

Because of the number of men at the top of the service, its seldom appreciated how much the NHS relies on low-paid women's work. Medical records are kept, filed and traced by women; medical notes typed; chemists and doctors reimbursed; appointments made, catering arranged, meetings organised, data prepared, telephones answered, wages paid – all this work that enables the medical side to function is done by an unseen army of women, many of whom have worked for years in the NHS and are 'rewarded' by average take-home pay for clerical and secretarial staff of £70 per week.

A report commissioned by NALGO in 1986 commented that 'secretarial and clerical staff employed by the health service are well qualified and experienced workers who tend to stay in one post for a considerable length of time,' but found that they are 'grossly underpaid for the vital contribution they make to the health service.' The researchers went on to report their 'overwhelming impression not just of a poorly paid and often undergraded workforce but also of an even more serious underlying malaise,'

the symptoms of which are identified as 'unrealistic workloads, pressure to get work completed, and lack of recognition from colleagues who seriously undervalued the contribution of secretarial and clerical staff.'

The remarkably successful medical secretaries' disputes in 1986-7 were rooted in this undervaluing of women's work in the NHS. It was not just money – though that was important – it was also the refusal to recognise the contribution they made, the brushing aside of their legitimate sources of grievance. The women spoke of a consistent undervaluing by health authorities of the role they played in organising and supporting the consultants. They resented the fact that their long service and commitment to the NHS was systematically exploited; they could get better money for less work elsewhere, but their decision to stay meant that they had to try to live on poverty wages. 'Some women have offered 30 years service to the health service,' said a woman from Inverness whose two-year struggle for regrading ended in strike action. 'With the responsibilities we hold, and the workload, we feel we are worth more than personal secretaries grade.'

The medical secretaries' strike at Luton and Dunstable in March 1986 set off a wave of claims and action. The Luton and Dunstable secretaries had waited literally years while their claim for regrading had wound its way through the established appeals mechanism. The anger when the final appeals stage failed to give them justice led them out on a three-week strike, and their success was crucial in signalling to health authorities that the patience of medical secretaries was at an end.

The first strike had many of the characteristics which were to become familiar in subsequent disputes. The strike was well organised, benefitting from the efficiency and organisational skills that medical secretaries bring to their normal work; morale remained high, partly because of good press coverage and support from the consultants. They refused to be bought off by management offers which did not bring improved gradings for the majority of members. By the end of the strike, the women involved had proved to the management that they were a force to be

reckoned with; in many ways, this was as important as the improvements they had won in their gradings.

NALGO had agreed that claims should be put in at local level rather than attempting to negotiate a national agreement with a management side which had shown itself incapable of addressing the issue of low pay. The Luton and Dunstable strike generated an enormous amount of interest and many medical secretaries joined NALGO for the first time. Well-attended union meetings brought together many who had previously felt isolated and out on a limb. Medical secretaries who had no experience of union activity worked with NALGO full-time officers to put together claims and coordinate action.

In many cases their clear determination and the threat of industrial action persuaded health authorities to reach agreements. In the North West Region, for instance, there was a great deal of work and activity which led to new agreements in a large number of districts without all-out action. In other areas, strike action was necessary. Selly Oak medical secretaries gave impetus to the campaign with a 5-day strike in February 1987. This was an important breakthrough which led to agreements in other West Midlands health authorities. A particularly bitter struggle took place in NW Durham in the summer of 1987, where the management (with a meanness all too characteristic of the NHS) baulked at increasing the pay for part-time staff. In Coventry, an obdurate management was faced by a cheerfully resolute group of medical secretaries who refused to be deflected by long drawn-out negotiations and threats of dismissal. For 6 weeks, over 70 women held out, resisting the emotional blackmail which they believed the management was using against them. Strike pay was augmented by donations and fund-raising events, including a disco, which kept up morale as well as raising money for the hardship fund. Local MPs were lobbied and the local press gave the dispute sympathetic coverage. 'They were not easy times,' commented one of the secretaries as they returned triumphantly to work. 'I am very proud of my colleagues. We are a close-knit community standing up for what we believe.'

What lessons can be learned from the success of NALGO's medical secretaries campaign? It has clearly shown that there is deep anger and resentment among the women who have worked for years in the NHS with little reward or acknowledgement. It showed that local improvements can be won at a time when government interference in national negotiations makes it difficult to make progress. And it demonstrated that local campaigns, well co-ordinated and publicised, can have a national effect. The DHSS now knows that medical secretaries exist ... and perhaps waits with some trepidation for the next group of forgotten women to make their presence felt!

10 *Answering the nursing crisis*

by Judith Carter (National Officer, COHSE)

Over the last few months it has been impossible to avoid continual media coverage of the nursing crisis – the problems arising from the shortage of qualified nurses in the NHS. It would be easy to assume that all this sudden attention reflects a crisis in nursing that has virtually developed overnight. The reality is that this crisis has been taking shape for a number of years, and policy makers in the government and DHSS have been fully aware of the situation. Indeed official statistics have warned for a number of years that a 'demographic timebomb' has been ticking away, and was due to explode in the late 1980s. It was always known that the number of elderly people – who take up a large proportion of NHS beds and require most care – has been steadily increasing at a time when the number of female school-leavers with the appropriate qualifications to become nurses has been falling.

The DHSS and its political controllers have been reluctant publicly to accept the facts spelled out by their own statistics. Instead they have constantly argued that nurse shortages were limited to a few specialities and a few geographical areas. COHSE and other organisations on the Staff Side of the Nursing and Midwifery Staffs Negotiating Council have been highlighting for years that the problems are much more widespread than the DHSS or the government wishes to acknowledge.

Now that the crisis is beginning to bite, everyone is being forced to admit that the problem does exist. Indeed, with the mounting evidence of beds being closed and operations cancelled because of the shortage of nurses, it is

impossible for the government to continue pretending that everything in the NHS is rosy. We do have a nursing crisis, and it will get worse unless something drastic is done now. There were nearly a million 18-year olds in 1982, but by 1994 that will have fallen to 600,000. This means that the NHS will have to recruit in the order of 50% of the total number of suitably qualified female 18-year olds into nursing in the 1990s to cope with staffing requirements.

The present crisis is not only one of a shrinking pool of labour. It is also a problem of retention. At the moment there are about 30,000 nurses leaving the NHS annually: a small proportion of them are going to the private sector; an increasing number to overseas health services, and the largest proportion leaving the profession altogether. The present crisis would be much worse if nurses did not work so much unpaid overtime, or work as 'agency' and 'bank' nurses on top of doing their full-time jobs. It has been estimated that well over half of all nurses work overtime that is often unpaid – which means they are subsidising the NHS by more than £150 million each year. If nurses were not so dedicated (and hence open to exploitation) then the present crisis would already have been a catastrophe.

A catastrophe, however, still looms on the horizon unless drastic action is taken now. The recruitment problem can only be dealt with by dramatic increases in nurses' pay levels. The NHS has to recruit more female school-leavers at a time when increasing opportunities are opening up for young women in the growing service sector and industries which offer much higher earning potential. Equally, more men have to be recruited into nursing. The likelihood of this happening is remote when at present a qualified nurse earns 47% less than a police constable and 42% less than a firefighter after the same length of service. Only by paying nurses comparable earnings to what potential recruits could earn in alternative employment will the crisis ever be brought under control.

Similar arguments apply to the *retention* of qualified staff, although the picture is more complicated. Overall

shortages of funds for the NHS have resulted in nurses facing increased workload and much greater levels of stress. Higher salaries may help retain those nurses who leave the NHS because they cannot live on their low wages, but unless the basic problem of underfunding is tackled, many nurses will continue to leave the profession as the stress levels reach breaking point. Yet what does the government offer? Cheap mortgages for nurses in London (now made more difficult by Budget restrictions on tax relief for joint mortgages) may help resolve problems in the capital, but inevitably at the expense of surrounding areas. Similarly they argue that Regional Pay should be introduced – another method of transferring nurse shortages from one area to another. Alternatively, they suggest building up the private sector, while never acknowledging that because the private sector does not train nurses, any growth in this sector can only drain nurses from the NHS and worsen the crisis even more. It costs the NHS about £15,000 to £20,000 to train a nurse; so this is simply a policy of subsidising private medicine from the public purse – while running down the NHS.

COHSE has been at the forefront of the demands for the use of external pay comparability and for a new clinical grading structure where pay levels are related to the work undertaken and based on equal pay for work of equal value. Only these proposals, in conjunction with increased funding for the NHS, can help resolve the existing and ever-worsening nurse shortage. The only realistic hope is an alliance between the NHS unions, the nursing profession as a whole, the medical profession, and the general public, to apply pressure on this and future governments. Much of the present publicity on cuts and nursing shortages has come about because the medical profession has at last come off the fence.

Many nurses have traditionally responded to the problems of inadequate pay and excessive stress by leaving the service. COHSE will be campaigning for nurses to continue the present fightback by becoming actively involved in their trade union: this will enable them to fight effectively on their own behalf and on behalf of their patients.

11 *Junior doctors in the front line*

An interview with Zoe Penn (MPU)

Working regular 120-hour weeks, forced to change jobs every 6 months, and with their compulsory hours of overtime paid at only one third of basic rates, junior doctors believe they earn every penny of their £1,000 per month salaries.

'If you include all the compulsory extra hours we work, our hourly pay is not that much higher than the porters,' said Zoe Penn, a registrar with the Obstetrics and Gynaecology unit at Westminster Hospital.

Junior doctors like Zoe perform much of the surgery and provide almost all of the out-of-hours emergency cover in Britain's hospitals.

Their hours are notoriously long: back in 1981 a Parliamentary report condemned doctors' hours as exploitative and detrimental to patient care. Six years later, even more junior doctors are working excessive hours. Zoe is a member of the Medical Practitioners Union which is campaigning for a statutory limit – of 60 hours per week.

For Zoe, most 'normal' days begin at 8.30am and run through to 7pm, with no official breaks. On top of this two nights a week and two weekends in every five, she is 'on call'. A night 'on call' at the Westminster adds up to a gruelling 33-hour stint: a weekend is 57 hours.

'I'm quite lucky here: When I was at Barnet, it was an 81-hour weekend every three weeks. People say we are not necessarily up all of that time. That's true: but you can be. Last time I got 9 just hours' sleep out of 57 on call. That was 2 hours the first night, and a lucky seven hours the next. But of course it's during these hours that you're

doing emergency work, which is always more difficult. We get emergency caesarians, gynae cases, all sorts. You have to make decisions urgently, you're the only one there, with just a very junior GP trainee to take blood and write notes.

'The adrenalin keeps you awake for the demanding things, it's the routine things that suffer. By the Monday morning theatre session after being up all weekend you have to be careful not to sit down, or you will fall asleep.'

Exhausted staff can find it hard to cope with the emotional needs of patients, especially on the labour ward.

'The first thing that suffers is your compassion. With difficult deliveries, caesarians or still-births you can wind up thinking "that's all I need", instead of giving support to the patient. That's very sad.

'In the middle of the night, when you've been woken up on call, the patient becomes the enemy. You do the right things, but you do everything as quickly as possible: they need more than that.'

A constant pressure on junior staff is the need to move from job to job, always on short-term contracts, until eventually they find a consultant's post of their own. Since she qualified in 1982, Zoe has worked at no less than eight hospitals. In four more months she must move on again.

'This is why people get really cross when they come back to outpatients and keep seeing a different doctor each time. The one they saw before could be in Dundee. There is no continuity. In some places all of the junior staff can be replaced on the same day: only the consultant stays the same.'

Another pressure is the decline in the NHS as a result of spending cuts.

'I was a student here four years ago. There used to be a canteen open all night. It wasn't the Savoy, but you could get bangers and beans to fill you up; you can get really hungry at 3am. The on-call rooms were always clean, the bedding changed, and a clean towel.

'Now there is a revolting soup machine, some cold drink dispensers and a microwave for snacks. The on-call room is filthy. Five doctors use it in turn, so the bed should

be changed every day, but that isn't done. You come in to find dirty sheets at 1am. The windows blew in in the hurricane two weeks ago, but have not been fixed – there is just a blanket over the window. There is no towel and no heating, all of the showers are broken, and they give us hard loo paper! None of these things in themselves is important, but all together they make life miserable on a 57-hour shift.

'Four years ago you could see your face on the polished floors, everything was cleaned once a day. Now cleaning has been privatised and the place is filthy. There aren't enough ancillary staff or clerical staff.'

Nursing shortages and bed cuts also affect Zoe and junior medical staff.

'On the neonatal wards we can wind up having to do nursing jobs for lack of staff. There should be one midwife for each woman in labour. Often we don't: at the London I often had to sit up at night with labouring women. We only have one 12-bed ward for gynae patients. This can mean we have operating theatre time, with anaesthetist and nursing staff standing by, but we can't admit enough patients to use it for lack of beds.'

Zoe believes that many junior doctors are deeply worried about the decline of the NHS, but that the sheer pressures of the job prevent many from becoming active in campaigning for improvements even in their own conditions.

Meanwhile many are voting with their feet. In London and many other parts of the country, shortages of junior hospital doctors are becoming almost as serious a problem as shortages of nurses.

(This interview was conducted in November 1987)

12 *Dental services under attack*

by Diane Plamping (Lecturer, Community Health and General Practice)

What was achieved with the foundation of the NHS in 1948 was the imposition of a nationally-determined scale of fees on the dental profession. The dentists themselves remained independent contractors, controlling the quality and quantity and access to care. As 'gatekeepers' they could accept or reject any patient at will – though once they accepted a person they were obliged to make them 'adequately dentally fit' (a term never clearly defined).

This set-up left people seeking dental treatment in a weaker position than they had with doctors. A patient could be turned away from *every* local practice, and the local Family Practitioner Committee had no obligation to find an NHS dentist. Even if accepted for treatment, patients' status with a dentist was for that course of treatment only; they were not on that dentist's 'list'; once treatment was completed they had no rights, (not even to have pain, resulting from that treatment, treated). In addition, within the course of treatment the dentist was paid on a piecework system: the more they did, the more they got paid. The items of care which gave higher profit margins than others tended to be given more often than those that paid less well.

All this was bad enough: but within 4 years of launching the NHS the government introduced patient charges – at first a fixed amount. Then came proportional charges – with a ceiling. Since then the amounts of money involved have been rising so fast that many people are now unsure whether they are having NHS or private treatment. This is

understandable when they are told so little about what treatment they are receiving and how the final charges are calculated.

The net effect has been a service which has failed to serve the needs of the community in two ways. It has not reduced inequalities in the dental health or the provision of dental treatment. As with every other field of health in Britain the poorest sections of society have more ill-health and less access to treatment than the richer groups. It has also failed to encourage preventive care: still only 5 million people receive fluoridated water, though this would *halve* the numbers of cavities in children, and slow down the rate at which decay grows around and under fillings in older people.

The government is now proposing to introduce proportional charges (to 70% of the cost, with no ceiling). This is hardly likely to reduce inequality. Since poorer people tend to go less regularly to the dentist, it is likely to cost them more for treatment when they *do* go. Already the cost is deterring many people from seeking care, according to British Dental Association figures.

Secondly, the government is planning to abolish the free check-up. Again past problems cloud the issue here, because few people expect to come out of a check-up visit without paying something. That is because there is a charge for X-rays, which most dentists feel they need to make a full diagnosis. However, charges for check-ups are not likely to encourage greater take-up of the service by those in need. In addition, like eye checks, dental checks have a potential for preventive screening: 2,000 people a year die of oral cancer, most of them over 55 years old: yet pensioners are not eligible for free treatment unless they are also receiving suppplementary benefit. Once again the poorest will be hit hardest.

Thirdly, the government plans to abolish the statutory responsibility to carry out school inspections. This appears to have little impact until we remember the already weakened state of the Community Dental Service. This is the salaried service which tends to be the fall-back to treat children whose parents don't have their 'own' regular

dentist, and other groups of people who tend to fall by the wayside of general practice – housebound people, pre-school children and people with disabilities.

Several health authorities have already tried to close down their Community Dental Services, but have been prevented from doing so because they must keep a service to carry out statutory inspections. Now that service looks very vulnerable. Its loss would be a blow against public health, forcing the most needy to compete for treatment in a system that has never served them well. It would bring a loss of preventive work, and remove any possibility of a planned service providing monitored care. Current services are quite inadequately monitored.

In addition, the government is conducting an experiment in capitation payments for child dental health, under which a dentist would be paid for having the child on their 'list': the danger is that this will simply lead to a situation of 'supervised neglect', with necessary treatment not being given. Independent monitoring is vital to prevent this – and only the Community Dental Service is available to do this.

A strengthening of the CDS could play a key role in ensuring that public money channelled through the independent practitioners was used to pursue public health rather than private gain. At the same time fundamental changes are needed in the way dentists are trained and paid: the current government plans are simply shifting the burden from collective tax-funding to individual payment for treatment by each patient.

We are witnessing a creeping privatisation, similar to what has happened to opticians. Dentists, too, could face a change in the structure of fees, changed rules on advertising to 'encourage choice', new 'reviews' of their 'monopoly' position, and eventual complete separation from the NHS. For all the weaknesses and problems with the NHS, such changes would make things far, far worse.

13 *Grim prospects for migrant workers*

by Mandana Hendessi (Migrant Services Unit)

The National Health Service has been one of the biggest employers of migrant workers in Britain. The term migrant is used to cover those people who originally came to Britain from non-Commonwealth countries to undertake semi-skilled and unskilled work, as well as refugees and those seeking asylum. A large number of migrants entered Britain as work permit-holders between 1950 and 1980 to work in the NHS. Italian, Spanish and Portuguese work permit-holders in the main arrived here in the 1950s and 1960s, while Filipinos, Thais, Latin Americans, Moroccans and Egyptians came in the 1970s.

As a whole, women outnumbered male migrants on arrival. This is still the case in some communities, particularly Filipino, where almost 88% of the 30,000-strong community are women.

The work permit system was designed by the government to regulate the flow of migrant workers into Britain, and direct them to sectors where their labour was needed. Permits were issued by the Department of Employment to the *employers*, only after they had satisfied the Department that they had tried unsuccessfully to recruit local and EEC labour for the post, and demonstrated that the wages and conditions offered were no less favourable than for similar jobs in the area. Permission of the Department was required if a work permit holder wished to change jobs. Visas granted by the Home Office to work permit holders were only issued for a specific job for a specific stated period of time (usually 12 months) at the end of which it could only be renewed if the permit holder had complied

with the conditions laid down by the Department. Employers were, therefore, placed in a powerful position. Most migrant workers, on the other hand, were forced to endure low wages and bad working conditions; some were even cautioned by their employers against joining relevant trade unions.

The hierarchical structure of the NHS is rigid and primarily reflects the class division in our society. However a closer examination shows inherent racial and sexual inequalities: consultants are mainly white, Oxbridge-educated men; white women are predominant in higher nursing grades, administrative and clerical work, whereas ethnic minorities are disproportionately over-represented in lower nursing grades and clerical jobs. Although some district health authorities have adopted equal opportunity policies in recruitment and promotion, discrimination continues to operate in both these areas. A Commission for Racial Equality study of nursing schools published in 1987 found that in Greater London, where ethnic minority communities form 14% of the population, only 1% of trainees were from ethnic minorities. In a school in Slough – where the ethnic population is 31% – only 5% of trainees come from ethnic minority groups.

The NHS still uses 'word of mouth' methods and unsolicited letters to get recruits for certain posts. Ethnic minority women are usually steered into the lower category of nursing, the State Enrolled Nurse qualification, regardless of their educational and practical capabilities. A Filipino woman, Adelia, who holds a BSc in Education from a university in the Philippines was recruited by the NHS in 1973. She told the Migrant Services Unit:

> I was interested in exploring various career opportunities in nursing, but I was told by the hospital's personnel officer that I had only been permitted to do SEN. When I asked him why, he replied that my qualification was not high enough for a higher nursing grade!

Training is another story. Most migrant workers in the NHS have been given very basic training, which is not

geared towards career and personal development. On arrival, the NHS encouraged migrant workers with poor English to attend English classes. However, much to the workers' dismay, these classes only taught them very limited English. Carmen, a Spanish auxiliary nurse in a North London hospital told the Migrant Services Unit:

> When I first came to this country, we had to attend English classes held at the hospital. But we were only taught the language of the job. I could hardly speak English, but I knew what 'mop' and 'bedpan' meant!

The recession has placed many workers, especially migrants, in a position of jeopardy. They are now having to compete for a declining pool of jobs with a new supply of unskilled workers, consisting largely of part-timers, many of whom are married women forced into the job market by deteriorating economic conditions. The 1985 Labour Force Survey found a growth of 300,000 in part-time employment (to 4.4 million, 21% of those in employment) in the four years to 1985. Over 60% of part-time workers were women.

Many migrant workers have been the losers. Employers' preference for cheaper part-timers, for whom they have no statutory obligations in terms of sick pay, holidays or maternity benefits has caused loss of jobs and prolonged unemployment for many migrants. The government policy of privatising hospital ancillary work has rendered many migrants unemployed, replaced by part-time British workers. Today 75% of the cleaners employed by the private contractors are women working less than 16 hours per week.

See *Migrants, the Invisible Homeless* by Mandana Hendessi, published by Migrant Services Unit/LVSC, 68, Chalton St, London NW1.

14 *Fighting for house and home: the attacks on NHS accomodation*

by Rosie Newbigging (London Health Emergency)

Low pay, unsocial hours and the worsening housing crisis have forced health workers in this country to rely on their employers to provide low cost, accessible accomodation for many years. Often far from decent, and in fact in many cases sub-standard, NHS accomodation has enabled some health workers, some of the lowest paid workers in our society, to at least have a roof over their heads. Nurses and ancillary workers, in particular, have often been forced by extreme levels of low pay into a position of dependency on NHS accomodation – a situation which is far from ideal.

Since 1979, a significant plank of the attacks on the rights, pay and conditions of NHS workers has been the denial of access to NHS accomodation to many health workers and in some instances the threatened eviction of health workers from their homes.

Back in 1983 the infamous *Rayner Scrutiny* on NHS residential accomodation recommended selling off the vast bulk of NHS accomodation and a drastic reduction in the categories of staff who qualify for housing to those staff whom the NHS had a statutory responsibility to house; (some junior hospital doctors, first year learner nurses; and some 2,000 short-term staff for whom 'no local authority or private rented accomodation is available, or could be generated'). The effect of this policy would have been to reduce the numbers of workers living in NHS accomodation to just 39,000 – meaning that (according to Rayner's own figures, widely seen as an under estimate) 56,000 workers would be forced to leave their homes. In addition to the thousands required to leave, many categories of staff

entering into NHS employment would be forced to seek alternative accomodation, creating further recruitment and housing problems.

The government had, however, significantly under-estimated the outrage which this policy would provoke. Its announcement quickly led to nurses and ancillary workers being issued with notices to quit: in some instances the threat of eviction led to an uproar, including hostile press comment. To fight the proposals, a campaign, initiated by London Health Emergency, brought together a coalition of trade unionists, migrant workers' groups, housing campaigns, labour councillors, health campaigns, residents' committees from various hospitals, and members of the public.

Two particular events forced the government into a partial retreat on the issue. First, early in 1986, Phillipa Kelly, a newly-qualified nurse in Ealing, received a letter from a firm of solicitors acting on behalf of Norman Fowler, then Secretary of State and thus effectively her landlord. The letter stated that since Philippa Kelly was now qualified, she should be responsible for finding her own housing. Of course this completely ignored factors such as the severe shortage of housing in London, low pay and the consequent problems in recruiting nurses to work in the NHS. However, Phillipa was willing to stand and fight, and strong opposition from her union, COHSE, together with media attention and a major public outcry at the injustice of this move, forced the withdrawal of the eviction notice. Fowler under pressure issued a new health circular, stating that 'no one will be made homeless as a result of this policy' and that 'the process of rationalising property holdings must be carried out with proper regard to the interests of existing tenants and licensees.'

Many other health workers took action to fight this policy, although resistance was localised and sporadic, taking place only as and when potential evictions were threatened. Workers at Guy's Hospital (Lewisham & North Southwark) and St Leonard's Hospital in City and Hackney DHA also refused to move; but the struggle which did most to expose the government's policy

involved a group of migrant women workers in two hostels in Paddington, North London.

This particular episode revealed the basic hypocrisy and injustice behind government attempts to attack health workers' housing, and also demonstrated the damaging consequences of its privatisation programme. At the same time it showed how a group of traditionally powerless workers could take on the authorities and achieve a victory, albeit a temporary one. In February 1986 private contractors Mediclean were awarded the contract for cleaning St Mary's and St Charles's Hospitals in Paddington and North Kensington DHA. Some staff were offered jobs with the company, but nevertheless *all* former NHS cleaners living in NHS accomodation, whether or not they were taken on by Mediclean, were told they would have to get out of their NHS homes.

The DHA, however, did not bargain for the resistance that the workers/residents would demonstrate in the following months. The residents, about 20 in total, were all women, and predominantly migrant workers. Migrant workers in the NHS have, historically been subjected to consistent exploitation and institutionalised racism since they were first recruited during the 60s and 70s, when British welfare capitalism required a cheap source of labour. Many were specifically recruited to work in the NHS, and for many of these migrant workers a condition of entry was that they live in tied NHS accomodation. The combination of government policy on NHS accomodation and privatisation meant that migrant workers were faced with the possibility of losing their jobs *and* their homes.

The residents at the two Paddington hostels, supported by organisations such as the Migrant Services Unit, London Health Emergency and SHAC – The Housing Advice Centre, plus local Labour councillors, the local Labour Party and Paddington and North Kensington Health Emergency, as well as their unions NUPE and the GMBATU, stood firm in the face of pressure from the DHA. The women stayed put in their homes and refused to move; after all some of them had been living in the hostel for as long as 15 years. Press attention focussed the public

mind on the plight of these women and support grew for their cause and for other NHS residents in similar situations. Finally in October 1986 the DHA bowed to pressure and agreed to let the women stay.

This outcome was a significant victory for the women involved. The DHA's decision also had repercussions in other districts – Paddington and North Kensington had received a lot of adverse publicity from the whole episode and other DHA's were reluctant to face the same outcry. However the position of the remaining residents at the hostels remains insecure; rents were virtually doubled by the DHA in the past year and in October 10 1987 the DHA reneged on their previous commitment to allow the women to stay indefinitely (although no notices to quit or eviction notices have yet been issued). The campaign to oppose evictions has been reinstated.

Since the Paddington campaign the government and DHAs have been less willing to force the issue of reducing NHS accomodation; but many health workers, including those whose jobs have been privatised, have still been pushed out of their homes – even if not quite as quickly or brutally as the government perhaps orginally intended. The devices used to force them out include short-term contracts, and offers of alternative accomodation in local authority housing; letters asking residents to vacate their rooms have been used rather than eviction notices.

However, many DHAs were themselves far from happy with the Rayner plan, which could only worsen their already often desperate shortage of nurses, particularly in the inner-cities. The 'Rayner Scrutiny' policy of disposing of NHS accomodation is itself clearly being re-scrutinised. Just two years after the health circular requesting DHAs to look at ways of disposing of accomodation, the DHSS asked the four Thames RHAs and the Oxford region to submit plans to the DHSS on how accomodation could be improved 'if' the RHAs were given the cash. For ancillary workers however, the crisis continues, and the fight to defend their homes is a vital issue in today's NHS.

15 *Cuts by the back door: privatisation and competitive tendering in the NHS*

by Rosie Newbigging (London Health Emergency)

The story so far

Rats in the kitchen, cockroaches on the wards, jobs lost, exploitation of health workers on a massive scale, standards plunging and public outcry – all this is the result of the government's programme of competitive tendering and privatisation of ancillary services in the NHS.

Under the provisions of a health circular issued in 1983, health authorities were required to seek competitive tenders for catering, laundry and domestic services, and were encouraged to look for opportunities to do the same with other services. This circular was backed up by a number of actions designed to ensure that private contractors were successful in winning tenders wherever possible. These moves included instructions via Kenneth Clarke (then Health Minister) that no private contract be terminated – no matter how awful the firm's performance – without Ministerial approval. There was also a notorious letter from Victor Paige (then Chair of the NHS Management Board), which set out to stop DHAs doing their own vetting of private contractors, or even asking contractors to specify performance rates of employees: this created the danger that contractors could submit ridiculously cheap tenders on the basis of impossible, superhuman performances from their staff – only to come back asking for more money or go bankrupt. Paige also took steps to make it even *more* difficult for DHAs to get rid of incompetent contractors.

Despite all these vigorous attempts to ensure maximum privatisation of ancillary services, the policy has, in that respect, been a major failure for the government. Even DHAs not known for their readiness to stray from government policy have shown profound reluctance to privatise services. Following the initial flurry of privatisation in 1983 and 1984, services have, in the majority of cases, remained 'in-house'. As of February 1987, 79% of contracts awarded had gone in-house with only 21% awarded to private contractors.

As privatisation failed to realise the massive profits that the contractors hoped for, many of the smaller companies were squeezed out of the market, or merged into one of the two giant multi-nationals which currently dominate the contract cleaning market (domestic services is the area which has been subjected to the most privatisation). As a result it is now more accurate to describe a situation of *monopoly tendering* rather than competitive tendering, since the two giants BET and Hawley (now ADT) largely battle it out between themselves for contracts.

A catalogue of scandals and an obvious deterioration in standards go hand in hand with the destruction of employment rights of ancillary workers – the vast majority of whom are women, and many black or from ethnic minorities. Privatisation of services has almost invariably been accompanied by major cuts in staffing levels – often involving redundancies, denial of the right to trade union membership, cuts in pay, cuts and changes in hours worked (with a massive shift to part-time working). The loss of full-time status and NHS conditions has brought other attacks such as loss of maternity leave, loss of rights under employment protection legislation, loss of sick pay, holiday entitlements, pension rights and in some cases even the loss of housing.

The very process of competitive tendering has meant that cuts are inevitable. Even though tenders have increasingly gone 'in-house' rather than private, this is by no means a victory for those who are committed to maintaining standards and jobs in the NHS. It represents an insidious attempt by management to match the worst excesses

of private firms and do the dirty work of the government in a more covert, less troublesome way than actual privatisation.

Fighting back

There has been a significant level of resistance on a localised level to privatisation and competitive tendering. This resistance has undoubtedly contributed to the reluctance of Health Authorities to privatise and has brought the dangers of privatisation to public notice. At Barking Hospital, the strike was provoked by new contracts drawn up by Crothalls involving an average cut of 41% in hours and wages. Some day-time staff previously taking home £57 a week could expect as little as £17 a week. Holiday and benefit entitlements were also to be drastically reduced. Crothalls, part of the Pritchards group (now taken over by the Bermuda-based ADT) was an example of the way in which multi-national corporations have tightened their grip on the contract cleaning market and the exploitative means by which they seek out their profits. In South Africa, Pritchards were revealed to be paying poverty wages to black South African workers, contravening even EEC recommendations on pay levels.

In fighting privatisation there were also some victories: at Littlemore Hospital in Oxford a solid strike forced management to withdraw plans for competitive tendering. However, the toll of 11 thousands of lost jobs and the sorry state of many of our hospitals both show the cost of privatisation and competitive tendering in the NHS.

Medical and professional services are also under threat as well as support services. Kidney dialysis has already been contracted out in some districts. Recently South Lincolnshire DHA awarded a £100,000 contract for orthopaedic surgery to the private AMI Park Hospital, Nottingham. The list goes on, and the future looks bleak. However the current wave of fightback in the NHS, particularly with Scottish trade unions taking specific action over privatisation, may yet turn the tide of destruction.

16 *Pathology faces privatisation*

by John Chowcat (National Officer, MSF)

The time had arrived, proclaimed the new Secretary of State before the flashing cameras and pre-arranged applause of the 1987 Conservative Party conference, to dispense with 'sacred cows' and outmoded ideology. He could 'see no reason why other functions should not also be subject to competitive tender' in addition to hospital cleaning, laundry and catering activities exposed to bids from profit-seeking private corporations since 1983.

Outside the Blackpool venue, white-coated Medical Laboratory Scientific Officers (MLSOs) lobbied delegates in bitter protest against low NHS pay rates and high staff turnover – marking the frustrations of a skilled workforce progressively deprived of financial resources by a government keen to promote their private sector rivals. Inside, senior DHSS advisors explained to a confused press conference that the speech was indeed understood to refer to such clinical support services as hospital pathology laboratories, radiography and pharmacy.

The scene had been set for the third-term Thatcher government's new assault on the NHS. John Moore's career as the 'radical' Tory exponent of private health provision in Britain had been launched, and a deadly serious threat to the nature and quality of a range of key hospital services directly concerned with patient care had been publicly revealed. Speculation over the practical implications of this major extension of the privatisation process spread rapidly through the ranks of the 90,000 professional and technical staff employed in the NHS.

On November 11, the Secretary of State personally

replied to an enquiry from the President of the Royal College of Pathologists in the following terms:

> As you point out, I did not refer to any specific services in my speech, and I am sorry if misleading reports of it have led to anxiety among members of your College. I can confirm that Ministers have no plans for a central initiative involving privatisation of pathology services, and hope this assurance helps to remove their anxiety.
>
> It is the case that we encourage individual health authorities to consider the possibilities for securing greater cost-effectiveness in the provision of all NHS services. If any of them were to take the view that this objective could be further advanced by changes in the way in which their pathology services are provided or developed, I would expect them to take full account of the views of the profession before decisions were made. In particular, I would expect them to ensure that the quality of services, and of the specialty in general, did not suffer in any way.
>
> In this connection, I am sure it would be helpful if your College were to form a view on those aspects of pathology services which it considers must be safeguarded in the event of proposals by local management for changes. I would be glad to convey the College's considered view to health authorities.

The chosen strategy, therefore, was to *avoid* a frontal attack on the principle of public service in these important areas (doubtless in view of the attendant risks of damaging controversy in the mass media and health service press): but to 'encourage' quiet local initiatives by individual health authorities within broad guidelines approved by the relevant consultants' organisation. This 'creeping privatisation' approach, however, was already known to union activists in hospital labs and other professional departments around the country, who had been alerted by warning circulars to monitor local-level developments and notify their union (then ASTMS, now MSF) centrally. A clear picture had already formed.

A list of functions considered ripe for potential privatisation had been circulating among senior health authority

managers across the UK since the early weeks of 1987. Half way down one version of this document, alongside such services as hospital transport, maintenance, portering and telephones, was a specific reference to the laboratory services. 'This is part of a process to be implemented throughout the NHS,' stated the Wirral health authority circular on the subject, adding: 'There is no discretion for individual authorities to 'opt out' of examining the feasibility of seeking competitive tenders.'

Tory success in the June General Election hastened these local preparations. A 'cost reduction diagnostic review', undertaken by the private consultants Coopers and Lybrand for the Burnley health authority stated, for example, in August: 'Pathology services are being considered by the DHSS for the next stage of service competitive tendering. The District will therefore need to consider now how best to meet this new challenge in responding with an efficient, cost effective service. Major changes in employment practices and the management of workload increases would appear inevitable if the in-house service is to remain viable within a new competitive environment.'

The nervousness of central government in its desire to avoid a public national-level debate on this delayed 'second round' of privatisation grew as the nature of the threat to patients from 'quantity-before-quality' commercial pathology firms became more widely known. A large number of London Weekend Television viewers were warned of the stark problems already associated with private pathology companies. *The London Programme* reported on 800 cervical smear test slides sent in to one commercial lab. Twenty two slides already identified in advance as definitely positive were deliberately included in the batch. Ten of these were misdiagnosed, half of them being described as 'normal'. A sad picture emerged of the low standards of service, arising directly from the inferior treatment of lab staff, due to the quest for maximum profits. Long hours of work were accompanied by an absence of union-negotiated salary structures and conditions of employment. Indeed, the deeply unhappy reputation of several companies active in this field deteriorated to the point where

leading figures in the sector felt obliged to restore their image by establishing an 'Association of Independent Pathology Laboratories' in order to exploit the opportunities offered by the John Moore regime. The sector will duly appear to 'regulate' itself, to try to avoid more public relations disasters.

Nor was the overall process assisted by the public admission of the Association of British Laundry, Cleaning and Rental Services (the employers' group representing established contract companies) that NHS competitive tendering for their own type of activities since 1983 had proved a failure.

But the prize to be won if the strategy were to succeed is tempting indeed for the Thatcherite 'radicals'. Privatised clinical support is only a small step away from privatised clinical activities on the wards. Little would then remain of any concept of a 'National Health Service'.

The need for a powerful trade union and community campaign to resist all such plans is apparent. An ASTMS leaflet headed *Privatisation – a Warning* was distributed urgently in thousands of copies in October, and posted on hospital union notice-boards to alert staff in vulnerable departments. Angry MLSOs confronted the pro-privatisation principal MLSO of Wexham Park Hospital, Slough, in meetings where he sought to justify his failed project – to involve a private firm, the International Hospitals Group (IHG) in utilising his NHS lab facilities outside of normal day hours. At one seminar in London, the audience insisted on formally voting on his arguments – showing an overwhelming majority against.

The closeness of St Thomas's Hospital, London to the Palace of Westminster was also usefully exploited when numerous MPs from all parties were persuaded to attend an 'MLSOs Open Day', to see the valuable work performed daily in the labs, and listen to the staff. The case against privatisation was strongly argued, providing a helpful prelude to a mass lobby of MPs in February.

This growing campaign can and must succeed. Powerful allies can be won in every section of society in the battle to preserve this important public service, which is a vital facet of our NHS.

17 *Private inroads into health care*

by Paul Brotherton (Greater London Association of CHC's) and Celia Miller (City & Hackney CHC)

Infiltration by the private sector has been one of the biggest changes to affect the health service since it was set up. This has happened in a variety of ways: together the changes add up to a radical shift in the nature of the NHS and open the way for a 'market' system of health care in Britain. Four types of involvement can be seen:

▷ Health authorities paying private hospitals to treat NHS patients;

▷ Health authorities selling services to private buyers to 'generate income';

▷ Private companies being hired to provide NHS services;

▷ Increased charges to patients.

These changes are a result of deliberate government policy, and have almost all occurred since the Conservative election victory in 1979. The government's first two terms saw a drive towards cost-cutting in the NHS. DHSS funding for hospital and community services consistently failed to keep up with increasing needs, and management became geared towards making 'efficiency savings', with many jobs in support services privatised as a result of competitive tendering. By the time of the third Conservative win in 1987, the way had been prepared for a new and more radical drive towards private health care. Years of NHS bed reductions, lengthened waiting lists and staff shortages had persuaded more people that 'going private' was the only way to get a good service. This applied not only to

the well-off or the growing numbers covered by private medical insurance (5.3 million in 1986): pensioners and inner-city residents became increasingly willing to scrape up the fees for a private consultation when the NHS seemed to have failed them.

The trend towards the private sector has been actively encouraged by ministers. Edwina Currie, for example, said on BBC Radio on December 8 that 'I would like to see a growth in the private sector. If people have got the money – and many people have done rather well out of this government – then I would encourage them to seek their health care elsewhere.'

The new 'private is better' ideology, and several years of business-style management have persuaded NHS managers and strategists to seek entrepreneurial solutions to their funding difficulties.

- *Health authorities paying private hospitals to treat NHS patients*

During 1986 and 1987 many health authorities began to buy capacity from private hospitals for the treatment of patients from long NHS waiting lists. Examples of this include children's ENT cases in Bath; hip replacements in Bromley; and surgical cases in South Lincolnshire. Worthing DHA even set up a deal with a seaside hotel in which patients given ophthalmic operations at an NHS hospital were then transferred to the hotel instead of a hospital ward for recovery.

Such schemes reflect the shortage of NHS facilities in relation to local need, but the basic problem is not being solved. Having set up a special fund to reduce waiting lists, the government allocated £5m of this specifically to have patients treated in private hospitals or in other health authorities. While this helps some patients to receive quicker treatment (though not necessarily by the consultant or even in the town they had expected), the cost to the NHS is that funds desperately needed to build up local services are being diverted elsewhere or to private hospitals.

The use of the private sector is not just related to surgical care. An increasing number of people are being accomodated in private nursing homes as an alternative to long-stay NHS beds. In England and Wales the proportion of the elderly population living in private nursing homes rose by some 52% between 1979 and 1984, while the corresponding figure for people in NHS geriatric beds *fell* by 13%. The massive growth in private nursing home places has been fuelled by the funding of many patients through social security payments, and is encouraged by DHAs. Indeed Riverside DHA has employed a special 'Home-finder' to find alternative placements, including private nursing homes, for elderly people currently occupying NHS beds.

Although the replacement of large geriatric wards with smaller community units is desirable, there are serious concerns about the patchy quality of private nursing homes. They are often set up by people with no experience or qualification in health care, and form a simple business venture akin to letting out bedsitters. Staffing arrangements are often grossly inadequate. The Harlow Heath nursing home in Harrogate, for example, was closed by magistrates on New Year's Eve 1987 when it was found that some of the patients were seriously ill and not one registered nurse was on duty over the holiday period. This poor substitute for NHS care is being offered to so-called 'priority' care groups!

- *DHAs selling services to private buyers in attempts to raise income*

The shortage of funds in the NHS has driven some DHAs – much to the glee of the government – to engage in 'income generation' schemes. DHAs have long gained money (but not profits) from pay beds, and have also raised very modest sums from other sources (even including renting out a maternity ward in Barnet for filming *Eastenders*). However, this new competitive scramble for money is on a different scale altogether, and has profit as

its leading motive. This puts NHS hospitals in the market place in an attempt to emulate Harley Street, and has serious implications for local patients.

The first, highly-publicised manifestation of the new-style money-making was in City & Hackney DHA, which includes St Bartholomew's Hospital. The high status of Barts was seen as a good selling point, and a number of schemes, varying widely in practicality, were put forward during 1987. Barts is aiming to sell services both to the private sector and to other health authorities (the so-called 'internal market'), and such plans have found great favour with the government: Mrs Thatcher is known to believe that 'the money should go with the patient'.

Buying and selling services between DHAs does not raise any more money for the NHS, however; it merely re-allocates funds between districts. This process also interferes with the traditional right of GPs to refer patients to the hospital and consultant they choose. If adopted on a large scale it would create enormous administrative problems.

One of the first private schemes to be set up by Barts was a private breast cancer screening service. This uses NHS equipment and employees working overtime to offer mammography screening to 'business-women' employed by a City firm, which pays for the service. The clinic screens women aged 40 and over, though the Royal College of Physicians states that breast screening among women under 50 is ineffective in reducing deaths. This illustrates another danger of private medicine: it encourages unnecessary intervention, sometimes against the patient's best interests. For NHS patients in Hackney, no breast screening is available, and even high-risk women can only have mammography after referral to the consultant breast clinic.

Other health authorities are now investigating ways of boosting their income from private sources. These include Central Manchester, which has been reported as setting up a deal to provide private in-patient care to the local police force. Salford and Oxfordshire DHAs are planning the involvement of a private health company in the building of

new NHS/private day case facilities. The company is contributing towards the cost of building the units, in return for managing and drawing profits from the unit's private work.

It is not difficult to find problems with the expansion of private work in NHS hospitals. The process will strengthen the two-tier system of health care and will widen inequalities in health. Private facilities will give those who can afford it, either individually or through their companies, an extra chance to jump the queue or to take advantage of services which are not available to the rest of the population.

Income generation schemes also tend to divert staff, equipment and other resources away from agreed priorities. There is already a chronic shortage of nurses and other staff in many Districts, and expanding marketable areas can only be done at the expense of other clinical activity. Poor earners will become poor services.

A further problem with income generation lies in its uncertainty. Private sector and cross-district contracts tend to be for short periods of time and the repeated scramble for more money will dictate a short-term and piecemeal approach to funding and planning services. However the DHSS believes that income generation will raise £20m in 1988-9 and some £70m in three years time: money-raising is clearly going to be an increasing pre-occupation of health service managers.

- *Preparing to privatise NHS services*

The government's 1987 White Paper on Primary Care includes incentives to shift services such as child health surveillance and cervical screening from health authorities to GPs, and could open the way for further privatisation. The expansion of preventive care by GPs will encourage cash-starved DHAs to regard their own services as expendable, and some have already drastically curtailed their family planning services. But in practice, GPs will not fill the gap: there is no obligation on them to carry out this preventive work, and many will not choose to. Many

people, especially the homeless, are not registered with a family doctor at all.

Though transferring services to GPs will relieve DHA budgets, the cost to the taxpayer will actually *increase*: closing family planning clinics in England and transferring services to GPs would cost an estimated £9.2m extra.

The White Paper talks of a 'greater degree of competition' amongst GPs, leading to a service led by 'consumer demand': the government's view of consumerism in any field usually involves strengthening private services at the expense of the public sector. The White Paper also suggests private primary care services might be developed as an alternative to the NHS.

- *Increased charges to patients*

The Primary Care White Paper now proposes to abolish free dental checks and eye tests. High Street dental and ophthalmic services are moving further and further away from the NHS and towards a fully private system. Although hospital services have so far escaped the threat of charges, the subject is clearly on the political agenda. At the end of 1987 Tony Newton said that 'Quite a lot of people feel that it is not unreasonable to at least contemplate whether expenditure on food for people who are in hospital and not at home should be taken into account.' Even this cautious floating of the idea of 'hotel charges' was later played down by the Prime Minister, but it is surely only a matter of time before the subject re-surfaces.

The idea of a publicly-funded NHS free at the point of use is receding. Treatment is increasingly being paid for individually, either by the patient, or by a private company or by another health authority in a market situation. It may seem unthinkable to suggest that British health services will soon resemble those in the USA, but the current interest in alternatives to an NHS funded by taxation would have been unthinkable only a few years ago.

The first challenge must therefore be to re-assert the principles on which the NHS was founded 40 years ago. The myth that profit-making enterprises are inherently

more 'efficient' than public bodies, and that the latter are automatically a drain on the economy, needs to be exposed.

The second challenge is to identify exactly how the NHS should work. It is not adequate simplistically to call for the reversal of every policy since 1979: the NHS was far from perfect then. It was undemocratic and heavily dominated by the medical profession. It concentrated on high-technology intervention rather than examining the causes of ill-health, and failed to give the patient real choice. With proper investment and organisation a publicly-funded NHS can be both consumer responsive and effective in improving health. The task facing all of us is to collaborate and explore in detail how this can be brought about.

18 *Thatcherism and the rise of commercial medicine*

by Dave Mathieson and Ben Griffith
(NHS Unlimited)

Although private practice, like poverty, has always been with us, it is no coincidence that both have grown rapidly under Thatcherism. The effect of increased unemployment, poverty, bad housing and overcrowding on the nation's health in the last eight years has been well documented and is painfully evident to all but the government. The growth of private practice, equally harmful to the nation's health in its way, has attracted less attention.

Prior to 1979, private practice was insidious, nasty and manifestly unfair but no threat to the well-being of the NHS. Perversely, its practically dormant existence merely proved even further that the NHS was an excellent system. At no point in the history of the NHS has private practice been banned. Whilst that would have been ethically desirable, it was never absolutely necessary because of the success of the NHS. Patients made their choice – and overwhelmingly they chose to go public and use the NHS.

All this was anathema to Mrs Thatcher. Despite her rhetoric about the individual's 'right to choose', it was a situation she could not tolerate. All the while protesting their good intentions for the NHS, the government set about undermining it with all the patience of mediaeval besiegers. From the outset their real strategy was clear – to underfund the NHS and simultaneously encourage private practice. This ensured there would be an inevitable deterioration of the NHS, but that it would not affect everybody equally. The better off and the chattering classes who might begin to complain the loudest were being bought off by being encouraged to opt out. The motor to this was private medical insurance.

Private medical insurance

Private insurance grew rapidly and about ten percent of the population now carry private medical insurance compared to about two percent ten years ago. This growth had little to do with active individual choice: most of the newly insured are entitled to private treatment only because they work in a company which has negotiated a group scheme. These schemes are frequently restricted to management, so this growth has only benefitted social groups A and B(i) – ie the healthiest classes in our society. There are no policies as yet which will take on new clients over retirement age, and existing policy holders are often shocked to find their premiums soar as they grow older. As one private health insurer put it 'We are not a social service.' Quite.

Even for the young employed and healthy, the benefits of these policies have more to do with kudos and prestige than with good health. Many of the more complex, expensive areas of diagnosis, care and treatment are excluded from cover. One Tory MP, Michael McNair-Wilson, discovered that at a crucial period in his life there was no choice to be made:

> . . . I have been the victim of a rare kidney disease. Without kidney dialysis I would have been a dead man. . . . Although I am a member of BUPA, it is a service that it does not provide because of the expense . . . Had my treatment depended on my ability to pay, I would not be alive today. The NHS met my need for treatment without requiring me to show that I had the funds to pay for it. It operated on supply and need, not supply and demand. That is why it is such a precious asset to us all.

Since most people are not rich enough to pay for all the treatment they may need out of their own pocket, at the time when they need it, they would have to rely on private medical insurance. But when people actually get sick, they tend to forget about the private sector: half the people with private health insurance actually opt for NHS treatment

when they are sick. If they all went private, the health insurance outfits would go bust!

As Michael McNair-Wilson discovered, private care gives only an illusion of security without any comprehensive substance. However it has made it possible for more people than ever before to queue-jump waiting lists for routine treatment, even if it meant a longer list for sicker people. To provide this care it was necessary to release the carers from their obligation to the NHS.

Consultants' contracts

One of Mrs Thatcher's first acts when she took office in 1979 was to change the conditions of the most senior clinical staff working in the NHS, the consultants. From 1980 their contracts were changed to allow them to do more private practice. In the past, consultants who held full-time contracts with the NHS were not allowed to take on private work at all. Under the new regulations they were allowed to earn up to ten percent of their NHS salary from private practice. Part-time contracts were also changed to ensure that the consultants who held them were guaranteed more NHS work if they chose to take it. In effect, this gave highly paid consultants a guaranteed minimum income from the NHS while they built up an even more lucrative commercial practice outside the service.

The change had two effects. Firstly, by loosening the constraints on the consultants it quite simply allowed a lot more private practice to be done, much of it to the detriment of NHS patients. Although some doctors would like to have us believe that they are God, even they cannot be in two places at the same time: if they are treating private patients, they are not treating NHS patients. Secondly, by allowing them to earn more in the private sector, the government for a time effectively silenced one of their most powerful groups of potential critics, and undermined their loyalty to the NHS. This strategy worked until recently, and will probably work again. The consultants are unlikely to protest at any new changes Mrs Thatcher makes which leave them better off. 85% of con-

sultants now do some private work, and on average earn more than £19,000 per year extra on top of their NHS salaries. Apart from Tory ex-ministers, no other body of people being sustained by the state is encouraged to moonlight on such a scale.

Paybeds in the NHS: the thin end of the wedge

The government also reversed the last Labour government's policy on pay beds, which were slowly being phased out. Under this government, their numbers have steadily increased, so that there are now nearly 3,000 private beds in the NHS – an increase of about 25%. But this policy was not the success Ministers had hoped. Private patients were seeking treatment elsewhere, and the number of private patients using pay beds *dropped* by about a third during this time from 90,000 to just 63,000 a year. To compound the government's embarrassment, those patients who do use them frequently leave without paying. In 1986-7 nearly £1m of bad debts were written off – a 25% increase on the previous year. Despite this clear message from the market place that pay beds carry high risks and low returns, the government is pursuing the policy.

Until now, pay beds have been seen as a peripheral facility in the NHS, used by the wealthy few, and the charges were only expected to cover marginal costs. But now the government has changed the law to allow health authorities to make *profits* from their pay beds, and is putting pressure on health authorities to increase their private patients in order to generate revenue. At a time when they are cutting clinical services in the NHS, some health authorities are spending hundreds of thousands of pounds on the private patient wings in order to attract back the fee-paying patient. A two-tier system is being erected for their benefit, at the expense of clinical services in the NHS.

Private medicine outside the NHS

Most private patients now use private hospitals, but many are still not making a profit. Since 1979, in the acute sector,

there has been an increase of 50 private hospitals and 3,488 beds, (representing a net increase of 30% in hospitals and 50% in beds). However few of these places are able to deal with the seriously ill: they mainly undertake routine, elective surgery which can be paid for under private medical insurance – though sometimes they are unable to cope even with this. Apart from using staff trained at the taxpayers' expense, they rely heavily on the NHS in other ways. Most private hospitals are incapable of dealing with serious illness or complex operations. Few have even the rudimentary facilities of even a small General Hospital (60% do not even have their own pathology lab). These deficiencies can mean that private hospitals are ill-equipped to deal with unexpected patient needs.

The Prime Minister experienced this problem for herself when she sought treatment for a detached retina at a private hospital: it did not have the equipment needed to complete the operation, and this had to be hurriedly borrowed from the local NHS hospital. For others the consequences of such bungling have been lethal. Complications developed during an operation at the private Ross Hall hospital near Glasgow and the theatre equipment there was inadequate to deal with the situation: surgeons called the NHS emergency services, but were unable to save the patient's life.

Conclusion

Under the flimsy guise of 'choice' and a spurious philosophy of consumerism, Mrs Thatcher has for eight years done her level best to diminish freedoms and destroy real choice in health care. It is hard to predict the system of health care which her twisted logic will finally arrive at. All we can say for sure is that for many people – particularly those who need health care most – the system will be far worse and far more expensive than it is now. As one entrepreneur of private health care recently summed up with admirable candour: 'The bottom line to me is profit.' Mrs Thatcher will never be that honest.

19 *Mental health: 'The revolution that is going wrong'*

by Chris Heginbotham (Director, MIND)

Mental health care is approaching a crisis point. Although this could be mistaken for an emotive overstatement of doubtful accuracy, a glance at some of the facts and figures is sufficient to sustain this assertion. From *Panorama* in 1986, and *The Times* with a powerful series of articles on the lack of care for those with the most severe mental illnesses; from recent reports by groups as divergent as the trade unions and the Royal College of Psychiatrists – every commentator points to a serious lack of planning and care for the most vulnerable.

Mental health care (and that for people with mental handicap and elderly people) has been historically underfunded. Successive governments, both Labour and Conservative, have offered rhetoric but little practical action. Labour in 1976 issued a green paper and set up joint finance to aid the transition from hospital to community services: the Conservatives in 1981 issued a further green paper setting out additional ways to make such financing more flexible. A new, miscellaneous Act and Circular in 1983 formalised some of these mechanisms, though had the unfortunate side-effect of suggesting that community care was only what could be bought via that Circular. At root, the strategy of the DHSS has been to leave mental health care (and the other priority groups) to local government and health authorities, with precious little guidance on the way care ought to be provided. As closure plans for large hospitals have come to fruition – some 10,000 psychiatric beds have been lost since 1979 – no new money has been provided for mental health services.

Indeed, the last few years have seen a substantial squeeze on hospital and community health service expenditure. Most health economists have calculated that the NHS and local government health care-related services need an additional 2% per annum real growth in revenue to cover changes in technology, population growth and particularly demographic change (important because of the increasing number of very elderly people, especially those suffering from dementia). Yet in the last six years the real change in NHS purchasing power has been 2%, 0.8%, zero, -0.1%, 0.2% and 0.3%.

Frail and confused elderly people are making up an increasing proportion of society. Over the period from 1974 to the year 2000 it has been estimated there will be a dramatic increase in the number of elderly people. During that period the number of people aged 85 and over is expected to double (increasing by 450,000), and those in the 75-84 age range to increase by 35% – another 715,000 people. By 1987 much of the increase in the 75-84 age range had already taken place, and the last years of the century will see fairly stable numbers in this group; but those in the 85-plus range will continue to increase, and less than half the projected growth has yet taken place. The increasing number of those aged over 75 is already putting a major strain on health and social services. To put the figures a different way: on top of an already over-stretched service, there will be added in the next decade another 250,000 very frail elderly people over 85.

If the current rates of disability and dependency continue to prevail, by the end of the century at least half of the additional elderly people will probably need help taking a bath, one-fifth of those living in their own homes will be bed-bound or at least housebound, and a substantial proportion will be suffering from incontinence. Approximately 1 in 10 of all persons aged over 65 suffer from dementia, and prevalence increases steeply with age, reaching 22% of those aged 80 and over. Yet many elderly people over 75 have no children or close relatives.

Adult mental illness services, too, are woefully inadequate. Although beds have been lost from the large psychi-

atric hospitals, the service is still largely bed and institution-orientated. Few community mental health centres have yet been opened, and only in one or two places can it genuinely be said that a comprehensive community mental health service exists. 20% of the beds in the NHS are filled by those with psychiatric problems, yet these command only 11% of hospital and community health service resources. 1 in 8 of the population will be deemed every year by a GP to have some sort of mental health problem, and about one-fifth of those will see a psychiatrist. There are 200,000 admissions to and discharges from mental hospitals every year. Developing local care is the right answer – but community care is not a cheap option. Community services if anything are likely to be staff-intensive and more expensive than warehousing disadvantaged and disabled people in large hospitals.

Community care must be provided in settings which patients value as places that they choose to go to, and should offer appropriate support, help, care, and treatment in a locally accessible and flexible way. To provide such care means increasing the basic budgets of mental health services, as well as providing transitional finance to fund community services with the attendant closure of the large hospitals. Basic mental health care probably needs another £500m per annum, though that could not all be spent at once and would have to build up over a period of, say, five years. Transitional finance at the same level is also needed.

Community services are also woefully lacking in day-care, employment rehabilitation, home-help and peripatetic sustenance, as well as local treatment services – such as psychiatry, psychology and community nursing. A great deal of additional coordinated infrastructure will be required before the hospitals can finally close. The run-down of beds in hospitals continues to the point where some patients cannot get admitted to a facility that they need. The present government's answer is to seek to fund groups which pick up the disadvantaged 'under the arches', rather than fund the care which would prevent them reaching that stage.

The only new money in recent years has come from the

fiasco of board and lodgings. In 1981 the government expanded the availability of board-and-lodgings payments for homeless people – principally because of the severe shortage of decent accomodation for young people and for those leaving institutions. By opening up 'supply' and allowing a demand-led change, it has fuelled the private sector and pushed up the budget by more than a factor of 10 in six years. The likely out-turn this year may be as high as £600m. Indeed this was one of the reasons for Sir Roy Griffiths' review of community care.

In December 1986, the Audit Commission published their impressive report *Making a Reality out of Community Care*. Within 24 hours, the government had announced that Griffiths was to undertake a review, and this effectively scotched any debate on the Audit Commission's report. This was a pity, as it was well-researched. Sir Roy Griffiths was given the remit to consider how some sense could be knocked into the current mess of multiple agencies providing different sorts of care for differing groups of clients with different financial mechanisms and varying rules. His solution: to promote local authorities as the lead agencies for health care, services to mentally handicapped people and elderly people; and to give to local authorities the board and lodgings money, the joint finance (which is at present channelled through health authorities) and Social Fund monies for community care. The local authority's brief will be to purchase the most effective care for each client from the private and voluntary sectors.

The disadvantages of this idea outweigh the advantages. On the plus side, there is no doubt that community care needs to be better co-ordinated and one lead agency would help. If local authorities were able to act as case managers, assessing the needs of clients and ensuring that the client received the proper and relevant care at all times, then the change would be welcome. Yet the dangers are all too apparent. Many local authorities are rate-capped and in grant penalty. Providing them with ring-fenced, tightly-controlled money earmarked by central government in the form of Social Fund payments, joint finance and some welfare benefits could give the government easy control

over expenditure, but it would be local government, yet again that would be pilloried for not providing the right sort of care. And probably social workers will be asked to become needs assessors, advocates and gatekeepers, all rolled into one. If such a mechanism is established, an independent third-party advocacy agency to support the clients will have to be set up.

The future of mental health care ought to be community care. Yet the current financial and organisational mess and the historic under-funding of mental health care do not bode well. Present discussions about funding of the NHS have shown that the 'priority' groups are now being accorded the lowest priority. The Griffiths Review could be used as an excuse to hive off long-term care to local authorities, leaving the NHS ripe for privatisation. But what does that do for those in acute distress, or where there is a need for collaborative services between health, housing, social services and the voluntary and private sectors? The danger of Griffiths is a 'chronic' service – the cheapest option organised by the least well-funded, provided by the profit-conscious. Hardly a recipe for the best care for the most disadvantaged.

20 *Hazards ahead: the case for an occupational health service*

by Rosemary Ross (Socialist Health Association)

Awareness of the need to protect workers from the effects of their employment stretches back deep into history. The human cost of building the Egyptian pyramids or mining gold for the Pharaohs was immense: but the rulers of the day could replace their slaves cheaply. In Roman times, Pliny noted the diseases affecting workers in quicksilver and lead mines, and amongst the potters of the day. The efficiency of the growing Roman Empire depended on the health of its citizens – and the Romans were pioneers of public health measures such as supplying clean water and building sewers.

With the growth of manufacturing industries in Europe, doctors began to note industrial diseases and recommend ways of preventing them, such as ventilating mines to prevent suffocation. Dr Turner Thackrah was the first English doctor to publish a systematic study of industrial workers in Yorkshire in 1831. Evidence of the effects of industrial processes and insanitary urban housing conditions built up steadily throughout the century.

The first Factory Acts in the early nineteenth century began the long, slow process of legislative controls – starting with the working hours for children – which have been won by the hard- fought battles of trade unionists for improved working conditions. The 1961 Factories Act, the 1963 Offices, Shops and Railway Premises Act, and the 1974 Health and Safety at Work Act, together with an immense and complex series of regulations, are the fruits of this struggle. Yet preventable ill-health and injury associated with stressful, unsafe working conditions continue

– and increasingly can be seen to have wider implications than the health of the workers themselves. The extent of environmental pollution and the dangers of toxic wastes – chemical and nuclear – are only grudgingly being recognised. The rapid development of new technologies brings new hazards. The process of assessing their effects on health is inevitably long.

But despite legislation and regulation there is still a true ring in the words of Robert Owen in the middle of the last century:

> We manufacturers are always perfecting our dead machinery, but of our 'living machinery' we are taking no care.

When it comes to the crunch, the scale of values illustrated in a quotation from *The Guardian* of 1967, citing two cases which came before the Inner London Sessions on one day remains valid:

> Causing the deaths of four welders working in an enclosed space without the obligatory air supply: £20 (£5 per head). Stealing £1.50 from a telephone kiosk: one month's imprisonment for each 5p stolen.

It is in the interest of employers (mainly in large-scale and well-unionised sectors of industry) to ensure that their workers can be quickly back on the job after injury or illness. And this has led to workplace health care – and even compulsory private insurance – for some key sectors. In the midst of the current debates on the government's underfunding of the NHS, the voice of the CBI is again calling for a service which produces a healthy workforce, for the same reasons of self-interest. But workers should not be fooled into thinking that their interests are the same as the employers'.

Among the pioneers of the concept of a National Health Service, Dr Benjamin Moore, who worked in Liverpool in the early decades of this century, included in that concept a proper occupational health service, because:

> Disease is secondary to the calls of industry and commerce; the overcrowding and insanitary

> conditions of many workshops are a dishonour in the face of our knowledge as well as a constant menace to life and to health.

Dr Moore's ideas influenced the generation of doctors who established the Socialist Medical Association in 1930. The integration of an occupational health service within the NHS was included in SMA memoranda and pamphlets, and incorporated in the Labour Party's statement in 1943 *National Service for Health*. Resistance came from the Ministry of Labour which did not want to surrender control of the Factor Inspectorate. Once the Act was passed, and recognised as a great step forward, the SMA concerned itself with what had *not* been achieved. This was a formidable list, beginning with:

> 1. A unified service
> 2. No occupational health service
> 3. Private practice was inside instead of outside the National Health Service . . .

A fully integrated occupational health service has remained a fundamental principle of the SMA (which continued to argue the case in the 50s, 60s and 70s in seminars, pamphlets and union branch discussions) and now the Socialist *Health* Association. In 1955, Aneurin Bevan, writing in *Tribune*, was emphatic that:

> When I was at the Ministry of Health it was understood that the industrial health service would form the second part of a unified health service. . . . There are some who believe that an industrial health service should be separate and distinct from the National Health Service . . . I regard such a proposal as muddled, inefficient, wantonly extravagant and opposed to the true interests of the worker.
>
> It is muddled because it makes too sharp a distinction between disabilities arising from industrial employment and those from other causes. It is true that occupational disabilities and the conditions making for them have received, and still receive, too little attention. This would not be remedied by over-specialisation.

During the early 70s, when the subject was on the political agenda, the SMA published a discussion paper on *The Development of Occupational Health Services* which surveyed the needs and discussed finance and organisation in terms which are relevant to the debates of the late 1980s. Arguing against an industrial levy, the paper saw such a system as 'inflationary, for the costs would simply be passed on to the consumer. Under a system of *progressive general taxation, especially on profits and capital gains*, the funds required could be raised more equitably and with less inflationary consequences ... the effects of a levy could be retrogressive and counter-productive when applied in economically weak regions ... the administrative costs ... would be substantial compared with simple provision from general taxation.'

As for organisation, the paper argued for integration in the NHS, with occupational health functions carried out in health centres and hospitals with common usage of staff, buildings and equipment, to encourage 'continuity of care, uniformity in outlook and economic management.' This would encourage better coordination, facilitate uniformity and confidentiality of medical records and health survey procedures, promote better use of medical and environmental investigations to identify and monitor occupational hazards, and 'ensure professional independence from possible pressure by management or patients in industry.' The paper did not underestimate the complexity of the problems of establishing such a service, with its needs for suitably qualified, salaried staff. However, the benefits would be 'a reduction in mortality and in certificated sickness absence.'

The Health and Safety at Work Act of 1974 was welcomed as an 'enabling act', which laid on trade unions the continuing responsibility for constant vigilance rather than providing the integrated service and research needed to protect workers from long-standing as well as newly-emerging hazards.

True to the Tory philosophy of 'getting government off the backs of the people', current trends to de-regulate working conditions, especially for part-time and home-

workers are causing the situation to deteriorate, and inspectorates are bled of manpower. New working conditions are imposing new strains on workers, whose only other option is unemployment – and the hazard to health that entails. Sweated labour has returned. YTS trainees are exposed to dangerous working conditions without compensation. Stress is increasing in many jobs, from one-man operated buses and trains, operation of computers in air-traffic control rooms, and deteriorating conditions and 'flexible' shifts. Fumes from new chemical compounds and hazards from VDUs and fluorescent lighting are just samples from the growing list of new hazards. The appallingly stressful working conditions in the NHS itself cry out for an appropriate occupational health service, together with the need for counselling for those whose jobs involve immense emotional strain. Yet the NHS is among the more culpable employers in not caring for its own staff – and now that some ancillary staff have been 'privatised', their plight is even worse.

The SHA wants to keep occupational health high on the agenda for improving the NHS. But Britain remains far from achieving the targets of the World Health Organisation programme *Health for All by the Year 2000*:

> By 1995, the people of (Europe) should be effectively protected against work-related health risks. The achievement of this target will require the introduction of appropriate occupational health services to cover the needs of workers; the development of health criteria for the protection of workers against biological, chemical and physical hazards; the implementation of technical and educational measures to reduce work-related risk factors, and the safeguarding of specially vulnerable groups of workers.

Meanwhile there are welcome initiatives, such as the Sheffield Occupational Health Project, begun in 1979. This is providing help to individuals and valuable research data on work-related illness. Project workers, funded by the Family Practitioner Committees under the ancillary staff scheme, have been attached to GP practices. They inter-

view patients in the waiting room about their occupational history and health problems which many had not associated with their work. This has led to claims for compensation from employers, but above all to the spread of information about avoidable hazards at work – through trade union meetings and campaigns. This Project is an important contribution to the concept of sharing the responsibility for ill-health. Resigned acceptance of ill-health as just 'part of the job' is privatisation at its worst.

21 *That's the way the money goes!*

by Sue Lister (National Executive member, MSF)

The present Government *is* spending more money on the National Health Service than any previous Government. Yet we have a terrible crisis: there isn't enough money, there isn't enough equipment, people are waiting longer and longer for operations. So where *is* all the money going?

Pay accounts for 75% of the NHS budget, and pay awards have been underfunded year after year: last year the pay settlement for nurses and other staff covered by Pay Review Bodies was an increase of around 9%: other sections too received pay awards higher than the government's original 3.75% target increase. Yet only part of this extra cash was paid out by the government, which left local health authorities to find an extra *£170m* to meet their pay bills: in fact if Thatcher does agree to fund this year's nurses' pay award in full it would be a major change of line.

Inflation too has had a major impact on the NHS, since the cost of drugs and NHS equipment (the Hospital Services Price Index) has gone up much more than the Retail Price Increase. Equipment in particular has dramatically increased in cost.

A general X-Ray Room supplied for Oxford's John Radcliffe Hospital by Siemens about 12 years ago (when it was being built) averaged £20,000: the equivalent today costs £80,000. The other addition to the cost is the NHS cannot replace a piece of equipment with an exact equivalent, because of technological, scientific and medical advances. These of course mean that more can be done, but

more sophisticated equipment has to be bought.

An easy way to understand this is to compare non-medical equipment. Your old twin-tub washing machine may have been the best available when you bought it, and served you well, but when it eventually breaks down and can't be repaired you may well replace it (if you can afford to) with a fully automatic, front loader which also tumble dries. It does more – but costs more: the 'state of the art' has moved on. When your Box Brownie camera breaks you buy a modern version, not another Box Brownie. So when the Nuffield Orthopaedic Centre in Oxford replaced its X-Ray Screening Room, which had cost £45,000 to instal 17 years earlier the 'state of the art' replacement in 1987 cost £340,000.

The NHS also took on a lot of very old buildings in 1948 which have had to be refurbished, rebuilt or replaced. Indeed even now, in 1988, 81% of NHS hospitals currently in use in England were built before 1918! The cost of rebuilding and new building has been huge: the backlog is estimated at £4 billion. Many planned new buildings have not been completed. The Royal Free Hospital in London and the John Radcliffe Hospital in Oxford were both supposed to have 3 Phases, but the third phase plans were scrapped because the money ran out before they were built.

Some new hospitals and units have been 'moth-balled', because they are cheaper to keep closed than to open. The moth-balling of a new hospital was the basis of a very funny episode of *Yes Minister*. Sir Humphrey pointed out that a hospital without patients was cheaper and much more efficient. The Tories have realised that to have *no* hospitals is even cheaper!

The number and type of operations available have dramatically increased. This does not just mean high technology, high cost, transplant surgery, which has only seriouly developed to any degree of success in the last 10 years. There has also been a big expansion in operations which were once 'high-tech', but which we now take for granted – like hip replacements. A replaced hip lasts on average between 10 and 15 years. So as people live longer,

the NHS is now revising many of the hips that it previously replaced: this is good for the patients, bringing a vital respite from agonies of arthritis: but it all costs money. Now knee replacements are becoming increasingly common, though they were a rarity until only a few years ago.

Do these figures imply that the Tories theory of NHS funding being a 'bottomless pit' is correct? No: because 'infinite' demand would assume that we all live for ever and that we all want endless operations. This is nonsense: the majority of the population will not have *one* hysterectomy, and even a woman is not capable of having two. The majority of people will not need to have *either* of their hips replaced, let alone have them revised.

Decent housing and standards of living would reduce disease, make our bodies stronger and mean we would need to use the NHS less. If the Tories want to reduce the cost of the NHS they should improve pay, working and living conditions.

And let's not forget the question of profit: drug companies and other suppliers make massive profits out of the NHS. This is illogical, since the Health Service is a monopoly buyer in Britain: how come the seller is still allowed to dictate the price? Is that what they mean by 'business methods'?

22 *Behind the statistical smokescreen*

by Alison Macfarlane, Radical Statistics Health Group

The early years of the NHS were a time of great expansion in the range of statistics collected about the services being provided in hospitals and, to a lesser extent, in the community. Forty years later many changes are under way. New statistical systems are being introduced and the people who devised them say these will give a clearer picture of what is going on in the NHS.

Ironically, this happens at a time when the very same statistics are being used to paint a picture of the NHS which is totally at odds with most people's experience. According to figures which the government quotes whenever it is challenged, record sums of money are being poured into health care and increasing numbers of doctors and nurses are treating more patients than ever before.

Faced with this statistical smokescreen it is tempting to switch off and dismiss the figures as 'just statistics' or 'damned lies'. This is ducking the issue. What actually happens is that the government selects convenient statistics from standard sets of figures and uses a number of devices to present them in a way which flatters its record on the NHS. Radical Statistics Health Group's book *Facing the figures: what really is happening to the National Health Service?* looked in detail at the government's claims about its generosity towards the NHS. This short article sets out some of the questions which readers could ask when faced with bewildering statistics. It aims both to expose ways in which statistics can be presented misleadingly and also to suggest ways in which they could be used more constructively.

As the statistics which eventually emerge are affected by the way they are collected, analysed, presented and inter-

preted, it is worth looking at each stage separately.

Which statistics are collected?

Most of what are loosely described as 'health statistics' are collected by government departments or the National Health service as by-products of administrative or legal processes. The nature of these processes, which range from the registration of births, marriages and deaths to the administration of services, inevitably affects the characteristics of the statistics which emerge from them. In particular, very few of the statistics are actually about people's health!

Although the new data collection systems which are being introduced are much more sophisticated than the old NHS 'statistical returns' they are replacing, the statistics which emerge are not very different in character. They are mainly administrative statistics, which tend to focus on the use of facilities such as hospital beds, operating theatres and clinics and on the work of staff, in terms of hours worked or visits made.

Thus, for example, they tell us how many operations of a given type are done, but little about the circumstances of the people who were operated on or whether their treatment was successful. Similarly, a death certificate can tell us what the doctor who completed it thought the person died from, but this does not necessarily relate very closely to their health problems when they were alive.

The only way to get round these problems is to do surveys which go out and ask people about their health problems, including those for which they have not consulted the health services. Surveys tend to be more expensive than using statistics from official resources, which may mean that they are less likely to be done at a time of spending cuts.

On some occasions, it is difficult to avoid the conclusion that decisions about what information should be collected are overtly political. For example, the government has a ready supply of statistics about the numbers of beds provided in what are described as 'new hospital schemes'. It is

much more vague about the numbers of beds lost through closures. When asked about this in a parliamentary question, Norman Fowler replied, 'I see no purpose in keeping centrally a full inventory of furniture in each of our hospitals.' He tried to justify this on the grounds that, 'In every case, closures are only approved by ministers when they are no longer necessary for patient care and the resources can be put to better use elsewhere.'

It is also unclear what constitutes a 'new hospital scheme' anyway. In the late 1970s, DHSS collected information about 'new hospital schemes' in terms of the building of capital projects costing more than £2 million. From 1979 onwards, this was changed to capital schemes costing more than £5 million. Subsequently, the threshold was lowered to £1 million, and as a result the number of schemes went up considerably and, over the years inflation is continuously lowering this threshold further. The numbers were further swelled by counting successive phases in the development of the same hospital separately. In addition, the numbers of 'schemes' now include not only those which have been completed and those which are being built, but also those which in which building is not even due to start for several years!

How are statistics collected?

The way statistics are collected tends to reflect the way services are operated, rather than focussing on the people who use them and the care they receive. Thus, people are counted each time they are discharged from hospital, visit an out-patients department or are visited at home by a health visitor or district nurse. So, for example, if a person has six stays in hospital during a year, they are counted as six 'in-patient cases'.

Although DHSS, and their opposite numbers in health departments in Wales, Scotland, and Northern Ireland give instructions to health authorities about how statistics should be compiled, authorities sometimes interpret them in different ways. This means that it is not always clear to what extent differences in districts' statistics reflect real

differences in their services. At present, attempts are being made to tighten up definitions, so there might be some improvement in the future.

This is one example of the way in which instructions about data collection can change over time, making it difficult to compare one year's statistics with another. Another example is the instruction given by DHSS in 1979 to English health authorities not to include people waiting for day case treatment in waiting list statistics. As they were not identified separately beforehand, it is impossible to judge the effect of this change on overall totals. Collection of waiting list statistics for day cases started again on April 1 1987, but they are now identified separately.

The changes in NHS statistical systems introduced in England in 1987 were fairly wide ranging and similar changes are taking place in Wales and Northern Ireland. This may make it difficult to compare statistics collected before and after the changes.

There are other other changes which can affect the way statistics are defined and make it misleading to compare statistics for two points in time. For example, the reduction of nurses' and midwives' contract hours in 1980, to comply with EEC regulations, affected the statistics about the numbers of these staff. Because so many nurses and midwives work part time, statistics about them are usually expressed as 'whole time equivalents'. In other words, each nurse or midwife is counted according to the proportion of the full week she or he works. When the working week was reduced from 40 to 37.5 hours in 1980, a part time nurse or midwife who continued to work the same hours became a larger whole time equivalent overnight. Then, additional staff had to be taken on to make up for the shorter hours worked by full time staff. This is usually ignored in statistics which compare the present numbers of nurses and midwives with the numbers before 1980. So the 63,000 extra nurses and midwives which featured in the Tory Party's 1987 general election advertisements would have amounted to only 32,000 if adjusted for this change in definition.

How are statistics classified?

There are standard systems for classifying and grouping items such as diseases and causes of death, operations and social class. These are all changed from time to time for very obvious reasons. New operations appear on the scene and older ones fall out of use. Views about the nature and causes of diseases may change and, as a result, it may be decided to classify them in different ways. New diseases can appear, as happened with AIDS. The social class classification is based on occupations and has to be modified as old types of job disappear and new ones develop. In addition, jobs can go up and down the social and economic spectrum as they gain and lose pay and status.

If a classification is designed for one purpose, it may be difficult to use it for a different one. For example, the social class classification was designed to group the range and types of job done by men. As a result, it is not a very effective way of grouping women according to their occupations. What is more, it has no way of classifying couples according to both their occupations.

How are statistics tabulated and analysed?

The question as to whether like is being compared with like also arise when looking at the way statistics are tabulated and analysed. For example, in government statements, NHS spending figures are corrected for inflation using a statistic called the Gross Domestic Product Deflator (GDP). This reflects the way inflation affects the economy of the country as a whole. The way the NHS spends its money is not, however, typical of the economy as a whole, and the costs of the goods and services it buys have risen faster than general inflation. So adjusting NHS spending figures in this way does not give a valid measure of changes in what the NHS can buy for its money.

Often global statistics are quoted about spending, staffing and facilities in the NHS as a whole. This ignores what is happening in different parts of the service. Spending on the family practitioner services, which include services provided by general practitioners, dentists and

opticians, has grown ahead of NHS pay and prices since 1979. These services have not been subjected to the cash limits which have been imposed on the hospital and community health services. As a result, the running costs of these services increased much more slowly between 1979 and 1982, and has scarcely kept pace with NHS pay and prices since 1982.

When figures are quoted for the United Kingdom as a whole, this can mask differences between Scotland, Northern Ireland, Wales and England. In the same way, figures for England as a whole do not reflect variations between its regions and districts. Because of the process of NHS resource allocation, spending on the running costs of the hospital and community health services has fallen behind NHS pay and prices since 1982 in the losing regions although it has increased ahead of them in other regions. For the same reason, there have been similar differences between districts even within the same region.

What statistics are presented?

Choosing convenient statistics and ignoring inconvenient ones can make a considerable difference in the impression which is created. The failure to mention closures when talking about new building developments has already been mentioned. Another example is the way the government continually tells us that there are more doctors and nurses than in the late 1970s.

This is true nationally, even when the numbers of nurses are adjusted to allow for the reduction in the working week, although it is certainly not always true locally. Less often mentioned is the larger *decrease* nationally in the numbers of ancillary staff. It may be that some of them have been replaced by staff working for private companies, but there are no statistics to tell us how many. The government is proud of the decrease in what it describes as 'support staff' whom it does not acknowledge as giving care to patients. On the other hand, doctors and nurses can find themselves doing tasks which would be more appropriately done by clerical or ancillary staff.

Government spokespeople often mention the fall in the perinatal mortality rate, which is the proportion of babies who are stillborn or die in the first week after live birth. Although this trend dated back well before 1979, the Tories had no hesitation in giving themselves credit for it. What they did not mention, however, was what that there was no corresponding fall in the postneonatal mortality rate. This is the proportion of babies who die, at ages greater than one month but under a year after live birth. This rate has scarcely fallen since 1976 and has fluctuated from year to year. This only came to light when statistics for 1986 showed that there was a rise in the infant mortality rate, which includes all deaths in the first year of life. What had happened was that the decline in the death rate for babies aged under a month had slowed down considerably, while the postneonatal mortality rate rose by a larger amount and more than cancelled out the decrease.

How are statistics presented?

Presenting statistics in graphs and diagrams can often give a clearer picture than tables of numbers. Only the other hand, graphs can be positively misleading, particularly if they are not drawn in a straightforward way.

A form of presentation common in DHSS publications is a graph showing series of figures expressed as a percentage of the first point in the series. This can be helpful when comparing changes over time, but can be misleading if the numbers presented in this way are very different in magnitude as happens in the graph opposite. It is taken from the Annual Report of the Health Service in England for 1986-87 and shows an apparently huge increase in day case surgery. When the actual numbers of day cases are plotted, however, it can seen that although they are increasing rapidly, they are still relatively small.

Presenting numbers of any innovation, such as heart transplants, in terms of a percentage increase in numbers will almost inevitably show a considerable increase, even when the numbers themselves are still small. The replotted

graph also shows that some of the changes are part of longer trends which date to the 1970s.

There are other scales which can be misleading. Sometimes figures are plotted on a logarithmic scale. This can be helpful to people who are experienced in interpreting statistics presented in this way, but is wide open to misunderstanding by people who are not.

Even when figures are plotted on a straightforward linear scale the message can be altered by careful choice of start and end points, or by cutting vertical scales. The way this can be done is illustrated by plotting the series of waiting list statistics in different ways.

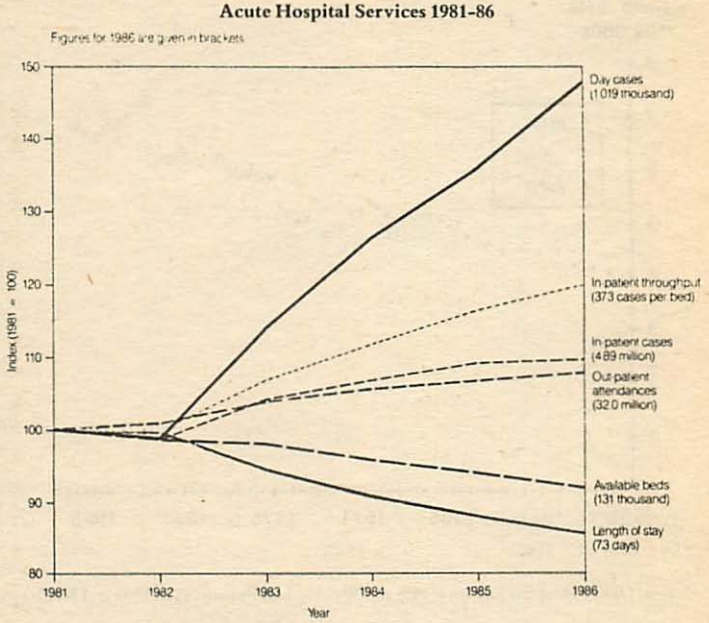
How are statistics interpreted?

All the points which have been mentioned already can affect the way statistics are interpreted, but there are a few more to watch out for. The first is the assumption that statistical correlation implies causation. In other words, if two changes occur over the same time period, then one will have caused the other. Thus government politicians will give themselves credit for any improvement which occurs during their term of office, even when it is part of a longer term trend and unlikely to be related to their policies. Opposition politicians, using the same logic, will blame the government for anything which gets worse, irrespective of whether the government could have influenced it. In fact, statistical correlation does not imply causation, although a lack of correlation does rule out a straightforward causal relationship, provided the numbers on which this is based are large enough to detect a positive statistical association, should it exist.

All too often, advantage is taken of the fact that most people are unaware of where statistics come from and do not, for example, know that there is a difference between 'inpatient cases' and people having inpatient treatment. Changes in definition can also be ignored, for example, when quoting figures about numbers of nurses and midwives before and after 1980 without adjusting for the change in their contract hours.

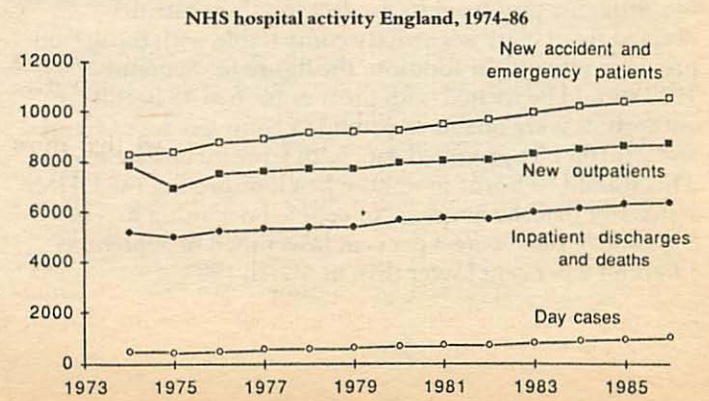
Two ways of looking at hospital activity statistics

(a) as presented in the annual report of the Health Service in England for 1986–87



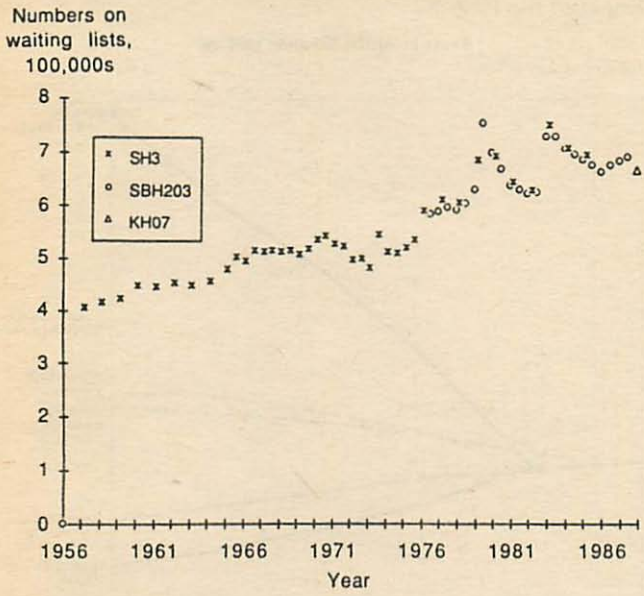
Source: Reproduced from the annual report of the Health Service in England

(b) an alternative view



Source: Data in DHSS Statistical Bulletins 2/86 and 5/87

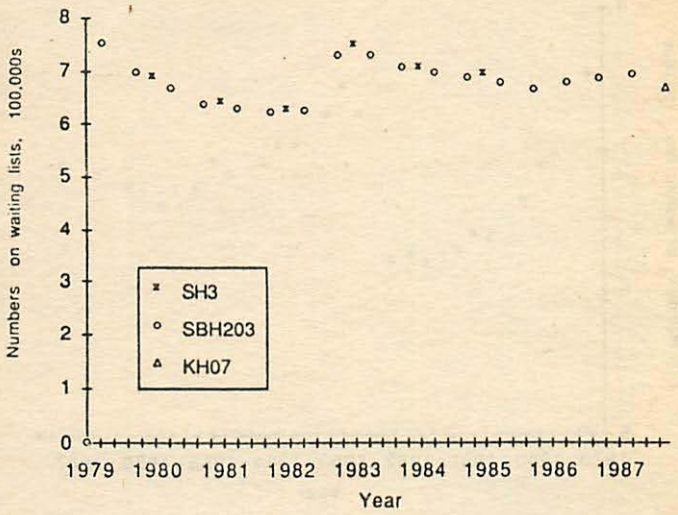
Numbers on waiting lists for in-patient treatment, England 1956-87



Source: DHSS Hospital Return (SH3) and Waiting List Returns (SBH203 and KH07)

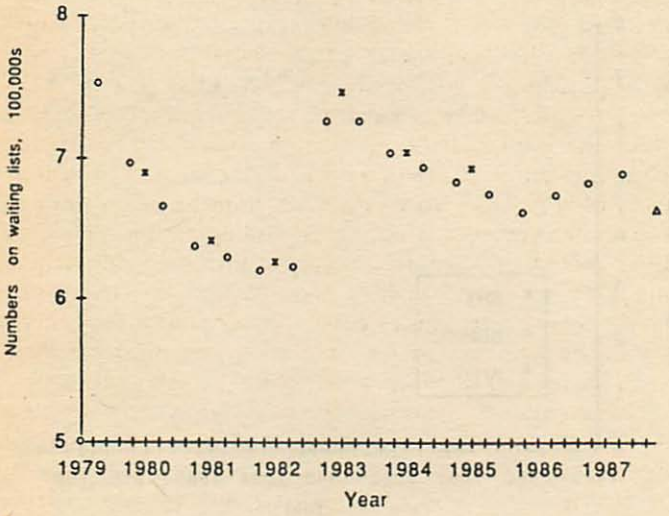
Return KH07 was introduced in April 1987. It is compiled in a different way from its predecessors, so statistics derived from it are not strictly comparable with those from previous returns. In addition, the figure for September 1987 should be treated with great caution as 48 health authorities were unable to provide a complete set of figures and a further 31 provided data with large inconsistencies. This should be borne in mind when interpreting the DHSS statement that the numbers of people on waiting lists in September 1987 were 3 per cent lower than in September 1986 and 4 per cent lower than in March 1987.

Numbers of people on waiting lists for in-patient treatment England, 1979-87



Starting the graph from the March 1979 peak means that the troughs and peak which followed cannot be compared with earlier long term trends.

Numbers of people on waiting lists for in-patient treatment
England, 1979-87



Cutting the vertical axis at 500,000, rather than zero, exaggerates the scale of the peaks and troughs.

What is left out?

The most important thing to be left out of health service statistics is any reference to the population for whom services are being provided. The real question about providing health services is not the abstract one about whether there are more or fewer of them, but whether the changes in type and level of service match changes in the structure of the population or its need for health care.

To assess this need, much more information is needed about the health of the population, and how it varies in space and time. There is a great dearth of such statistics, many of which are more time consuming and expensive to collect than statistics about deaths and operations. This is a symptom of an attitude to health and health care which implicitly assumes that operations are always 'vital' without asking whether some people might find it more beneficial to their health to go on holiday or improve their physical surroundings by redecorating their living room!

This article has tried to suggest ways of seeing through the Tories' statistical smokescreen. For the future we need to move beyond this smokescreen to collect statistics about the health of the population in order both to plan a health service which would evaluate the care it provided and wider policies which would tackle the social and economic causes of ill health. In the words of the 1944 White Paper, the aim should be 'the promotion of good health rather than the treatment of bad'. Statistics are never neutral, but instead reflect the values of the society from which they emerge. If our goals include moving towards greater equality and social justice, then we need statistics to evaluate our progress in that direction. Instead, what we have at present is a smokescreen of statistics intended to distract attention from the way the health service is moving away from those goals.

Facing the figures: what really is happening to the National Health Service, by Radical Statistics Health Group, was published by Radical Statistics in 1987. Copies, price £3.95 plus 50 p p&p can be obtained from Radical Statistics Health Group, c/o BSSRS, 25 Horsell Road, London N5 1XL.

23 *AIDS research: too little – and too late?*

by Hugh Lowe (London Health Emergency)

Health Emergency has warned of the remorseless progress of AIDS, and pointed out the pathetically tiny resources being devoted to biomedical research in the search for a cure. The latest figures for AIDS cases and the reports of the International AIDS Conference fully vindicated those calling for a massive increase in research funding.

This year it is estimated that AIDS treatment will cost the NHS more than £80 million. This is about half of the *total* funding of the Medical Research Council. In face of the threat which AIDS now clearly presents, the cuts in funding for research in past years can be seen for the short sighted idiocy they were.

The Medical Research Council working party on AIDS defined 24 areas which needed to be investigated urgently. These include not only the obvious ones to do with finding a drug which will actually cure sufferers and vaccines to protect people against catching AIDS, but studies on the epidemiology of the disease both in the West and in Africa. It is not realistic to suppose that cure or vaccine will be found just like that, even with extensively funded research. There are further areas which are concerned with testing any drugs which may suppress the effects of AIDS (there is at least one already known) and testing any likely-looking vaccines.

The known drug which suppresses the consequences of AIDS, AZT, is made by Wellcome. It is very expensive to produce, and is still only being used in trials at present. If it turns out to be useful, there must be a demand that it, and any other drug or vaccine, must be annexed exclusively by

the NHS and be available on NHS prescription only. However, a drug which only suppresses symptoms, and therefore must be taken continuously, leaves much to be desired: continued research for something better is vital.

It may sound obvious to say pull all the stops out in the search for an anti-AIDS drug or vaccine: but things do not work quite like that. Research on a narrow field very often turns out to be wasteful if not counterproductive. What is neccessary is to restore basic biomedical research, which has been slaughtered by cash limits and cuts.

Not only is AIDS a very nasty sexually transmitted disease, but it is a very odd one as well; likewise the AIDS virus is quite peculiar as viruses go, and so the scientific answers will probably turn out to be even more unexpected than usual and are unlikely to be found without wide ranging research.

Ten years ago, the idea that some new and dread disease might suddenly appear would have been laughed out of court; now that the unthinkable has happened once, it might again. If we permit governments to axe research, we run the risk of being unprepared the next time.

The government's AIDS propaganda campaign, (on which they spent considerably more than on research), seems to have had little effect, and the experience of publicity campaigns in the USA shows that was to be expected. The latest information from the USA also indicates that as the number of sufferers increases, the disease spreads outside the so-called 'high risk' groups to the rest of the population, thereby keeping the overall rate of increase roughly constant. The number of full blown AIDS cases in the UK *doubles* about every 10 months, and so do the number of deaths from the disease. This means that in the last year more than half of all AIDS sufferers there have ever been (about 1,200) have developed the disease, and the same is true for the number of AIDS deaths.

In a few years most deaths in the 18 to 45 age group will be due to AIDS. If the cost of treating AIDS victims remains roughly the same per case, before the end of the century, the cost of AIDS treatment alone will equal what is now spent on the whole of the NHS. Probably the treatment

costs will go down considerably; but even so, this problem makes the so-called 'Thatcher review' of the NHS look completely ridiculous. In the circumstances what private company is going to offer insurance against AIDS at a price more than a very few can afford?

The message on AIDS remains as before: a huge increase in bio-medical research is a vital necessity. The total number of front line AIDS research workers is only in the hundreds. This is totally absurd seen against the threat which clearly hangs over us.

24 *The case of the vanishing ambulances*

by Stuart Barber (Area Officer, NUPE)

It is a frightening fact that should a major disaster occur in London the Ambulance Service (as well as the NHS hospitals) would not be able to cope with the resulting casualties. The tragedy at Kings Cross station, where 31 people died, illustrates the problems faced by the London Ambulance Service (LAS), which has been bled of resources in the last 5 years. Only 14 ambulances were available to ferry the injured to hospital – leaving many to be transported by the police. Further, because the 14 ambulances had to be deployed from other areas, nearly a fifth of London was left without an effective emergency service. Staffing is so stretched that the first two crews to arrive at the scene had only just completed their training period.

Not a fortnight passes in London without someone dying as a result of an ambulance either not being available or arriving too late at the scene of an accident. Already in 1988 NUPE and MPs have raised demands for an inquiry in the management and funding of the LAS. The latest such call, from Frank Dobson MP, was for a Judicial Inquiry into the LAS following the release of a confidential internal 'log' which outlined the undermanning, underfunding and lack of competent management at the time of the Kings Cross events.

1980-88: the '10 Year Plan'

The LAS is one of the few London-wide NHS services, managed by a sub-committee of SW Thames Regional Health Authority on behalf of all four regions and 30 health districts in the capital.

From 1980 onwards the LAS began asking any non-emergency patients who were able to walk to get either a bus or a taxi to hospital to reduce demand for ambulances. While the LAS carried less passengers, part of the work-load was transferred to what was called the 'Hospital Car Service', which consisted of private car owners paid a mileage allowance to ferry patients to hospital. The cost of this 'Service' to the LAS nearly doubled between 1980 and 1984: the savings made were no more than an accountancy exercise.

In 1984, in an attempt to 'streamline' the LAS a 10-year Strategic Plan was drawn up, to operate from 1985-94. The clear strategy was one of trimming demand to match resources.

The frail, the elderly, and expectant mothers were to suffer, as scarce resources were concentrated on emergency cover. It is frightening to note that this strategy was adopted despite the admission in the 10 year Plan that:

> The historical trend of increasing volume of patients will continue (. . .) accentuated by an increase in the number of home illnesses resulting from DHA plans for maintaining a greater number of elderly and infirm patients in the community.

The Plan further recognised that:

> Because of DHA policies we expect demand to increase by *240% over 10 years*. In particular day hospital patients, which are considered to warrant a high priority for ambulance transport; i.e. an increase of day hospital patients from 12,715 per week in 1984 to 30,860 patients per week in 1994.

Despite identifying these increased demands on the service, and the fact that congestion in London traffic 'is 10 times more than the national average', and despite noting that the fourth terminal at Heathrow 'will result in an increase of 5 million passengers', the Plan initiated a cost-cutting programme which is now reducing the service to a poorly-funded 'safety net'.

The following cuts were proposed:

- A 0.5% annual 'cost improvement' over 10 years;
- Reduction in overtime equivalent to 56 full time staff (against existing overtime equivalent to 488 staff)
- Reduction of 70 leading ambulanceman jobs
- Reduction of 6 hospital liaison officer jobs
- Dispersal of inner zone control
- Review of Admin and Clerical staffing

It was envisaged that total 'recurring annual savings' for the 10-year period would be £8.43m. Not only would fewer jobs exist, but staff would face a reduction in wages through 're-negotiation of national agreements relating to subsistence, travelling expenses and overtime.'

The Plan declared a need 'to revise the present emergency categories *omitting maternity cases* which account for 5% of the total demand.'

1985-7: The first Two Year Plan

The ink was barely dry on the Strategic Plan before the LAS issued a new document in early 1985. This identified an effective £400,000 cut in revenue because the 1984-5 pay awards had not been fully funded by the government. The solution to the admitted underfunding was further economy measures, including:

- Privatisation of cleaning and caretaking services, affecting 47 jobs;
- Reducing regular meetings with union representatives;
- Reappraisal of the use of non-emergency services by district health authorities;
- Using volunteers or taxi firms to transport some psychiatric day patients;
- Urging doctors, dentists and midwives to ensure that their patients have 'genuine need' of ambulance transport.

1987-89: The second Two Year Plan

A new document issued by LAS in late 1986 confessed that over the previous two years there had been:

▷ A total reduction in non-emergency patient journeys of 30%;
▷ A huge (44%) reduction in transport for 'walking cases' – mainly the elderly and disabled;
▷ A 9.4% reduction in day patients transported (1,200 less each week compared to 1985).

The new Plan looked for more savings but admitted:

> The areas of search are diminishing and if the 0.5% reduction per annum in the LAS budget is to be maintained it will *become increasingly difficult to ensure that services to patients will be unaffected.* (emphasis added)

The report also admitted that despite improvements in productivity the Service faced a shortfall of 233 staff to meet current levels of demand, and 'because of the need to ensure that the A&E demand was met in full, *the impact of the short-fall fell on the non-emergency service.*'

After four years of continuing reductions in the Service the ambulance drivers embarked upon an overtime ban in November 1987, which lasted one month. During this overtime ban a shortfall in staff resulted in a number of widely publicised deaths because insufficient ambulances were available. A typical night during the overtime ban was portrayed by a confidential 'log', which showed that on the night of November 28:

> • 25% of ambulances could not move for lack of staff;
> • Of the remaining 70 available ambulances, 15 were 'single- manned' for part or the whole of the night, leaving only 55 fully-staffed ambulances – 58.8% of the service that should be provided.

The overtime ban ended on December 1, but on New Year's Eve, 78 hard-pressed crews had to be 'supplemented' by 20 ambulances provided by the volunteer St John's Association.

1988-89: The third Two Year Plan

At a secretly held meeting in December 1987 another 'Two

Year Plan' was hastily put together and issued without consultation. It drew up 'emergency' measures including new cost-cutting to be introduced *before* the previously-endorsed 1987-8 plan had run its course. The meeting heard that:

▷ The total bungling of computerisation of Central Control had cost the LAS a further £2.14m; it was agreed that this would be taken from capital funds, meaning that any further capital spending would be met from 'cost improvements' (cuts)

▷ An overspend of more than £500,000 from 1986-7 had been cut from the 1987-88 budget

▷ In the first 9 months of the year 'economies' of £267,000 had already been made.

The meeting was told that:

> Extreme economy measures are currently under consideration in order to protect patient services and fund the establishment levels on which this plan is based . . . As the scope for savings becomes more limited it is unrealistic to assume that further pressure on the budget from underfunded pay awards can be relieved without affecting patient services.

To make sufficient 'front line' staff available, the staffing levels on the non-emergency side would be slashed by 160 whole-time equivalent posts (wte); but 36 wte emergency posts would also be cut, and overtime working would be massively cut. The net effect was a reduction of 77 jobs, plus 100 equivalent jobs worked as overtime, as well as a reduction of 90 non-emergency ambulances from the fleet of 571, and a huge increase in use of the hospital car service to 240,435 journeys in 1988-9 (182% up on the 85,027 in 1985).

Already the elderly and infirm have suffered the brunt of the LAS cuts. Non-emergency cases carried have fallen by over 20% from 2.3m in 1983 to 1.8m in 1987. In 1983 only 9% of patients were carried by non-LAS transport: by 1987 this had almost doubled to 17%. More are being

taken by taxis and 'volunteer' hospital car drivers, leading to a slow but inevitable 'privatisation' of the non-emergency service. In Portsmouth a local taxi firm already transports the majority of non-emergency patients.

Meanwhile, though numbers of emergency patients have increased by 10% since 1983–4, manpower and resources have not expanded: people are dying as a result of insufficient ambulances and crews being available, as Coroners Courts are increasingly hearing. Government guidelines require that 90% of all 999 calls should be responded to within 14 minutes: however, confidential LAS documents show that in the three months to September 1987 this was achieved in only 87% of calls made, putting an average of nearly 12,000 lives at risk in July, August and September alone last year.

While patients suffer, ambulance staff, too, feel the pressure, with drivers on the road facing verbal and physical abuse from frustrated and angry relatives, and control officers too facing mental and physical stress: sickness levels have rocketed, producing worse staff shortages.

The Way Forward

It is generally accepted that the weapon of 'all out' strike action would hurt the public, and NUPE realises that the fightback has initially to take other forms. A campaign has been launched for a Judicial Inquiry into the LAS to highlight the bureaucracy and secrecy which surrounds it. The LAS is unique in:

▷ not having 'open' monthly meetings;
▷ being accountable directly to the DHSS for financing, allowing direct central government control;
▷ not having its own independent management board, thus excluding local authority and trade union nominees.

NUPE is producing leaflets for use by ambulance staff explaining why either the expected ambulance was late or did not turn up at all, and a postcard for members of the public to send to the LAS to ensure that formal complaints are registered, and brought to the knowledge of the powers that be.

The sensitivity felt by LAS has led to a number of senior lay union representatives being privately 'warned off' talking to the media by senior management. Such a response has of course only strengthened NUPE's resolve.

25 *Campaigning for the NHS: 'The Worms Turn'*

by Dave Shields

In the wake of the defeat of the miners in 1985 and the subsequent collapse of opposition to rate-capping, prospects for resistance to public sector cuts were severely limited.

NHS unions suffered a financial blow as privatisation of ancillary services began to take a toll of membership figures, and though they waged successful campaigns to retain union political funds they showed themselves reluctant to campaign for action against NHS cuts in the run-up to the General Election. Such action, felt some leaders, might jeopardise Labour's electoral chances. The time was not ripe, they argued; the members were apathetic and would not respond to a call for national action, especially after the defeat of the 1982 pay campaign and the strikes against privatisation at Barking and Hammersmith. The struggle was declared to be 'political', by which was meant waiting for the election of a Labour government.

Union branches were urged to broaden their appeal to local NHS users – the broader the appeal, the better. The theory was developed that the more non-Labour supporters that could be roped in, the more 'successful' a campaign would be. Unions were urged to cast off their old, confrontational, 'class-oriented' image in favour of a more cuddly and user friendly one. This strategy of embracing the wider community had the effect of alienating most NHS workers from the campaigns that were set up: as a consequence the campaigns lacked teeth and were condemned to failure. This in turn led to more demoralisation in the workplace, while those community activists that did

try to build local defence campaigns tended to blame union 'apathy' for their failures. The effectiveness of the whole strategy was most clearly illustrated in the disastrous 1987 General Election result.

There were exceptions, however. In the Bethlem and Maudsley psychiatric hospitals in South London hospital workers including nurses and medical staff staged a series of actions and strikes against cuts during 1986. A November strike by COHSE members received official national support. The Bethlem (the old 'Bedlam' Hospital) and Maudsley are both specialist teaching hospitals drawing from a wide catchment area across the country, and belong to a Special Health Authority (SHA) separate from the SE Thames RHA. The strength of their campaign rested on the active involvement of hospital workers, organised through stewards on the Bethlem and Maudsley Action Committee (BEMAC). Senior consultants, themselves appalled at the level of cuts being proposed by the SHA, gave high-profile public support to the campaign which succeeded in holding off the cuts for a period as a direct result of the protest strikes.

Meanwhile a struggle of a different nature was unfolding across the Thames in the Tower Hamlets health authority. Tower Hamlets – one of the most deprived areas in Europe – had already witnessed a spate of hospital closures: in late 1984 came a threat to the popular Mile End Hospital. Managers were anxious to integrate most of the services at Mile End into the larger London Hospital in Whitechapel, including the loss of casualty services at Mile End. If the plans went through, few people expected acute services to remain for local people at Mile End. Among those opposed to these plans was Wendy Savage, a senior consultant in Obstetrics and Gynaecology, and a lecturer at the London Hospital Medical School. On April 24 1985 she was suspended from duties pending an inquiry conducted by the health authority into alleged malpractice.

Quite clearly Wendy Savage had been singled out because of her outspoken and sometimes unconventional views on childbirth, in which she advocated non-interventionist natural methods which maximised women's choice

and involvement. This brought her sharply into conflict with her male colleagues, as did her refusal to carry out private work. Should the Mile End have closed, it could have spelt the end of community-orientated women's services in the area. Wendy Savage's work and popular approach would have been submerged into a larger department of the London Hospital.

The attack on Wendy Savage provoked a storm of local and London-wide protest from women's organisations and an energetic campaign to secure her reinstatement. Hundreds of local mothers with their children became active in the campaign, which was also turned against the male establishment consultants in the London Hospital hierarchy with the slogan 'Wendy's the best: Investigate the rest!' The campaign was also taken up by hospital workers and their unions who recognised what was at stake. Eventually, a year after she had been suspended, and after the health authority had spent hundreds of thousands of pounds trying to victimise her, Wendy Savage was reinstated. During the period of the campaign in her defence, the health authority had also temporarily shelved their plans to axe the Mile End casualty.

Perhaps one of the most remarkable successes during this period was that notched up in Hammersmith by the campaign to Save West London Hospital (SWEL). The hospital is situated off Hammersmith Broadway, and has had to battle repeatedly for survival against successive closure plans. In 1974, when the new Charing Cross Hospital opened only half a mile away it seemed as if the end was finally in sight. The West London's casualty unit closed, leaving the hospital with the district maternity unit, a handful of clinics and a few wards for the care of the elderly and elderly mentally ill.

It was for its maternity unit that the hospital was most famed, rated as one of the best in the country in Sheila Kitzinger's influential *Good Birth Guide*. Though the building itself had been allowed to become dilapidated, mothers would travel from far and wide to be seen by the hospital's maternity specialists, who offered a wide variety of choice on methods of delivery, and placed the emphasis on the

woman having the baby rather than less personal, 'high-tech' methods. Midwives at West London felt more involved, and many had chosen to work there because of its philosophy. Linked to the maternity unit is the Neonatal Intensive Care Unit, with six specialist neonatal and six Special Care baby cots. These deal with difficult, low-weight or premature births, either in the maternity unit or elsewhere. Because of the national shortage of these cots, cases are referred to West London from as far afield as Bath, Peterborough, Hastings, and once even from Norway. The success of these two units is measured by the very low perinatal mortality rate in the area, despite higher than average levels of deprivation. More babies on average survive in NW Thames region than any other region in Britan, yet at West London Hospital the survival rate is even higher than the regional average.

Small surprise, therefore, that when Hammersmith and Fulham AHA tried to transfer this unit to Charing Cross Hospital there was a huge public outcry. Local people felt that if the maternity unit was transferred it would be at the expense of the unit's special approach to childbirth. These feelings were shared by the Professor of Obstetrics Mr Norman Morris, who together with local mothers organised a successful campaign of resistance to the scheme; the plans were dropped in 1982.

In 1985 however the Hammersmith and Fulham district was merged with Victoria to form Riverside DHA – whose main function was to push through huge cuts including the closure of several hospitals to trim annual spending by 25% within ten years. It was clear that a major teaching hospital would have to go as well as smaller hospitals if this were to be done. Nobody was surprised that by 1986 the West London was once again the first candidate for closure, with no plans to replace its facilities locally. Expectant mothers were expected either to travel several miles to central London's Westminster Hospital, or to be treated at Queen Charlotte's Maternity Hospital: but neither offered the same sort of care as West London, while maternity beds and the life-saving baby cots would both be drastically cut back.

If West London's maternity unit closed, the rest of the hospital could not hope to continue: this was why Riverside DHA proposed to close it completely by April 1987. They did not find it so easy. A dozen or so women working in the hospital were outraged by the plans. One of them was also the grand-daughter of an elderly patient on one of the hospital's wards. More than one of them had had their own babies at the West London. They decided to form a campaign to stop the plans. They began with a petition, then followed up with a public meeting called by the local (Labour) council. The local health branch of NUPE became involved, and in June 1986 SWEL was launched.

SWEL organised fortnightly open meetings for supporters – or more frequently when needed. Campaign stalls were arranged at local community events and in shopping centres at weekends. Petitions, stickers, pamphlets, balloons, and other material were used to get over the message to the local community that a fight was on to save their hospital. The local hospitals' Joint Shop Stewards Committee called a successful lunch-time protest rally in July against the plans, medical students and student nurses threw themselves enthusiastically into the campaign, organising discos and their own demonstrations in support of the hospital.

Public meetings were held in Hammersmith, Fulham and Chiswick. In all over 1,000 people came to local meetings; in October over 300 marched through the streets of Hammersmith and Fulham to voice their anger. By November 35,000 had signed the SWEL petition opposing Riverside's plans. The campaign drew its support both from hospital workers and from the local community. Parents of children born at the West London and local pensioners were strongly involved; school students did projects on the effects of closure, and local Labour Party Young Socialists took up the campaign, which had the single aim of persuading DHA members to vote down the closure at its November meeting.

Workers at the hospital, however, were adamant that if this failed they would resort to more direct forms of ac-

tion. Some women in the Special Care Baby Unit declared their willingness to go to prison if necessary to stop it closing. A massive campaign was built around the key handful of workers in the hospital who were prepared to fight, though many of them were at first not even in a union and had no experience of campaigning: without them the campaign could not have developed the way it did.

In November several hundred campaigners demonstrated outside the DHA meeting; SWEL had already prepared an effective counter - document and lobbied individual DHA members. In the event the DHA plan fell for lack of support: SWEL had won, against the odds.

This tremendous victory had an inspiring effect among the Riverside staff organisations. It also showed, as had the Bethlem and Maudsley campaign and the Tower Hamlets struggle, that where even temporary victories are won by campaigning it helps lay the ground for future action. Since last June, all three areas have been at the forefront of a new wave of health campaigns including strikes and demonstrations – with Tower Hamlets once again defeating a new threat to the Mile End casualty in October 1987.

The notion that 'old' forms of industrial action have somehow been superseded by new forms of protest looks ridiculous in the face of the popular revolt against NHS cuts since January 1988. While many health workers are moving onto the scene for the first time, bringing in new energy and ideas, the 'realists' who had argued that the Thatcher years meant dropping any confrontational approach are having to rethink their position. The conditions in today's NHS seem to have more effect in determining the consciousness of health workers than opinion polls and those who want only to follow them.