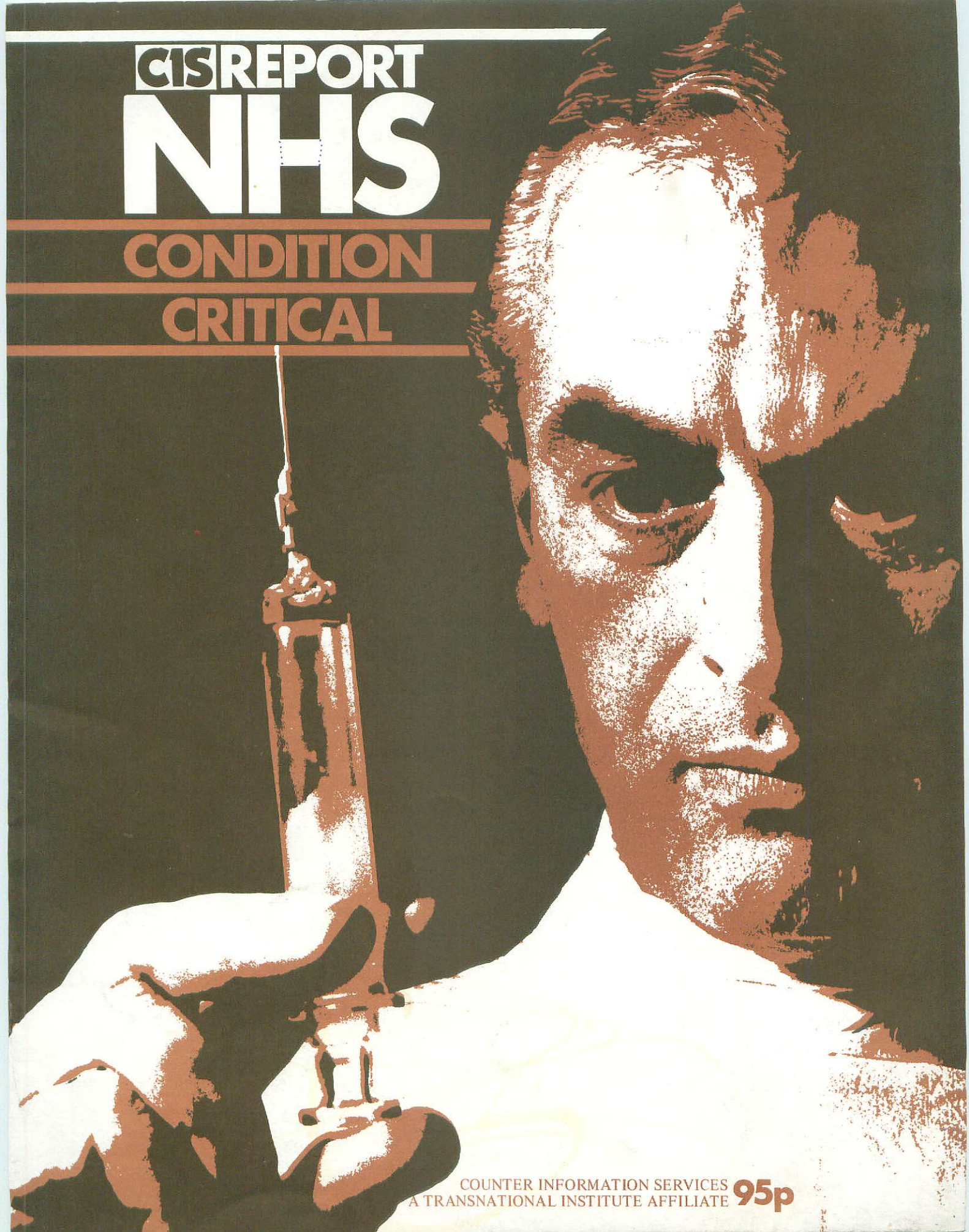
CIS REPORT

NHS

CONDITION CRITICAL



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Contents

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The NHS

The NHS is a huge, centrally controlled organisation. At the top, theoretically in control, are four Ministers – one each for England, Wales, Scotland and Northern Ireland. The Secretary of State for Social Services is responsible for the NHS in England, which is administered by the **Department of Health and Social Security** (DHSS), along with personal social services and social security.

The NHS is run from the top downwards, presently through three tiers: **Regional Health Authorities** (RHAs); **Area Health Authorities** (AHAs), and District Management Teams. The 14 RHAs in England (average population 3m) are responsible for translating national policies into regional objectives and structures. The 117 AHAs (average population ½m) have full operational and considerable planning responsibilities, and employ most NHS staff. The **Districts** (average population ¼m) are the smallest units for which the full range of general health services can be provided.

The new Tory reorganisation will abolish the middle tier – the AHAs – leaving a two-tier system of RHAs and Districts below the DHSS.

GPs, dentists, opticians, pharmacists and so on, are self-employed, not employed directly by the NHS, and they are administered separately from the hospital system through Family Practitioner Committees. These committees are largely dominated by the medical professions, but are theoretically responsible to the AHAs.

The **Community Health Councils** (CHCs) are supposed to 'represent the local community's interest in the health services to those responsible for managing them', but their function is purely advisory.

The NHS is paid for out of general taxation (income tax, VAT etc), and to a smaller extent, National Insurance contributions.

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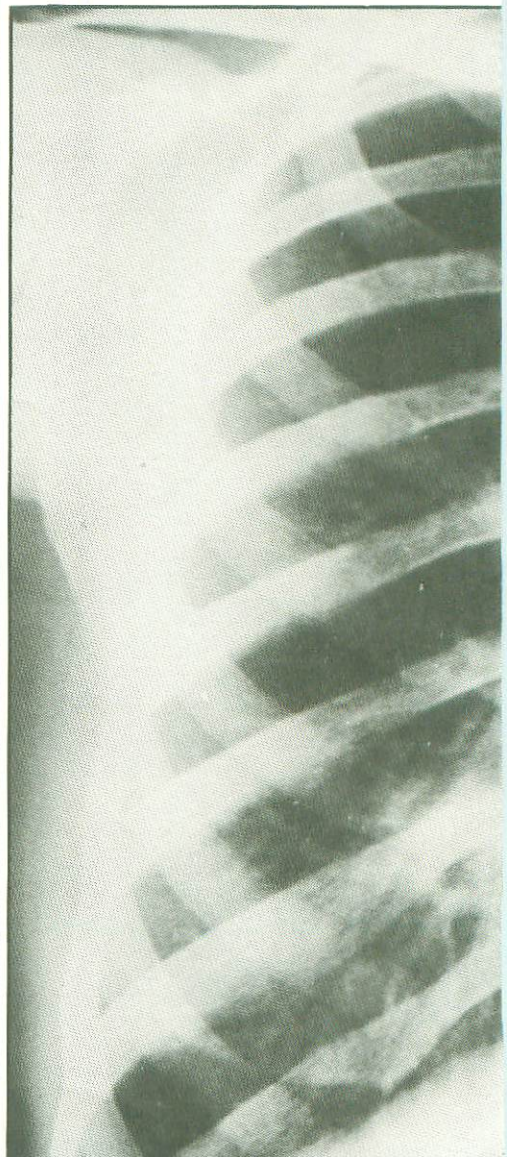
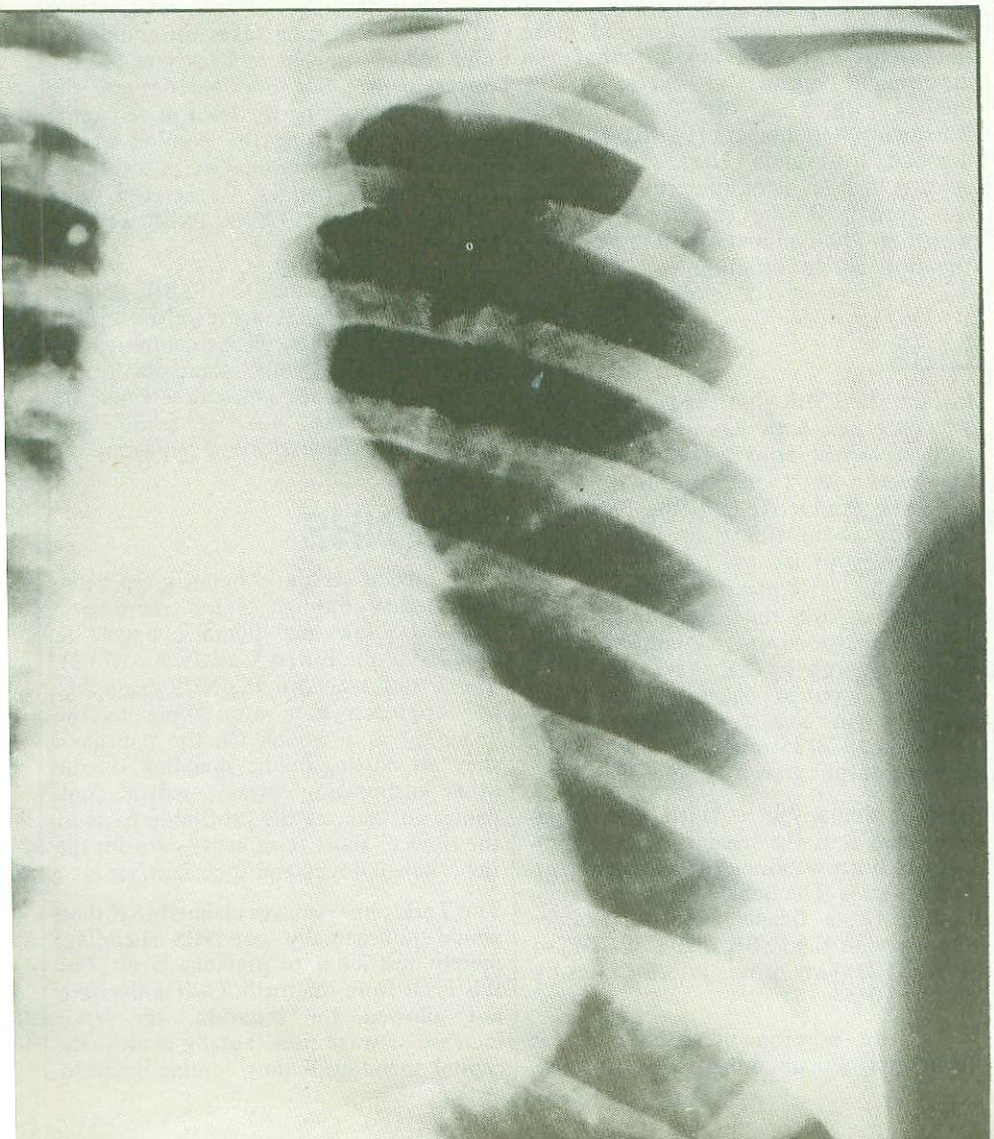


CONDITION CRITICAL

In February 1980, in Liverpool, a 92 year old spinster died alone at home after a warning that she did not expect to survive being discharged from hospital. The senior consultant defended his decision to send her home by saying that he was under pressure to cut the number of old people's beds. In Durham, one hospital has decided to switch off the heating at night to save money, and only the intensive care and maternity units are excepted. In Enfield, North London, patients have been stranded in an upstairs ward for three years because the lifts are broken and the Area Health Authority claims to have no money to install new ones. According to the Consultant General Physician, 48 geriatric patients are not receiving adequate treatment.

In 1979, a doctor in Hackney was quoted as saying, 'We have real problems getting emergency admissions into hospital, even people with miscarriages and suspected heart attacks. I sometimes have to phone three or four hospitals to find them a bed and then its often miles from their home'.

The list of penny-pinching measures, callous and often fatal reductions in beds, and wholesale closures of hospitals, lengthens daily and it shows no signs of stopping. The National Health Service is in crisis and the root cause is the government's attack on welfare spending. The 1979 Tory White Paper on public spending began, 'Public expenditure is at the heart of Britain's economic difficulties'. The announcement of an immediate £3.5 billion cut in public spending for 1979/80 showed little regard for the consequences.



Popperfoto.

The situation is now far worse than anyone wants to admit. The real cuts that are hitting the NHS are much more severe than the government claims. The method of financing the NHS, and the imposition of annual cash limits means that government statements on the amount to be allocated to the NHS each year are irrelevant. Instead there is a process of squeezing over the years that creates a state of perpetual crisis, with a constant need to find money saving schemes. The result is a steady worsening of the service.

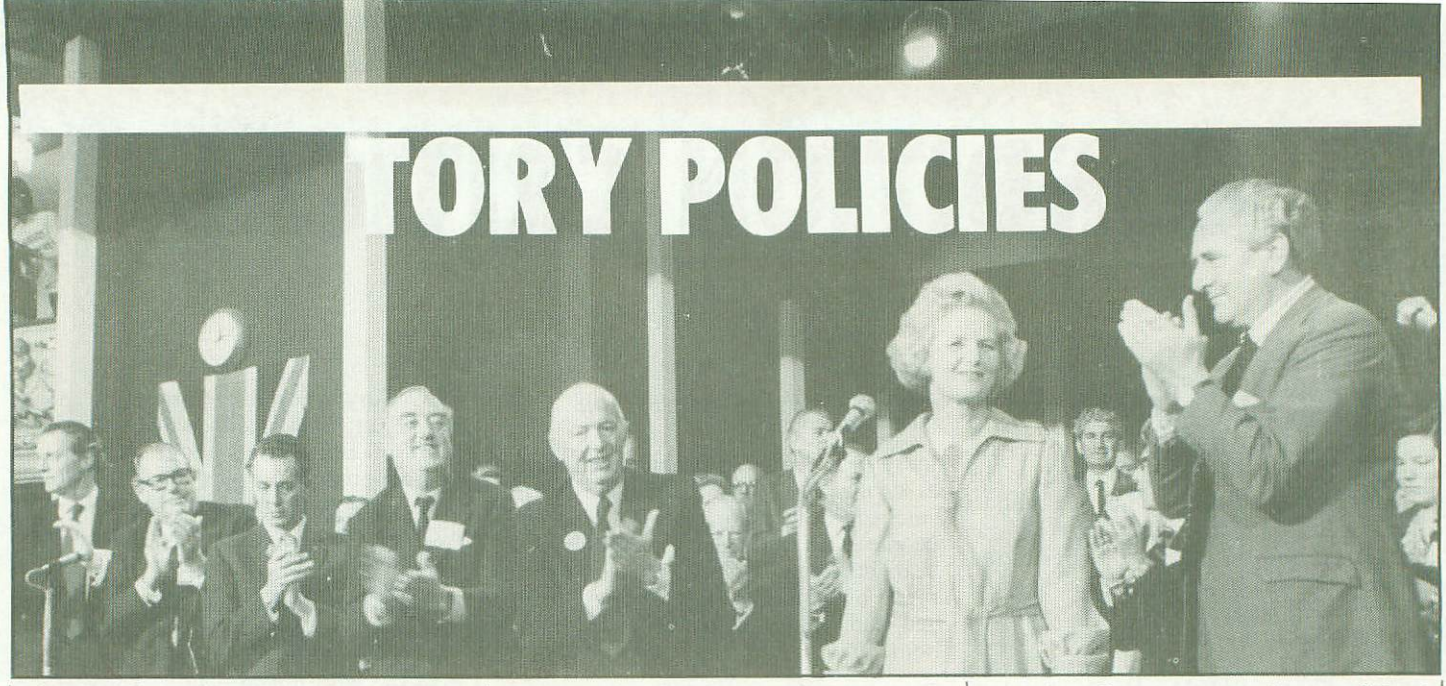
Despite the fine promises of successive governments, the old and the long term ill and disabled are being increasingly confined to ghetto type institutions, or else offered no care at all.

Alongside the assault from a government determined to reduce welfare spending whatever the consequences, the NHS is being opened up to profiteering in a big way. The drug companies have always had a privileged role inside the health service. Now the government is openly encouraging the development of private medicine, on the grounds that this is one way to solve the problems of the NHS.

The government's new legislation will remove any real fetters on the growth of medical care for profit, and offer a queue-jumpers' charter to those who can afford to pay. At the same time the government admits that it is not prepared to fund an adequate health service. As private medicine expands, the strain on the NHS, in terms of staff, time and resources, will become more acute.

Behind the day to day closures, a longer term process is occurring. Unless defensive steps are taken, it will mean a total transformation of the NHS and health care in Britain. The public service will offer less and less to the old, the chronically sick and the mentally ill, and to all those who cannot afford to pay. In the present political climate, only the wealthy can be assured of a healthy future.

TORY POLICIES



The Tories are determined to drive down living standards in their attempt to bolster the profitability of British capital. Their approach is multi-faceted. High levels of unemployment are calculated to depress real wages and discipline workers, while cuts in public spending reduce the 'social' wage. At the same time, private companies are being encouraged to take over the profitable areas of welfare provision.

This is backed by a political campaign against the very idea of the welfare state. Tory propaganda is forcefully asserting that welfare services once considered as rights can no longer be afforded. Coupled with this they are proclaiming the virtues of private enterprise, in particular its ability to enter the welfare sector.

Monetarism

At the heart of Tory economic policies lies deflation – the depression of economic activity. Through the combination of high interest rates and lower public spending at a time of world recession, unemployment has been forced up beyond two million. This is not an accidental by-product – it is the centre-piece of the Tory strategy.

The results can already by seen. Wage rises are already running below the rate of inflation, hard won improvements in working conditions are being lost in productivity deals, and shop floor union organisation is weaker than for many years.

Another aspect of Tory attempts to force down living standards is the decision to keep public sector wage rises well below the rate of inflation. **The public sector will be used as a pace setter to control wage demands throughout the economy. This determination was clear in the introduction, shortly after coming to power, of contingency plans to use troops and volunteers against public sector strikes where practicable.**

The Tories use the economic theory of "monetarism' as the pretext for these policies. Everything, they argue, hinges on the level of public spending and, more importantly, on the amount that the government spends in excess of its income, which is the Public Sector Borrowing Requirement (PSBR). It is this demand for funds, they say, that is causing high levels of interest and fuelling the growth in the supply of money, which in their monetarist philosophy is the root cause of inflation.

Lies

In fact, the PSBR that the government is so concerned with has been drastically reduced in real terms over the past five or six years. As a percentage of Gross Domestic Product (GDP), the PSBR has fallen by about 40% since 1975, and is now down to its 1972/73 levels. And while the government's White Paper claims that 'over the years public spending has increased on assumptions over economic growth that have not been achieved', public spending on programmes (in cost terms) fell by 4% between 1974/75 and 1978/79, while national output grew by 6% to 7%.

There is similarly little truth in the argument that it is the need for the government to borrow money that is keeping up interest rates. The Bank of England's own model of the financial system assumes that a rise in the PSBR of 1% of GDP, or around £2,000m, moves interest rates by less than 0.2%.

It is the government itself that is deliberately maintaining high interest rates, in order to squeeze the overall level of borrowing, and reduce the growth in the money supply.

Similarly, despite the propaganda implying that it is only overspending that causes a rise in the PSBR, it is in fact a product of the government's wider approach. Reducing taxes on companies and the rich means less revenue for the government. So does deflating the economy, lowering the level of economic activity, and raising the number of unemployed. Higher interest rates mean higher debt charges – no less than £3 billion of the 1979/80 PSBR went on debt interest.

As well as increasing the PSBR, government policies directly increase the burden on welfare services. High unemployment and declining living standards mean greater demand for medical services and community care, but far from being expanded, these services are being cut.

The NHS

'The private sector is being given more opportunity through liberal economics, liberal tax laws and liberal competition policies' (John Biffen, *Guardian* 7.10.78). The Tories' plans for the NHS exemplify the approach they are taking to the economy as a whole. On the one hand they are cutting public spending, on the other encouraging private medical companies to take on the profitable parts of the service: short term acute care for the rich, the employed and their families.

The Tories have always claimed that they would not actually cut NHS spending, merely restrict it to previous levels, but this is far from the truth. Cash limits have not allowed for inflation, the VAT increase or wage rises. Totally inadequate capital spending is now coming home to

roost as poorly maintained buildings deteriorate. In all the Tories made a real cut of 5-6% from budget last year.

As part of the cuts and as a method of depriving people of the service, charges are being raised viciously. Prescription charges at £1 per item are a real deterrent from visiting the doctor. **The principle of a health service free at the time of need is being abandoned, and once again, as in pre-NHS days, it is the poorer members of society who are deprived of health care.**

As public spending is cut, the government is exhorting health authorities to turn to public charity for funds. The legalisation of lotteries in the Health Services Bill is just the tip of the iceberg. The years before the NHS showed that charity is no substitute for welfare. The glamorous sections such as heart transplants or test tube babies may be able to continue, but who will fund long stay geriatric or mental illness hospitals?

The other aspect of this policy is the proposed use of volunteers. Although the voluntary agencies have made clear that they are not in a position to prop up failing statutory services, both the Home Secretary, Whitelaw – 'we must encourage people to take up voluntary service', and Jenkin – 'we must create vigorous involvement' in voluntary work, seem to have other ideas.

Private enterprise

The Tories are determined to extend the profit motive into health care. Private medicine is a primary beneficiary of many of the government's policies. The Health Services Board, set up to oversee the phasing out of pay beds, has been abolished. General policy is that there should be 'adequate provision' of pay beds – i.e. enough to satisfy the insurers and consultants.

The private insurers and hospitals will gain considerably from extended tax relief on covenants. If employers become responsible for the first eight weeks of sick pay, as the government proposes, this too will provide a major boost for private group medical schemes.

Already consultants' contracts have been changed to make it easier for them to work outside the NHS. They can now spend up to 10% of their time on private work without losing any of their NHS salary.

There are moves towards a two-tier-system in the ambulance service. Outside London, the same ambulance service covers emergencies and out-patients. 'Patients First' considers splitting the two services from each other and the Tories will try to push this through. It would allow them to divide the ambulance workforce, whose militancy has long been decisive. It would also facilitate farming out the out-patients services to private companies, and subsequently charging for it. The end result would be the disappearance of the non-emergency public service.

Double standards

Reducing the effectiveness of the NHS, benefits private medicine in many ways, for private medicine's main selling point is the inadequacy of the NHS. Yet the very areas worst hit by the cuts, such as geriatric and mental illness provision, are those in which the private sectors has no interest. **The result is in essence a two tier health care system, where long term care, and health care for the poor and unemployed, is relegated to a second-class public system, while private companies reap their profits from those who can afford to pay.**

Reorganisation

The 1974 reorganisation created a three level management structure, with 14 Regional Health Authorities (RHAs) overseeing 127 Area Health Authorities (AHAs). The AHAs in turn supervise District Management Teams. The Tories are now planning to abolish the middle level – the AHAs.

In their place will go some 150 to 180 district health authorities. The 14 RHAs will be in charge of reviewing structures in the region, of appointing the 20 members of each district health authority (the chairperson will be appointed by the Secretary of State) and of effecting the changes in structure, which should be completed by mid 1982.

Management of the NHS has always been a controversial issue. Many critics focus on lack of local control and the unnecessary hierarchical management structure, and the Tories often justify their attitude to the NHS by stressing these criticisms. 'Patients First', the Tories' consultative document, continually emphasises the need for decisions to be taken at a local level, and for an integrated health service.

But behind the rhetoric, the Tory reorganisation will centralise financial control, and ensure that there is absolutely no freedom of movement at a local level.

The Tories are changing the law so that the district health authorities will have a statutory obligation to stick within cash limits. There will be no room for flexibility – overspending can no longer be carried over to the next financial year. Even the Secretary of State will be powerless since an Act of Parliament will be required before any further money can be allocated to health authorities.

The abolition of the AHA will mean that the RHAs will be strengthened. They will become responsible for administering almost double their previous number of health authorities. At the same time, local authority representation is being reduced from one-third in the current AHAs to one-fifth in the new authorities. For the first time the Secretary of State will have the power to sack authority members. 'Patients First' off-handedly rejects the Royal Commission recommendation that the RHAs should either become accountable to Parliament or the responsibility of local government. The possibility of elected representatives on District Health Authorities is dismissed as 'not appropriate'.

So the Tories are planning to tamper with the lower levels of the NHS while leaving the top rungs intact. As before, the medical profession will retain its power within the service, and users will have no more say than they have at present.

Myths

The Tories have launched a propaganda campaign to back up their attack on the NHS. Jenkin in particular is stressing the idea that patients are abusing the NHS, wasting GPs' valuable time with trivial

complaints, and being admitted to hospitals at whim – simply because the NHS is there and free.

A cursory look at the relevant figures shows that statements like this stem from little more than prejudice. People don't visit their doctors more often – in fact the number of times each patient visited their GP fell between 1955 and 1970.

In any event, the NHS isn't free. We pay for it. It's paid for out of taxes, National Insurance contributions and charges. In effect when sick people pay for prescriptions they are paying twice: once in taxes and once for medicines.

What's more, it's not true that Britain spends an excessive amount on the NHS. Compared to almost all competing economies, Britain spends comparatively little on health care. In 1976, Britain spent £111 per capita compared with £250 for France, £295 for the Netherland, £367 for the USA and £437 for Sweden. As a proportion of GNP, France and Germany spend 21% more than Britain does, while Sweden, Canada and the US spend 58% more. Britain also has fewer doctors – in 1976 there were 140 active doctors per 10,000 people compared with 153 in France, 199 in West Germany, 178 in Sweden and 172 in the US.

Death

The results of underfunding show up in unnecessary deaths and suffering. Comparing health services isn't easy, but one of the accepted ways of doing this is to compare perinatal mortality (still-births and first-week deaths) and infant mortality rates. British infant death rates are high: the UK is ninth in the European league for infant mortality, and is falling back. The perinatal death figures aren't much better: with 17.6 per thousand in 1975 compared with 16.3 in the USA, 13.3 in Denmark, 13.9 in the Netherlands, and 11.3 in Sweden. As the Chief Medical Officer admits: '. . . among . . . countries with broadly similar social and economic backgrounds England's performance is not impressive'.

Another study of infant mortality emphasises the point. In 1974 there were 219.4 deaths per 100,000 from enteritis and diarrhoeal diseases in England and Wales, compared with only 27.2 in Sweden and 99.2 in Belgium (*Royal Society of Health Journal* 6.12.79). Diseases of this nature are generally preventable if they are treated early enough. Investigations into the reasons for the high death rate in Britain have concluded that it is due to parents' failure to consult a GP in time.

Patrick Jenkin

Charles Patrick Fleeming Jenkin, Secretary of State for Social Services.

In 1968, Distillers Company, which had marketed Thalidomide, made its first offer of compensation to the parents of the children deformed by the drug. The offer was derisory. The subsequent outcry led to a massive campaign against the company. **Charles Patrick Fleeming Jenkin MP was legal adviser and company secretary to Distillers at that time.**

Elected to Winston Churchill's old seat of Woodford in 1964, Jenkin's silence throughout the Thalidomide saga was remarkable, particularly for a politician who has built his career on a veritable mountain of words and who has been described as 'a person who meets every problem with an open mouth.'

Even the Tory press has pilloried him for his absurd effusions, and his aptitude for getting into a self-inflicted mess. His best known outburst came during his first ministerial post as Edward Heath's Minister for Energy during the 1974 energy crisis. He suggested that 'people ought to clean their teeth in the dark and shave by candlelight.' Fleet Street unanimously greeted the suggestion with contempt.

But worse was to come. Mrs. Jenkin sprung to his defence and had herself pictured cleaning dishes by hand next to an unplugged dishwashing machine. Her claim that they had turned down the central heating and taken out many of the bulbs in the house was given wide press and television coverage. The following Sunday the *Observer* printed a picture of the Jenkins house taken the previous evening. Lights were on in every room. Even the outside light was on.

Shortly afterwards, Jenkin was invited to speak to the Dundee University Students' Union, and found himself at the centre of a race row. Asked during the meeting if he had any idea how many immigrants there were in Dundee, he answered 'I don't know, it was dark when I arrived.'

In opposition where he could do less harm, his outbursts went largely unrecorded. He still managed to make a fool of himself during a controversy over the use of ministerial cars. He admitted that he had tailed Lord Balogh through the streets of London to see if he was using an official car in an unauthorised way. Seemingly unable to distinguish between authorised and unauthorised usage, his accusation in the House were quickly followed by public apologies to Lord Balogh.

It is no secret that such bumbling has led to him being regarded by his own side as 'long on intellect and short on understanding.'

Jenkin was appointed Secretary of State for Social Services in Margaret Thatcher's administration. His excesses are no longer simply verbal. When, in 1979, he declared that hospital patients 'should pay for their own keep,' even the Tory press scoffed. People groaned when he claimed that what was wrong with the NHS was that people expected too much from it. Today, he is actively frustrating people's expectations and needs with respect to health care.

Jenkin's philosophy, which in another period was accepted as absurd, is today's policy protected by Thatcher's monetarist ideology. It took a battle in the courts to reverse his impetuous, and as it turned out illegal, action to remove the members of the Lambeth, Southwark and Lewisham AHA. **But Jenkin has now changed the rules. The new NHS Act embodies many of the procedures that will smooth the way for implementing the Jenkins plan.**

Charles Milligan (Nursing Times).

Popperfoto

People are under, rather than over, utilising their GPs and with fatal consequences.

Politics

The Tories choose to ignore all the evidence that the NHS needs more resources. They repeatedly claim that the UK's economic crisis means that funds are just not available for adequate health care.

This is completely dishonest. If the government was politically committed to a proper NHS it would raise the necessary money. It is not just a question of Tory tax cuts for the very rich; or of tax avoidance and evasion, despite the scandal of the millionaire Vestey family paying negligable tax. Companies generally have been granted so many tax concessions over recent years that in many cases their tax bill is virtually nil.

Even allowing for limitations on public spending, **the decision to run down the NHS is a political one.** While education, health and housing bear the brunt of the cuts, spending on defence and law and order soars. The government is preparing to spend £5 billion plus on modernising Britain's nuclear missiles while old people die through lack of hospital beds.

Finally, the whole method of raising government finance contributes massive funds to the City in interest payments. This accounts for a major part of the borrowing requirement of the forecast PSBR of £8,536m for 1980/81, debt interest is expected to account for £3,613m, all payable directly to the holders of government stocks.

Tories will exploit voluntary traditions: Charity is no substitute for welfare.

Second class

Overall, Tory policy is for a major restructuring of health care in Britain. Their plans for NHS reorganisation, combined with their overall expenditure programme, would mean progressive reductions in services and facilities, with even tighter financial control than is exercised at present. The drastic effects of the rundown in the health service would feed, and be compounded by, the virulent development of the private medical sector.

Only those who could afford to pay, would have access to the best health care. People most in need – the old, chronically sick, unemployed and poor, would be segregated into a second class public system. A two tier health care system would operate, with the private companies reaping the benefits.

As the Principal Finance Officer at the DHSS put it: 'We would have a second class health service in ten years.'

The Workforce

The NHS has nearly always exploited the dedication of its workforce. No other industry could get away with the low pay and exhausting work that its employees put up with. Nearly a million people work for the NHS, and most of those work in the hospital sector. Hospital nurses comprise by far the largest section of health staff employed in the NHS, making up well over a third of the total. The ancillary workers, those employed in domestic, portering and catering work are the second largest group making up about 22% of the total.

The latest figures on NHS employment are those collected by the Royal Commission in 1977 and are given below:

NHS staff: UK 1977

	Number	*%*
Total	*1,003,000*	*100*
Doctors	67,200	6.7
Dentists	17,100	1.7
Other practitioners*	27,800	2.8
Nursing and midwifery	430,500	43.0
Professional and technical	64,700	6.5
Ancillaries	219,700	21.9
Ambulance service	20,900	2.1
Administrative and clerical	123,200	12.3
Works and maintenance	31,600	3.2

*Mainly pharmacists and opticians.

The most startling feature is that well over 75% of those working in the NHS are women, making it the biggest single employer of women in the country. Women work mostly as nurses or as ancillary staff, with the more senior and prestigious positions filled almost entirely by men. There are presently less than one in five hospital medical posts throughout the UK filled by women.

Just as significant is the number of migrant workers working in the health sector, particularly hospitals. Migrant workers have played a key role in maintaining the NHS in operation. Since the early 1940s successive administrations have recruited labour from overseas. Although the exact number working is not available perhaps as many as 60% of hospital staff were born outside the UK.

Research carried out by North London Polytechnic at one London Hospital has borne this out.

Percentage of Overseas Workers in Each Occupational Group:

Occupation Group	*Proportion of Workers from Overseas*
Ancillary & Maintenance	78%
Clerical	20%
Professional and Technical	29%
Nurses and Midwives	72%
Doctors	32%
ALL OCCUPATIONS	60%

(Source: *Migrant Workers in the NHS*).

Most of these overseas workers are women. In the sample above, it was found that 79% of the total, four out of five workers, were women. Although workers born in Britain tended to be found evenly in the different occupational groups, the vast majority of overseas workers were concentrated in nursing, midwifery and ancillary or maintenance work, which are also, by and large the lower paid jobs in the NHS.

Pay

The NHS may be one of the largest employers in the UK, but it is also the one which pays some of the worst wages. Stark disparities exist within the sector. The basic rate recently awarded by the Government to Consultant Surgeons for example, is £19,870 while a nurse will receive a little over £3,000 and an ancillary worker £2,800.

Who Earns What on the Wards

Consultant surgeon	*£15,510-£19,870
Senior registrar	£8,770-£11,220
Registrar	£7,600-£9,260
Divisional nursing officer I	£7,227-£8,316
Divisional nursing officer II	£6,581-£7,669
Senior house officer	£6,700-£7,600
Divisional nursing officer III	£6,190-£7,280
Senior nursing officer	£5,972-£6,942
Nursing officer	£5,351-£6,391
Junior house officer	£5,400-£6,100
Ward sister/charge nurse	£4,698-£6,024
State registered nurse	£3,368-£4,107
Head porter	£3,740
State enrolled nurse	£3,033-£3,659
Nursing auxiliary	£2,507-£3,209
Special porter	£3,100
3rd year student nurse	£3,000
General porter	£2,974
2nd year student nurse	£2,862
Ward orderly	£2,834
Cleaner	£2,831
1st year student nurse	£2,747

Source *Sunday Times* 1.6.80.

*Consultants pay can be increased by 'merit' awards. They are also encouraged to do private work. It is not unusual for consultants to receive £40,000 or more.

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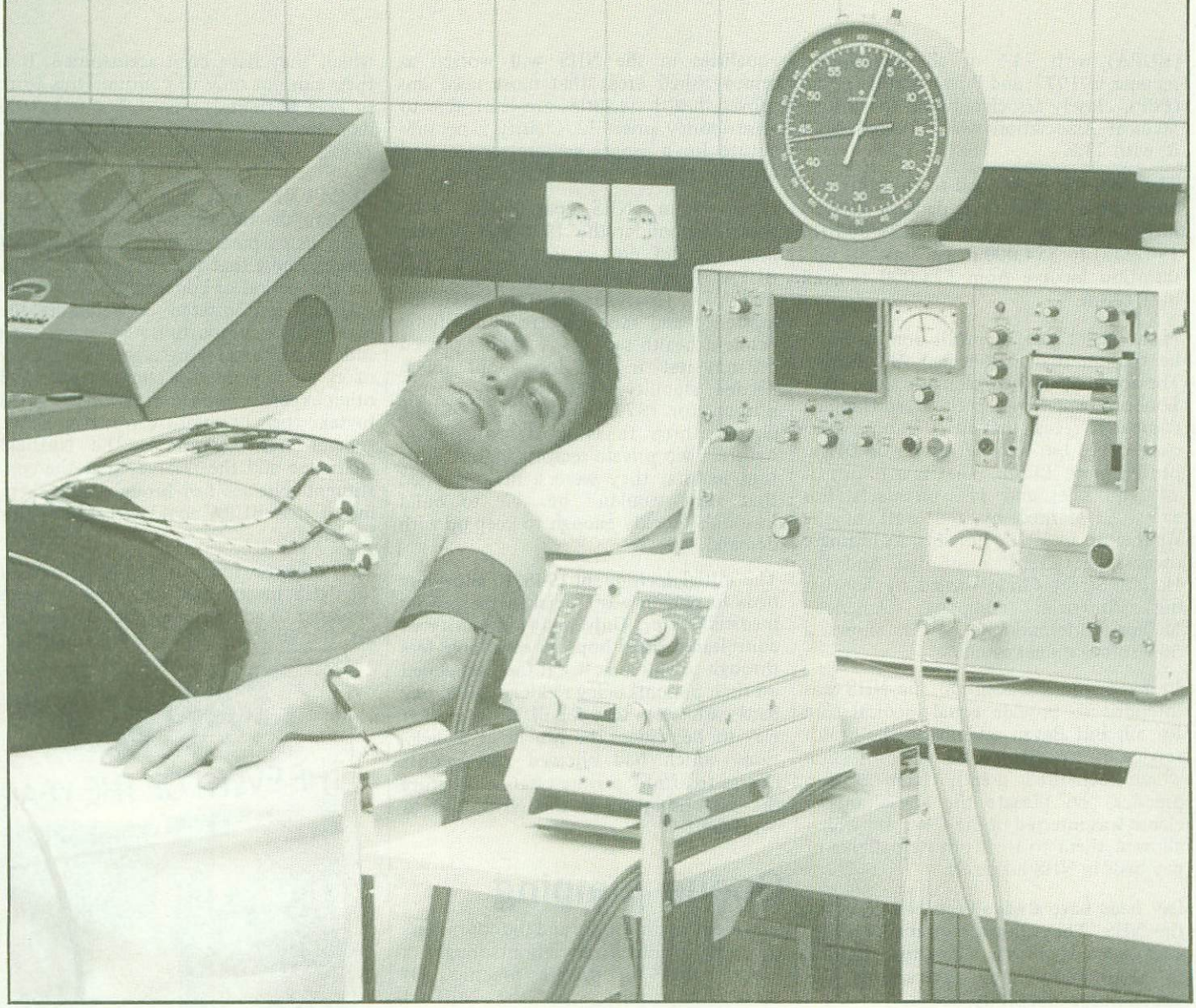
MEDICINE FOR PROFIT



Health is a major industry. The private sector, ranging from drug companies and flash American hospitals to a wing of a convent run as a home for old people, is doing well over £1bn worth of business a year. And as a result of Tory policy and the run down within the NHS the private medical industry is growing and profiting.

Until recently private medicine in Britain was about queue jumping and pay beds or specialist treatment for the very rich. The Minister of Health Gerard Vaughan has now said he would like to see 25% of treatment carried out in the private sector, and as the NHS is cut this threat becomes increasingly possible.

The private medical sector in Britain is strong and growing. Its finance is centred round the two dominating medical insurers which control something like 95% of the provident business – the British United Providence Association

The provident duopoly – BUPA and PPP combined results

	1979	1978	1950
Subscribers	1,232,000	1,074,000	45,000
Subscription income (£000s)	122,667	105,812	184
Less: cost of benefits paid and administration (£000s)	96,569	76,806	150
Underwriting profits (£000s)	26,098	29,006	34
Plus: investment and other income (£000s)	12,434	8,419	
Profits (£000s)	38,532	37,425	
Profits as a percentage of subscription income	31%	35%	

Note: given these profits, its not surprising that BUPA's and PPP's combined investments, at £151m, were well over twice as large as the benefits paid out that year. They would have been far larger but for the funds diverted to charities, particularly the Nuffield Nursing Homes Trust.

(BUPA) with 74% of all subscription income in 1977; and Private Patients Plan (PPP), closely associated with the British Medical Association which helped form it, with 23%.

The NHS has been good to the insurance companies. Within three decades BUPA's membership has grown from 39,000 (in 1947/48) to 854,000 in 1978 and its subscription income from £74,000 to well over £78m.

Phenomenal rates of profit don't seem to be too unusual in the medical business. The accounts of the Wellington Hospital in London owned by the US based Humana company, reveal that in 1978 on a turnover of £5.6m and net assets of £4.9m profits were £1.5m. That is a return of 24% on sales and 31% on assets. For every £1 earned by the staff of the Wellington in 1978, Humana, its ultimate owner, get £1.14 in profits. And the Harley Street Clinic owned by another big American company, American Medical International (AMI), shows a 66% return on net assets.

In its original conception the NHS was intended to provide equal medical care for all. But Bevan established the health service incorporating a medical profession which benefited greatly from private practice. To placate the consultants a clause was inserted in the 1946 Act which allowed them to treat private patients in pay beds in NHS hospitals.

Pay beds have always been bad news for the NHS. They divert resources, nursing staff and consultants, and allow the rich to skip queues thus aggravating the situation for everybody else.

In 1976 the Labour Government committed itself to phasing pay beds out of the NHS. In spite of this they still exist and the Tories have now repealed the phase-out decision. Their 1980 Health Service Act is a charter for private medicine. It not only relaxes restrictions on the private sector until they almost disappear, but it also encourages Health Authorities to raise money by 'voluntary' means such as street collections.

Health Authorities it seems should supplement inadequate funds by asking people, who already pay taxes that finance the NHS, to make private donations. Inequalities in the NHS will worsen as impoverished areas that most need improved health facilities are least able to raise money privately. Charity is no substitute for a proper welfare service, and can only mean a decline in standards.

Even when NHS pay beds were threatened under the 1976 Act, private medicine did not go into a decline. A BUPA Think Tank report commented that '. . . (the) Act has formalized the existence and raison d'etre of the independent health sector . . . and has proved instrumental in bringing about much needed stability.' The number of subscribers for 1979 increased by 174,000, almost three times greater than ever before. Two private sector administrators told us that they were a little worried that they wouldn't be able to build hospitals quickly enough to keep up with demand.

The initial decision, in 1948, to allow pay beds to remain was crucial to the private medical sector. Only a tiny minority of consultants could hope to earn large fees through private practice if they depended on their patients being rich enough to pay hard cash when they fell ill. If the market was to be wider, the provident associations which had allowed the middle classes to afford private treatment before the establishment of the NHS, had to continue.

Queue jumping

The medical profession and the controllers of the provident associations fought a bitter battle for private practice. Of central importance was the Nuffield Foundation. Immediately after the war Lord Nuffield underwrote the formation of a unified national association to incorporate most of the existing schemes. This provided the nucleus for the continued development of provident funding of private practice despite the introduction of the NHS. It allowed private medicine to continue to reach beyond the confines of the very rich. The organisation was BUPA.

From the start BUPA's concern was with the 'gentlefolk'. Its directors saw their role clearly: 'The governors feel . . . they are making a not unimportant contribution to the efforts of the middle class to maintain the amenities and standards to which they have been accustomed. It is their aim not only to continue this work so long as there is a need, but to extend its scope.' *(BUPA Second Annual Report, 1949).*

BUPA's first task, in its early years, was to stem the tide of subscribers abandoning their membership of provident schemes now that the NHS was in being. 'In this period of consolidation the management concentrated on retaining the maximum proportion of existing subscribers, employing a generous policy of ex gratia grants for convalescence and other expenses for members who preferred to take their hospital treatment in a free general ward' (*Bryant*). The Nuffield guarantee and the reserves that the constituent schemes had brought with them meant that BUPA could well afford this 'generosity'.

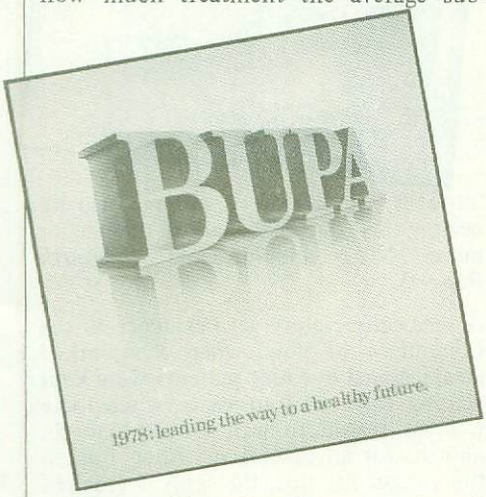
The immense fund of goodwill towards the NHS meant that most people were prepared to accept being put on a waiting list. But BUPA moved quickly to exploit

this shortcoming. Its 1949 report stressed the point: 'Subscribers value the opportunity of making their own arrangements in illness, thereby short-circuiting the procedures of the State Service'. They could use this to sell group schemes to company management. The excuse that their time was too valuable to be spent

waiting for NHS treatment gave management sufficient justification to have their company, large or small, pay their BUPA subscription as a tax free (and tax deductible for the company) perk. Group scheme enrolment very quickly grew to exceed personal subscription.

All that BUPA had to do was survive the upheaval that the establishment of the NHS caused for its business – and it had plenty of reserves to do that. With subsidised pay beds and risks strictly limited and spread over a large number of policies, BUPA's insurance became a money spinner.

The company knew pretty accurately how much treatment the average sub-



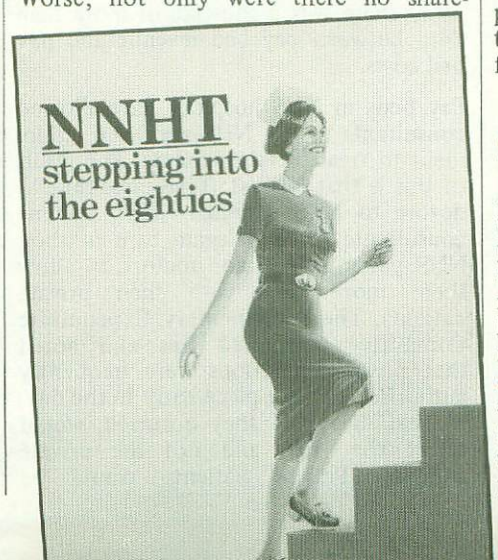
scriber would need each year, and could calculate how much that treatment would cost and how much administration of the scheme would cost on top. It set its subscription rates accordingly. **In only two out of BUPA's first twenty years life, 1948 and 1964, did the cost of benefits paid out and administration exceed subscription income.** And even in a 'bad' year, 1964, the excess over income was tiny.

But insurance provides other income to the company apart from underwriting profits. Large additional profits are made by taking the punter's premium at the beginning of the year, investing it, taking the profit from that investment, and then paying claims and expenses from the original capital. The underwriting profit or loss ignores investment profits. Most insurers make small underwriting profits and large investment profits. For BUPA which was run conservatively and had no real competition, both were large. **Over its first 20 years, underwriting surplus totalled £1.8m., but with investment profits on top, reserves rose from £91,000 to £3.6m.**

This rapid growth of profits and surplus in the 1950s left BUPA in an odd position. As a 'non-profitmaking' body it had no shareholders to whom it could pay out the profits. The surplus could be invested in expanding BUPA's empire but the market was limited, with BUPA holding the majority of it. A heavy sales push, to be effective, would have to be aimed against the NHS on whose facilities BUPA was dependent, and would present the danger of drawing severe political criticism.

Problem

This posed a considerable problem for BUPA's administrators. They were drawn predominantly from the world of medicine, provident societies and actuarial practice and investment and manipulation of large reserves was not their forte Worse, not only were there no share-



holders to pay the profits to, but BUPA was having to pay corporation tax on those profits.

One obvious solution would have been to reduce the premiums paid by subscribers. This, however, would only have saved BUPA's subscribers money. On the essential criterion – that of enhancing BUPA's power, prestige and influence – it would have failed.

One strategy was left. BUPA's business was insurance for private medical care. If expansion of the insurance side was limited, BUPA's future could best be enhanced by the development of a strong group of private hospitals, something which at that time did not exist.

In 1957 BUPA sponsored the formation of the Nuffield Nursing Homes Trust (NNHT) 'in order to ensure the development of modern hospitals outside the NHS' (*BUPA Reports and Accounts 1978*). It was set up as a charity and BUPA allocated £100,000 to it.

BUPA could have moved directly into the hospital business itself. The promotion of the NNHT however, had a number of advantages. The first was that NNHT, as a charity, would be tax exempt. BUPA could make donations by convenant, enabling NNHT to receive those donations gross of tax. If BUPA financed its own hospitals it would have had to pay corporation tax (currently 52%). Money covenanted to NNHT could be invested before paying tax and so go twice as far in terms of the initial investment. What is more, if that investment produced a profit, it would not be liable to tax either, freeing even more money for further investment.

Solution

Another advantage is that the NNHT can secure donations from other sources. In part it gets money from other charities and medical insurers but it also commonly supplements funds for new hospitals by high powered local fund-raising drives. Not surprisingly, those who can afford private medical care can also afford, or more often their businesses can afford, to be generous when it comes to supporting the establishment of new private hospitals.

Nevertheless NNHT's main support has come from BUPA. 'BUPA was able to provide, not only for its own massive expansion, but for NNHT's provision of the increased nursing home accommodation which that expansion had made essential . . . the two organisations, whose head offices adjoin, and who share the same telephone number, work in the closest conjunction. For their purpose is the same and their work is complementary' (*Bryant*).

Today the product of constant surpluses and reinvestment in the industry are highly visible. The NNHT still receives support in one form or another from both of the two main provident funds (over £14m from BUPA already) as well as continuing its fund raising efforts. NNHT has 30 hospitals with over 1,000 acute beds, employs 2,434 people whose average wage is £68 a week and has assets of £24m. And it is still growing.

Altogether there are over 1100 private hospitals and nursing homes with almost 31,000 beds in England and Wales. The great majority though are small nursing homes caring mainly for the elderly sick. Not all of them provide facilities for paying patients, a good number concentrating wholly on broader social and charitable objectives.

The important hospitals from the private medical business' point of view are the 120-plus 'independent surgical hospitals' with some 5,400 beds between them (compared with 2,533 pay beds in NHS hospitals) which will treat anyone at a price. This is where the high turnover, high value added business is concentrated.

Expansion

These hospitals are still expanding rapidly. In 1978, six new hospitals were completed, adding 228 'new' beds. And in its final report of January 1980 the Health Service Board stated that 1173 more beds were under construction or fully authorised.

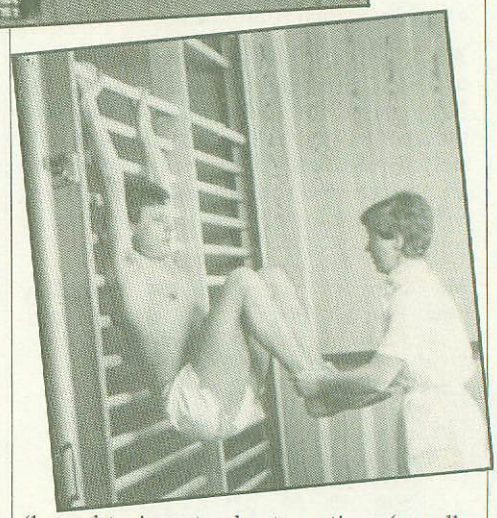
The proponents of private medical care argue that it relieves the burden on the health service without taking resources from the NHS. This has never been true. The very existence of a large private sector means that the public sector can not function as well as it should, and that those in positions of power do not personally experience the NHS's shortcomings, thus limiting pressure to improve the service. Since 1946 the health service has been underfunded; private medicine has both aggravated its inadequacies and protected the privileged from those inadequacies.

Pay beds have never given as much to the NHS as they have taken out of it. In 1974 revenue from pay beds was £14.3m, while one estimate of running costs (based on DHSS Hospital Costing Returns) for these beds was £21.5m. The NHS was subsidising the private sector to the tune of £7m in one year.

And that's not the whole story. Capital costs are not being covered either. In 1971 private patients were charged only £1 a week towards capital costs. That such charges were totally inadequate is shown by the fact that in 1978 BUPA spent £2m on merely refurbishing the 68 bed Nightingale BUPA hospital: that works out at £28,000 per bed.

Although there have been increases in the capital cost element charged revenue from pay beds still doesn't cover costs. In 1979 there was a shortfall of more than £4m between pay bed revenue and pay bed costs.

Pay beds in NHS hospitals have allowed consultants to use NHS staff and equipment to treat private patients. The result of this is that NHS staff have less time to devote to NHS patients. NHS part-time consultants often delegate care of their NHS patients to junior doctors, to allow them more time with their private patients. The Parliamentary Expenditure Committee confirmed this and noted that private operations were frequently authorised to take place early in the day, so that delays, if they occurred, would affect the NHS and not the private patients. Private patients would be



'brought in at short notice (usually leading to) the cancellation of one or more NHS appointments'. (*Fourth Report*).

A medical secretary gave evidence to the Committee of how, when she worked at a regional eye unit patients were kept waiting three or four years, when there was no reason to wait longer than six months for an operation. 'When I asked the reason for this, the reply I received was: "If we keep them waiting long enough, they get fed up with being unable to see, and agree to become private patients" (*Fourth Report*) Junior Hospital doctors reported that the theft of NHS resources was 'so common as to excite no comment'. 'Often private patients recieve laboratory or X-ray services for which they do not pay the hospital, although the consultant receives his fee'. (*Fourth Report*).

Schemes

PPP has a scheme which is specifically designed for queue jumpers. It offers immmediate access to an NHS bed, or, if there's a waiting list of more than six weeks, you can go at once to a pay bed or a private hospital.

In 1959 there were 548,671 NHS beds –

Popperfoto.

(Left) Private health care yesterday and today. (Above) NHS yesterday and . . . tomorrow?

by 1977 the number had fallen to 469,849 despite the fact that the demand for the beds has grown. Expenditure cuts mean closed wards and reduced bed numbers and staffing bans. And it is the private sector which benefits. As one private insurer said 'You know if you've got a hernia you're not going to die from it but it would be nice to get it sorted out, and that I think is what more and more people will go into'. People with unpleasant but so-called non-urgent medical problems are being increasingly pushed towards the private sector to avoid the long NHS waiting lists.

Nuffield and the other private hospitals claim not to poach NHS staff, but when NHS vacancies aren't advertised, because of cuts, unemployed nurses will inevitably be attracted to the private sector. The NHS is finding itself paying to train staff, which it can't afford to employ. The private sector, which does no training itself, then benefits from their skills.

What people don't usually know is that when they're most in need, private insurance will not cover them. In 1977 nearly 50% of all NHS beds were used by geriatric, psychiatric or maternity patients. These people would not be covered by the insurance schemes.

BUPA has inserted a clause in its rules which states that 'For claims in respect of charges by hospitals arising from any geriatric, psychogeriatric conditions, any payments . . . shall be restricted to an aggregate maximum entitlement of 180 days in any year'. PPP similarly has a clause stating that 'All expenditure must be reasonable and be necessarily incurred, and be wholly and exclusively for the purpose of *curing* a medical condition or to relieve the *acute-episodes* of a chronic or incurable medical condition'. This neatly excludes long term psychiatric, chronic, terminal and geriatric illnesses.

To discourage or prevent older people from insuring, BUPA and PPP refuse to accept new registrations from people over 65, and PPP has a 25% surcharge on subscriptions from people enrolling after their sixtieth birthday.

So those most in need of medical care won't be able to use a private system which has consistantly fed off the NHS. Nor will people who can't afford to pay.

A spokesperson described BUPA's subscribers: 'Traditionally it has tended to be middle and upper management . . . you don't tend to get your average sort of bricklayer or dustman.'

Bias

When asked whether BUPA expected an increased uptake from poorer people the answer was . . . 'at the moment there is a catch, which is that you have to pay to get in . . . as much as I'd like to say that it's nothing, there is the price of admission. Therefore like all products it's self selecting, to the extent that it's sold to people who can afford to buy it. That means that the D's and E's just simply don't have the money'. (D's and E's in BUPA terminology refer to sem-skilled and unskilled workers.)

And then there's the geographical bias. 'The most attractive area for private hospital development is really the South East of England . . . There's quite a lot of money around generally. You know, rather than say Liverpool where you might have a relatively high proportion of unemployed and lots of social problems.' In 1978, 46.9% of PPP's 205,119 subscribers lived in or near London while only 1.7% came from Merseyside.

For the consultants, private practice is a lucrative business. In 1978 BUPA spent £15.85m on specialists and surgeons, which is almost half of what they paid hospitals (NHS or private) for accommodation. An American Medical Europe employee said that while a coronary artery bypass operation done in the provinces might earn a consultant £300 '. . . the number one fellow in London . . . is now charging between £1000 and £1200 for the same op.'

The consultants hold the power. Junior doctors can't complain when they see abuses because it is the consultants who decide who gets promoted and who stays behind.

Private practice has been made even more attractive for consultants. In September 1979 Patrick Jenkin gave consultants permission to spend up to 10% of their time on private work without losing any of their NHS salary. Consultants who do a higher percentage of private work now only lose one-eleventh of their NHS salary as opposed to the previous two-elevenths, even if they more than double their income.

The Tories are the private sector's best friends. As one American Medical Europe employee put it; 'We know Gerry Vaughan very well and we know Patrick Jenkin well. We know what they're thinking as it were, and they know what we're thinking.'

But what they're all thinking about is a two class health system where the really sick, the old, the unemployed and the poor are left with a run down NHS. As one BUPA researcher summed it up . . . 'I think if private medical care ever got beyond five million people (it already covers 2,765,000 people) it would become such a threat to the NHS that quite frankly it would change beyond recognition.'

THE LONG DECLINE

Summoning visions of rapacious patients, Patrick Jenkin said early in 1980 'We must begin to protect our doctors, nurses, hospitals and clinics from the ever mounting pressure of demand which seems sometimes to threaten and engulf the service'. The present attack on the NHS is more virulent and far reaching than any in its thirty-two year history. It is accompanied by a barrage of propaganda claiming that financially the NHS is a bottomless pit, that the service is abused by patients, and that a halt must be made to years of profligate expenditure.

Yet in reality, the NHS has always been under-funded and has been consistently unable to provide a full health care service.

Created in 1948, the NHS had to contend with the chaos of existing health provision, without ever being given the resources or powers to fundamentally change the structure. Before the NHS General Practitioners and consultants operated as private entrepreneurs, earning a living in the market place alongside voluntary hospitals funded by charity, and a network of local Poor Law hospitals that had been municipalised in 1929.

The original plan for the NHS was wide-ranging. It called for a service that would be free at the point of use and paid for out of general taxation; the nationalisation of the hospitals; and the transformation of general practice into a system of primary care based on health centres where family doctors would work with nurses and social workers.

From the start, the dominant pressure groups of the medical profession fought to ensure this would never happen. They were aided by a vociferous campaign against the NHS waged by the Tory party in opposition. Under the banner of 'clinical freedom' the doctors refused to become salaried employees of the state, and instead maintained their entrepreneurial status. The consultants in particular fought for the right to private practice. They were less concerned about the nationalisation of the hospitals, realising that funds for the increasingly expensive forms of treatment could only be provided by the state, and that many of the voluntary hospitals were in poor financial straits.

The final compromise left the NHS deeply flawed. The consultants were allowed to work for the NHS either full or part-time, with access to NHS facilities for their private patients. They also won a very high level of representation on the decision making bodies of the NHS.

The GPs were allowed to continue running their practices as businesses. They were given a modestly increased but more reliable salary. Since the NHS had no control over individual GPs it was impossible to rectify the enormous regional inequalities in health care that it inherited.

Limbo

Instead of a new and properly organised health care system, the NHS meant in effect simply the nationalisation of the hospital structure with doctors maintaining their access to private practice. The whole area of primary care (non-hospital services in direct contact with the public) was consigned to a limbo of undirectable GPs and local authorities who were made responsible for health visitors, home helps, child care and ambulance services. No attempt was made to regenerate the ageing hospital stock, or to redress the regional and class differences in facilities. It was as if the architects of the NHS expected a change in ownership and funding to solve the problems of the private system overnight.

From the very beginning, the government spread fears about the cost of the NHS. In 1950/51 a ceiling of £351m was set, with any new developments to be funded from savings elsewhere. As early as 1949 the principle that health care should be free at the point of use had been breached by the Labour Government with the passage of an Act enabling prescriptions and certain other items to be charged for. In 1951 Labour empowered charges for dentures and spectacles. In 1952 the new Tory Government imposed a charge of one shilling per prescription.

Despite press hysteria, the cost of the NHS was in fact barely rising in these early years. In real terms spending on the NHS rose only £11m in the first four years – hardly enough to keep pace with the 2% growth in the population. As a percentage of GNP, spending fell from 3.75% to 3.25%. At the same time there was a real *decline* in investment, and capital formation fell from 0.8% of national fixed capital formation to 0.5%.

The money the NHS receives is earmarked for either capital spending or current spending. Capital spending is for the purchase of assets with a long life, such as land, buildings and equipment. Building a new hospital, or installing an operating theatre, would come out of capital spending. Current spending is for buying goods and services that get used on a day to day basis: wages, the cost of food and so on come out of current spending.

The creation of the NHS saw the slowest rate of hospital building for two centuries, despite the fact that of the 2,800 hospitals the NHS inherited, over 45% had been built before 1981, and many were falling apart. In the seven years between 1948 and 1955, not a single new hospital was built, and only six were finished in the next ten years.

No serious attempt was made to deal with the problem of an old and deteriorating stock of hospitals until the 1962 Hospital Plan for England and Wales. It proposed the closure of 1,250 old hospitals, the building of 90 new ones, and work to extend a further 360. The backbone of the national hospital system was to become District General Hospitals of 600 to 800 beds. The total number of hospital beds was to be reduced from 470,000 to

430,000, and the plan envisaged that £500m would be spent between 1962 and 1971.

Anxiety over costs bedevilled the plan from its inception. By 1966 when economies of scale and technological solutions were given precedence and the plan was revised to enlarge the size of the new hospitals, it was clear that the hospitals were not being built quickly enough, and that they were costing much more than had been envisaged.

Capital funding did grow as a proportion of total spending, reaching 12.8% of current expenditure in 1973/4. But it was too little too late, and in 1973 the Tory cuts hit capital spending, reducing the ratio to 9.9% in 1974/5.

Overloaded

The grandiose plans of the '60s for large District General Hospitals have now been abandoned. By 1974 it was clear that authorities could afford neither the capital nor the revenue for large schemes. The DHSS response was to design small, intensive use, first-phase hospitals of around 300 beds, which could perhaps be expanded later. The prototype of these nucleus hospitals is currently being built in Newham in East London. The limited scale of the nucleus hospital means that a twin hospital is needed to provide a complete local service. In the case of Newham, its twin, with a further 245 acute beds, can only be a large, late 19th century hospital situated well outside the health district boundary.

Cuts in capital spending often lead directly to closures. In Wandsworth, the Area Health Authority failed to install a lift in Queen Elizabeth House because the money would have to come from their capital account. Since the hospital was mainly for elderly patients, this meant the upper floors could not be used. The hospital was classed as under-utilised and closed.

The inadequacy of capital funding is not the only failure of the NHS, nor is it the greatest. Primary care, the first stage of treatment, including GPs, is the foundation of a health service and a healthy population. It has been completely neglected.

The founding Act of the NHS declared 'It will be the duty of every local health authority to provide, equip, maintain and staff health centres' for these were seen as the way to construct a well organised and national primary care system. But little was done to create these health centres, and in fact the structure of the NHS meant that from the outset this priority had been abandoned.

General practice became a backwater which carried on the pre-NHS traditions of independent one-person practice. Before 1948 the location of family doctors was determined by what the market would bear, resulting in a heavy concentration in the wealthy South East and better-off semi-rural areas. The situation has changed remarkably little in the last 30 years.

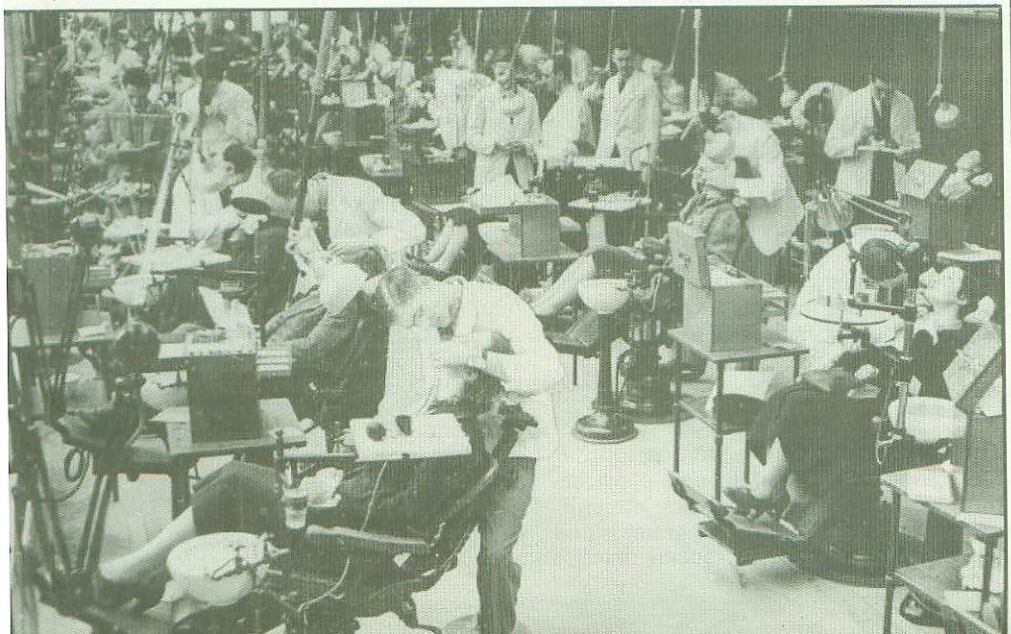
GPs in working class areas are often overloaded, and as a survey of one inner city area put it: 'The predominant picture is one of ageing single-handed doctors . . . working in isolation from inadequate premises and bypassed by many of the innovations in the delivery of medical care.' (*Journal of the Royal College of Medical Practitioners* 1972) The overall picture is summed up: 'The industrial revolution has passed general practice by: it remains a cottage industry, under-organised, under-capitalised and over-worked.' (*Brotherston*).

In 1948 ten health centres were opened, and by 1969 this had risen to only 87. The reorganisation of the NHS in 1974 gave a new impetus to the building of health centres, but there were still only 731 by 1977. In city centres where the need for comprehensive primary health care is greatest, the lack of health centres is most pressing. Only 15% of doctors in the metropolitan counties in England work from health centres, compared to a national average of 17%. By the end of 1975, Greater London had a mere 54 health centres, and Liverpool just five.

The Liverpool Area Health Authority presides over a declining inner city, with old housing stock, an old population, declining services and old GPs. In 1977, with a national target of one health visitor per 3,000 population, Liverpool had one per 6,170. But despite government plans to increase the number of health centres, the local authority was unwilling to build more because of doubts about adequate revenue finance in the future.

The result is that people in Liverpool, many of whom can't get GPs to visit them, go instead to casualty departments. They are forced to use hospitals as substitute health centres.

There were always criticisms about the structure of the NHS. A number of proposals for reforms were put forward over the years but never implemented. But in



Early days: Health care for all.

Popperfoto

1970, when the hospital programme was in disarray, primary care was suffering from years of neglect, and the NHS cracking because of underfinancing, Keith Joseph produced a plan for reorganisation.

In the words of a NUPE official, the reorganisation which finally took place in 1974, was 'a disaster of major proportions'. In fact, it is impossible to find anyone who has a good word to say about it, and even the Tories themselves now admit their mistake.

Reorganisation

Joseph, instead of dealing with the real problems within the NHS, concentrated on the management. He hired McKinsey, the management consultants, to change the structure, and said when presenting the proposal 'their essence is the emphasis they place on effective management.'

Despite Joseph's claim that '. . . the purpose behind the changes proposed is a better more sensitive service to the public' the reorganisation was about one thing, and one thing only, administration.

The major change was the creation of a third tier within the NHS, the Regional Health Authorities. They were placed on top of a pyramid of command of health authorities. The effect was a management structure responsive to central control. Any form of local control over the decisions of finance and day to day running of the services, was broken. As Joseph said the government believed that substantial local participation in the health authorities 'would have led to a dangerous confusion between management on the one hand, and the communities' reaction to management on the other'.

In fact the resultant confusion was centred on the hierarchial structure. The NHS was thrown into chaos as administrators tried to adjust to the new system of control. They never properly succeeded and by 1980 the Tories had produced a new scheme; the removal of one tier in the NHS, this time the Area Health Authorities.

Throughout the 1950s and 1960s, the NHS suffered under-funding and inertia – it never got sufficient money to revitalise or restructure the service. And then, with Barber's mini-budget of 1973, spending was actually cut. As part of a 20% across the board reduction in government capital spending, health and social service capital expenditure was axed by £69m and prescription charges were raised.

Cuts

The effects of this cut were serious. It represented a 60% cut in new construction work because of existing commitments. The health centre programme and postgraduate training in general practice were particularly hard hit. According to the professional associations in the NHS, immediate maintenance work costing £100m was needed for the hospital system, and they called for an injection of £500m and an increase in the proportion of GNP going to the NHS to 6%.

In 1975/76, the service was hit again. The Labour Government cut another £75m from its budget. By now the system was in crisis, as projects were abandoned, schemes altered in mid-stream, and services reduced. The next year (1976/77) saw a projected budget increase of 2.7% – but the effects of cash limits and inflation meant that this figure was out of date before it had even been published. The resulting unplanned cuts were almost half the size of the next round of planned cuts – which took place in the year 1977/78. This time capital spending wasn't cut, although the nucleus hospitals announced in 1975 were cancelled or postponed. Instead current spending suffered. A staff standstill was imposed in April 1976 that led to 52,000 unfilled vacancies.

Besides the publicly announced budget cuts, the use of cash limits on current spending brought a whole series of hidden cuts that have left health authorities reeling at the end of every financial year. It had been government policy not to make allowances for either the true rate of

All our futures.

Fifth Class Treatment

Health is political. If you are an unskilled, low paid, manual worker (social class 5) – you are two and a half times more likely to die before you retire than if you are in the professional and high income bracket (social class 1). The class inequalities in health have not been erased by thirty years of the NHS.

Whatever indicator you choose, the inequalities remain. The risk of your baby being stillborn or dying within the first month, if you're in the bottom social class, is double that in the top class, and if your child survives to the age of one it is twice as likely to die before it reaches fourteen. The likeliest cause of death will be an accident, and the risk of death by fire, falls and drowning, is *ten* times as high for boys in social class 5 as for their peers in social class 1.

The risk of death in class 5, between the ages of fifteen and sixty-four, is between one and a half and two times the risk of death in class 1 for both men and women. And once you've retired, the picture is no better.

It's not just premature death. The rate of long-term sickness is twice as high among unskilled manual males as among the professional classes, 2½ times as high among class 5 women.

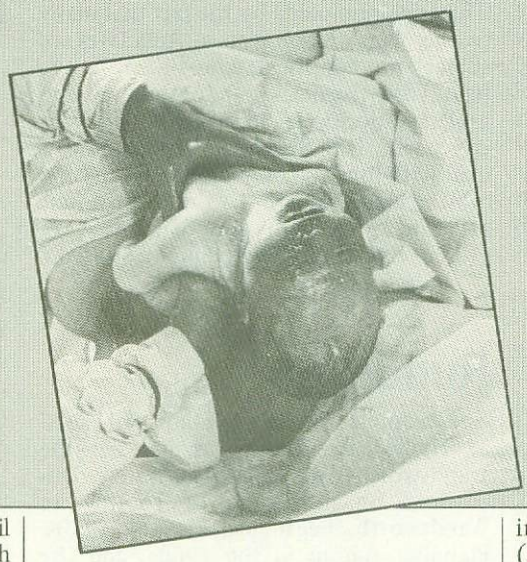
These inequalities have been getting *worse*, not better, as funds to the NHS have been cut back. Throughout the 1960s and early 1970s the relative health experience of the unskilled and semi-skilled manual classes has been worsening. Among men of working age, there was a greater gap in mortality between class 1 and class 5 in 1970-72 than in 1949-53. And those who most need health care receive the least attention. 'Higher income groups know how to make better use of the Service; they tend to recieve more specialist attention; occupy more of the beds in better equipped and staffed hospitals . . .' and so on (*Titmuss*).

While there is no clear pattern between the number of times people in different classes visit their GPs, it is known that middle class patients have longer consulations than working class patients, and that even though working class patients have generally been longer with the same GP, doctors tended to have more knowledge of the personal and domestic circumstances of their middle class patients.

Preventative medicine goes largely to those in the upper classes. Women from social classes 4 and 5 receive far less antenatal care, cervical cancer screening, family planning advice, radiography, or immunisation for their children.

Differences in sheer availability, and at least to some extent in the quality of care in different localities is one way in which social inequality prevades the NHS. Reduced provision means greater journeys, longer waiting lists, longer waiting times, difficulties in making an appointment, shortage of space and so on. The other factor is that the cost of attending a doctor, or clinic is far greater, both financially and psychologically, for those in social classes 4 and 5 than at the other end of the scale. Missing a half day's pay, or having to organise someone else to look after the children, or feeling that job security is at stake, exacerbates the lower levels and poorer quality of provision to which working class people have access.

Environmental and social factors cause ill health. At the present time the NHS contributes to the situation where those in most need recieve the least care.



inflation, or for pay awards; in April 1979 a DHSS circular stated that cash limits would not be fully adjusted for the Clegg pay awards. The present Tory government has refused to compensate for the impact of VAT increases it imposed, or for inflation. This in itself is expected to cause a shortfall of £120m in the year 1979/80 resulting in random staff cuts and ward closures.

The crippling squeeze on NHS funds has been aggravated by the impact of RAWP – the Resource Allocation Working Party. It has long been recognised that there are considerable differences in the standard of care and facilities around the country. RAWP was set up to reallocate resources between regions, so that existing regional inequalities would gradually be overcome. In 1975 the Working Party produced its first formula to measure the 'need' for services in each region. It recommended that current budgets based on existing beds and case loads should be replaced over a period of ten years by target budgets based on 'need'.

Although overcoming regional inequalities is clearly necessary, this cannot be done while overall resources are being cut.

RAWP meant a reduced commitment to maintain the existing pattern of health services. The Working Party decided what constituted 'need' and its definition, based on death rates, took no account of factors such as class structures of population, social deprivation, and the availability of other facilties, which are vital in determining real need. RAWP concentrated on overall provisions and not on the gross underfunding of various sectors like the old or mentally ill. In a place like Liverpool, where people are forced to refer themselves to hospital because of lack of primary care, RAWP judged the number of hospital beds to be too high and axed them without taking into account the social conditions which led to this self-referral.

Reallocation

Given that the change in resource allocation took place in a period of reductions in overall allocations, regions that RAWP said were 'overfunded' suffered significant cutbacks. And while they were hit doubly hard, 'deprived' regions benefited only marginally. At the current rate of readjustment, it will take to the year 2000 before the RAWP formula brings the North West region to parity with other regions.

The rigid application of the RAWP formula within regions has compounded the problems caused by the cuts to a serious degree. In 1976 the South East Thames Regional Health Authority used the RAWP method to reallocate revenue between its Areas: this meant a 13% increase for rural Kent and East Sussex (£18.5m), a standstill in Outer London Bromley, a 19% cut for Greenwich and Bexley (£7.5m) and a 13% cut for the inner city area of Lambeth, Southwark and Lewisham (£11.5m).

By July 1979, after five years of financial cutbacks and rigid reallocation policies, the Lambeth, Lewisham and Southwark Area Health Authority had accumulated a deficit of £4m. As an immediate response the Area Team of Officers proposed the closure of three hospitals – one of them a children's hospital for which there were no alternative facilities. The early closure of a further two hospitals was to be explored. As well as this, ward closures were recommended throughout the Area, and the use of voluntary redundancy, retirement and redeployment to achieve lower staffing levels. There were also proposals to reduce the number of patients, particularly in high cost specialities.

Crippling

In one district, Guys, this meant that 1,170 fewer patients needing expensive care such as thoracic surgery or cardiology would be seen each year. The number of patients receiving acute care (including general surgery and gynaecology) was to be cut by 2,700 a year. There were already long waiting lists, with 398 urgent cases waiting for acute

services. Half of these people had been on the waiting list for over a month.

As part of these cuts, 24 old people were removed from Guys Hospital in the middle of the night, and moved to New Cross, over three miles away. Many of their relatives were not informed until after it had happened. St Olaves, with its purpose built facilities for the mentally ill, was closed. In Lewisham there are now no in-patient psychiatric beds and no facilities at all for mentally handicapped children.

Other services were also drastically curtailed, with Family Planning and community health care being pushed onto the GP service. Two health centres due to be opened were postponed, a plan for a community hospital was abandoned, and a community care centre on the Lambeth Hospital site was rejected. The upgrading of geriatric wards and a psycho-geriatric assessment centre, both of which had been agreed in 1977, were abandoned for lack of funds.

The Area Team admitted that it did not 'underestimate the trauma likely to result, and has every sympathy with those concerned, patients, staff and management.' Despite public proclamations that cuts would not harm patients, Gerard Vaughan, Health Minister, wrote to the chairman of the Regional Health Authority on 2 August 1979 'We do of course understand that the decision not to increase cash limits to take account of price inflation, including the increase in VAT will make it difficult for many authorities to keep within their cash limits, and that there will inevitably be some effects on patient services.'

Chaos

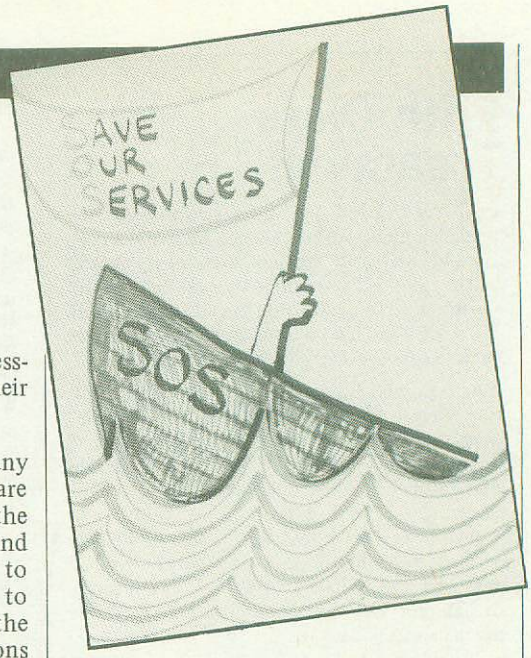
The accumulation of five years of cuts, RAWP, and cash limits has thrown the NHS into chaos. Patients are suffering the continuous erosion of standards, and staff are under ever-increasing pressure as beds are reduced, occupancy rates raised, and throughput speeded up. It is difficult to assess the overall effects, partly because the DHSS has little understanding of the impact of its own policies.

DHSS officials admitted to the Select Committee on Public Expenditure that they had no critieria for adequately assessing the effects on the ground of their decisions in allocating resources.

This is compounded by the fact that many of the plans and projects at Area level are subject to continual adjustment in the light of financial circumstance, and arbitrary decisions are taken on a day to day basis. The NHS is in no position to deal with long standing problems, and the arbitrary and random nature of decisions affecting long term developments have effectively reduced any planning to zero.

Rundown

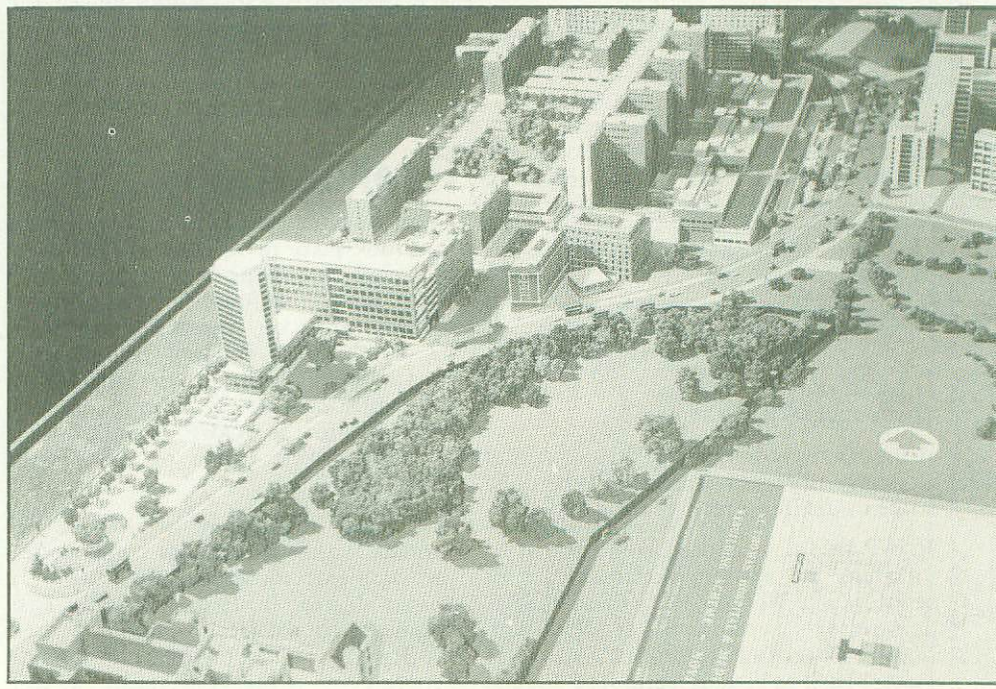
For example, St George's hospital, sited at Hyde Park Corner, is part of the Wandsworth Area Health Authority. Discussions on moving it to Tooting, in Wandsworth, began back in the 1950s. Planning started in the 1960s, and the new hospital was designed to have 1400 beds and to be built in three phases. The first would provide 300 beds and outpatient facilities, phase two a further 700 beds, and the final phase would be 400 beds for neurosurgery, psychiatric care and geriatrics. The Hyde Park Corner building was to be closed with the completion of phase three.



Building did not start until 1973, and almost immediately the planned size was cut to 1200 beds. In 1975 the DHSS refused to fund phase two on the original scale and placed a ceiling on expenditure of £10m. Phase two was revised down to 340 beds, and it was decided that the Hyde Park Corner site would be closed as soon as phase one was completed. This was partly because the DHSS has stopped giving special grants to commission new buildings, so that the extraordinary costs of bringing new buildings into use have to be met from overall allocations.

In Liverpool, the Area Health Authority had to delay the opening of a large modern teaching hospital, while it closed

The planners dream.



The resistance grows.

five other hospitals and two maternity units. It estimated that the running costs of the new hospital would be £1.75m a year more than that saved by closing the five others.

Over the past ten years, the number of hospital beds has fallen by 12%. The DHSS claims that this is an inevitable part of a process of centralisation. As new District General Hospitals come into operation, they say many small hospitals must inevitably close, not because of cuts but as part of the modernisation. There is a dangerous particle of truth in this. But while many hospital closures have been planned for some years, they are taking place at a time when overall plans are cut. Beds are being reduced, wards and special units closed, purely to save money and not as part of a rationalisation process.

The centralisation of hospital services raises its own problems, especially when other public services are being cut. People have to travel further for out-patient services, and for the old or poor this means using public transport. And in many places like Liverpool where people rely to a great extent on local hospitals for basic health care, the closure of a local hospital means a real reduction in primary health care.

The rundown of the hospital service is partly hidden by the increasing productivity of NHS staff. Fewer beds and shorter stays for patients is the rule. While staff work harder, patients need more care in the home. The overcrowding in hospitals means that even emergency admissions suffer: from time to time many hospitals are closed to all emergencies.

While the hospital service is being run down, public spending cuts are also hitting community care resources. Home nurses, meals on wheels, and so on are all being reduced. Similarly, preventative medicine, far from being boosted, is being cut. Mass X-Ray units, cervical smear tests and Family Planning clinics are all going, and spending on health centres has fallen from £23m in 1975/76 to £17m in 1979/80.

After 30 years of underfinancing, and the neglect of primary care, the NHS is being reduced to a second class, emergencies only, service.

COOKING THE BOOKS

The mid-1970s marked a major turning point in the NHS's history. At the same time as it was being reorganised, and RAWP was being introduced, the service was reaching the end of its post-war boom. Public health care was no longer a growth area. The glamorous building programmes for a health service of the future were now replaced by the squeeze. The health service would cease to be a political asset for central government – it would be an increasing liability as that squeeze took effect.

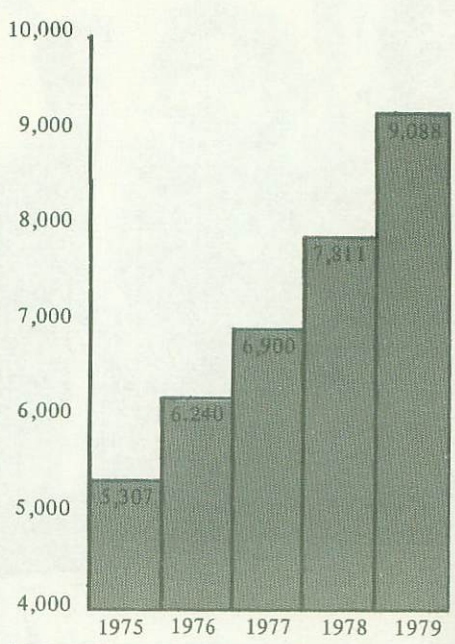
The cash limit system, introduced in 1976/77, provided a means of imposing severe cuts while throwing apparent responsibility for them onto the local health authorities. It also enabled the full extent of those cuts to be concealed for up to three years.

In budgets before cash limits, finance for the NHS was allocated in 'volume' terms. This meant that money would be provided to cover the purchase of a given amount of goods and services, everything from labour and bedpans to bricks and mortar. If, for instance, a District's budget provided for the employment of 1,000 nurses, the cash would be provided to cover the wages bill, whatever increase they won in that year's pay round. Similarly, the government would provide the funds for the District to purchase a given amount of heating oil, however much its price changed.

The result was that the health authorities were not caught short by unforeseen price or wage increases – it was the government that paid the bill. There was the advantage from the government's point of view that its plans had meaning: it knew what sort of an NHS it would be getting in the coming year, even if it didn't know exactly how much it would cost.

That was not too much of a problem during the years of fairly steady growth, even though it did leave room for overcharging by suppliers and contractors. The economic crisis of the mid-1970s, with the pound and the government on their knees to the IMF, meant that all that was to change. The cash limit was one of the major instruments of that change. It meant that it would no longer be what was brought that was important, it would be how much was spent.

NHS Expenditure in Cash Terms



Spending on Health Services in Great Britain 1978-79, at current prices

	£m	%
Hospital and community health services*	5,309	67.7
Hospital (capital)	448	5.7
General medical**	450	5.7
Drugs	863	11.0
General Dental	329	4.2
General Opthalmic	90	1.1
Central Admin. & Other	349	4.5
	7,838	100

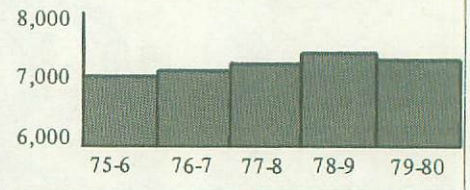
*Includes school health.
**GPs and services provided by them.

Cash limits

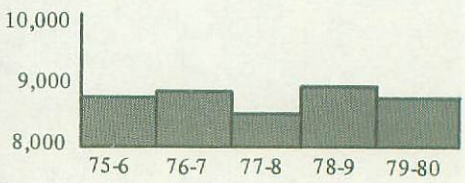
Cash limits were applied across the whole spectrum of government spending, but the NHS was among the worst hit. About 80% of NHS spending is cash limited: the main exclusions being prescribed drugs and the GP service.

Cash limited budgets are just that: the health authorities are given a set amount of cash to spend during the year. How much they are able to buy, what level of service they will be able to provide, depends on how much inflation eats into the limited amount of cash.

NHS Expenditure in Cost Terms

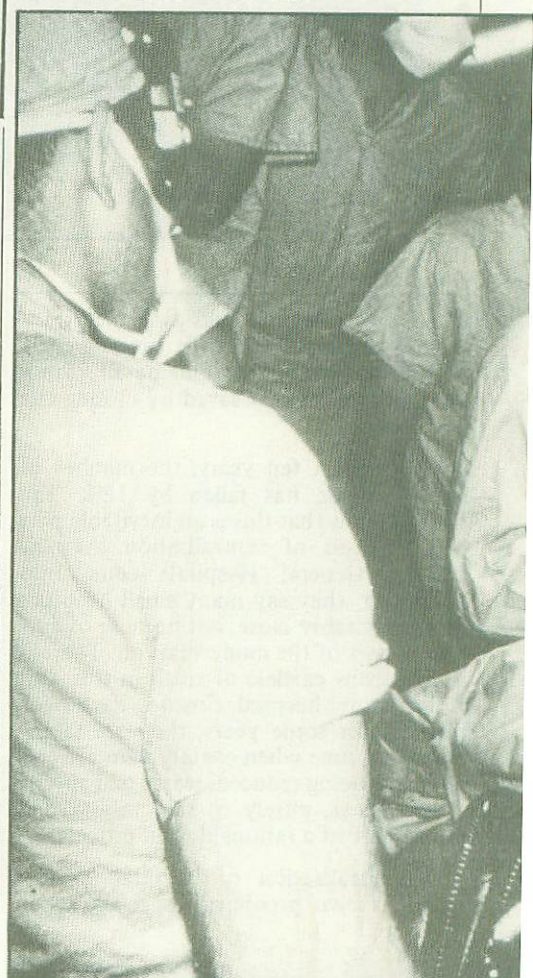


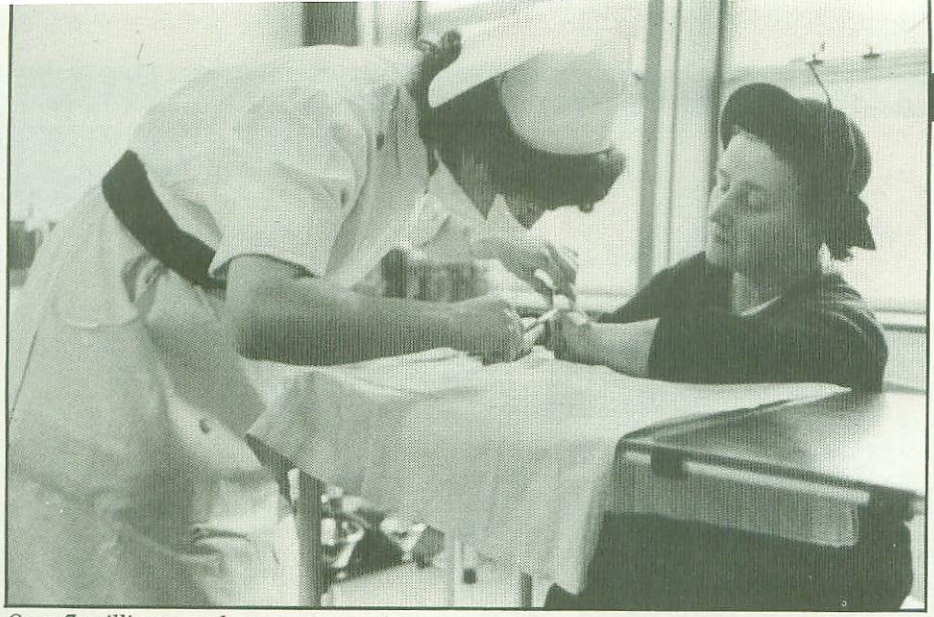
NHS Expenditure in Volume Terms



Source: CIS from government statistics

Heart transplant under way.





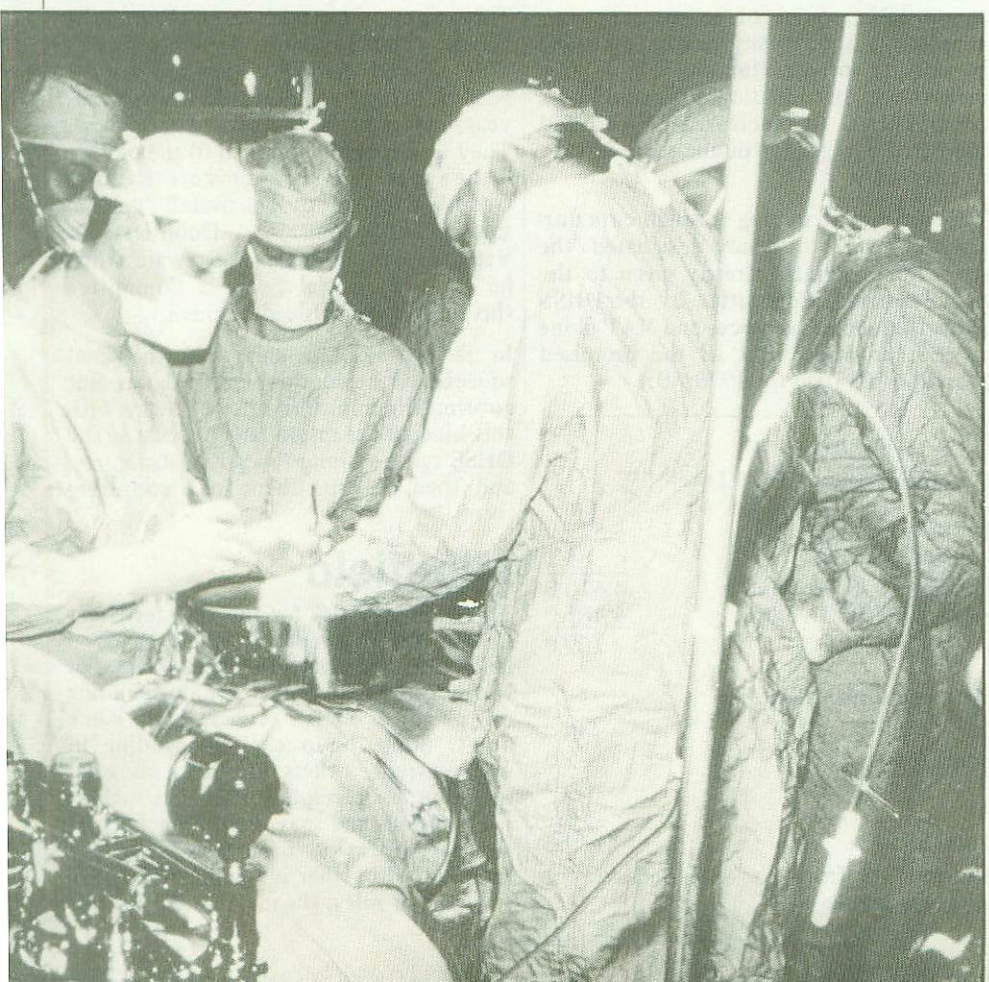
Over 7 million people go to out-patient clinics each year.

The introduction of cash limits marked a considerable regression in government administration techniques. 'Volume' budgeting was originally introduced precisely because inflation made cash budgeting without any indexation practically impossible to administer – there was a constant flow of applicants to the government during the year for more funds to make up the shortfall caused by higher prices. And that was in the days when inflation of more than 5% was considered to be disastrous.

Cash limits on purchases could arguably have been justified as a method of limiting excessive profits of private suppliers to the goverment. But they would have to be applied with indexation, i.e. linked to the rise in prices, so that the spending authorities would have realistic guidelines within which to work.

NHS –Sources of Finance – 1978/79

Consolidated Fund (Taxes etc)	*NHS Contributions*	*Charges*	*Misc.*
88.2%	9.5%	2.0%	0.3%



But the government was not interested in realistic budgeting. Its purpose in introducing cash limits was quite different. The form of the cash limits, with the government setting an arbitrary assumed inflation rate for the coming year, meant that the government greatly increased its control over spending. At the same time it appeared to place greater responsibility with the spending authorities.

Before cash limits, once the budgets had been decided in volume terms at the beginning of the financial year (in the April budget), any subsequent cuts had to be a postitive act of government policy, and had to be announced and brought to Parliament. With cash limits the government can impose continual cuts throughout the year more or less at its own discretion. All that is necessary is that inflation should be greater than allowed for in setting the cash limits – which it invariably has been.

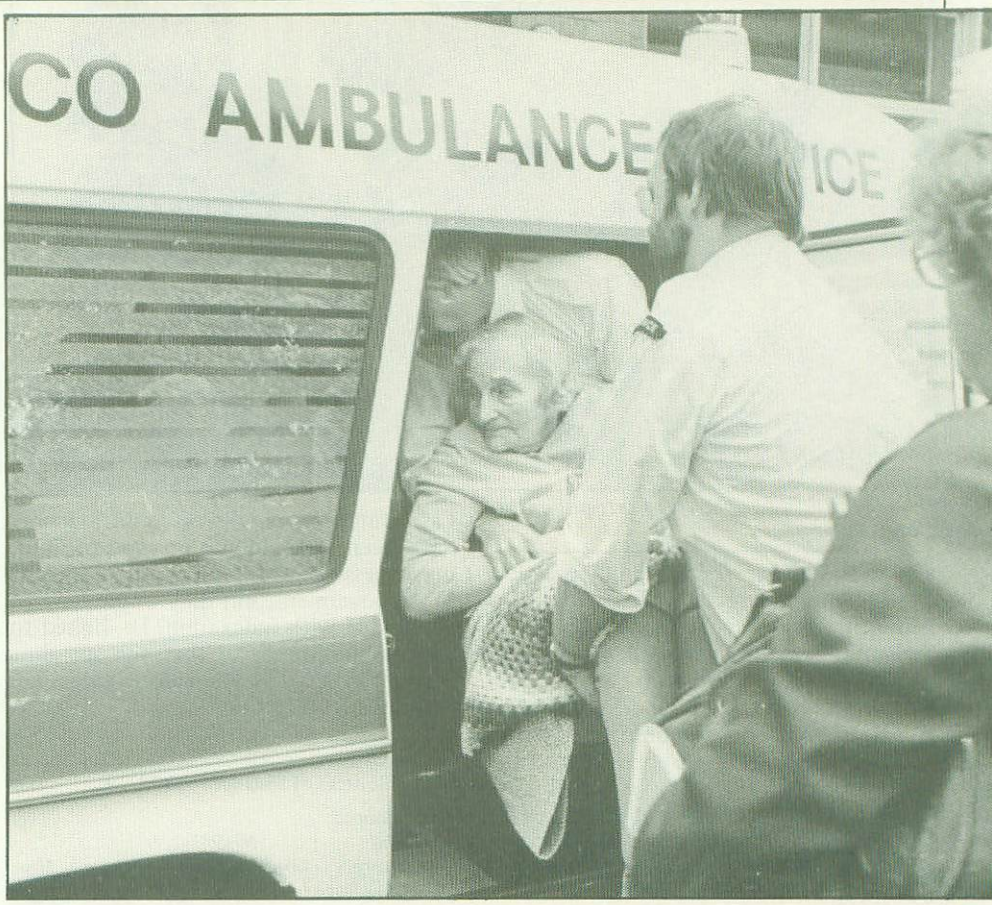
This has put the spending authorities such as the NHS in a ridiculous position. Consider it: **a multi-billion pound organisation providing a vital service, unable to plan its operations for even a few months ahead with any certainty.**

Public funds are the NHS's lifeblood, just as sales income is to a major corporation. But while a corporation can raise its prices when costs rise because of inflation, cash limits mean in effect that the NHS is barred from doing so. The problem is inflamed by the fact that private corporations also have large reserves of capital to turn to when times are bad, while the NHS has none and is not even allowed to borrow money.

Promises, promises

The result can be gauged by comparing budget promises with what actually takes place. **Ever since the introduction of cash limits, the government of the day has been able to make bold promises of a secure future for the NHS, whilst knowing that a hidden agenda of cuts can be imposed.**

At the beginning of 1979, for example, the government revealed its spending plans for the coming financial year in its Expenditure White Paper, as usual. This promised a 2.1% increase in the NHS's budget in volume terms for the year from



Gina Glover.

(Right) Private ambulances remove patients from St Benedicts' geriatric hospital.

April 1979 – March 1980, compared with the previous year. The NHS was to grow in real terms. According to the figures the service would be almost 7% larger than it had been just three years earlier in 1976/77.

That was the promise. The government made another, a little later on. Inflation would be further reduced, and so cash limits for public spending could be set at very low levels. The NHS would be given enough cash to allow for price increases of 8% and wage cost increases of 5% over the year. At that time, prices generally were rising at an annual rate of 20%, and earnings at 11½%.

The situation went from bad to worse from the NHS point of view. By the end of the year, March 1980, prices generally had in fact risen by 19¾% and wages by 18% and it seems almost certain that prices for goods supplied to the NHS rose even faster. The DHSS keeps a separate index of these prices, but refuses to divulge it.

So prices and wages were rising much faster that the NHS's income, and all that the health authorities could do was cut spending or persuade the government to loosen the cash limits. They tried to do both. The government refused to increase cashlimits significantly and forced through round after round of severe cuts . . . simply by not doing anything except stand by and let inflation take its toll. A large measure of that inflation was caused by a combination of increased VAT and increased charges for public services such as electricity.

This process of forcing through cuts during the year is officially designated 'the squeeze'. Estimates already given to the Social Services Committee by the DHSS show that increased prices and VAT alone more than wiped out all the promised growth of £85.1m for 1979/80:

NHS – England

Squeeze at Survey 1979 Level

	£m
1978/79 Volume	4,524.9
Planned growth	85.1
Planned 1978/80 Volume	4,610.0
Actual 1979/80 Volume	4,481.0
Total Squeeze	129.0

Main parts of the Squeeze

	£m
Squeeze on: Pay	25.0
VAT	35.0
Prices	69.0
Total Squeeze	129.0

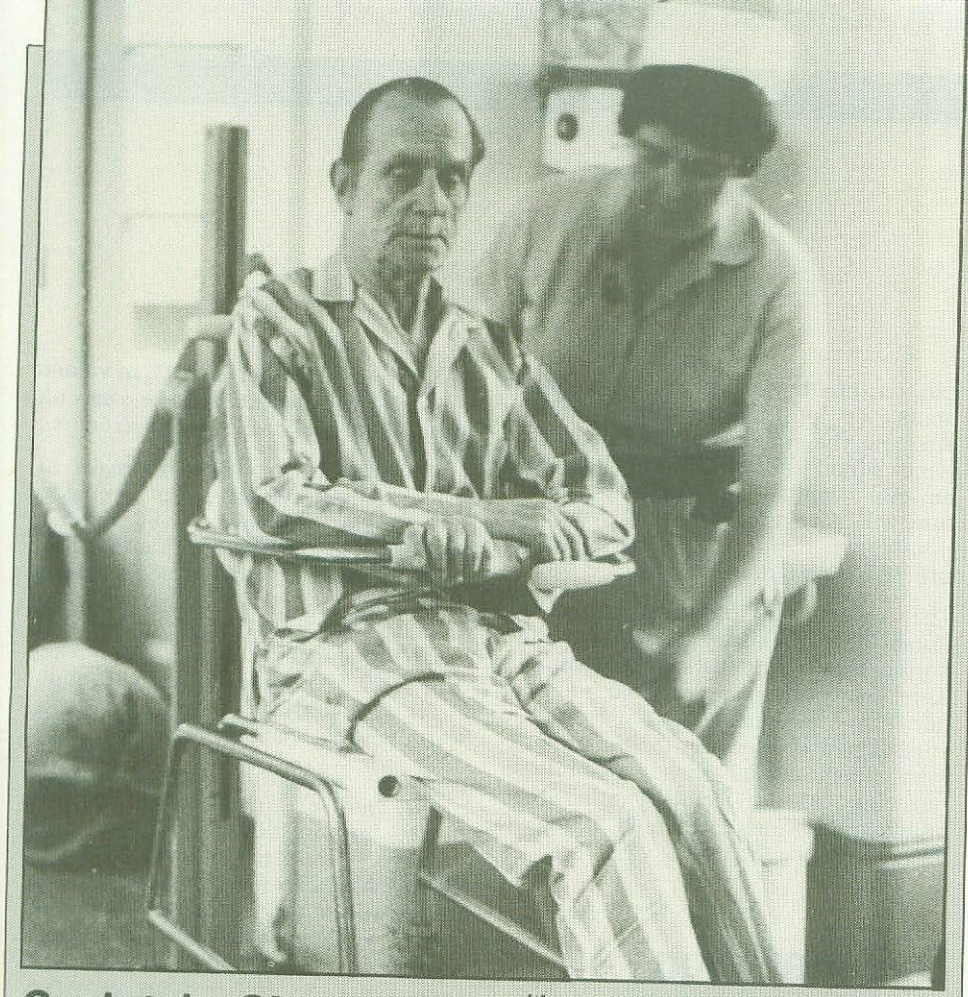
Source: CIS from Social Services Committee Evidence

These figures fit in with those given in the March 1980 Expenditure White Paper. This showed 1979/80 spending on the NHS as being 0.6% down on the previous year, instead of the planned 2.1% increase. They also roughly conform to the picture being conveyed by Ministers such as Gerard Vaughan of an overall 'volume squeeze of about 3%'. Doubtless Dr Vaughan was perfectly well aware when he told the Social Services Committee this that he was misleading them.

In fact, it is quite clear that the total squeeze was nearer double this figure. But government ministers can get away with this kind of deception largely because the DHSS takes so long to update its figures, and then presents them in a confusing form.

Minefield

There are statistics for the UK, for Great Britain, for England and Wales, for England, for Scotland, for Wales and for Northern Ireland. Some include spending on personal social services and some don't. Some lump capital spending in with current, others are given as total spending less receipts for charges such as prescription and pay beds. Then there are the different bases used for the finances. Altogether it is a minefield with two golden rules: the more useful a set of



Gina Glover.

Geriatric Ghettos

'There are hospitals in South East London where patients are clothed from a common pool of personal laundry. To possess the clothes you wear is a dignity so taken for granted by most people that it is hard to imagine the devastating implications of seeing someone else wearing the clothes that you wore last week' *(Snow).*

The number of old people is increasing. The kind of comfort and care they get from the NHS is deteriorating. Geriatric patients are a low status group in a health service increasingly preoccupied with high technology and medical prestige. Because of the inadequacies of local authority care and changes in family structure, more and more old people end up in hospitals for no other reason than that there's nowhere else for them to go. 'The oldest long stay patients seem to be outside the mainstream of the health service, 'blocking' its acute beds' (*Snow*).

Ironically, geriatric patients rely for care on a system that is not specifically designed to treat them, and are cared for by staff who lack the resources to treat them properly. Money spent on the old in hospital is scandalously low. **The most recent figures (1977) show that expenditure each year on beds occupied by geriatric patients is a little over £5,000, compared to £20,000 a year spent on medical and surgical patients. Nor is there the medical staff available to look after them. There is one medical staff member per 48 geriatric beds, compared with an average of one per 13 beds for English hospitals as a whole.** Not surprisingly geriatricians continue to be the lowest status specialists in the Health Service.

Medical research has failed to respond to the increased demand for treatment of geriatric and related illnesses. Teaching hospitals place a low priority on the diseases of the elderly, categorising them unofficially as 'junk. All of which leaves old people relying more and more on a hospital system that doesn't want them.

The DHSS guidelines for geriatric bed provision is 10 beds available for every 1,000 population aged 65 and over. In fact 73 out of the 90 English AHAs failed to meet this standard, and some had less than 5 per 1,000 beds available.

An already inadequate service has been further savaged by public spending cuts. Contraction of the service is at once fundamental and petty. Entire geriatric hospitals are being closed as at St Benedicts, Tooting, while in Tower Hamlets long stay patients are being refused their daily Ribena leading to Vitamin C deficiency.

This all adds up to more suffering and neglect for the old. Working people who have struggled all their lives to contribute to a system designed to support them in their old age are being confronted by a government which has cut taxes and reduced provision for those who need support and care. Jenkin's concern can hardly be any consolation: 'This retrenchment will have an adverse effect on progress towards the new pattern of services we should all like to see.'

statistics appears the more likely it is to be either substantially inaccurate or else completely out of date; and don't expect to be able to compare anything with anything else.

It takes about a year after the event to get anything like accurate figures for volume spending on the NHS. That would not be so bad, were it not for the fact that during that year the DHSS changes the price base in which it gives those figures . . . 1979 Survey Prices replace 1978 Survey Prices, and so on. The problem is that the two bases can't be compared; it's practically impossible to check the Minister's statements based on 1979 prices against last year's promises made in 1978 prices.

Judging by the way in which their figures move, moreover, the DHSS has a distinctly odd method of estimating spending. Because the government pretends that inflation will be unrealistically low when it sets the cash limits, it seems that the DHSS also feels it must assume that inflation is lower than it actually was – even after the event – until its final figures actually prove otherwise. It's a basic accounting error: an organisation gets so used to budgets it begins to present them as reality. In this case, however, **the error, a relic of bygone pre-cash limit days, is obviously retained because it is useful in concealing the overall level of the cuts. So it will not be until the 1981 White Paper that it will be revealed that the present official 0.6% cut for 1979/80 was in fact closer to 2% – a 4% squeeze.**

Advantage

Aside from the amount of time involved, the advantage from the DHSS's point of view is that these changing totals are set against figures for the previous year which are themselves in the process of being adjusted to take full account of price changes and base changes. For example, the most recent year for which final figures are available is 1976/77 – three years ago. According to the promises in the 1979 White Paper, spending in 1979/80 should be 6.7% more than in 1976/77. By the time the figures reached the 1980 White Paper, the increase had been reduced to 3.2%. Given that the squeeze was tightest at the end of the year, the final set of figures will not

appear till the 1982 White Paper. By then it may well become clear that over the two years the squeeze – the gap between the promise and the reality – was a full 6%.

The fact that their figures are constantly inaccurate is a great help to the government in its lambasting of 'excessive public spending, over-manning and too high pay increases in the public authorities.' They point to how the cost of the NHS has soared over recent years. And indeed, if you look at cash spending on the service, it has nearly doubled, from £5,307m to £9,088m over the five years 1975 to 1979.

If, however, you take as your measure the figures for spending by the NHS in volume terms, and make due allowance for the DHSS's errors, you find that the NHS is only minutely larger in physical terms than it was five years earlier. And if you look at spending on the NHS, relative to other costs in the economy, you find that it has actually gone down in real terms over those five years.

Yet the NHS needs to substantially increase spending each year just to maintain today's inadequate standards. Demographic growth changes alone – the result, for instance, of population growth and people living longer – and changes in medical science have meant that something like 1% needs to be spent on the NHS each year just to stand still. Even on the basis of the government's own figures, there has already been a substantial reduction in the NHS's capacity to cope with the demands made on it.

Defect

What is more, the NHS accounts have a major defect. There is no capital accounting carried out whatsoever. This means that there is nothing to show that the service's capital assets – from hospitals to stocks of supplies – are being properly maintained, updated and replaced as necessary.

The importance of this has long been recognised. A study in 1956 pointed out that 'while current expenditure on the hospital service cannot fall below a certain minimum each year if the service is to be maintained, capital expenditure can, on the other hand, and within broad limits, be postponed without greatly affecting the running of the service for *some* period of time. In the long run, however, capital and current expenditure will have to arrive at a given relationship if the service is to continue' (*Abel-Smith & Titmuss*).

That report went on to point out the dismal state of existing hospital facilities, noting that nearly half of all hospitals were then over sixty years old and over one-fifth over ninety years old. At the current rate of expenditure, it calculated, even if all capital spending went on replacing existing facilities rather than building new ones, it would take 220 years to replace the stock.

Degeneration

The NHS then, apparently, was burning up capital that had been invested in earlier years – its buildings and equipment were getting steadily older and more inadequate. The question is whether the same situation exists today. To judge by the slump in capital expenditure, it most certainly does.

In 1972, capital spending on Hospitals and Community Health amounted to over 15%, or almost one-sixth, of current expenditure. Since then it has been axed to less than half that level. And to the extent that there has been some continued spending on new rather than replacement projects, the proportion going to cover depreciation is even smaller.

The point is that without any capital accounts, it is difficult to even guess at the extent to which the government is now burning off the capital investment of earlier years. Certainly there are numerous stories of cuts being made in basic maintenance provision and also minor capital items that would pay for themselves from savings in just a few years. If basic maintenance is suffering, then doubtless outdated but still operational assets are not being replaced.

All the concealed cuts, from using up capital to cash limits, mean that in order for the NHS to reach its promised level in 1980/81 it would need an increase in spending of the order of 10% in volume terms. What is it getting? The same old story of promises backed by covert cuts.

So Vaughan can continue to make his grand promises. 'We have kept our pledge to maintain spending on the National Health Service for the health authorities' planned growth . . . to 1982/83 averaging about 1¾% a year . . . we have set what we believe is a realistic and fair cash limit . . . the total increase in cash as compared with 1979/80 is over 30%. That is about £1,600m extra cash coming into the health field' (Social Services Committee).

It sounds wonderful, but what of the covert squeeze? When pressed, Vaughan admits that in this government's eyes 'cash limits are paramount once the year starts. They take precedence, once they are set for the year, over the volume that is why we have the phenomenon called 'squeeze' . . . If anything has to give, it is the volume. So the half per cent (i.e. 1980/81's promised real growth), I agree, would be the margin that would begin to be squeezed if the cash limit were not adequate' (*Ibid*).

Despicable

And, of course, the cash limit is not adequate. Although Vaughan claims all pay increases are either fully covered or allowed for in the 14% increase, at the same time he admits that cash has been deducted on the assumption that 'certain savings from greater efficiency' i.e. a squeeze on the workforce, will make it up. On the prices side a 14% increase was given. Although inflation, then at around 20%, has subsequently declined, it will have to fall to low single figures by the end of the year to end up at 14% overall. This is out of the question, and so a substantial cut is being imposed.

The Government, confident at having got away with last year's drastic cuts, feels it can continue a nil-growth policy – and still appear to be being generous.

What's more, nil-growth will undermine the NHS in exactly the way and at exactly the rate they want it to. Slowly starving the NHS of resources will forge it into being a second class service – and private medical companies will profit.

IN SOUTH WALES

'If they close this hospital down it will be a tragedy . . . I'd be just dead.' (Mostyn)

The Prince of Wales Hospital at Rhydlafar is the only specialist orthopaedic hospital in the whole of South Wales. It stands in an area of heavy industry and mining where accidents, especially bone injuries, are common. One patient, Mostyn, had been a miner since the age of fourteen. He suffers from osteomylitis, dust in the lungs, and has had a series of accidents in the pit that have left him psychologically and physically weakened. To him the hospital supplies not only medical treatment, but also the vital '. . . somewhere to come, somewhere to talk to people, something to do.'

'I'm only too grateful for this place and for what it's done for me . . . If not for it I'd be in a corner.' (Betty).

The population of South Wales is an ageing one with at least 14% over the age of 65, and an expected significant increase in the number of people aged over 75. To them, rheumatoid arthritis is a common disease. It is excruciatingly painful leading to the breaking down of bones, grinding of one joint on another, the fever of inflammation and crippled limbs. A simple operation can often relieve the pain. **But in South Glamorgan there are already 1,000 people on the consultants' waiting list and an estimated 1,000 more waiting simply to see the consultants.**

The situation can only get worse and the lists are expected to double or triple within the next few years. Already in East Glamorgan people wait 3½ years for major operations and there are grave suspicions that GPs no longer encourage people to seek operations. Often patients are not even told that a simple operation that could alleviate their suffering exists. For elderly people this means living out their last days in unnecessary pain. And as conditions worsen 'cold' (non accident, non emergency) orthopaedic cases are left waiting as trauma cases take precedence. East Glamorgan now has no 'cold' orthopaedic beds and in mid Glamorgan a consultant said that of 14 beds, 9 are being used for trauma cases. Patients are shoved into any wards with free space.

Rhydlafar hospital is two miles outside Cardiff, in a beautiful spot in the countryside. It is designed for orthopaedic patients, with all the buildings on one level so that using wheelchairs is no problem and immobilised patients can be moved in their beds. A regular bus service passes the doorway and staff can be easily found in mid-Glamorgan. The hospital is an important source of employment in an area which is becoming destitute of jobs and a vital lifeline for the patients, many of whom are paralysed.

But Rhydlafar hospital is threatened with closure. Since the spring of 1979 the Health Authority has been hinting about closing it and an order is expected in January 1981. Maintenance work that has been on the books for years has still not been done. Already two wards have been shut: staff have been given conflicting reasons for this ranging from difficulties in recruitment to dangerous wiring. Whatever the reason, there is no doubt that as time passes the wards, which are being used as junk rooms for other hospitals, are deteriorating.

The shortage of beds caused by the closures means that patients are being pushed out of hospital faster than ever. In 1979 patient turnover increased by 35%. The cuts in social services and home help means that only the vigilance of staff prevents dangerous shuffling between home and hospital. 'We've been lucky so far . . .' said one senior therapist, 'nobody has died yet'.

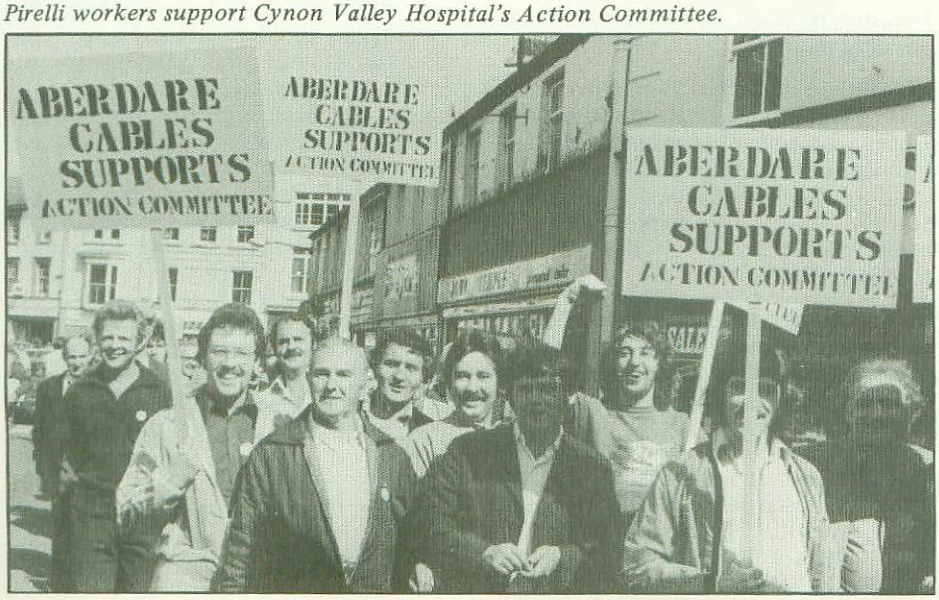
Fragment

The staff at Rhydlafar have years of experience behind them. 'In orthopaedics you live, eat and breath orthopaedics . . . (it's a) long term business, the expertise is long term, continuity is long term . . . break it up and you won't get the expertise . . . you just can't fragment it.' (Sue Goodall, senior occupational therapist). Yet fragmentation is exactly what the Health Authorities are doing. South Glamorgan no longer wants to have regional responsibility for orthopaedics and the mid Glamorgan and Gwent Health Authorities are angling for their own prestigious units. According to staff the changes, made in an atmosphere of cuts, will mean reduced services. The staff and patients are fighting to maintain and renew the existing centres of excellence and argue that only that way will patients get proper treatment.

There are two moods to Rhydlafar hospital. Amongst the staff and patients there is an air of mutual trust – there's a friendly atmosphere where severely disabilitated people can have real contact with each other and learn to adjust to a frightening outside world.

Behind the scenes the staff are struggling to maintain the service. Cuts are every-

Pirelli workers support Cynon Valley Hospital's Action Committee.



Real Eyes.

where. Cleaning materials are now in short supply and ancillary staff have been instructed to use only water to clean floors – unless an infection breaks out. Washing up liquid replaces the more expensive disinfectants and the result is slippery floors in a place where many people have difficulty walking. 'In any home you'll find more cleaning material than in a hospital' (Jean Cousins, Health and Safety Representative).

Laundry supplies are drying up and staff find themselves using pillow cases to supplement the mere 20 tea towels they are given each week. The hospital is run on bonus schemes and understaffing. Staff are not being rehired when vacancies arise and rumours of imminent closure help to keep potential workers away. One more ward closure and Rhydlafar might fall below the 100 bed level. Rhydlafar is a teaching hospital and so, by law, the orthopaedic school can be closed if it goes below 100 beds. The closing of the school would lead to severe shortages of staff within the hospital and would also mean the end of training of specialist orthopaedic nurses in Wales.

Tredegar, on the head of the Sirhowy Valley in North Gwent, is the birthplace of the NHS. Under the old miners' medical aid schemes hospitals, health clinics and doctors were made available to the public. Nye Bevan was MP for Tredegar and Walter Conway, the originator of plans for the NHS, was born in the local St. James' hospital.

St. James' is now closed. The Health Authority which recently spent £1m modernising it and equipping it with every kind of facility including an up to date special baby care unit, paid £95,000 to dismantle it. 26,000 signatures of protest were ignored. The old Grove Clinic, where the first miners' doctor was based, has been closed. Once there were two health centres, one at the top and one at the bottom of the village, and one clinic – now there is only a gerry built health centre in the middle so people from either end have to walk.

The nearest general hospital is the 400 bed Neville Hall at Abergavenny, 17 miles away. The catchment area of the hospital is so large that people living on the fringes of it have to travel 23 miles to get there.

An Ombudsman report into health provisions in the area concluded that '. . . live at the end of the catchment area and you're done for.' (CR Hughes). Fares are a minimum of £2 return. Public transport is infrequent, few buses, and only three of the fifteen trains that serve the valleys are still running, so it's not surprising that people have become more reluctant to go for checkups. A visit to a relative can take from six in the evening till half past ten – an impossibility for people with young children. Car ownership in S. Wales is well below the national average. In 1971 while over half the families in Britain had cars, less than 40% in S. Wales did. Depression, as a result of icreasing isolation, is becoming common amongst patients.

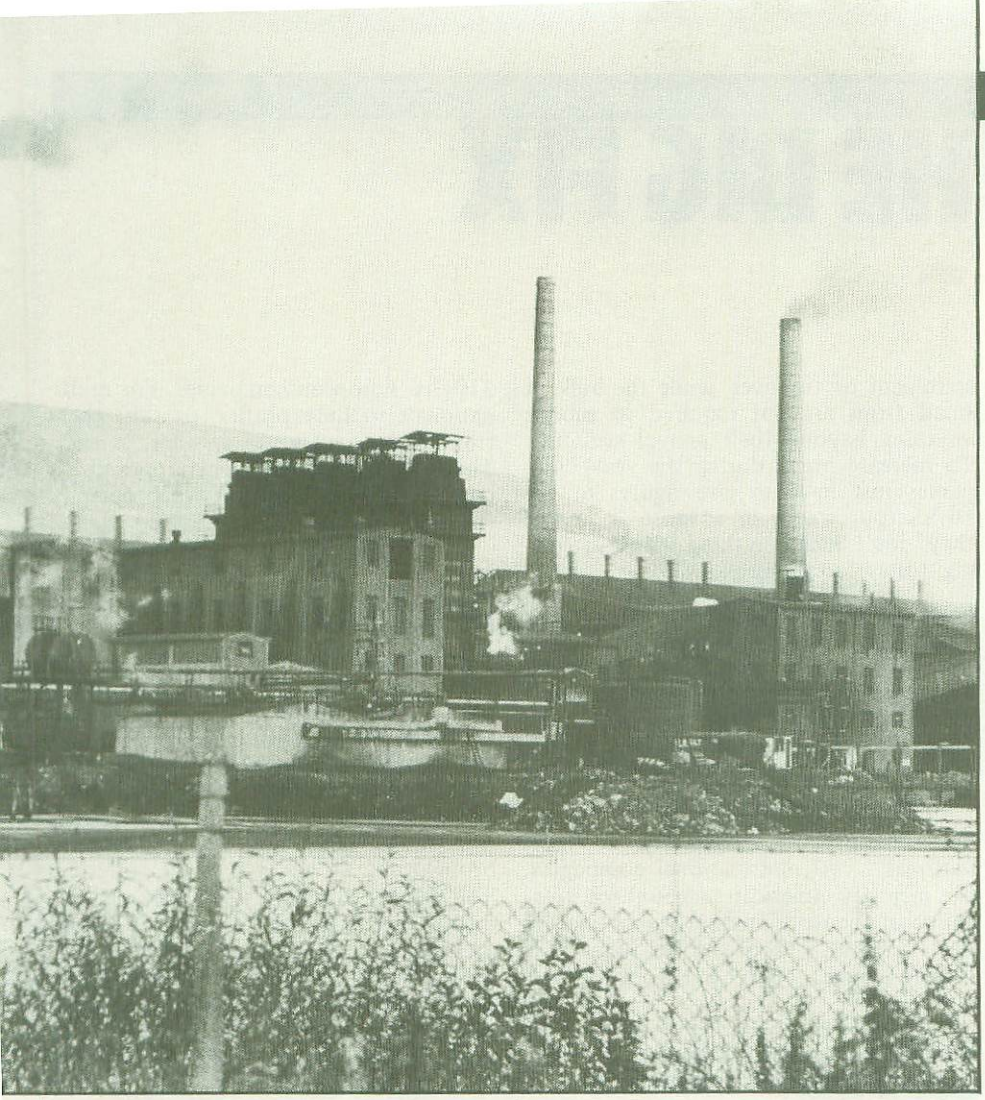
'Recently a miner was injured in a colliery . . . he was talking to them in the ambulance . . . couple of miles short of the hospital he asked his friend to hold his hand . . . and then he died . . . he bled to death . . . Nobody can prove that they couldn't have saved him if the hospital had been closer.'

The catchment area consists of a network of five valleys lined by houses. Often only a narrow road runs from the top to the bottom. The Head of the Valleys Road situated above them is high and freezing conditions are normal. And it is along this road system that ambulances will have to drive long distances to Neville Hall. Residents, who have nothing but praise for the ambulance drivers, say it could take as much as 45 minutes for an ambulance caught behind a slow moving truck.

St. James' was a general hospital with a friendly atmosphere. Neville Hall, in contrast, is described as 'more like a factory.' The Tredegar General Hospital in the area has now been changed into a geriatric hospital and while the Health Authorities originally promised 80 beds it will eventually only have 60 even after extensions to the hospital are built. Because of bed shortages people are forced to negotiate an obstacle course before they can get proper care. One man who had nursed his invalid wife for years, was offered a holiday. When he applied for his wife to be taken into hospital while he was away he was forced to see a doctor who would check if he was unfit enough to need a holiday.

Waiting lists are becoming longer and longer. Now it's not uncommon for people to be given appointments in 60, 65, 70 weeks time. One five year old who needed a tonsil operation was told she'd have to wait two years. When her parents took her privately she was given the operation the next week.

Most people in the area are angry. Their health care has deteriorated rapidly.



'. . . we were pleased when people all over the country were given a health service like ours . . . (but) I don't think there's anyone in the area that wouldn't wish they were back under the old medical aid scheme' (CR Hughes). Centralisation combined with an overall cut in services means that people now have to travel further to obtain less.

Alien

St. David's is a local hospital set in an inner city area. It used to provide all general services including casualty and accident departments. In 1974 the accident unit was closed; three and a half years ago the minor casualty unit was axed. Despite a campaign to re-establish the services and constant promises from the Welsh Office that the casualty unit will reopen, there are few signs of action.

As a result people are forced to travel to the Cardiff Royal Infirmary (CRI) a journey involving two buses. Facilities there are not up to the extra demand since the CRI already serves a population of 340,000. One nine year old boy with a bad cut had to wait four hours for treatment. And that was on a quiet night. It's anybody's guess what would happen if there was a major accident like a pile up on the M4: a couple of emergencies and the place comes to a halt. On Saturday nights after the rugby, people wait for seven to eight hours for treatment – fights are common, the presence of police is considered normal. And at night, the ambulance service is cut by half.

The new 800 bed University Hospital of Wales at Heath Park Cardiff was built without any emergency facilities. Even NHS staff who need emergency treatment have to be rushed to the CRI. The Heath Hospital is a consultants' dream: a huge new building with up-to-date technology, it is equipped to deal with the 1% of rare and prestigious diseases. The doctors are happy but the other 99% of patients object. They find the hospital alienating, impossible to negotiate and unfriendly. 'It's probably lucky they don't have a casualty unit . . . go in there and you would never find your way out of it' said one member of the St. David's defence campaign.

Kill

St. David's hospital has a maternity unit which services the West of Cardiff and the whole of the Vale of Glamorgan. For people in the surrounding area St. David's provide a good service and it has an excellent record for childbirth. Women who live further out are less fortunate: residents argue that there is a real need for two maternity units, one based at St. David's in Cardiff, and one further into the Vale.

The Health Authority has ignored this and instead plans to close the St. David's unit and move it to Llandough outside of Cardiff. Women from the west of Cardiff will be forced to take two buses to get their maternity care. On top of this the new unit will, by 1978 estimates, leave South Glamorgan 40 maternity beds short – and that doesn't count a possible baby boom.

Llandough is high in the hills and might easily become inaccessible in the winter. But that doesn't worry the Health Authority who said at a public consulation that they will fly pregnant women in by helicopter!

Health care in South Wales is reaching an all time low. The area is poverty stricken with increasing unemployment as pits and steel mills close down; bad housing and a damp climate combine to make a high level of ill health. But as things get worse people are getting less and less from the NHS. Some of the cuts are grotesque: cancer patients whose hair falls out as a result of radiotherapy will no longer be supplied with wigs. Women can now only get a cervical smear every three years although the recommended time between them is one year. South Glamorgan Health Authority is taking measures to save £1m in a year and their proposals include continental breakfast, and a cut in Family Planning Services.

While this happens, private medicine is booming. BUPA plans to build an 80 bed private hospital in the area, and American Medical International is also building one. As waiting lists get longer there are reports of patients who go to see consultants privately, pay a £15-£20 fee for one consulation, and as a result are booked in for NHS operations.

As one elderly resident of Tredegar said 'This is where the National Health Service was born, and I reckon this is where they started to kill it off.'

THE BIG FIX

Only advertising and oil are more profitable than drug manufacture – and at the centre of drug company profits in the UK lies the curious and cosy relationship with the Department of Health and Social Security.

In 1979, doctors wrote more than 370 million prescriptions for drugs costing over £750m. Thirty giant companies sold over 70% of these drugs. **The price the NHS paid was not determined by the cost of the drugs, but by secret negotiations specifically designed to guarantee the well-being of the drug companies' profits. The Pharmaceutical Price Regulation Scheme (PPRS) means that the NHS pays to ensure dividends for drug company shareholders.** In 1979 profits from sales of drugs to the NHS came to over £125m.

The DHSS starts its statement on the operation of the price-fixing scheme as follows: 'The Health Departments and the Association of the British Pharmaceutical Industry (the companies' mouthpiece) record their common interest in securing . . . a strong, efficient, and profitable pharmaceutical industry . . .' To ensure this profitability, companies can charge more or less what they like for a drug, provided the company only makes 'reasonable profits' overall on NHS sales.

Secret

But the DHSS flatly refuses to disclose what 'reasonable profits' are. 'The reasonableness of the profits earned by individual companies in home sales of NHS medicines will be a matter for negotiation, having regard to the circumstances of the individual company, the contribution which it makes or is likely to make to the economy, including foreign earnings, investment, employment or research, the special characteristics of the pharmaceutical industry and the profitability of United Kingdom manufacturing industry as a whole' (PPRS).

The basis for negotiations over price are the companies' own audited accounts. Only the 65 firms doing more than £1½m worth of business with the NHS have to submit a complete audit, and a forecast of returns. Others merely have to produce a copy of their annual accounts and a statement of turnover, while the bulk of small firms are not required to submit anything beyond their annual accounts. To increase prices during the year, companies just have to give figures to the DHSS four weeks in advance – and if they don't hear anything within a fortnight they can go ahead.

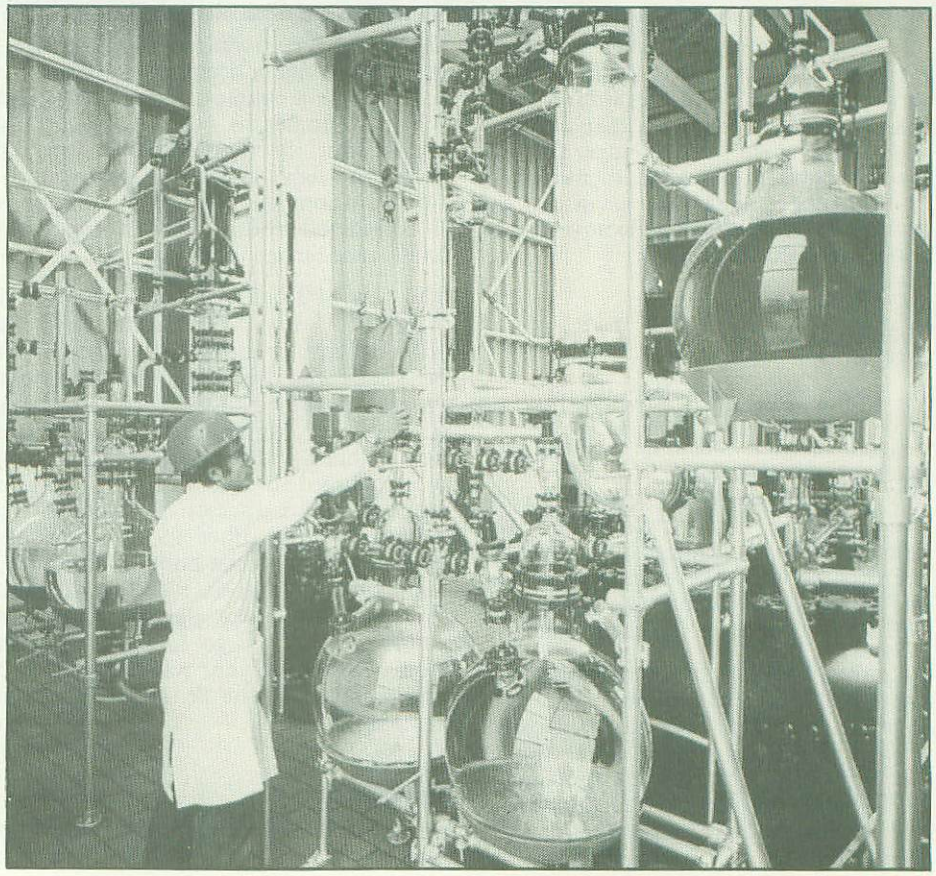
Since the 'reasonable profits' refer to the company's overall profitability, and not the costs of, or profit on, individual drugs, firms can hide profits on their best sellers behind those on less profitable lines. We are paying for, without having any control over, the drug companies' failures, past, present, and future.

The pharmaceutical industry is international – 50 multinational companies, the majority American, account for two-thirds of the world market (excluding the Eastern bloc). 73% of the UK industry is foreign-owned, 40% by US firms, and 31% by European companies. For multinationals to hide profits, or shift them from one country to another, is easy. They do it through transfer pricing – over or undercharging between parts of the multinational.

Price-fixing

Transfer pricing was at the heart of the British government's case against the pharmaceutical giant Hoffman La Roche. In 1970, Roche Products (UK) was purchasing the ingredients for Librium and Valium at £370 and £922 per kilo respectively, from the parent in Switzerland. But those same ingredients could be brought for £9 and £20 a kilo in Italy. The Roche subsidiary then marketed the drugs at inflated prices, declared artificially low profits, and the real profits were transferred from the NHS to Roche, where they were hidden in inaccessible Swiss accounts. Roche in the end paid back £12m of 'excess profits' for the

Beecham's pharmaceutical plant.



period from January 1970 to April 1973, but was allowed to up the price of Librium by 50% and Valium by 100%. In 1979, the NHS spent over £9½m on the two drugs.

For the DHSS to rely on the drug companies' own accounts implies a degree of trust that is, in the light of the behaviour of the companies themselves, unwarranted. Overcharging is general throughout the industry. When Pfizers won the race to patent tetracycline, they secured the deal by making secret price-fixing agreements with the other interested US giants. Any company granted a licence to produce, would sell the drug at £65 per thousand. The cost, including research, was £5 per thousand. In 1962, the NHS put out a new tender for tetracycline. The US companies reduced their price simultaneously to £55 per thousand – but the contract was won by Italian and Danish firms charging only £25 per thousand. The NHS saved over £1m in one year.

Just as shocking is the drug companies' Third World pricing policy, disclosed by the World Health Organisation in 1975. US firms were selling Vitamin C at $2.40 a kilo in the UK, and $10 a kilo in India. Tetracycline antibiotics costing $24 to $30 in Europe were being sold to India, Pakistan and Colombia for between $100 and $270.

These are the companies with whom the DHSS negotiates behind closed doors.

Although there are some checks to see that manufacturers aren't selling the same drug at widely different prices overseas, this only ensures that they sell the drug at the same price everywhere. Indeed, many foreign governments use the NHS price as a benchmark, so that to get as high a price as possible from the DHSS will benefit the company world-wide. So it comes about that a large British drug company, is reputed to have agreed an artificially high price for one drug, so that it could sell the drug for that price in India. It then secretly paid back the DHSS part of the revenue from sales made to the NHS.

Super profits

No wonder then that the drug industry is so profitable – the pharmaceutical industry has consistently manifested one of the highest rates of return of any manufacturing industry. In 1979, according to the *Financial Times*, gross profits on NHS sales were 21% (12.4.80). A 1978 survey found that of the 99 companies considered, 13 had a return on capital of over 30%, and the average rate of return stood at 21.6%. In 1977, the recorded pre-tax rate of return for the chemical indusry was 18.2%, compared to 17.6% for manufacturing industry as a whole. But pharmaceuticals are more profitable than other chemical manufacture. For example, drugs are only 5.9% of ICI's sales, but over 10% of its profits (1979). Similarly, drugs form 36% of Beecham's sales, but 58% of its trading profits (1979).

Tranquilisers – a bumper harvest.

Early promotion.

The companies themselves cannot be relied upon to keep prices fair. They will charge, not what the drug costs, but what the market will bear. But doesn't the cut-throat competition between the companies serve to keep prices reasonable?

The pharmaceutical industry is dominated by a relatively small number of giant multinational companies, whose power, internationalisation, and diversification are constantly increasing. **It is an industry characterised by the ability of leading firms to maintain high prices and market domination against firms with lower prices for identical products. Competition is intense, certainly, but it is waged in the arena of promotion, advertising, and new (or supposedly new) products. Price competition does not enter into it.**

The DHSS price scheme, therefore, plays directly into the companies' hands. Indeed, the DHSS allows companies to write off the costs of research and development and advertising against profits.

R & D

Drug companies are always quick to justify their high profitability on the grounds that they bear uniquely high research and development costs and take enormous risks.

Though the sums of money involved are large, they are not inordinate when compared with company income or with expenditure on advertising. R&D takes only 10-15% of income compared to 20% on promotion.

While there can be no doubt that the fundamental research needed for real innovation is both costly and risky, the drug companies hide the fact that the bulk of this kind of basic research is carried out in university departments, and then made available, free of cost, to the industry. In 1978, only 28% of British drug research was sponsored by the commerical companies, 27% by the Medical Research Council, and 45% by the DHSS and University Grants Committee (*Guardian* 1.9.78). Most of the significant pharmaceutical innovations of the past 30 years have been discovered in academic institutions, and then exploited commercially by drug companies.

Media Smears

'Angels of mercy' and 'dedicated workers' are the media's customary labels for the nurses and ancillary staff who save life and care for the sick. But in its treatment of disputes and industrial action taken by NHS staff fighting for better services the praise turns to venom.

When health workers, who are traditionally badly paid and over-worked, try for a living wage or to save health care standards, the media homes in with abuse and hysteria. Vast resources are lavished in attempts to paint the workers as society's worst enemies and as mindless people of 'bad will'.

YORKSHIRE POST

During the Low Pay strikes in the winter of 1978/79 a campaign of hate obscured the fact that the strikers were among the worst paid in the country.

'PICKETS HIT CANCER WARDS was the 1½" headline in the *Daily Mail*, followed by 'WHAT RIGHT HAVE THEY TO PLAY GOD WITH MY LIFE' in the *Daily Express*. The following Sunday the *Sunday Express*, again with banner headlines, screamed 'MEN WITHOUT MERCY'. In an article that was to set the tone for most of the other newspapers, the paper continued, 'The object of the strike action is supposed to be to put pressure on the employer . . . But now the game has changed. Public suffering is not an accidental by-product of the NUPE strike, it is its specific target'.

OBSERVER

Even when strikers were allowed to put their side of the story, they never received visual prominence, so that the overall impact of the headlines and the lead-in paragraphs remained. 'AMBULANCEMEN LEFT DYING WOMAN' headlined the *Sunday Express*. The story was a lie. But no attempt was made to talk to ambulance staff and the headline served its purpose.

EVENING Times

'HOSPITAL STAFF LET MOTHERS GO HUNGRY', together with pictures of a new born baby and its mother in the *Daily Mail* with the headline 'THE STRIKERS' VICTIM JUST 8 DAYS OLD'. – No comment from the strikers was printed. The press successfully categorised the workers as callous people motivated by bloody-mindedness and greed.

Daily Mail

The greatest venom was saved for health workers' elected leaders. Press coverage ranged from straightforward abuse to crude ploys aimed at isolating the leaders from the support of the membership. 'THE SHOCK TROOPS OF NUPE UNDER FUEHRER ALAN FISHER' was the *Sun* headline (9.2.79)

THE Sun

for an article that portrayed NUPE members as victims of deception. NUPE Divisional Officer, Colin Barnett, was described by the same newspaper as 'this self-opinionated little pip squeak.'

The media hysterically exaggerated any expression of hostility towards health service workers. 'Angry Mums' led the *Sun* (1.2.79) 'rolled up their sleeves and went into action

DAILY Mirror

yesterday against hospital strikers threatening the safety of their sick children.' Hospital workers on a picket line outside one hospital were shown being assaulted by 'hospital volunteers' dressed in riding gear and mounted, allegedly carrying food through the pickets. The media applauded, pointing out that most of the pickets were foreigners.

THE GUARDIAN

This campaign certainly led to the demoralisation of a workforce that had little experience of, and certainly disliked taking industrial action. The strike crumbled.

EVENING POST

The point was not lost on hospital management. In the winter of 1979 the management at Charing Cross hospital explicitly used the media to defeat striking engineers. Press and TV were invited to the scene as cancer patients pleaded with the engineers to lift their picket. One man 'coughing blood' (*Daily Mirror*), was reported shouting: 'If I don't get my treatment I'll die, I'd like to put a bomb under you.' Television viewers were treated to the sight of doctors arguing with the pickets. One doctor smashed down a make-shift shelter erected by the pickets.

DAILY EXPRESS

Yet Ministerial decisions to cut whole hospitals, decisions that would mean certain death for hundreds of people who might otherwise be alive win the newspaper's unqualified approval. When will we see 'THATCHER'S VICTIMS, THE OLD, THE SICK, THE POOR' in banner headlines across the front page of the *Sun*?

Most of the research the companies do carry out is in 'safe' research – research that will produce profits. The bulk of this research will be occupied with molecular manipulation – producing 'me-too' drugs. When one company patents a profitable drug, or the patent on a company's own drug is running out, maximum effort will be put into producing another similar drug – just different enough to get round the patent laws. Never mind that it makes no difference to the fight against disease – the new product will assist the fight for profits.

So it comes about that there are over 130 antibiotics on the market, 31 of them simple derivatives of tetracycline; more than 80 tranquillisers and over 100 analgesics. At the same time almost no research is being done into relatively infrequent though possibly fatal, diseases. There's no money in a rare condition. Indeed, medicines that do exist to treat rare diseases are being withheld from the market because companies claim they can not afford the cost of safety evaluation for drugs with 'limited sales potential'.

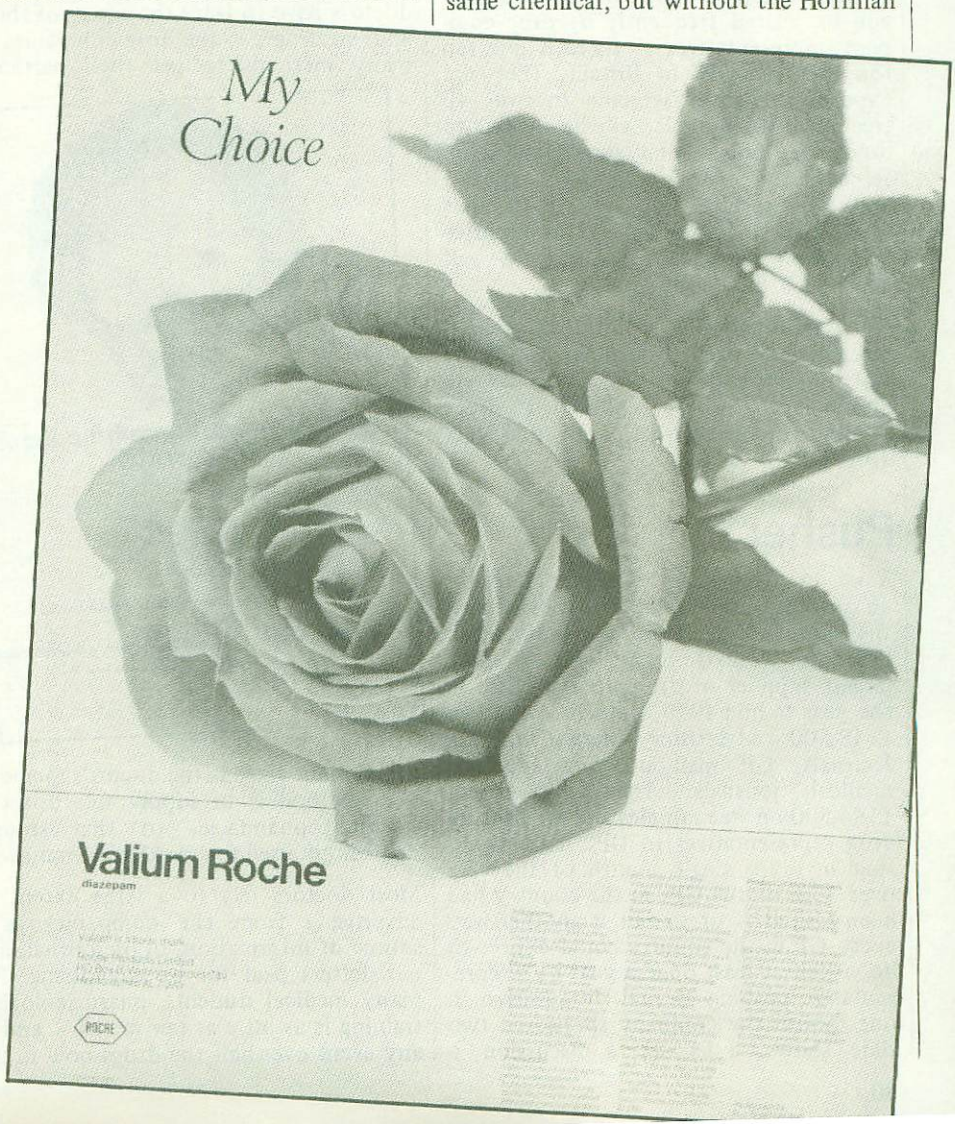
The other aspect of the companies' approach to research is the marketing of huge numbers of useless drugs. Once a drug has progressed a certain part of the way through the testing and development process, once a certain amount of money has been invested in it, nothing short of the appearance of severe side effects will prevent its being marketed. Heavy promotion will make up for deficiencies in its effectiveness. In 1965 a group of medical experts evaluated 2241 of the 3000 pharmaceutical products on the market. They concluded that 35% of them were ineffective, obsolete, or irrational combinations of other drugs. Few of them were ever withdrawn. In 1970, the MacGregor Commission which published a list of 'unacceptable' (toxic or ineffectual) drugs, was disbanded by the Tory government. In the USA, an investigation by the Food and Drug Administration found that 60% of the 2000 drugs tested lacked evidence for their therapeutic claims. Some of these drugs were ordered off the US market, but the drug companies, undeterred, carried on selling them in other counties, notably in the Third World, where regulations are looser.

The similarity between many drugs on the market means that pharmaceutical industry spends vast sums on advertising and promotion – establishing its particular brand of drug in the mind of the prescribing doctor, rather than cheaper, though pharmacologically identical alternatives. Much of the money supposedly spent on research is in fact a disguised form of promotion, general market research and so on. Once again, the DHSS takes the company's word for it as to how much is spent on research.

Promotion

Far more is spent on advertising than on research. Indeed, more is spent pushing products to General Practitioners than on educating doctors. This is where the ruthless competition between companies is expressed, and where the irrationality of the drug industry is clearest, an irrationality for which the NHS pays.

Drug company profits are based on GPs prescribing a drug by its brand name. The retail chemist then has to supply that drug, and cannot substitute an identical alternative. A given drug can be identified in three different ways – by its generic or chemical name, by its approved name (as listed in the British Pharmacopoea); or by a brand name chosen by the manufacturer. There is no difference between a brand name drug and the equivalent generic drug – except its price. Valium costs 78% more than diazepam – the same chemical, but without the Hoffman



La Roche brand name. Butacote, an arthritis drug produced by Geigy costs over five times as much as the unbranded phenylbutazote (*Daily Telegraph* 27.11.79).

A survey into the 13 most commonly prescribed drugs found that if their generic equivalents had been prescribed instead of the brand name drugs, this would have knocked £25m off the NHS drug bill. For these 13 drugs, the manufacturers' price was 40-100% above the generic equivalents (*Lancet* 9.2.80).

The average family doctor in Britain receives over 1 cwt of advertising literature a month, including gifts of diaries, records, etc. from which the brand names of drugs beam out. In addition the doctor will be visited frequently by drug company representatives – there is one rep for every 7 GPs in Britain. They are exposed to advertisements in over 40 free medical journals, will be invited to lunches, dinners, film shows and conferences at the drug company's expense, and will receive hundreds of pounds worth of free drug samples. This intensive promotion cost the industry a self declared £78m in 1978.

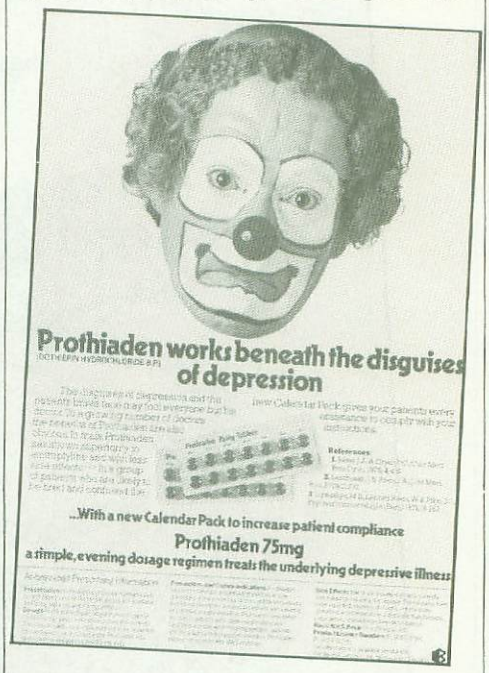
Not surprisingly 85% of all drugs are prescribed under their brand names. Of the top 600 prescription drugs only 39 are unbranded. In all unbranded drugs account for less than 5% of the total NHS drugs bill.

Pusher

Take one drug as an example. Merital is an anti-depressant marketed by Hoechst, the world's largest drug manufacturer, based in West Germany, and fifteenth largest supplier of drugs to the NHS. In the year to mid 1979, Hoescht spent over £148,500 advertising Merital in GP Journals, GP mail-outs and specialist medical journals. They also spent £184,500 on free samples and on visits by drug representatives to GPs. This meant that in every single month of the year over 10% of the GPs in the country had been visited – or to put it another way every GP in the country could expect to be visited at least once a year by a representative pushing Merital. In addition in one month the company sponsored two slide shows, a lecture, a discussion, a

buffet lunch, buffet dinner and sit-down lunch for GPs to promote Merital.

The propaganda starts early. Trainee doctors have to learn the names of thousands of drugs, so the drug companies use many methods to get their particular



brand name fixed in the doctor's memory. One method is to supply free drugs to hospital pharmacies so that student doctors get used to a particular brand.

Most doctors rely to a large extent on advertising from the companies as a source of information, or on journals and newsletters paid for by advertising. For many medical students, pharmacological training is as little as ten weeks – and in any event over half the drugs now in use have been introduced in the last fifteen years. The busy GP has no choice but to rely heavily on advertising, or journals financially dependent on advertising, for information about drugs.

'I know that because of shortage of time, pressure of work and tiredness, I do sometimes allow myself to be influenced by advertising pressures. There have been tremendous changes in drugs and treatments since I left medical school in 1961. To keep up to date I have to rely on various sources for information about what drugs are available, and all too often these sources are directly or indirectly the drug companies themselves . . .

'There are about 66 very similar varieties of painkiller, mixtures of aspirin, codeine and paracetamol. When a patient comes and says that the painkiller I gave last month didn't work, what flashes across my mind but the wonder painkiller that the drug rep talked about yesterday?' (GP Pontefract).

Pressure

Drug promotion is not random. The industry spends its money pushing some 12% of the drugs it produces. New drugs, especially the highly competitive ones like contraceptives, have to establish their place in the market. Old drugs whose patent is running out have to be firmly fixed in the doctor's mind so that alternatives will not be prescribed. The more effective drugs don't need to be pushed, they will be prescribed anyway. As the former medical director of Squibb Pharmaceutical put it **'Advertising is called upon to make successes of research failures . . . the problem arises out of the fact that they market so many of their failures.'**

In allowing companies to offset the bulk of advertising costs against profits when negotiating drug prices, the NHS is being made to pay for the intensive pressures put upon doctors to prescribe a particular drug – even though that drug may be identical to a cheaper alternative, or indeed may be more or less ineffective.

At a time when the NHS is being savaged by financial constraints, the cosy relationship between the DHSS and the drug companies ensures an unfettered flow of funds into shareholders' profits.

FIGHTBACK

In 1973 the low pay issue exploded in the NHS. It was the product of decades of resentment among the nurses and ancillary workers who make up the bulk of the NHS workforce. Apart from the doctors, health service workers were trapped by the voluntary traditions that have always been associated with caring for the sick. Added to which, the overwhelming majority of those who work in the health service are women which provided the NHS managers with a further excuse for keeping wages down.

Health service workers would have taken action earlier if it had not been for the particular responsibilities associated with their work. But in 1973, faced with the ravages of inflation, ancillary workers, followed a year later by the nurses, took an unprecedented step. They went on strike for higher wages.

It was the end of an era. The quiescence of those working in the NHS could no longer be taken for granted. The build up to the 1973 strike led to a high level of organisation. People in their thousands joined unions like NUPE, the growth of whose membership symbolised the growing confidence of health service workers.

Although the full demand was not won, for eighteen months the increase plus the 'sliding scale' supplements left the NHS workforce better off than it had ever been.

But there were disadvantages. The strike had been effective because of the lack of experience on both sides, management and the workforce. The willingness of the workforce to take industrial action led to the imposition of new procedures for disputes and negotiation. **At the same time working methods, long known in factories, such as Measured Day Work, were introduced into the hospitals.** The 1974 reorganisation reinforced this process. With wages taking more than 70% of the total expenditure in the NHS, the government and management were determined to keep pay under control.

Cuts

Although the first cuts took place in 1973, it was the expenditure cuts of the 1976 Labour government which were most clearly felt inside the NHS and which quickly led to concentration and closure. The overwhelming feeling inside the NHS was one of disbelief. Harold Wilson issued a series of White Papers 'Back to the Community','Prevention and Health – Everbody's Business' and 'Whose Priorities' which sought to cloud the real effects of the cuts.

The principle of the more equitable distribution of resources was used to legitimate the first major round of cuts in the NHS. Hospital administrators and Area managements, many of whom had helped build the NHS and who would have resisted straight cuts, were provided with an argument justifying the cuts and their consequences.

Closure of hospitals was the first and simplest way that the NHS management could save money. A whole crop of small units – general hospitals, maternity units (in London the projected falling birth rate reinforced the arguments) and so called anomolies like women's hospitals, were closed.

Little account was taken of the level of feeling in the communities affected nor of the people working in the threatened hospitals. But, because of the 'consultation procedure' introduced at the time of the 1974 reorganisation, consultation with those affected was unavoidable. As the closures and partial closures were announced an extensive resistance movement began, the repercussions of which are still being felt.

Work-Ins

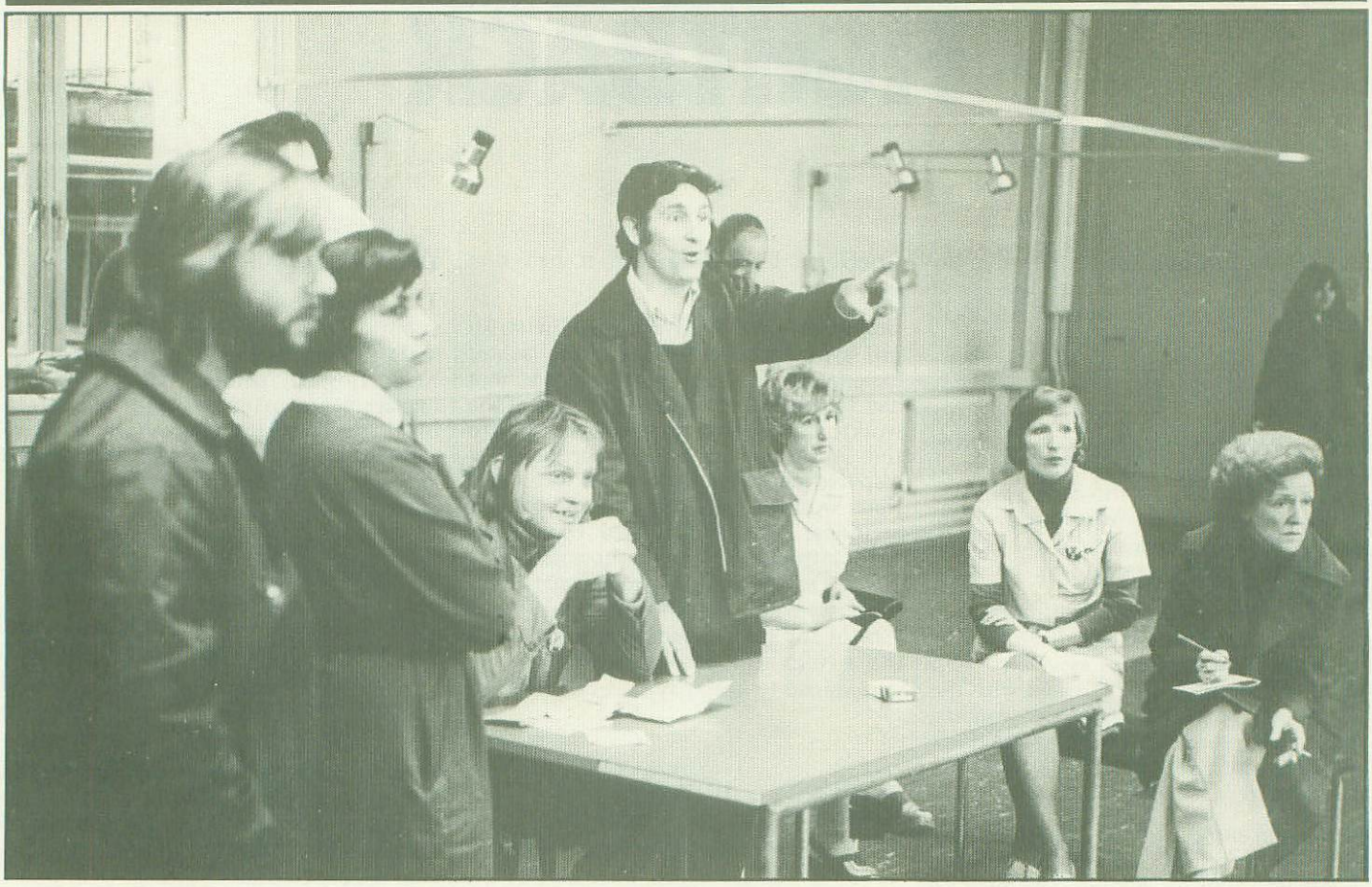
The Elizabeth Garrett Anderson hospital for women was the first work-in in November 1976. Protest at the planned closure of the hospital turned into an occupation by staff and workers and a massive campaign of support to get the decision reversed. Despite the difficulties the hospital was able to function normally for a long time. Many of the doctors were supportive. The principle that patients must be treated no matter who is in management has been the single most important factor in the success of the work-ins.

The EGA occupation was quickly followed by actions in Hounslow Hospital in Middlesex, the Weir Maternity Wandsworth, two wards at South Middlesex and Plaistow Maternity Hospital, (East End), all of which came under workers' management. St Nicks in Plumstead was declared a "protected" hospital by the workers.

The sight of hospitals shrouded in

Closures provoke outrage in the community.

G.M. Cookson (Socialist Challenge)



Laurie Sparham (IFL)

Joint action meeting to fight closure at St Benedict's Tooting.

banners announcing these occupations became a commonplace.

Support from the area affected by the closures and from other workers was crucial for these work-ins. In some areas campaigns were fought with work-ins being threatened but never actually taking place. Other services too were threatened with closure, but as in the case of the Wallsend Ambulance Service in South Tyneside, a broad based campaign delayed closure and eventually led to the decision being reversed. The lessons and experiences spread.

Not all the campaigns were reactions to closure. **The people of Dacorum near Hemel Hempstead, who had been waiting 27 years for a hospital to be built in their area began to feel that despite the promises the chances were fading, and embarked on a sustained and imaginative campaign to get the hospital built.**

1978

1978 had begun with hundreds of campaigns taking place all over the country to defend the NHS and demand adequate health care. Many struggles were waged in isolation, but 1978 also saw the beginnings of co-ordinated activity as the unions took action and organisations like 'Fightback' were set up to link campaigns and work-ins.

Early on in the year the whole NHS was nearly brought to a standstill by a dispute involving the electricians and plumbers. A sustained work-to-rule stopped short of a total stoppage following the intervention of the union leadership. This dispute marked the beginning of what was to become all too familiar to health service workers – vitriolic press campaigns.

The press attacks did their best to hide the positive nature of many of the campaigns such as the one that grew up in 1977/78 to fight staff shortages. Non-replacement of staff, and ill conceived rationalisation programmes, provided NHS administrators with a fairly easy way of making savings. The results were dangerous to patients. 'There should be 11 trained staff in the orthopaedic ward' wrote a staff nurse at the West Middlesex Hospital. 'In fact there are only four. We can't give the patients enough time and care. So they stay in bed too long. This means they risk getting deep vein thrombosis, chest infections, pressure sores or suffer from muscular wastage. Some get severely distressed.'

The complaint was echoed throughout the UK. Staff shortages closed the cancer ward at Northwick Park Hospital, reduced the number of casualty departments open at night in London, and forced Cleveland AHA to call on the Ministry of Defence for anaesthetists. The health union COHSE calculated that the NHS was now short of 70,000 full-time staff.

Work-ins

Closures continued with health authorities shutting what they could get away with. Sometimes when thwarted they would reverse the decision, only to initiate closure proceedings a year later.

But the campaigns continued. Two of the most notable were the Bethnal Green Hospital campaign in East London and that in South Wales.

Bethnal Green is a 300 bed hospital in one of the most unhealthy areas of East London. It has nearly one third of the acute beds in the Tower Hamlets health district. As part of cuts and reorganisation the Hospital was to be used for geriatric patients only. The area clearly needed the hospital as it was, and change of use would mean a geriatric hospital

without the necessary back-up services on site.

Despite the decision to terminate Bethnal Green's activities, doctors, nurses and ancillary staff resisted and kept the hospital operating as normally as possible. Staff shortages led to three wards being shut, but the casualty department staged a work-in and GPs were encouraged to keep referring patients.

On July 14, 1978, the Cynon Valley Action Committee occupied the administrator's offices in Aberdare General Hospital. It lasted 8 weeks and won significant concessions on the reorganisations and closures that had been planned by Mid Glamorgan AHA.

This attempt by the AHA echoed what was also happening in Liverpool and was to happen later in Sheffield, Ealing and Oxford. The opening of a new hospital, in this case in the next valley in Merthyr, led to the announced closure of two local hospitals – Aberdare and Mountain Ash. This was a closely knit working class community with a tradition of fighting for social services and health facilities. Health and other workers, pensioners, NUM and Trades Council representatives and local politicians joined forces to fight the closures.

It was the announcement of closure of the children's beds at Aberdare that led to the action. When support spread into factories and pits in the area, the AHA was forced to reverse the closures, and to meet all but two of the additional demands made by the action committee.

Day of Action, January 1979.

Oxford's aged

In 1977 there had been an occupation in South Oxford to save the local nursery from closure. This had been widely supported but had ended when the local authority had 'vandalised' the nursery building and made its use impossible. Far from disappearing, anger re-emerged when the area management attempted to close down the Longworth and Cowley Road geriatric hospitals.

Closure of these, and many other hospitals, was made easier by the fact that it was no threat to the interests of the powerful medical lobby. In this case another hospital in Oxford, the John Radcliffe would provide the necessary beds for geriatric patients and would no longer involve consultants in time-consuming trips to the old geriatric hospitals. The fact that the two old hospitals were ideal for geriatric patients who lived locally, was ignored. Aged patients would be transferred from ground floor buildings in tranquil grounds to the upper floors of the new high rise hospital in town.

Winter of discontent

'People's expectations were extraordinary, there had been lots of campaigns. Expectations were much higher than they had been in 1973/74, and few imagined there would be any resistance to an all-out strike.' (Ancillary Worker 1980).

Pay throughout the health service had once more become a serious issue. The gains made in 1973/74 and 1975/76 had not been consolidated. The years since reorganisation had seen the introduction of much tighter industrial relations followed by a loss of traditional privileges and the introduction of industrial management techniques.

'After 1975 the tide in our favour began to flow the other way. The NHS was reorganised, the most obvious manifestation of this to ancillary workers was the massive influx of bureaucrats. The whole atmosphere changed when the cuts loomed up . . . for the first time stewards met resistance when they applied for time off . . . now the crackdown started. All the perks and fiddles which were an unspoken part of the wages after 1973 were taken away whenever possible . . .' (West London Hospital Worker).

The wages position was bad. The Labour government's 5% incomes policy spelt bad news for the hospital workers. In addition to the special treatment given to the police, the services, firemen and university teachers by January 1979, a number of other industries with industrial muscle had managed settlements well over the 5%.

Low pay had become such a scandal that the unions with members in the low paid sectors decided to present a united front on the issue. No action was taken until the last group, the ambulance workers, had had their pay demand turned down. A national one day strike of public services was organised for the 22 January 1979. Yet apart from that 'day of action' the lead given by the union leadership was confused. NUPE advised a work to rule and 24 hour stoppages in pursuit of the claim. 'It was a tombola. Hospital workers were left to do what they wanted in pursuit of their wage claim, with little or no guidance from the unions' was how one hospital shop steward put it.

In practical terms this meant little or no concerted action between hospitals. Action was sporadic, and those who did protest were easy targets for the anti-NUPE campaign that built up in the press and on the television.

In the North of England and Scotland things went better. In some instances co-ordinating committees were set up to orchestrate the action, to monitor its effects and to deal with the media. For example in Hull and Stockport strike committees controlled who worked and who picketed. Assisted by 'dispensation' committees the whole function of management was usurped and hospital workers found themselves in strong positions to make demands.

But in many areas, hospital workers were dealing with industrial relations managers who had been trained in industry. By victimisation they were able to provoke all-out strikes. With no national back up, all-out strikes lasted little more than a day before a sense of responsibility and demoralisation set in and hospital workers went back to work. This was a pattern repeated in a number of hospitals. Even at Hull, control by the workers committee was broken by management escalating the action to an all-out strike. Within 24 hours management were back in control.

The necessary co-ordination never came. The unions lacked the conviction for a full controntation with a Labour government, and in April 1979 the four unions accepted the employers' offer.

The struggle had been for a minimum of £60. The settlement left ancillary workers with just under £46 basic rate. The nurses who also had a pay claim outstanding quickly settled for 9%, their claim for special treatment ignored.

Hospital occupations and work-ins spread. St. Georges Hyde Park is occupied.

Mark Kusner [I.F.L.]

Fightback continues

The demoralisation felt by health service workers was followed by a significant exodus of people from hospital jobs. Many of those who had led the fight for unionisation and against the cuts left in despair. And yet in spite of this the anger felt at the effect of the cuts continued.

Although many of the work-ins and campaigns that had begun in 1977 had ended only in postponement of closures or in defeat, these tactics continued. But the lengths to which the area and district health authorities were prepared to go had been illustrated by the violent end to the Hounslow occupation and work-in in 1977.

New work-ins began at St Benedicts Tooting, Princess Mary's Hampton Richmond, Etwall South Derbyshire, The Gables and St Georges in London, Princess Mary Margate and Stoke Mandeville (Roehampton).

East Kent Times.

Administrators force a patient into private car during the raid on Princess Mary, Margate; April 1980.

Cosh Limits

The contingency plans that exist to counter industrial action taken by hospital workers is an indication of the lengths the NHS authorities will go to break the resolve of the workforce. The increased frequency with which the authorites will use violence to end work-ins is another.

The Hounslow raid

On Thursday 26 October 1979, Health Authority officials moved into Hounslow Hospital aided by a private ambulance company, the police, top nursing officers, administrators and consultants.

Twenty one elderly patients were hauled from their beds, pushed out half dressed into the pouring rain and bundled into ambulances and a mini bus. In the process, beds, mattresses, sheets and other furniture in the wards were thrown over the floor and beds smashed. Nurses cried and patients were confused and distressed.

'The patients were not even allowed to put on their dressing gowns. There was no regard for their welfare' (nurse Hounslow).

'The wards looked like a battle ground, with beds dismantled, half eaten food on the floor, a patients case notes lying on top of a locker. The hospital looked like it had been invaded by the gestapo' (Ron Keating, Ass. Gen. Secretary NUPE).

'Old ladies had to queue up for an hour, crying all the time as we remonstrated with the AHA people to cover them against the cold. The nurses went back to the wards and just broke down and cried. They hadn't told me about the move, either as a nurse or a relative of a patient' (Sister Stella Rose).

Etwall – Derbyshire

On 'Black Friday', 21 March 1980, the successful 3½ month work-in at Etwall pre-convalescent Hospital in South Derbyshire was smashed in a raid in which the whole village of Etwall was cut off by a massive police operation lasting five hours.

For two weeks previously, Derbyshire Health Authority had threatened that they would clear the hospital by March 21. They had told local GPs that for every patient they referred to Etwall, they would lose 2 beds elsewhere. They threatened relatives of patients that if they continued to use the hospital then medical cover would cease. They also told staff that if they remained at Etwall, then they would never be employed elsewhere.

But despite the threats and the blackmail, the work-in continued. Ambulance drivers had agreed not to cooperate in the removal of patients, nor to cross the 24 hour picket line.

Area administrators began the raid at 5am in the morning. One hundred and twenty police cordoned off the village and forced the pickets away from the entrance to the hospital. At 10.30 am senior administrators drove 7 ambulances requisitioned the day before into the hospital grounds and the patients were unceremoniously bundled into the vehicles and driven off.

Pr. Mary, Margate

Just three weeks later the work-in at Princess Mary was raided in a similar action. The work-in at the pre-convalescent hospital began in February 1980 in an attempt to stop closure and loss of jobs. On 11 April the management sent out a circular to the London hospitals that normally referred patients to Princess Mary, asking them to stop referring patients. The unions, working jointly (COHSE, NUPE, AUEW, EEPTU and GMWU) countermanded the circular and referrals continued.

The raid in mid April was carried out by District administrators with the assistance of the local police. Twenty of the 52 patients were made to enter a fleet of private cars, and were driven off while the police restrained the staff. Pictures published in the local newspaper showed patients being forced into cars during the raid (*East Kent Times*).

St Benedicts

St Benedicts geriatric hospital was kept open by staff and workers for almost a year following an AHA decision to close it down. Withdrawal of patients was only possible following the intervention of the police to clear pickets and barricades, an action that lasted a week. The AHA hired private ambulances to remove patients after NHS drivers had refused to enter the hospital. Hospital workers warned that the removal and dispersal of geriatric patients was likely to kill some of them. Indeed, in little over a month following their removal, three patients had died.

Many were to end violently soon after the Tories were elected, *see Box.*

Front-line

Despite the resolve of the government to cut health expenditure, the resolve of the workforce to preserve it remains strong. The campaigns continue. Many AHAs have found that resistance and other factors has made implementing a policy of cuts extremely difficult. There is some evidence that the forcible transfer of patients is meeting with less and less support and co-operation among health service administrative staff.

Etwall hospital, the scene of a huge police action to remove patients early in 1980, is according the AHA to be *re*-opened. St Benedicts geriatric hospital, also the scene of a violent raid by AHA officials, still has many patients in residence. St George's Hospital, Hyde Park Corner in London remains closed but the decision to re-open it as a private hospital has had to be delayed because of the political sensitivity of the issue.

The NHS is in the front-line of the Tories attack on public expenditure, but the struggle by patients, health service staff and workers to retain and improve it shows every sign of continuing.

THE NATIONAL HEALTH

Old people have refused to be moved from geriatric hospitals; catering staff have prevented 'economy' meals being served to the sick; and whole hospitals have been kept open by patients, staff, workers and doctors. At the Lord Mayor's Banquet, the Governor of the Bank of England complains, as he has complained since 1975, that government borrowing is too high. The baying of the businessmen and financiers signals approval. Only a stone's throw away, at Bart's hospital, workers have been driven to the point of despair trying to cope with the consequences of policies designed to please the wealthy.

The fight against the cuts in health care continues, while arguments in favour of cuts become more and more absurd, and further and further from people's real needs.

At government level, social need and political priorities are being assessed on economic criteria alone. 'I'm fed up with people talking about social when what they should be talking about is economics', roared one fiscal expert in a radio interview.

The reduction of all social needs and priorities to a set of false economic equations lies at the heart of the Tories' policies. There would be no NHS as we know it if the present economic free-for-all went unchecked.

Which would suit the monetarists of both political parties. 'No matter what you call it, industry must make a profit . . . public spending will be cut and channelled into private hands to encourage investment' (Callaghan, 1976). The scenario is familiar. At any pretext, the needs of working people are pushed aside in order to get private profit back to levels that satisfy the finance and business sector. As a health authority official admonished a group campaigning for a much-needed hospital: 'These people are motivated by considerations other than money'.

The defence of the NHS has to win the argument that economic concerns are not enough, that an economic system based on maximising profit will never provide for social needs. It is a political decision to build missiles rather than hospitals, and it is a political battle to save the NHS.

Politics

The people who work in the NHS will be in the front line of any defence of health care in Britain. Caring for the sick and infirm inevitably involves large numbers of people, and the NHS wage bill represents more than 70% of the total cost of running the service. A health service 'on the cheap' has only been possible because of the low wages paid to most of the workforce, and the dangerous levels of understaffing.

When governments decide on a head-on clash with the workforce, a general attack on the health service is sure to follow. This happened in 1974 and 1979. Not only were large cuts imposed, but the very idea of the right to health care was called into question. If the workforce cannot defend itself, then inevitably health care will be eroded. Under a Tory government ideologically committed to run down the NHS, the task of the unions is even more critical.

Freedom

As part of their attempts to reduce workers' living standards, the Tories have sought to limit the general freedom of trade unionists to organise. In the NHS they have gone even further. A confidential circular issued by the DHSS to health authorities advises them on contingency plans to defeat the workforce. This covers everything from 'the provision of outside telephone lines independant of an exchange' and the use of 'volunteers', through to the use of troops. 'Plans for assistance from the Services are in existence, and were used in the case of the Ambulance Service strike.' (DHSS HC (79) 20).

The right to health care, and everything that goes with it, are under attack. As British capitalism's crisis deepens, the distorted economic ideology of monetarism seeks to turn back the clock. The first things to come under the axe are those that mean a better life and better conditions for working people. Millions of people have patiently paid their taxes and contributions, some over a whole lifetime, for a welfare service to meet their needs. Now they see these services being cut, and in some cases handed over to private enterprise, and all in the name of improved profitability for the direct benefit of a few.

Faith and good works alone cannot save the NHS. Only a united and coordinated stand by trade unionists both inside and outside the NHS, involving those who need the service as well as those who run it, can assure progress in health care.

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