A HEALTHY FUTURE?

The future of Northern Ireland's health service: a reply to the Hayes Report and the Socialist Alternative

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PREFACE

Northern Ireland's health service is in crisis. We have the longest waiting lists in the NHS with over 60,000 now waiting for treatment (a rise of 20% over the last year) and perhaps the longest waiting lists in Europe. The number waiting for over a year for heart operations, or over 18 months for other operations, has risen by 2100 over the last year. The *Sunday Times* has also revealed that another 10,000 people are on undeclared and unofficial waiting lists (24th May 2002). Casualty departments are in chaos on a nightly basis with dozens of patients lying on trolleys waiting for admission to hospital. Northern Ireland is short of 3,000 doctors and over 10,000 nurses. We have fewer heart surgeons and brain surgeons than anywhere else in the NHS.

This crisis has a clear cause. The NHS has been under-funded for decades. The Thatcher and Major years pared spending to the bone. When Tony Blair came to power in 1997, he continued with the Tories' spending plans for the first two years of his government. Since 2000, spending has risen but no real improvements have been seen as the increased finance is being soaked up by the accumulated deficits of the Trusts, or is being diverted into the coffers of the private sector.

The needs of the North's health service are great. Craigavon Area Hospital alone needs £90 million over the next ten years merely to bring its services up to scratch. The Northern Ireland Confederation for Health and Social Services, representing the Boards and Trusts, estimates that the local health service requires an extra £100 million a year for the next ten years to "bring the service up to an acceptable level". Total health spending in 2002-2003 will be £2520 million, an increase of £224 million over 2001-2002. Most of this money will be required just to maintain existing services however, leaving only £46 million for new developments.

Over the last period the situation in Northern Ireland has deteriorated relative to the rest of the NHS. The cutbacks of the late 1980s and 1990s were sharper her and NI's health service is now receiving

£200 million less annually than it should receive. We need proportionally more spending in the North because we have greater levels of poverty. Ill-health is more common amongst the unemployed and the poor. Poverty both causes ill-health and acts as a barrier to receiving good health care.

NI people need 1850 heart operations a year, but only 800 are provided at the Royal Victoria Hospital. If you have a few thousand pounds to spare, however, you can pay for your operation privately and jump the queue. If you cannot come up with the necessary cash you enter a daily lottery. If you are lucky, you will survive until your operation. If you are unlucky, you die on the waiting list. This is the toll of class. Money buys life. Poverty kills.

This is an extreme example, though a very real one. More mundane illnesses carry off many more working-class people prematurely every day. If you are working-class, you are more likely to die of heart or lung disease, in accidents at work, or of almost any sort of cancer, than the middle-class. The estimates vary, but perhaps 22,000 to 100,000 people die prematurely because of their class each year in Britain.

Despite these problems the NHS has been an historic success story. It has delivered a high-quality, free service to everyone. That it has its failings cannot be denied and it is badly in need of resuscitation. Unfortunately the main political parties, the main doctors organisations and health service managers all agree on the solution to the problems in Northern Ireland's health service: implement the Hayes Report. The Hayes Report was drawn up at the request of Health Minister Bairbre de Brun. It recommends the closure of six acute hospitals and the widespread implementation of the Private Finance Initiative (PFI). De Brun has endorsed the Hayes Report in a follow-up document, "Developing Better Services", published in June 2002.

This pamphlet takes up the arguments of the Hayes Report in detail. It is necessary to do so because the assumptions made by Hayes are so widely accepted and are seldom challenged.

Even trade union and community activist, whilst they are uneasy with the message of Hayes, find it difficult to answer the arguments of those who would decimate our health service. To challenge Hayes, it is necessary to go into considerable detail on a number of points and to take up complex argument. This means that this pamphlet is, of necessity, difficult reading in places, although every attempt has been made to present its ideas as clearly as possible. It is hoped that community, health and trade union activists will persevere and study its arguments and conclusions.

If we cannot counter the ideas contained in the Hayes Report, we will ultimately be forced to adopt the position of the main parties, who can only conceive of defending one hospital by effectively calling for the closure of another.

This pamphlet focuses on our acute hospital services. This does not meant that primary care (services provided by General Practitioners, District Nurses and associated staff) or community care is not important. Rather, the pamphlet focuses on the acute sector because this is the area which the Hayes Report has reviewed. Of course, it is not possible to consider the hospital sector in isolation from other services. A genuine national health service must be comprehensive and all-embracing. It must endeavour to keep people out of hospital, not just treat them well when they are admitted.

To seriously challenge the Hayes Report, we must pick apart its conclusions but we must also question the whole basis of a society that forces us to struggle to maintain such basic services as a decent local hospital. And, ultimately, any serious consideration of the future of our health service forces us to ask the question: is this a sick society? Why can we not provide a quality health service for all? Is the way that society is organised causing ill-health? And ultimately should we not seek a fairer way to distribute wealth, and to ensure better health for all?

INTRODUCTION

In August 2000 Bairbre de Brun announced the establishment of the Acute Hospitals Review Group. It reported in June 2001. Its remit was to plan a way forward for NI's hospital service. The unspoken assumption was that it would once and for all decide on the future of the North's smaller, rural hospitals.

This pamphlet is not an attempt to dissect every line and paragraph of what has become known as the Hayes Report (after the chairman of the Group, Maurice Hayes). Rather it is a reply to the key ideas that underlie the approach of Hayes. It is an argument against unnecessary centralisation of services and against the on-going privatisation of the NHS. It is an argument in favour of democratic accountability in our health service, of increased funding, of adequate resources for both hospital and community services, of a fair deal for all NHS staff and of a real attempt to tackle health inequalities. The pamphlet borrows freely from the work of others, in particular the arguments of Professor Allyson Pollock who has written extensively in opposition to the Private Finance Initiative, from Julian Tudor Hart, a veteran GP and socialist activist from South Wales and from the publications of the Socialist Health Association.

Hayes argues that the Acute Services Review is all about improving services. Throughout the Report however, there is an acknowledgement of the financial background to the Group's work. There are many examples:

> "there continues to be significant pressure on the resources available" (page 19).
>
> "our proposals for the future.... must be affordable within the resources likely to be available. While undoubtedly there is a need for a substantial injection of funding, it is of even greater importance that existing resources are used as effectively as possible" (page 25).
>
> "It would be ... unwise to ignore the extent to which problems of under-funding may be compounded by not making best use of existing resources" (page 29).
>
> "to plan solely on the basis of a substantial increase in funding..... would not in our view be prudent" (page 34).

The bottom line is that the Hayes Report is finance driven. The question of "limited resources" is primary, from it flows all else. The "solution" is constructed to fit predetermined financial constraints. Maurice Hayes and his co-thinkers argue that change is inevitable, as indeed it is, but then falsely claim that the way forward they propose is based on good evidence and is the only real alternative. This is simply not the case.

Certain assumptions underlie the arguments of the Hayes Report, assumptions that are leading in the direction of hospital centralisation and privatisation across the NHS and across Europe. These assumptions can be summarised as follows:

1. Demand for health services is infinite and can never be met.
2. Resources are limited and will never suffice.
3. As a result of the above change is inevitable.
4. Change means increased centralisation (with the closure of smaller hospitals) as larger hospitals are both safer and more cost effective.
5. Change means increased privatisation as the private sector is more efficient and cost effective, and can inject resources which are not available to the public sector.

These are assumptions and they can be challenged. An editorial in the British Medical Journal,

written to accompany a series of articles on the future of acute hospital services, makes the point succinctly: "Distressingly little evidence is available on the best way to configure services" (British Medical Journal (BMJ) 1999:319:798).

And as for the argument that larger hospitals with greater numbers of cases allow doctors to become more adept at certain procedures, the same editorial states: "quantity and quality do seem to go together for some surgical operations, but not all - and evidence is much thinner on medical care".

The case for larger hospitals isn't even watertight when cost is considered. "There is virtually no evidence on costs, but nobody should assume that hospital mergers mean reduced costs. Indeed, bigger hospitals may mean higher costs for medical patients".

We will consider these issues in detail through the rest of this pamphlet. Chapter One outlines and counters some of the main conclusions of Hayes. Chapter Two examines specifically the widely held view that bigger hospitals are “better” than smaller hospitals. Chapter Three considers the implications of New Labour’s decision to implement the PFI throughout the NHS. Chapter Four looks at the economic and social background to attacks on the NHS and the entire Welfare State. In Chapter Five we explore New Labour’s record to date and in Chapter Six, we outline the way forward and propose alternatives to Hayes.

CHAPTER ONE

THE HAYES REPORT DISSECTED

Introduction

The situation Hayes found when he toured the North speaks for itself. "Many buildings were in poor condition and badly maintained. Morale was universally low - people felt isolated, under stress and undervalued. We were told repeatedly that hospital services had been cut to the bone, and that successive cuts had resulted in a lack of elasticity. Hospitals which operated to nearly full capacity were unable to cope with sudden surges in demand, pressures which had previously only been experienced in the winter months were now apparent throughout the year, and patients, especially elderly patients, were waiting unreasonably, in some cases impossibly long times for elective treatments which would transform the quality of their lives". Despite these finding the Hayes Report proposes further cutbacks.

If the Report is implemented Northern Ireland's health service will look very different ten years from now. Services will be concentrated in only nine acute units adding to the distress and inconvenience of patients and relatives as travel times increase. At least 500 more acute beds will have disappeared - Hayes recommends a cut of 500 but allows for a cut of up to 1200 if certain requirements are met. In addition the widespread implementation of the Private Finance Initiative in a new hospital building programme will put further downward pressure on bed numbers.

In 1981 there were 24 acute hospitals in Northern Ireland. Nine have since closed, and now there are fifteen. A number of the closures have occurred since 1995 - Ards (services switched to the Ulster at Dundonald), the Route (services switched to the new Coleraine hospital), and Banbridge and the South Tyrone (services now based in Craigavon). Of the very smallest hospitals (less than 125 beds) only three are left - Lagan Valley, the Downe and Whiteabbey. New hospitals have replaced some of those that closed but the overall effect has been a reduction in total acute bed numbers of 1400 (or 21% of the total) since 1990/1991.

The Hayes Report proposes the closure of six of the fifteen remaining acute hospitals. There will no longer be emergency care or maternity services available in the Tyrone County in Omagh, the Mid-Ulster in Magherafelt, the Downe in Downpatrick, or in Whiteabbey, the Lagan Valley and the Mater in the greater Belfast area. The South Tyrone in Dungannon was recently "temporarily" closed in salami slices, but according to Hayes has now gone forever. New hospitals are proposed, to be financed through PFI, and with fewer beds.

Hayes also proposes a new organisational structure. Reducing unnecessary "bureaucracy" is of course necessary but it is probable that the result will actually be the loss of 1000 low paid and very necessary administrative jobs and an increased burden on those who are left. Senior managers are likely to be redeployed or to receive handsome payoffs. Importantly the new structures will not be any more democratic.

Inadequate Funding

The health service in NI has been severely financially strapped in recent years. The combined deficit of all the Trusts in 1998/99 was £6.8 million and in 1999/00 it was £15.6 million. In early 2001 the Assembly cleared the accumulated deficits and a stringent austerity programme was implemented by Bairbre de Brun's department. In one Trust area, for example, one hour of home help service could only be arranged if three hours were first stopped. Many Trusts stopped filling vacancies. Despite these cutbacks deficits began to rapidly accumulate again.

Over the three years to 2005 NHS funding in the North will increase by approximately £225 million but this will have little impact on the delivery of front-line services. It will be eaten up by accumulated deficits in day to day funding and by the need for essential investment in our crumbling infrastructure. An estimated £200 - £250 million is required just to carry out essential maintenance across the North.

Hayes admits that planned increases "will not be enough to keep pace with the higher demands for services from an increasingly elderly population, and increases in costs in areas such as staff salaries, drugs, goods and services, let alone any improvement to service provision". The expected savings from the proposed organisational changes in the Hayes Report amount to only £10-£15 million per year.

The NHS as a whole has been under-funded for decades. According to one authority, the NHS has lost out to the tune of an incredible £267 billion since the early 1970s, when compared to the European average. Historically, Northern Ireland has had a higher level of NHS funding than England but the gap has been closing now for many years. Between 1970 and 1984 for example, real expenditure increased by 7.5% in NI compared to a 11% increase in England. In contrast "productivity" or throughput increased by 30% in NI, significantly more than the 22% rise in England.

In the late 1970s a Treasury Committee examined the need for health care expenditure across the NHS. A majority of the committee concluded that Scotland required 7% more funding than England, Wales 6% more and NI 7% more. A minority felt that these calculations were too conservative and expressed an alternative view. They argued that Scotland actually required 18% more funding than England, Wales 12% more and NI a whopping 22% more. In the late 1990's Scotland actually received 25% more per head of the population than England, Wales 18% more but Northern Ireland only 5% more.

The arguments of the late 1970s still hold. NI requires greater funding for a number of reasons. Our population is more sparsely distributed, with higher mortality rates and morbidity (or sickness rate) and a higher birth rate. (Northern Ireland's place in mortality and morbidity tables has changed a little in recent years. There is more premature death and ill-health than in most English regions but less now than there is in Scotland and Northern England.) There is a greater level of economic deprivation (as assessed by the level of income, total and long-term unemployment, household size and condition) than in most of England, Scotland and Wales. Our population profile is also different with more young children. And of course the threat of shootings, bombings or riots has not gone away. This does not mean, of course, that NHS funding in England is adequate; rather, funding is even more inadequate in Northern Ireland.

The Hayes Report compares current funding levels locally with other NHS regions and with the South. (No attempt is made to compare with other European countries where funding is at a much higher level.) The figures demonstrate that the situation continues to deteriorate. In 1996/97 expenditure per head of the population in NI was similar to the level in the North East of England but 8% lower than in Scotland. By 1999/00 a gap of 5% had opened up with the North East and the gap with Scotland had widened to 13%.

In the year 2003/04 NI will be spending £141 million less than would be the case if spending was set at the levels of North East of England and £214 million less than the comparable Scottish figure. By then spending will be £737 per head of the population in NI, £819 per head in the North East of England and £861 per head in Scotland.

By 2009/10 expenditure will be £1052 per head of population in the North, £1207 per head in the North East and £1260 per head in Scotland. NI would then need an extra £273 million to reach the

North East's levels of expenditure and £366 million to match Scotland. Increasing our health service funding to the average EU level now would give us an immediate boost of £200 million. As can be seen from Table 1 the NHS as a whole is presently far below the average EU level of healthcare spending and has many fewer beds. The bottom line is that our health service is grossly under-funded. The Hayes Report can only be analysed within this context. It is an attempt to fit a service into pre-determined financial constraints.

Table 1

	Britain	**France**	**Holland**	**Germany**	**Italy**
Health Spending as % of GDP	6.8	9.4	8.7	10.3	8.2
Hospital Beds per 1000 of population	4.7	8.9	11.3	9.7	6.4

How Many Maternity Hospitals?

For five years fierce arguments have raged over the future of maternity services in Belfast and across the North. In Belfast the pendulum has swung alternately in favour of the Royal Maternity and then the Jubilee. Now Bairbre de Brun has come down in favour of the Royal and the Jubilee has been closed and demolished.

Everyone who took a side in this fractious debate gave the impression that they had considered the medical evidence with great care. Confusingly this included the senior medical staff from each site, who of course drew opposite conclusions. Given this which side was right? The answer is that the Royal is probably the best place to site a regional (covering all of Northern Ireland) unit for very ill babies. However, it does not follow that the Jubilee should have closed. We should not accept sterile arguments that one unit can only remain open if another closes.

The Hayes Report is suggesting the closure of several more maternity units. It is now time to call a halt to this process. As well as the Jubilee a dozen other maternity units have closed across the North in recent years. The trend towards larger units has some justification in terms of safety, but it tends to take obstetric care further and further away from local communities. In addition there is evidence that larger units become more heavily reliant on technology and medical intervention such as caesarean sections. Already the North has a higher rate of medical intervention, such as caesarean sections, during childbirth than any other NHS region (the Ulster Hospital in Dundonald has a higher rate than any other hospital in the NHS). Dissenting voices have been raised, including from a minority of consultant obstetricians (mostly women) and it is about time we had a full and open debate on the extent to which we wish to medicalise childbirth.

Both the Royal Maternity Hospital and the Jubilee could have remained open, the Royal as a regional centre for very sick babies and the Jubilee as a maternity hospital for the area it traditionally serves in Belfast who are not ill. All our existing maternity hospitals should remain open, with increased priority given to the wishes of mothers and with an increased role for midwives.

Are There Enough Beds?

Northern Ireland's health service has already seen a huge amount of change over the last two decades. To illustrate this point it is worth considering the area covered by the Northern Board (most of County Antrim, much of County Derry and some of East Tyrone), in detail. The Moyle in Larne, the Waveney in Ballymena and the Masserene in Antrim closed when the new Antrim Area

Hospital opened in the early 1990s. Similarly the Route Hospital in Ballymoney and the old Coleraine Hospital were replaced by the new Coleraine Hospital in 2001. Other smaller units, which once provided extensive services, such as the Ballycastle Hospital, have long since closed.

New hospitals were certainly required but unfortunately each time an old hospital closed and a new one opened the total number of in-patient beds was reduced. It is now widely acknowledged that the Antrim Area and Coleraine Hospitals are under severe pressure and often cannot find beds for those who need them. If the Hayes Report is implemented Whiteabbey Hospital and the Mid-Ulster Hospital in Magherafelt will close as acute hospitals and the Antrim Area Hospital will expand its capacity. The number of new beds in Antrim will not equal the number that close and total capacity in the area will fall. Health economists and planners argue that centralisation and new technology increase "efficiency" and fewer beds are thus required. There are simply too few beds now however, and the implementation of the Hayes Report will place even greater pressure on beds. The fine words and carefully honed arguments of economists are of little comfort to those who lie on trolleys for hours awaiting admission or whose operations are cancelled because a bed is not available.

The savage cutbacks of the last two decades have lead to increasing problems for the health service with every year. Every doctor and nurse feels under pressure every day of the year. Seldom do they feel that they have enough beds at their disposal. Admissions are postponed and patients spend hours in pain and distress waiting for a bed (this is also distressing for staff, of course). What used to be an annual winter crisis in the NHS is now a year round phenomenon.

Over the years bed occupancy rates (the percentage of beds with someone in them at any one time) have risen steadily. Rates at or near 100% are now the norm. To a particular type of manager an empty bed is an abomination, an indicator of inefficiency. They see hospitals in much the same way as they see supermarkets. An empty supermarket shelf isn't earning, isn't contributing to profit. It must be filled. Similarly an empty hospital bed must be filled immediately, or alternatively closed, all in the interests of efficiency.

There are major problems with this approach. It is best to always have a number of empty beds, if possible, as this allows a hospital to cope with a sudden influx of patients. Running at, or close to, 100% occupancy means that there is a crisis every week if not every day. Running at less that 100% occupancy is in fact efficient, not inefficient. And moreover, it is more humane and sympathetic. A hospital that is efficient in the eyes of its managers will not be efficient in your eyes if it can't provide you with the bed you need when you are ill.

There is overwhelming evidence that there are not enough beds in Northern Ireland as things stand. Northern Ireland has 2.8 acute beds per 1000/population compared to 2.4 in England, 3.1 in Scotland, 3.3 in Wales and 3.3 in the South. As a result waiting lists are much longer locally. There are 28 people on a waiting list for every 1000 people in Northern Ireland compared to 20.7 in England, 16.1 in Scotland and 27.2 in Wales. The numbers of those waiting for more than 12 months is 5.62 per 1000 in Northern Ireland but only 3.85 per 1000 in Wales, 0.97 per 1000 in England and 0.23 per 1000 in Scotland.

Staff have already made heroic efforts to cope with fewer beds. Between 1990 and 2000 there was an increase of 25% in the number of patients treated in Northern Ireland hospitals and average lengths of stay in hospital fell by 31%. Despite this, and our long and lengthening waiting lists, the Report concludes that "Northern Ireland does not need more acute beds". As can be seen, the opposite is the case. We need more acute beds.

Is Demand Higher in Northern Ireland?

Hayes makes much of the argument that demand for health services is higher in Northern Ireland than in other regions of the NHS and the South. The implication is that at least some of this demand does not reflect real need, is unnecessary and can be reduced.

The argument partly rests on the fact that waiting lists are longer in Northern Ireland. Over 60,000 people were waiting for elective (planned) treatment in the autumn of 2002 compared to 36,000 in March 1996. The number waiting for eighteen months or more increased from 632 in March 1996 to 5200 in March 2001. There are similar long waiting lists for outpatient appointments with 102,000 in the queue in March 2001 against 59,000 in March 1996. The number waiting for more than six months increased from 7300 to 26,700 over the same period.

It is perverse to use these figures to argue that demand is excessive locally. Waiting lists are more a measure of the extent to which services are deficient than they are a measure of demand for services.

Emergency and non-emergency admission rates are higher in Northern Ireland compared to the rest of the NHS. Once patients are admitted however they are not significantly more likely to have an operation (there are only 3% more operations per head of the population carried out in the North, when compared to England). Perhaps patients are more likely to be admitted here because of social deprivation or because of geographical distance from hospital. Once admitted they are treated well and not subject to unnecessary operations simply because they are there. Perhaps there are too few admissions in England and patients are too often left to suffer at home.

Rather than admissions being unnecessary, need may simply be higher locally, for a host of reasons. The figures are also distorted by the fact that the private medical industry is much larger in England and carries out a larger proportion of elective (or planned) operations. It is thus possible that there are in fact more operations per head of the population in England than in the North, especially in the more affluent areas, though need may be less.

Demand may appear to be higher in Northern Ireland at the present time for another reason. The number of elective (planned) admissions fell in Northern Ireland in 1996/97 due to a sharp 3% cut back in spending in that year. The slightly higher figures for Northern Ireland in 1999/00 may thus simply be a "catching up" blip in the statistics as surgeons struggle to get on top of their workload.

The Report concludes that "expected demand" in Northern Ireland in 2013 could theoretically be dealt with in between 3300 and 4100 acute beds. This represents a reduction to the current acute bed complement of between 400 and 1200 beds (the actual figure would depend on the rate of emergency work at the time).

These figures are arrived at by assuming that in the future "levels of efficiency" in Northern Ireland will dovetail with those of England. The measures of efficiency utilised are average length of stay in hospital, the percentage of procedures carried out on a day care basis (with no overnight stay in hospital) and percentage bed occupancy (the average percentage of beds actually occupied by a patient). The problem with using these figures are legion.

At present the average length of stay in Northern Ireland is 5.8 days compared to 5.3 in England. The percentage of operations carried out on a day patient basis is 62.6% in Northern Ireland compared to 66.2% in England. Average annual bed occupancy is 80.5% in Northern Ireland, 81.1% in England. It can be argued that lengths of stay in England are too short already (leading to a high rate of re-admission when something goes wrong after admission) and bed occupancy rates are too high (leading to recurring bed crises and some well-documented cases of actual deaths). Thus a convincing case could be made that England should aim towards our “efficiency” levels, rather than the opposite.

In any case if demand is higher locally are these targets achievable? If England reaches "higher" levels of efficiency by siphoning off much elective work to the private sector is this in the mind of Hayes and his co-thinkers? Do they expect private medicine to grow locally? Will private medicine be encouraged to grow locally?

Ultimately arguments about “high” and “unnecessary” demand on the NHS are patronising and a form of class discrimination. The well-off are “entitled” to whatever health care they wish, if they pay for it privately. No-one – not politicians, senior doctors or commentators – argues that they should not received unnecessary care. If they have the cash, they can have the care. The less well-off, however, are a different matter. They ought to moderate their demands and to accept that the NHS cannot provide everything.

Alternatives to hospital

It is often argued that large numbers of admissions to medical or surgical wards are unnecessary or, in the jargon of the NHS, "inappropriate". If we could only prevent these inappropriate admissions then there would be no crisis. Several studies have examined this issue and contrary to expectations few found evidence for huge numbers of inappropriate admissions.

In the most damming study, the author (Coast) found that 22% of admissions were designated as inappropriate in a rural area and 24% in an urban area (BMJ 1996;312:162-166 and Journal of Epidemiology and Community Health 1995;49:194-199). A second study (Victor) found an inappropriate admission rate of less than 1% (Journal of Public Health Medicine 1994;16:286-290).

Even if we accept that there are significant numbers of “inappropriate” admissions, given the increasing pressures on the system one would expect fewer, not more, as time goes by. The term "inappropriate" is value laden in any case. Its definition varies from study to study and what may be "inappropriate" to the health economist may not be to the patient or the patient's doctor, nurse or family. It is also a term that is likely to be applied more to the poor than the well off. The middle classes are more articulate in their demands on the NHS and are less likely to be labelled. The poor may well be in hospital not just because they are ill but because their housing is poor and they have little support at home. Is this appropriate?

There certainly is ample evidence that patients sometimes spend too long in hospital. This is often due to failings in other parts of the system with a lack of necessary home care and support. Often the problem is not one of too many admissions to hospital but one of too few places in the community to which patients can be discharged. It is also the case that the further away patients are from home the harder it is to discharge them - another argument against centralisation. Over the last decades society has become more and more atomised and the sick and elderly cannot rely on family support to the extent to which they once did. This is a factor in delaying discharge from hospital.

In contrast to the above situation, many patients are discharged prematurely from hospital, before they feel up to going home and before their doctors or nurses wish them to go, because of a shortage of beds.
Hayes places considerable emphasis on the ability of day surgery (when one arrives in and leaves hospital on the same day as an operation) to reduce future demand for hospital beds. Whilst there is some truth in this, and day surgery has expanded greatly in recent years (in 1985 17.7% of all admissions in England were treated as day cases; in 2000 the proportion was 38.9%) there is evidence that these operations often represent new work and are not an alternative to traditional inpatient care. Thus increased numbers of day case procedures in Northern Ireland in the future will not reduce demand for hospital beds by as much as Hayes assumes.

Hayes assumes a future bed occupancy rate of 95%. This figure is too high. It will not allow for the flexibility a responsive health service must have. As one author puts it: "As for planning levels of bed occupancy, there is a failure to appreciate that planning for a mean occupancy of 90% guarantees that hospitals will have insufficient numbers of beds on a substantial number of occasions because of the inevitable variations in daily admissions. Furthermore, it is often not appreciated that reduction in length of stay often require lower occupancy rates to retain sufficient flexibility to deal with random fluctuations in demand" (BMJ 1999;319:1361-1363).

In summary, Hayes cannot demonstrate that his proposals will significantly reduce demand for acute beds, nor can it be conclusively shown that large numbers of hospital admissions are unnecessary.

A Lack of Real Planning

Official documents and expensive reports are always couched in terms that suggest the experts know best, that they have studied the evidence carefully and that the way forward is clear. The reality is somewhat different. At a conference convened by the Anglia and Oxford region of the NHS to consider the future of acute hospitals in 1999 the participants agreed that the driving force behind change ought to be a desire to improve the quality of care but was in fact "the need to reduce costs and cope with staffing problems, new technology, and public expectations" (BMJ 1999:319:797-8). Planning for the future is based on a response to financial stringency. And when previous hospital closures have occurred "it is rare for the results of hospital reconfiguration to be evaluated" (BMJ 1999;319:1361-1363).

A similar process is evident in the Hayes Report - it is not proactive and forward thinking but reactive and restricted in its thinking by perceived wisdom concerning the value of smaller hospitals.

Today evidence-based medicine is the watchword - doctors and other health workers are expected to study research findings and then to implement them. In contrast, evidence-based management and planning are nowhere in sight. And planning appears to go out the window almost entirely when Private Finance Initiative (PFI) schemes are planned. As one author has argued: "The quality of PFI planning conflicts with governmental initiatives to improve the evidence base and standards and quality of clinical practice. PFI plans seem to have been absolved from these duties" (BMJ 1999;319:179-184).

Honest health economists (usually writing in professional journals rather than in the local paper) make interesting reading. One admits that financial pressures are often the real reason for hospital closures, but that it is difficult to be open about this. "The paradox of planning hospital changes is that the financial pressure that frequently provides the impetus for reform is often the very factor that is a barrier to implementation. It is difficult to convince an already sceptical public of the need for change if the reasons for it are purely financial" (BMJ 1999;319:1262-1264). The solution is to disguise the real reasons for hospital closure. "The planning process has effectively been reversed, with services being designed to fit predetermined reductions in capacity. The high costs of the PFI entail major reduction in service provision, acute bed capacity, and clinical staffing. Justifying these reductions, it would seem, has become the main planning task"(BMJ 1999;319:179-184).

Contrary to what the Hayes Report argues there is no consensus on the best way forward, and no evidence that centralisation should be pursued. "A difficulty for planners is the lack of clear consensus on how to undertake many important parts of the planning process. There is no agreed method for calculating even such basic building blocks as the demand for hospital care, the impact

of ageing, the length of stay, or day care rates. Public health departments may have undertaken needs assessment but no calculus exists to convert this into even simple measures to permit hospital planning. Attempts to set nominative targets have failed because they are not grounded in science and are not sufficiently flexible. Many of the methods used in these forecasts are poor and are often not updated between the initial plan and the eventual implementation" (BMJ 1999;319:1262-1264).

According to Nigel Edwards of the NHS Confederation and Anthony Harrison of the Kings Fund "Analysis of trust business cases for rebuilding and other developments.....show wide variations in the assumptions made about almost every aspect of future hospital provision. Despite the apparently increasing difficulty in meeting growing demand for hospital care many hospital plans envisage substantial reductions in the number of beds, and hospitals with large private finance initiative schemes expect reductions of 20-30%. But whether these can be justified in terms of either future demand or levels of performance is unclear" (BMJ 1999;319:1361-1363).

Cross–border Co-operation

Hayes makes the not unreasonable point that the health service in Northern Ireland and the health service in the South should co-operate as far as is possible in order to enhance care for patients on both sides of the border. This point has been seized upon by both Sinn Fein and the SDLP who argue that such North-South links have the potential to make a significant difference to health care. This claim is more a reflection of their interests in promoting an all-Ireland agenda than anything else. In a similar vein, John Dallat of the SDLP does not oppose privatisation of the post office in NI but instead argues that postal services should be considered on an all-Ireland basis. The logic of this position is that all-Ireland institutions are of necessity "good", whether or not they are public or private. Presumably it would be reasonable to sack postal workers and reduce rural services so long as the remnants of the Royal Mail linked up with An Phoist and the letter boxes were painted green.

The bottom line is that both health care systems are cash-strapped. Neither can "save" the other. Integrating the two services will achieve little.

In recent years nationalists and republicans have argued that the North can only benefit economically from linking up with the South and that the so-called Celtic Tiger will lift the Northern economy and transform all our futures. This argument is false. At the present time the Southern economy is rapidly weakening. The Celtic Tiger left a huge section of the population of the South behind, trapped in poverty and exploitation. As the world recession unfolds job losses are mounting. Tax revenues have recently fallen by 2% when an 8.6% rise was expected (Irish Times, April 4th 2002). Government spending rose by 20% over the same period. The southern economy, and still less the Southern health service, are not going to come riding to our rescue. On the basis of capitalism there will always be too little to go around and both health services will always be under pressure, if not in outright crisis. On the contrary, under socialism an integrated health care system would be natural and mutually beneficial.

There has been major investment in the southern health service in recent years (spending is up 60% from 4 years ago) and health spending is now proportionally higher that in the HNS – indeed it is approaching the European average. The starting base was very low however as the southern service had been starved of adequate resources for decades. Despite the recent increases in spending, the main hospitals expect to be in deficit by the end of the year and major cutbacks are taking place across the South.

Healthcare remains inferior in the South when compared to the NHS. Life expectancy is significantly shorter. The South has fewer GPs (0.45 per 1000 of the population) compared to the North (0.63 per 1000 of the population). There are also fewer consultants in the South (0.33 per 1000 compared to 0.46 per 1000 in the North) and fewer nurses and midwives (7.9 per 1000

compared to 8.7 in the North). The dissatisfaction of staff with poor wages and being taken for granted has made itself apparent in a numbers of strikes in recent years. Two years ago nurses across the service went on strike and in 2002 Accident and Emergency nurses and staff in day-care facilities for handicapped took action.

The South does have more acute beds (3.3 per 1000 population) compared to the North (2.8), England (2.4) and Scotland (3.1) and has an equal number with Wales (3.3). These figures are for public beds only – there are many more private beds in the South and the total acute bed supply is likely to be significantly higher.

The Southern health system is a peculiar, and very unequal, mix of public and private. There is absolutely no doubt that public care is inferior to private and the public hospitals have been under increasing pressure in recent years. An average fee of £25 is paid when someone sees a GP.

Conclusion

We can clearly state that the conclusions of the Hayes Report are not supported by the evidence. The proposals contained within the Report are driven largely by financial considerations. We will now consider two of the claims of Hayes – the argument that centralisation is vital for reasons of safety and efficiency, and that the private sector will rescue the NHS – in more detail in Chapters Two and Three.

CHAPTER TWO

CENTRALISATION OF SERVICES - IS IT JUSTIFIED?

Introduction

The centralisation of hospital services is an international phenomenon. "Hospitals in all systems have to deal with rising expectations and, more often that not, a need to contain the costs of health care. Outside the developing countries the generic response to this has been to reduce hospital stays and to improve the efficiency of the system, a strategy which seems to be a least partly successful. The experience of the health systems in the United States and the United Kingdom shows that cost pressures and changes in health care delivery mean that this strategy will lead to hospital mergers and closures in the longer term" (BMJ 1999;319:845-8).

The NHS already has fewer acute beds per head of the population, and patients have a shorter average length of stay in hospital, than in 20 other OECD countries (1995 figures -see Table 2).

Table 2

	No of acute beds per 1000 population (1995)	**Average length of stay in days (1995)**
Australia	**4.3**	**6.7**
Austria	**6.6**	**7.9**
Belgium	**4.8**	**7.8**
France	**4.6**	**5.9**
Germany	**6.9**	**11.4**
Ireland	**3.4**	**6.7**
Italy	**5.3**	**8.8**
UK	**2.2**	**4.8**
USA	**3.3**	**6.5**

Source BMJ 1999;319:845-848

Between 1978 and 1990-91 506 small hospitals closed in England. The majority of these had less than 250 beds. With the introduction of Trust hospitals in 1991 the Department of Health stopped collecting data on the total number of hospitals, though bed numbers are still collated, so we do not know how many more hospitals have closed in the last decade. Overall two-fifths of the total bed stock closed between 1982 and 1994-95. A quarter of acute beds closed (Table 3). Since 1995 the rate of bed closure has slowed and in 2001 numbers actually rose by a few hundred in the aftermath of the then Health Minister David Blunkett's admission that be closures had gone too far. Overall, however, a further 13,000 beds have closed since New Labour came to power.

Table 3 Changes in numbers of NHS beds in England 1982 to 1994-95

Year	**All Specialties**	**Acute Care**	**Geriatrics**	**Mental Illness**	**Mental Handicap**	**Maternity Care**
1982	**348104**	**143535**	**55646**	**83831**	**46983**	**18108**
1994-95	**211812**	**108008**	**36795**	**41827**	**13211**	**11971**
% change	**-39**	**-25**	**-34**	**-50**	**-72**	**-34**

Source: BMJ 1999;319:911-914

The total number of beds per 1000 population in England has fallen from 7.4 to 3.9 over the period in Table 3. The number of acute beds has fallen from 3.1 to 2.2 per 1000. At the same time as the number of beds has been falling the amount of work has been increasing sharply, though there is

some controversy as to what extent the NHS workload has actually increased.

Are More Patients Being Treated?

The official figures demonstrate a two-thirds increase in the total number of patients treated in the NHS in England between 1982 and 1995. The throughput rate (cases per bed) increased by 81% for acute beds between 1982 and 1995. These figures are not entirely accurate, however.

The introduction of the values of the market put the onus on NHS managers to prove that their hospitals were increasing "throughput". Consequently procedures that had previously not been included in returns to the NHS Executive were included and one stay in hospital became several "episodes" of care if a patient was moved between different wards or between different consultants.

The increased throughput figures are probably thus a combination of three things: a real, and unquantifiable, increase in activity; the counting of what was previously not counted - a false increase; and double-counting and various other slights of hand - straightforward cooking the books. Despite these caveats it is important to note that there has been a real increase in NHS capacity, because of new technology and new approaches, despite the decrease in bed numbers. It does not necessarily follow that some beds could have been safely closed. Instead, the same number of beds should have been maintained, thus allowing greater flexibility in the system and the ability to treat previously neglected illnesses.

The average length of stay in hospital has been declining since the birth of the NHS. Between 1982 and 1994 the number of acute beds fell by 2.6% per year whilst the average length of stay fell by 3.1% per year. This is largely a good thing - no-one wants to remain in hospital unnecessarily - but everyone has a relative or friend who did not feel well enough to be discharged but were nevertheless asked to leave. The average length of stay cannot fall forever (eventually it would reach zero) and the argument that it is already too short is supported by evidence of increasing rates of re-admission after discharges (when patients relapse and need to return to hospital).

Outpatient attendances in the NHS increased from 35.6 million in 1992 to 41.6 million in 1997-98, an increase of 16.8%. Some of this increase at least, will be accounted for by the "more efficient" counting of cases already outlined. Total casualty (accident and emergency) department attendances have not increased, fluctuating around a mean of 13.6 million over the last 20 years. Despite this a report in October 2001 described casualty services as being in crisis across the NHS and in the same month Belfast City Hospital nurses threatened to walk out when their department ground to a halt as dozens of patients were lying on trolleys because no beds were available.

There is evidence that whilst we are not significantly more likely to attend an outpatient department or a casualty department than we were in 1982, we are more likely to be admitted to hospital. Just why this is, is not clear. The introduction of new technology and new interventions must play some role - there are now treatments available for certain conditions were before there were none.

Overall those figures do not bear out the argument that the NHS is in difficulty largely because of an overwhelming tide of spurious demand. Could it just be that any increase in demand has been entirely manageable, any difficulties are a result of cutbacks?

Hayes utilises the fact that Northern Ireland has more acute beds per head of the population than England to argue that we have "too many" beds. Given that almost everyone, including the New Labour government, now accepts that bed closures in England have gone too far it is more logical to argue that we have too few beds, and that England is in an even worse situation. When David

Blunkett accepted that bed closures had to stop and that bed numbers should in fact increase slightly (by 3000) he could do no other, given the weight of evidence. His pledges mean little in the context of the implementation of the Private Finance Initiative, but it is a useful weapon for hospital campaigners to know that the case for no more bed closures has been conceded.

Is bigger better?

There seems to be an unstoppable tide in the favour of the closure of smaller hospitals and the merger of two or more hospitals into super hospitals. The rationale for such action is the belief that bigger hospitals are more cost effective and safer. It is argued that bigger hospitals reduce average costs through the operation of economies of scale and that outcomes improve because of increasing average volumes of activity per clinician (that is doctors specialise in a very small area and get better through more practice).

John Posnett, director of the York Health Economics Consortium, has argued in a recent article that "this logic is not support by the evidence" (BMJ 1999;319:1063-1065). There is evidence that the most cost effective hospitals have between 200 and 400 beds. Those with fewer than 200 are more expensive but so too are those with 400-600 beds. There are still a large number of hospitals in England with fewer than 200 beds (see Table 4) and of course the closure of hundreds of smaller hospitals has not cured the ills of the English NHS.

Table 4 Distribution of acute hospitals in England by size.

No of beds	No of hospitals	Share of total hospitals (%)	Share of total beds (%)
<200	**149**	**36**	**10**
200-400	**106**	**26**	**23**
>400	**154**	**38**	**68**

The sparse evidence that there is suggests that two hospitals of 400 beds are more efficient (in financial terms) than one single site hospital of 800 beds. Generally when small hospitals are replaced by larger ones total management costs either increase or remain unchanged - which depends on the size of the new organisation. There is no basis for the argument that replacing multiple small sites with super hospitals reduces overall management costs.

Sometimes new hospitals are cheaper than the ones they replace, in terms of total costs. This is simple because capacity - the number of beds - has been cut. And of course new hospitals built under the PFI will eat up any savings which may result from reducing the number of sites in any case (this is explained further in Chapter Three).

The Hayes Report does accept that "the evidence on whether concentrating services in a reduced number of specialist centres results in improved outcomes is not clear cut".

According to Posnett "the literature shows quite conclusively that there can be no general presumption that larger units produce better outcomes for patients. The evidence of a positive relation between volume and outcome for a small number of defined procedures is reliable, but these effects operate at comparatively low levels of activity, certainly not large enough to justify notable concentration". What Posnett means by this latter remark is that hospitals do not need to be that large to gain the benefits that accrue from increased practice at a particular procedure for doctors.

In Posnett's view most of the published evidence that demonstrates that outcomes in bigger

hospitals are better is unreliable. In the case of intensive care units, the supposed superiority of larger units disappears when the severity of patients' conditions when they enter the unit is taken into consideration. Smaller units admit more severely ill patients and this is why their outcomes are worse.

Why some doctors or hospitals have better outcomes than others is not well understood. Greater levels of activity may not be the key. The availability of support services (such as imaging and intensive care), good ongoing training for doctors and high quality co-operation between doctors and between other members of staff may be equally, or more, important.

Posnett summaries his arguments in this way: "On the basis of available research evidence, bigger is not better: at present there is no reason to believe that further concentration in the provision of hospitals will lead to any automatic gains in efficiency or patient outcomes. Maybe the research base is inadequate, but the onus is on those who advocate the benefits of concentration to prove their case. In the future as general practitioners assume an increasingly influential role in planning the provision of health services, the perceived benefits of accessible local services may begin to turn the tide of professional opinion" (BMJ 1999;319:1063-1065).

The NHS Centre for Reviews and Dissemination has also reviewed the evidence and concludes: "there is no compelling reason to believe that further concentration of hospital services will result in improved efficiency or lead to automatic improvements in the quality of outcomes. In assessing the potential effects of increased concentration on access and utilisation the implications for disadvantaged groups in particular should not be overlooked" (Report 8,1997).

The Doctors' Views

The medical hierarchy appears to be of one voice on the future of small hospitals. A joint working party of the British Medical Association or BMA (the main doctors' trade union), the Royal College of Physicians of London and the Royal College of Surgeons of England argues that "comprehensive medical and surgical care of the highest quality requires the concentration of resources and skills into larger organisational units" (Provision of Acute General Hospital Services. London RCS, 1998).

The Royal College of Surgeons would really like to see super hospitals servicing populations of half a million or more. This would allow the "dream set up" of 15 consultant surgeons, 15 consultant orthopaedic surgeons, 30 anaesthetists, 24 hour a day operating, an intensive care unit and 24 hour pathology and X-ray services. This would mean only three acute hospitals in the North. The Royal College of Physicians are in favour of eight to ten acute hospitals for a population of Northern Ireland's size.

The medical Royal Colleges are professional bodies and not trade unions. They provide advice to the government on the required numbers of doctors nationally and on the training needs of doctors. All physicians must belong to the Royal College of Physicians and all surgeons to the Royal College of Surgeons (passing the required exams and receiving adequate training are the conditions of membership). The Colleges undoubtedly play a useful role and help to maintain high standards, though they are somewhat archaic in their titles and procedures and tend to be dominated by senior doctors in London and the Home Counties. As an extension of their role they have a lot to say about the optional configuration of hospital services. The main thrust of their arguments is that large hospitals allow for improved training, necessary sub specialisation and thus improve outcomes.

They surmise that if small hospitals (servicing populations less than 150,000) are to survive then

they need to be comparatively overstaffed. In essence, accepting the current restraints of the system, they issue edicts in the full knowledge that hospital closures will follow. Public opinion is ignored and little consideration is given to the special needs of rural areas.

The guidance of the Royal Colleges, supposedly given on training issues, can be very damaging for local services. To take one example, an accident and emergency department will lose its training recognition (the right to train junior doctors) if one of four "essential" services is removed from the hospital (the four are general medicine, general surgery, trauma and orthopaedics) and will thus have to close. A knock-on effect leads to the closure of one department after another.

In this way the Royal Colleges were instrumental in the closure of the South Tyrone Hospital, withdrawing training recognition from several departments. The Colleges argue that closure is not their intention, or their responsibility. In one sense this is true but it is evasive and disingenuous to try to avoid any responsibility. The eventual outcome of the withdrawal of training recognition is entirely predictable.

Of course the government, ultimately responsible for closures, accept Royal College decisions with barely disguised glee. The closure of the South Tyrone suited them down to the ground and they too were able to absolve themselves of responsibility. Indeed it appears that no-one was responsible!

Not all doctors support the views of the BMA and the Royal Colleges. These bodies take a conservative stance, focus on the needs of doctors in isolation from other staff and patients, and are London-orientated. They do not focus on the needs of local people in rural areas. They do not consider the possibility that good quality training is available in small hospitals. They do not use their strength to bolster small hospitals.

Whilst the medical hierarchy are in favour of greater centralisation there are dissenting voices. When the Joint Consultants Committee published a report in 1999 on the future of hospitals (Organisation of Acute General Hospital Services) its conclusions were attacked by Mr James Glancy, a consultant cardiologist and physician at County Hospital, Hereford. In his view "the conclusions of this report represent a scandalous misrepresentation of what little data exists on comparison in outcomes between small and large hospitals " (Hospital Doctor, 14th October 1999). He added: "Yet again doctors' leaders have shown how hopelessly out of touch they are with the grass roots of the profession and patients".

Dr Susan Coe in Perth challenged the idea that smaller hospitals are not safe. "I feel the need to challenge this idea that technology equals excellence. There are many good doctors who choose not to live in big cities and work in university hospitals. They know that sometimes they will have to refer patients on to a more specialised practitioner. They also know that their teaching hospital colleagues do not always get it right" (Hospital Doctor, 7th October 1999).

Dr D Forbes, also writing from Perth, questioned the role of "staff from large hospitals who wield political and academic power". In his view “clinical networks” can be developed to allow for specialisation and the closure of units is not required. Other letters in Hospital Doctor (30th September 1999) argued that smaller hospitals are in fact safer than large hospitals as one is less likely to contract serious, untreatable infections such as MRSA is in a small hospital.

The stated view of the BMA in Northern Ireland is that "hospitals servicing rural communities are not going to be staffed without considerable expansion and there's not enough resources to do that "(Dr Caroline Marriott, chair NI BMA Central Consultants and Specialists Committee, quoted in Hospital Doctor, 9th December 1999). "Putting It Right" (published by John McFall in 1999) dismissed the idea that the then 17 acute hospitals could remain open as it would require a 50%

increase in the numbers of consultant surgeons and physicians to achieve this. Now the Hayes Report proposes just such an increase at the same time as it proposes the closure of six acute hospitals. What has happened between the publication of the McFall report and the Hayes Report to justify this change in approach! Surely the BMA should now be reconsidering their position - if the staff are there the rural and small hospitals can remain open.

The Issue of Accessability

The medical hierarchy put a low premium on access to services, perhaps believing that everyone is as mobile as those in the moneyed circles they move in. There is evidence, however, that the further away some services are the less likely they are to be utilised. This applies in particular to consultations with general practitioners, to self-referral to accident and emergency departments and to attendance at breast and cervical cancer screening services. It appears that distance is less often a problem when someone requires acute care - patients will seek help regardless of the distance faced – but there is evidence for a greater deterrent effect for the poor.

Costs are shifted from the NHS to the patient as services become more concentrated, largely through increased travel costs but sometimes also through the need to arrange overnight accommodation. According to Posnett: "This effect is unlikely to be uniform across different sections of the population and the evidence is consistent with large deterrent effects for particular groups, such as those with low personal mobility or those in particular socio-economic groups" (BMJ 1999;319:1063-1065).

And it can be argued that the closure of rural hospitals will cost lives. Dr Kieran Deeny, chairman of the Omagh and District GP Association, wrote in the Belfast Telegraph (19/6/02) “A few years ago in our Carrickmore practice we had seven cases of meningitis in a 13 month period and I have no doubt that three of four children would have died had it not been for the close proximately of the Tyrone County and South Tyrone Hospitals”.

In the mid 1990’s an earlier report on the future of health care in Belfast - the McKenna Report- recommended that the City Hospital Accident and Emergency Department should close. The Report was met by an avalanche of criticism. One of the points raised was that the closure would reduce accessibility to good health care.

The Report, however, coolly stated that “accessibility is not the problem”. It went on to say that 90% of patients drive to or are driven to hospital (to use A&E services). The authors of this report are clearly immune to the realities of working class life in Belfast. At night, and especially at times of increased tension, working class people are fearful of travelling outside their own area.

This is not an irrational fear but a very realistic one. At such times one hundred yards might as well be one hundred miles. More than half of working class households do not own a car. Ninety-five percent of the households of those in “professional” occupations have a car, compared to only 38% of the households of manual workers. If rioting has stopped the buses or if sectarian attacks make travelling with certain taxi firms hazardous, what are they to do?

The Royal Victoria Hospital and the Belfast City Hospital are not directly comparable to hospitals in any other city on these islands, precisely because Belfast is not directly comparable. To think otherwise betrays much about the cosseted middle class lives of the authors. If local communities were represented on the various review groups these common sense points would not be missed.

Accessibility is also an issue in every other area of Northern Ireland. Local communities are comfortable with their local hospitals, built up over decades. Relatives can visit with ease, patients feel at home. In England, hospitals are much further apart but it does not necessarily follow that a

similar model should apply here. Hospitals ought to be large enough to be viable but not so far apart that lives are put at risk. In more rural areas, extra minutes can be vital. Every town and village cannot have its own hospital but there should be no area without ready access to a good hospital.

Where hospitals already exist, and have done so for generations, a good argument needs to be made before such a facility is closed. Local communities are perfectly entitled to be suspicious of closure plans which promise a better service a little (or a lot) further away. This does not mean that from time to time, however, such a move would be a genuine advance.

Conclusion

In conclusion, there is little or no evidence in favour of centralisation of our acute hospital services. It is difficult to demonstrate that the closure of smaller hospitals actually costs lives, just as it cannot easily be proven that larger hospitals are safer, but common sense tells us that, at least occasionally, the extra journey involved will lead to a fatal delay. And the delay is more likely to be fatal in poorer households without easy access to a car. People want their local hospital. They provide good quality care for the majority of patients, they provide much needed local employment and they are often a vital hub of the local community. In the absence of evidence that "bigger is better" the smaller rural hospitals should remain open.

CHAPTER THREE

PRIVATISATION BY STEALTH

Introduction

As the number of NHS beds has declined in recent decades, the number of private beds has expanded dramatically. Clearly something doesn't add up.

Over one hundred thousand NHS long-stay beds of various types have closed since 1979, whilst the number of private long-stay beds rose from 33,000 in 1979 to 385,000 in 1998. The new beds make a profit whilst the old ones didn't. The only place that profit can come from is through altering the terms and conditions of staff. Billions in public money has been paid to the owners of nursing and residential homes who profit from low wages (the fees of most residents are paid by the state). The market is increasingly dominated by large firms with annual profit rates of up to 20%. The industry is now whinging about their margins being squeezed, largely because of the introduction of the minimum wage, but it ought to be remembered that the huge resources they own have almost entirely been paid for by us, the public.

As the number of acute NHS beds has dwindled the private sector has also expanded its role in the acute field. The numbers of both private acute hospitals and private acute beds has increased. The private sector is now rubbing its hands in glee in anticipation of a further expansion as New Labour presses ahead with its plan to utilise private hospitals to carry out hundreds of thousands of NHS operations a year.

The number of pay beds (private beds) in NHS hospitals has also increased over the last two decades, though to what extent it is difficult to gauge as Trusts have not had to return figures in this area since 1991. This is somewhat ironic given the obsessive demands to collate figures for all sorts of "performance indicators". In fact the government conveniently can no longer tell us how many hospitals or A&E departments there are in the NHS! They collect the information that suits their requirements, and nothing else.

Table 5 outlines the position in 1995. The number of private institutions rose by 281% in the decade to 1995, the number of acute private hospitals by 23%, the number of acute private beds by 13% and the number of nursing home beds by a massive 430%.

Table 5 Changes in private sector provision in England

	Institutions	Acute hospitals	Acute beds	Nursing Home beds
1984	**1491**	**200**	**10067**	**32831**
1994/95	**5676**	**245**	**11363**	**173961**
% change	**281**	**23**	**13**	**430**

These changes have impacted on Northern Ireland as everywhere else. Every sizeable town and village has one or more nursing homes. Larger operators such as Crestacare employ over 2000 staff in more than 40 homes across the North. Northern Ireland also has two private hospitals - one in Limavady and one on the Malone Road in Belfast. (And surely if we are to debate the future of acute facilities these too should be thrown into the melting pot? And maybe they should close before the Tyrone County or Downpatrick?)

When all private (acute plus nursing home) beds are totalled up and added to the numbers of NHS beds it can be argued that the total bed supply has actually increased since the early 1980s. Beds

are not in reality being closed, they are being privatised.

For every five long-stay NHS beds that have gone, six private nursing home beds have appeared. Long stay psychiatric patients, patients with learning disabilities, and the ill elderly have moved out of large state institutions and into smaller (but not small in the sense of a family home) private institutions. There is also a strong association between the number of acute beds closed and the number of private nursing home beds opened (five beds in nursing homes opened for every acute bed closed).

The New Labour government has announced plans to open new "intermediate" beds, to take pressure off the acute sector. These beds will be in a private version of the old convalescent beds once widely available in the NHS. These beds, mostly in separate small hospitals scattered throughout Northern Ireland, meant that "bed-blocking" was rare. The convalescent hospitals were all closed in the 1970s and 1980s.

One group of health economists (Hensher and colleagues) have argued that "activity data on the private nursing home sector are not readily available, so it cannot be shown whether the workload in hospital can be directly substituted by the workload in a nursing home. However, the relation between bed numbers alone seems strong enough to suggest that nursing homes may be a very close substitute for hospital care" (BMJ 1999 319:1127-1130).

The Private Finance Initiative

The Private Finance Initiative (PFI) is a method of obtaining financing for building projects. The Tories introduced it in the 1990s in an attempt to keep "public" borrowing to a minimum a standing aim of monetarists. Doing so also kept their mates in big business happy as PFI schemes are very profitable indeed. Many people believe that the PFI is a source of finance that would not be available in any other way and that the private sector is being in some way generous, helping the NHS out of a hole. The truth is very different. There are alternative ways of obtaining finance for new hospitals. Traditional methods of financing are much cheaper, though ultimately the question must be asked, why should there be any profit in the building of hospitals?

If government finances are in good shape, new hospitals can be paid for directly out of accumulated tax receipts, with no need for borrowing. Public borrowing is much cheaper than PFI, though it too involves profits for the banks. The government pays for new projects by borrowing from the banks at commercial interest rates (currently very low) and then repaying the loans through taxation income. Under the PFI hospitals are built by the private sector and then leased back to the NHS over 20, 25, 30 or even 60 years. Paying the debt is deferred - it is paid from annual income (or the revenue budget) each year. We all know that this is more expensive in the long run - who buys on credit if they are in a position to buy outright? Who chooses the most expensive interest rate, rather than the cheapest, when they are buying a new fridge, or car?

The workings of the PFI are difficult to understand and transparency is further undermined by the use of "commercial confidentiality" to hide what is really going on. But understand we must, if we are to prevent it destroying our NHS.

The PFI was slow to get under way but since New Labour came to power it has begun to grow exponentially. Since 1997 six hospitals have been completed, work has started on a further 21, and 42 schemes, worth £5.4 billion, are under negotiation. Only four of these schemes are publicly funded, the rest are funded under the PFI. According to the health secretary, Alan Milburn it's "PFI or bust". There is no real competition between the private and the public sector – the private is favoured at every stage of the process.

The Hayes Report is clearly in favour of the PFI approach arguing that "Consideration should also be given to the scope for greater use of private finance, although recognising of course that this will have implications for the revenue budget". Hayes commends the findings of a similar review in Wales, and proposes that each of the three new health systems in the North "should" produce an integrated business case for the complete redevelopment of the acute services network in its area. This should then form "the basis of a PFI scheme".

It continues: "The Welsh Review identifies a number of benefits from approaching PFI in this way: It creates PFI schemes of a size and nature more likely to be attractive to the private sector. It provides capital funding at the front end of the planning period, enabling the modernisation agenda to be taken forward quickly and providing the stimulus for changes in clinical practice. It focuses the PFI process into a more concentrated period of time, enabling management to develop and maintain the skills needs to work successfully in the PFI environment".

PFI schemes create vast profits and thus always result in fewer beds (in Dudley, for example, 70 fewer), and in job cuts (190 in Dudley, where the staff fought long and hard to resist). To take a second example, the University of North Durham Hospital, built at a cost of £76 million, opened in April 2001 with 454 beds. The hospital it replaced, Dryburn, had 605 beds. Within weeks of opening management were forced to admit that the hospital was 54 beds short (Guardian, July 12 2001).

In Kidderminster in England the local hospital was closed as a result of the need to make a nearby new PFI hospital more profitable. Hayes is proposing something very similar here. The overall package has been put together with the concept of "PFI ability", or profitability, in mind. Hospitals will have to close in order to make PFI schemes in Northern Ireland more attractive to the private sector.

An Historic lack of Investment

Why is the hospital system in the North in such poor shape and why are we being told that the PFI is the solution?

The creation of the NHS in 1948 effectively nationalised (or brought into public ownership) the existing hospitals, some previously run by local authorities and some of which relied upon voluntary contributions. The new service inherited a crumbling Victorian infrastructure, in need of huge investment to bring it up to standard.

Between 1948 and 1962 there was almost no investment in new hospital buildings (the only new major hospital built anywhere in the NHS in that period was in fact Altnagelvin in Derry). Enoch Powell's ambitious 1962 Hospital Plan was supposed to change everything, rebuilding the NHS from the ground up. In fact only one third of the proposed 224 schemes were ever completed. A further third were commenced but not completed and one third never got off the starting blocks.

Any possibility of the Hospital Plan being realised came to an end with the 1974-75 economic crisis. Since then investment in new hospitals has been neglected by government after government. Only seven public schemes worth more than £25 million were completed between 1980 and 1997. As a result NHS staff struggle on in outdated and worn out facilities. By 1999 the NHS maintenance backlog was calculated to stand at £2.6 billion.

There has been no reversal of the historic decline in public investment, despite Tony Blair's boast that his PFI plans comprise "the largest hospital building programme in the history of the NHS". In fact, as critics have argued, the new hospitals "will be funded through extensive hospital closures and resources generated by NHS trusts, not by new government funds" and "the NHS must generate

efficiency savings to fund new investment" (BMJ 1999;319:48-51).

In fact in the period 1997/1999 there was negative government investment in new hospitals – the costs of all new developments were more than met by hospital closures, the sale of land owned by the NHS and capital charges (which we will go on to explain). Of the £8 billion spent in 1999-2002 all but £1.5 billion came from closures, land sales and capital charges.

Capital Charging

As a prelude to the PFI a system of " capital charging" was first introduced . Since 1991 Trusts have been charged, or taxed, 6% of the value of their current assets by the government. The charge comes out of their day-to-day finance. The introduction of this charge had a dramatic effect on the prospects for developing new hospitals. To take one example, before 1990 there was a plan to build a new 900 bed hospital, which alongside the existing hospitals, would provide a total of 1600 beds for Norfolk and Norwich. The plans changed when capital charging was introduced.

The original plan would have cost too much annually in capital charges and was replaced by a revised plan for 1000 beds in one hospital only. The new system of capital charging had cost 600 beds. Thus capital charging, introduced to facilitate the later introduction of PFI, had a negative effect from the start.

The idea behind capital charging was to introduce the values of market into the NHS. Instead of merely maintaining their buildings Trusts would pay the government a levy for their use despite the fact that these facilities are already owned by us, the public. It is then a small step to paying the private sector for the use of new buildings. In addition the introduction of capital charges introduced a revenue stream from within the NHS budget that could then be used to pay for PFI projects.

Capital charging contributed greatly to the huge financial pressures which Trusts found themselves facing by the late 1990s. Capital charges diverted hospital operating funds to pay for buildings and equipment that were already owned. The greater a Trust's assets (the more hospital sites and buildings it has) the greater the proportion of income it is necessary to set aside for capital charges. The result was pressure to sell "surplus" land and to close smaller units through mergers. In the same period miserly increases in NHS funding, which were not sufficient to cover wage increases or NHS inflation (higher than general inflation), and demands for 3% annual "efficiency savings", brought the service to its knees.

Smoke and Mirrors

Trusts can pay for PFI projects by using finance previously used to pay capital charges, by selling land or buildings, by cutting costs or by income generation (PFI schemes often have increased numbers of private beds and include shops and cafes). Even with these measures many PFI schemes are still unaffordable and the government have been forced to step in with external subsidies (the "smoothing mechanism"), have stolen funds intended for publicly built facilities elsewhere in the NHS, and have waived any cut from the proceeds of asset sales. As a result of these measures PFI facilities draw funds from the NHS at the expense of publicly owned facilities.

Smoke and mirrors are used to make PFI schemes seem better value for money than they are. All such schemes are compared with a notional publicly-funded equivalent, the so called public sector comparator. The comparison process uses two techniques, "discounting" and "risk transfer". Both techniques are dubious.

"Discounting" assumes that government borrowing would attract interest rates of 6%, when a lower rate is much more probable. The 6% rate was chosen for entirely political reasons. According to the Treasury's own guidance, "the practical choice of 6%, from the top the range .... is an operational judgement, reflecting, for example, concern to ensure that there is no inefficient bias against private sector supply". The 6 % rate favours private capital. It was adopted to "prove" what is untrue.

Despite the adoption of the 6% rate the public sector comparator usually comes out better than the PFI scheme. The "risk transfer" calculation was introduced to take care of this – a calculation which supposedly rewards the private sector for taking on "risk" previously carried by the public sector. Again the calculation is suspect. Firstly the 6% interest rate actually takes "risk" into consideration and a proportion of risk is thus counted twice. And secondly, private companies are in effect handed millions for supposedly taking on risk (for example, that necessary savings in clinical care will not be forthcoming) when most elements of risk are in fact retained by the Trust.

The bidding process is also heavily weighted in favour of the private sector. At an early stage of the PFI process a "preferred bidder" is selected. The "preferred bidder" wins the contract with a flimsy outline plan and then goes on to develop its full plan, ratcheting up costs all the way. The company suddenly discovers costs it hadn't spotted before, exaggerates its financial risks and labour costs and slips all sort of "financial adjustments" into complicated spreadsheets. The process is so weighted in favour of the "preferred bidder" that no-one ever calls halt at this point. The price of the project can thus rise two or three times between the selection of the "preferred bidder" and the signing of the final contracts.

Planning or Profits?

The PFI is very attractive to the private sector because of very high rates of return on investment. "Total costs (construction costs plus financing costs) in a sample of hospitals built under the PFI are 18-60% higher than construction costs alone. Shareholders in PFI schemes can expect real returns of 15-25% a year. The consortiums involved in these schemes charge the NHS fees equivalent to 11.2-18.5% of construction costs. If the Treasury were to finance new hospitals directly out of its own borrowing it would pay a real rate of annual interest of 3.0 -3.5%" (BMJ 1999;319:116-119). The £2.7 billion Scottish PFI programme will cost, at a conservative estimate, "£2 billion more than if the Treasury had acquired the assets directly". The higher costs "will be met locally through cuts in clinical spending and nationally through subsidies from NHS capital budgets" (BMJ 1999;319:116-119).

On average PFI schemes reduce the number of available acute beds by 31%. The government lie, and the lie of managers, is that bed numbers are decided by doctors. The Scottish health minister told the Glasgow Herald "it is the clinicians who decide on the number of beds" when cuts at the new Royal Infirmary of Edinburgh were criticised. One of the "responsible" clinicians retorted in the same paper: "We were told the maximum costs and told how this translated into maximum bed numbers".

Prior to 1990 planning of new services was based, at least in theory, on estimates of need. Now the "NHS Capital Investment Manual" describes affordability and value for money as the key criteria in planning.

Projections of " demand" have replaced estimates of need in the planning process. Measures of "efficiency", such as throughput, bed occupancy and length of stay have become the gold standard. Performance targets are set at unfeasibly high levels to make projected bed numbers appear

sufficient. Even to make this equation work "serious departures from the Department of Health's definition of admissions, bed numbers and performance measures" are required. "These departures from normal planning methods suggest that the main function of the current planning process is to justify cost restructuring: projected clinical activity has to be brought into line with the income and hospital capacity that will be available to cater for it" (BMJ 1999;319:179-184).

Why is the PFI so profitable?

To summarise, a number of methods are used to ensure that PFI schemes super profitable.

1. Shifting costs of care out of the NHS. As already outlined this has already occurred on a large scale in the NHS, especially in dentistry, optical services and long term care. Between 1986-87 and 1996-97 the number of NHS geriatric beds fell by 42%, the number of mental illness beds by 47% and the number of learning disability beds by 74%. The costs were transferred to users, carers and local authorities and new profits were generated for the private sector who now provide the bulk of long-term care. Most people in England no longer have access to NHS dentistry as dentists refuse to take on NHS patients and few are now entitled to free optical care. And of course prescription charges have risen by 600% over the last two decades.

   In the planning of NHS PFI hospitals the idea is to shift care costs by reducing the number of "inappropriate" admissions (as already noted, there are fewer of these than is often argued) and by avoiding "delayed" discharges (that is, getting people out of hospital as quickly as possible) so that the cost of caring for patients is borne by someone else. There is a problem with this approach, however, as delayed discharges result from poor community support. PFI schemes do not provide for improved support and often result in reduced community funding, as available finance is diverted to the private sector.

2. Increasing income generation and increasing numbers of private patients. Income may be generated by charges for car-parking and by leasing space in new hospitals to shops and restaurants. Increased income from private patients is also an integral component of many PFI schemes. According to the Norfolk and Norwich plans, for example, "East Anglia has a very high incidence of private medical insurance (21.3% compared to the national average of 13%). There are clearly opportunities for the trust to expand its income from private patients. The trust already provides 18 private beds and generates £1.65 million in annual income". Norfolk and Norwich, like many other Trusts planning PFI projects, aim to increase the number of private beds in their hospitals. In the past the NHS was in a position to convert private beds back to public use if the need arose. Under PFI this may not be possible.

3. Increasing clinical productivity. All PFI plans assume huge and unlikely increases in throughput. In the words of one commentator their plans "presuppose truly heroic levels of staff productivity" and "in effect, the hospital becomes a factory for conveyor belt care" (BMJ 1999;319:179-184).

4. Reducing the cost of the workforce. This is the most common way of reducing costs. The PFI plan in Edinburgh projects 18% fewer clinical staff, North Durham 14% fewer nursing staff. Staff costs (i.e. pay) are projected to fall even further: 17% in the former case, 22% in the latter. The proportion of unskilled nursing staff will rise from 25% to 37% in North Durham and from 21% to 30% in Edinburgh. These cuts are a direct result of increases in capital costs (that is, profits for the private companies involved), rising as a proportion of total income from 8% to 18% in Edinburgh and from 7% to 14% in North Durham.

Health is a labour intensive industry. Labour costs consume 62% of resources in acute NHS hospitals but less than 40% in acute private hospitals. Long-stay NHS hospitals spend 66% of their income on staff. The top ten private sector providers of long term care have screwed this down to only 55%. In 1999 the average annual wage for NHS community care staff was £20,000 and for NHS mental health staff it was £21,000. In private sector nursing homes wages were a pitiful £8,000 a year on average. This explains why the private sector companies made operating profits as high as 28% of income in 1997. The largest nursing home company, Ashbourn/Sun, with 8343 beds, paid its employees an average of £6900 in 1997 and made an operating profit of £228 million.

Under the PFI support staff will find their wages cut and ultimately this may apply to all staff. Such measures do not of course apply the bosses. The directors of the 15 top PFI companies awarded themselves average pay rises of 32% in 2001.

According to one of the parasitic consultancy companies that now hovers around the NHS "each million pounds of incremental PFI capital cost anything from £100,000 to £179,000 a year, requiring the elimination of four to five jobs to pay for it. An incremental investment of £200 million requires 1000 job losses, which might be significantly greater than 25% of the work force and is probably only achievable by reducing the number of doctors and nurses, although often these job losses will not be realised within the hospital undertaking the development, but in the local healthcare market" (Newchurch and Company, 1998).

5. Re-financing Deals. In a further twist in the PFI tale the private sector consortia involved are lining their pockets even further through "re-financing" deals. Re-financing allows developers to renegotiate the loans they have taken out to build a hospital at a later date (usually when the project is completed and supposed "risks" are past - risks that were often overstated in any case). Cheaper loans mean higher returns for shareholders.

   The developers who are building the £230 million Norfolk and Norwich Hospital are hoping to coin an extra £70 million through re-financing. The developers of the new Dartford and Gravesham Hospital in Kent (Carillian, United Medical Enterprises and Innisfree, a specialist PFI investment fund) are seeking to make £30 million through refinancing their £133 million project. The chief executive of Innisfree, David Metter, argues that "re-financing is a way of taking profits along the course of a project. It is a reward for the risks that are taken".

It is estimated that the private sector will eventually earn £30 billion a year through the PFI. The first £14 billion of PFI deals already agreed will net the private sector £96 billion over the next 26 years. According to one informed commentator: " De facto the giant corporations that carry out these contracts will come to control public expenditure and public policy" (Professor Allyson Pollock, Observer 8th July 2001).

International Privatisation

Big business is itching to get in on the PFI act. A new type of corporation almost entirely dependent on government contracts has developed in recent years. Banks are prominent players - Norwich Union, for example, is building GP facilities in Bradford. The US health care business is also keen to get its fingers in the pie. This sector is so profitable that the firms involved are known as "the darlings of Wall Street". During the 1990s huge health maintenance organisations, which provide a full range of services, came to dominate the US market and it is US foreign policy to export this approach. The PFI is their way in to the NHS. A subsidiary of Columbia HCA, the largest health maintenance organisation in the US, has already formed an alliance with Private Patient Plan (PPP), the largest private health insurer in Britain and is jostling for position.

New Labour's bowing down to big business has no bounds. A desire to promote the private sector in health is prominent in the 1999 Health Act and became more strident after the 2001 election. In 1998 the then Health Minister Paul Boateng declared that "if a local authority seeks persistently to undermine the private sector, the local authority will answer for it". In his words “the days when a local authority could get away with an approach to residential care which was always to prefer their own provision before that of the private sector are dead and gone and will not be tolerated”.

The PFI and Public Private Partnerships (as used in the London Underground) are central to New Labours' strategy (PFI is a type of Public Private Partnership). New Labour is implementing the PFI not just in the field of health but in every area of government. Between 1998-99 and 2001-2 £2.35 billion was invested in health through PFI schemes, £3.65 billion by the departments of transport, environment and the regions, £1.08 billion in defence, and £13.1 billion in total in the public sector. Accounting firms KPMG and PWC have launched a joint document with the Treasury - "Public Private Partnerships, UK Expertise for International Markets" - the aim of which is the development of "commercial opportunities" for British companies internationally.

Similar approaches are being pushed across Europe and further afield. The European Union is at the forefront of these developments and have openly declared that the widespread implementation of PPPs will help them meet the goals of reducing public expenditure and of creating fresh opportunities for private industry. (See "Making the Most of Opening of Public Procurement", published by the European Commission in 1997).

A whole raft of large companies, including Amee, Balfour Beatty, Amey, Serco, Mowlem, WS Atkins and Jarvis, are involved in the PFI scene. Mowlem , a building and services firm, saw its pre-tax profits rise by 20% to £30.3 million in the 12 months to December 2001 and its turnover rise from £1.4 billion to £1.7 billion. Its dividend to shareholders was increased by 10%.

A prominent "think - tank", the Institute of Public Policy Research (IPPR), is busily nurturing PPPs and the PFI. It meets in secret and pretends to be apolitical. In fact it is tied hand and foot to big business and the Treasury. Those who sit on its commissions have a vested interest in its conclusion that "the operations element of a PFI hospital should not be limited to the provision of ancillary services" but should also include the whole range of clinical services. Obviously the more services that are handed over to the private sector, the greater the profits.

Under union pressure, Blair has conceded that staff will not always be handed over to the private sector but neither has he excluded it as a possibility. Unfortunately, the key health union UNISON is focusing almost solely on protecting staff in this way, rather than resolutely opposing PFI in principle.

The global financial institutions that have become the target of anti-globalisation protesters in recent are busy promoting public - private partnerships across the world. There are various types of PPP, including what are known as design, build, finance and operate (DBFO), build, own, operate and transfer (BOOT), and build, operate and transfer (BOT) schemes.

When the International Monetary Fund (IMF) and the World Bank enforce their economic dictates on developing countries they insist that the PPP approach is adopted. Indeed acceptance of this approach is a precondition for further loans. As a result of this imposition massive cuts in existing public sectors are carried through. This means that schools and hospitals in developing countries are now in a worse condition than they were in the 1960s.

In 1996 the World Trade Organisation (WTO) implemented the "government procurement agreement" which opened up public contracts to international competition and the WTO, IMF and

the World Bank all seek to promote "markets in infrastructure provision". The European commission has used grants to stimulate the development of PPPs. The PPP market was worth 720 billion ECUS or 11.5% of the gross national product of the 15 member states of the European Union in 1994, and it has grown since.

The European Investment Bank admits that the PPP approach is more expensive than traditional methods of financing, but justifies its adoption by the claim that the private sector is less "risk averse" (that is, prepared to take risks in a spirit of entrepreneurship) and hence more efficient. The real world evidence is that the private sector is very averse to risk indeed. They want to have their cake and eat it. When schemes to provide new computing systems for the National Insurance Agency and Passport Agency went belly-up the government carried the can, refusing to fire the companies involved even though they were entitled to.

All across Europe smaller hospitals are closing. The drive towards greater European unity is leading to cuts in social spending as the various governments attempt to keep within the financial boundaries dictated by the Maastricht Treaty. The Treaty dictates "greater public sector restraint and budgetary discipline, emphasising the need for increased efficiency in spending on economic and social infrastructure". And of course PPPs and the PFI keep down government borrowing, in a totally artificial way.

The First PFI Hospital

The first PFI hospital to be completed in England was opened by Tony Blair to great fanfare in June 1999. It has been a complete disaster. According to The Observer (8th July 2001) "PFI has meant cardiac patients drenched with water flooding from broken pipes, sewage spilling out into the operating theatre, nurses left ventilating patients by hand as operations are plunged into darkness, broken equipment, second-rate maintenance as engineers are made redundant, flea-infested laundry, dirty wards because of cutbacks in cleaners, patients put in chairs because of the reduced number of beds, and dying patients remaining undiagnosed as waiting times doubled".

The hospital has no air-conditioning and during hot weather temperatures soar to 100$_0$ F. Hot weather expands the water pipes, which are joined together by cheap plastic sleeves rather than being soldered, leading to leaks. Cheap plastic joints have also lead to ceiling collapses. The emergency generator has failed on a number of occasions plunging the hospital into darkness and causing life support equipment to fail. Equipment breaks down because it is cheap and then cannot be easily fixed because the engineer has been made redundant. As a result operations have been cancelled.

The bed manager has been told to put patients into chairs for a few hours to allow other patients to use their beds. The wards are so small that doors banged into beds and had to be removed. Resuscitation trolleys were too big to get through the doors and had to be redesigned at a cost of £18,000. The ward walls are so thin that they cannot support shelves. Despite these problems the health authority pays £11 million a year for the hospital to a consortium run by the construction group AMEC. AMECs' shares are soaring as investors greedily eye its profit margins.

Some of the private contractors involved have spent a tidy sum on actually sacking staff. Building and Property Group (part of the Interserve group) run the ancillary services. They abandoned the existing family-friendly shift patterns (which allowed cleaners to pick up and leave off their children at school) and as a result more than 30 were forced to leave their jobs. The GMB union took the contractors to an industrial tribunal. The Building and Property Group backed down, paid £600 to each of 60 cleaners and reintroduced some family-friendly policies. The Group has spent £1.1 million in total on making people redundant and has actually produced a surreal document entitled "Redundancy Programme - Potential Upside". In October 2002 the Cumberland was found

to have routinely discriminated against women by a further industrial tribunal and 1400 nurses, cooks and cleaners won £97 million in back pay.

The chairman of the hospital medical staff committee has issued a stark warning to everyone in the health service. "The developers always think of the bottom line. You have to hold a gun to their head to get them to repair anything. If this is what Blair has in mind for the NHS, watch out".

The Cumberland unit the only disaster imposed on the NHS through the PFI. In Halifax, the PFI Calderdale Royal Hospital is known to its staff as Fawlty Towers. Power breakdowns have cut off life support machines and the hospital has been plagued by mice! Waiting lists have grown fourfold despite hundreds of patients being sent to a nearby private BUPA hospital. A £67 million PFI hospital opened in Bishop Auckland, next door to both Tony Blair's Sedgefield constituency and Alan Milburn's Darlington constituency on April 1st 2002. Already it is being described as a white elephant. The nearby £97 million PFI hospital of North Durham is short of beds and its waiting lists are lengthening. As a result, £120,000 was squandered within its first ten months of operation paying NHS consultants extra to treat NHS patients in private hospitals.

Conclusion

The Private Finance Initiative has the potential to decimate the NHS. It is ludicrously expensive and it leads directly to bed cuts and job losses. It is not an answer to the problems facing the NHS and it is not an answer to the problems facing NI's health service in particular. We cannot mortgage our future in this way. Once a PFI scheme has been launched, it has its own momentum and cannot easily be undone. The PFI must be stopped in its tracks before it does any further damage.

Again, it is important to emphasise, the government is providing little new net capital. New buildings are increasingly paid for out of the day-to-day hospital budget. "Under the private finance initiative the NHS pays more for less; paradoxically, the "largest hospital building programme in the history of the NHS" is being funded by the largest acute hospital closure programme" (BMJ 1999;319:48-51).

The PFI has the potential to impoverish the NHS, to dismantle the NHS and to privatise large chunks of the NHS. The conclusion of one group of critics is stark: "The PFI provides the conditions and the mechanisms for reversing the principles that health care should be funded out of general taxation, that public services should remain in public ownership, and that health services should be free at the point of delivery. The NHS has already undergone major redefinition with the redrawing of boundaries of responsibility for long term care, NHS dentistry, optical services, and routine elective care. The PFI continues this trend across the NHS and all public services. It is being implemented with virtually no public debate" (BMJ 1999;319:249-253).

CHAPTER FOUR

WHY IS THE NHS UNDER ATTACK?

Introduction

Despite its problems, the National Health Service remains the most comprehensive, fair and efficient health service in the world. For half a century it has been envied by countries around the globe. Now, however, its basic tenets are being questioned by almost everyone. The possibility looms that the NHS will cease to exist as a truly national, free and comprehensive service in the next period.

It is not only the health service that is under attack but every aspect of what has become known as the "Welfare State". We are told that because of our ageing population we face "a demographic time bomb" and with only "finite resources" it follows that "rationing is inevitable".

These ideas were first put forward by right wing "think tanks" in the 1970s, they were then taken up by the Conservative Party and soon became unchallengeable tenets in academic departments of medical economics and in NHS management boardrooms. Unfortunately these ideas have also been accepted by New Labour and are helping to shape their policies now that they are in government.

In one sense of course the NHS is facing a crisis. It is under attack as never before. This being so we must put the principle assumptions underlying this attack under the spotlight. Is there an iron law that says demand for healthcare rises exponentially and forever? Is it really true that people will blindly take whatever is on offer, if it is offered for free? Are resources, in any real and meaningful sense, finite? Or are there resources aplenty, and the economic and social system of capitalism prevents a fair distribution of these resources?

Are we facing a demographic time bomb, with an explosion in the numbers of old and "very old" just around the corner, threatening to swamp those of working, and tax-paying age? Or is the time bomb image just that, an image, a mirage, unreal, not capable of withstanding scrutiny of the figures? Is it a proven fact that big hospitals are more efficient and safer than small? Or is this unproven and a smoke screen for cutbacks. If these assertions are myths, as this pamphlet argues, in whose interests is it to perpetuate them and to propagate them? And finally, if all these arguments are marshalled to justify centralising hospital services in Northern Ireland, and they can be challenged, is there any reason to close any acute unit?

Health Service Myths

The ideological onslaught on the whole basis of the welfare state did not fall from the sky. It has its origin in the crisis of the capitalist system. As the editor of The Observer and social commentator Will Hutton reasons: "from the beginning the welfare state was not embraced by the entire political class, but seen as something that a conservative state had created at its discretion, for sound reasons, without cutting across the principles upon which that state had been founded". And he goes on, "the welfare state would be vulnerable once the political circumstances of its creation had passed away".

Political circumstances changed with the first world recession since World War Two in 1974-1975. Since 1974 the main capitalist economies have been characterised by historically weak economic growth punctuated by three major recessions (1974-75, 1980-82 and 1990-91). A fourth world recession is now developing. Growth in the 1990s averaged 2/3% a year compared to 5% a year in the 1950s and 1960s. This is the reason why there has been and is such pressure on social spending

(spending on health, education etc). The strategists of the capitalist (or ruling) class have set out to re-divide the cake: more for them (in profits), less for the rest (in wages and social spending).

The debate on the future of the NHS is driven by the widespread acceptance of a number of ideas about the Welfare State. It is necessary to examine each of these in turn and to demolish them in turn.

Myth One: Resources are Finite

It is argued that economic resources are finite and rationing is thus inevitable. In one sense resources are finite, of course, restricted by the Gross National Product, or the wealth of a country. There is no reason why healthcare resources should be fixed at inadequate levels however. International comparisons show that health spending is lower here than in other industrialised countries.

A conscious political decision is taken to spend a certain amount on the NHS. The amount can be increased by a political decision, as it has been recently. The proposed increase in spending over the next few years will help a little, but only a little. Much more is required. The resources are there to provide a high quality health service for all. Our society today is wealthy but very unequal. The richest 1% of the population owns 129 times as much marketable wealth as the 50% least wealthy. The perceived wisdom is that this is the natural state of affairs and nothing can be done to change it. This is certainly not the case.

Rigorous chasing up of the rich who don't pay tax and a return to 1979 tax levels would provide a huge increase in resources. Tax concessions to the well paid have amounted to more than £50,000 million since 1979. A massive £23,000 million is owed in corporation tax and £1,600 million in VAT. Each year £5,000 million of tax fraud is uncovered against only £500 million of benefit fraud. (Despite this each year 4000 people are prosecuted for benefit fraud, a mere 200 for tax fraud). A serious attempt to collect taxes due would go a long way to make up the deficits of the NHS.

The annual profits of Britain's major companies added up to an incredible £151 million in the late 1990s. Some of this was reinvested but £64 million was paid out in dividends to shareholders and in interest on loans. In a socialist society this money could be used in the interests of everyone not just a few. Most importantly, under socialism, democratic planning would also increase the total wealth generated. It is not just a question of how the cake should be divided: we can have bigger cake to begin with.

The resources the government currently spends are divided out in a number of areas. More than £20 billion is spent on defence. In a truly democratic society a real debate could take place about priorities. Do we need the Eurofighter more than we need hospitals and kidney machines? Billions could be diverted into health, housing and education.

Over the last three decades incredible wealth has been squandered by the problem of unemployment. Each unemployed or non-employed man costs £9000 per year in lost tax and income support. An estimated £36 billion a year went down the drain in this way due to mass unemployment in the early nineties. And of course the employed create wealth if they are given the opportunity to work.

Myth Two: Demands Are Infinite

Most health economists assume that demand for health care is infinite. They see this as an

inevitable result of a zero -priced service. This is a reflection of their cynicism and of their patronising attitude towards ordinary people, whom they assume will take whatever they can get for nothing. If their assumptions are true then why isn't there an infinite demand for free public toilets? Consider this for a moment and you will realise what nonsense health economists often talk.

As the South Wales GP and veteran socialist, Julian Tudor Hart, has pointed out there is no evidence that zero prices lead to infinite demand. Until 1979 the health service was, to all intents and purposes, entirely free. There was no infinite demand because "medical care incurs human costs even at zero price (going to the doctor is not like eating an ice-cream)". People don't troop off to the doctor like lemmings demanding needless treatment.

Tudor Hart continues: "Once any service is made freely available to the entire population as a human right, it is cheaper to give than to sell. No one has to be employed to collect the money, to make sure nobody gets care without paying for it, or to promote the product to maintain profits. Nobody has to collect profits, opportunities for fraud are minimised, and (though this is unimaginable to anti-socialists) many if not most people work more conscientiously in a public service run to meet serious human needs, than for managers running a business for profit".

Many NHS changes since 1974 have been attempts to control demand and to introduce the rigors of the market. Before 1974, administration costs took up 2% of the NHS budget. This figure rose to 6% after the 1974 reorganisation and to 11% in 1994 after the "reforms" of the early 1990s. Between 1987 and 1994 the actual amount spent on administration rose from £1.44 billion to £3 billion annually. In the USA administration costs take up 23% of spending. That is our future. Attempts to deal with a non-existing problem, infinite demand, lead to increased costs and decreased efficiency.

A good estimate can be made at every stage in life, from birth to death, of the incidence of disease. The cost of treatment and, of course, prevention can be calculated. For many services, total demand is already met, or nearly met. Minor increases in resources would fill the gap (childbirth for example is already well-covered). There are other areas for which services are patchy and for which there is pent-up demand. Hip replacements are a good example. There are long waiting lists for this operation. In addition there are many people, not on a waiting list, who would probably benefit from the operation. If they were all sought out and offered surgery, would they have the operation? The answer is that many wouldn't. In other words demand is less than real need. And even if everyone took up the offer of an operation there is still a limit to how much this would cost.

The number of older people has increased in recent years and has put increased pressure on the NHS. Since 1951 the proportion of pensioners in the population has risen from 11% to 18%. The evidence is however that the steepest increase has already taken place and we are not on the edge of an unaffordable population explosion. There certainly isn't any risk of infinite demand on the NHS from old people.

And of course the finite resources and infinite demand theories apply only to the masses, not to the elite. The experts argue that rationing is inevitable - there isn't enough to go round so somebody must do without. The most sickening aspect of this is unspoken: rationing is inevitable for the majority but does not apply to the rich minority. If you are well heeled you can buy what you want, whenever you want it.

Conclusion

The crisis of the NHS is the crisis of the capitalist system. This is a wealthy society and we can afford a good health service. If the system cannot deliver, then surely the system itself is at fault and it must go. Capitalism cannot ensure the future of the NHS and capitalism causes may of the

diseases that the NHS attempts to deal with. The future of the NHS can only be ensured under socialism - a democratically - controlled and planned society in which resources are commonly owned and used for the benefit of all. Until we win such a society it will remain necessary to defend our health service through struggle - arguments alone will not suffice.

CHAPTER FIVE

NEW LABOUR IN POWER: DID THINGS GET ANY BETTER?

Introduction

In the 1950s and 1960s a reluctant Tory Party tolerated the NHS at best whilst always nibbling at its edges. The 1970s saw Callaghan's Labour government making cutbacks in the NHS at the behest of the International Monetary Fund.

The Thatcher years brought financial stringency, serious consideration of outright and open privatisation alongside piecemeal and covert privatisation and finally, the misnamed "NHS Reforms". John Major's regime continued with what were, in reality, counter-reforms, to the opposition of just about everyone. His unpopular Government was finally swept from power in May 1997 and were replaced by Tony Blair and New Labour.

New Labour's theme tune during the 1997 election was the D-ream song "Things Can Only Get Better". The choice of this song was apt - Tony Blair's approach was timid and promised little, instead focusing on the record of John Major in order to win a majority.

After the election there was little enthusiasm for the new regime, rather a hope that things just might improve and overwhelming relief that the hated Tories were at last gone. Now that New Labour have been returned to power for a second time the question can fairly be asked - did things get any better? And, importantly, did New Labour in power deliver anything that a Tory administration would not have delivered?

Initially New Labour stuck to the Conservative's spending plans and spending on education and health was screwed down between 1997 and 1999. It began to rise from the year 2000 but the extra finance now pledged will make little difference as huge sums are required just to make up the accumulated shortfall from years of under-spending, especially the decades long lack of investment in new schools and hospitals, and much of the extra money is to be handed to the private sector. (New Labour have of course made a point of announcing the same spending increases several times over. The headlines looked impressive until their game was rumbled). And, of course, in the last analysis, Gordon Brown can only deliver on his promises if the economy stays on course. He has not, despite his boasting, abolished the cycle of boom and bust. A new recession means that all bets are off and we may never see much of what Gordon Brown has pledged.

Increasing Inequality and Collapsing Infrastructure

One "contribution" of New Labour to health has been to preside over a widening gap between rich and poor. Overall, after-tax incomes have risen less under this government than under six of the last seven governments since 1964 (the exception is the first Thatcher term from 1979 to 1983, a time of deep recession. The developing recession may well squeeze average incomes in the same way as in the 1980-82 recession).

New Labour are proud that the rich are getting richer. They accept the "trickle –down" theory, that all will ultimately benefit. Between 1978 and 1998 the richest one fifth of the population have seen their share of post-tax national income rise from 36% to 45%. The incomes of the chief executives of the 100 largest companies average £717,000. In 1983 there were 7,000 millionaires in Britain. Now there are 77,000.

There is little evidence of any trickle-down. Poverty remains endemic in Tony Blair's Britain. The

biggest concentration of poverty is in Liverpool. In the central L16 postcode area 65.8% of households earn less than £10,000 a year. In Vauxhall, Liverpool, the average annual household income is only £9,000. A few miles away in Heeswall, the Wirral, the comparable figure is £46,000.

Under New Labour some benefits have been increased but not to the extent that would be required to lift people out of poverty. In addition the government ignores the effects of the social fund in their calculations on poverty. In February 2000 709,000 claimants had an average of £9.42 deducted from their benefits per week to repay loans taken out to buy essentials. They were thus in reality reduced to an existence below the official poverty line but were considered to be above it by the government.

Overall there are half a million more people living in poverty now than there were in 1997. According to the Child Poverty Action Group (CPAG) the first two years of New Labour were "dire for poor children" and the cut in lone parent benefits was "arguably the first real-term cut in the level of social assistance paid to any group of claimants since social assistance was introduced in 1948".

By 1998-1999 there had been no decrease in the proportion of children living in poverty (still about one third). The government now claims that they have lifted 1.5 million children out of poverty. Independent experts estimate that the true number is actually 500,000 (Financial Times, 12/4/02). The new recession will see the number of children in poverty rising again as unemployment begins to rise.

New Labour spends less of Britain's Gross Domestic Product on public services that John Major's government (in the years 1997 – 2001 39.2%, 38.4%, 37.6% and 38.2% respectively compared to 43.6%, 43.2%, 42.6% and 41% in the years 1993-1997).

Britain's infrastructure is collapsing. Nowhere can this be seen more clearly than on the railways. It is clear that the private sector can deliver profits but that it cannot deliver good public services or safety. A massive programme of public spending is required but New Labour is not delivering. In the late 1960's net public sector investment reached 7.5% of gross domestic product (GDP). Under John Major capital spending was 1.6%, 1.5%, 1.4% and 0.7% of GDP in the four years 1993 –1997. Under Tony Blair spending fell to 0.6%, 0.7%, 0.5% and 0.6% of GDP in the years 1997 –2001. In real terms public investment is a tenth of the level of thirty years ago. As a share of GDP it is a twentieth. Public investment in Britain is less than in Germany (1.8% of GDP), Italy (2.2%), the US (2.8%), France (2.8%) and Japan (7.9%). Net capital spending last year was £3.2 billion. This is only 60% of 1996 -1997 levels and less than a quarter of the 1992-1993 level.

New Labours' Record on the NHS

In July 2000 New Labour announced their "National Plan" for the NHS with great fanfare. Funding has been increased in incremental stages but the figures are not as promising as they sound and there are real dangers to the future of the NHS contained within the plan. In April 2002 the government announced an increase in health spending of £40 billion over the next five years. This amounts to a 7.4% year on year increase above inflation and would take total spending from £65.4 billion in 2002 – 2003 to £105.6 billion in 2002 – 2008. NI's share of the increase amounts to £7 billion. By 2007 – 2008 the Euro average will be 10.7%.

The increase in health spending is not significantly larger than increases in the past, as has been claimed. In the five years 1971-1976, spending rose by 6.4% a year in real terms. Spending rose by almost as much again in the early 1990s as the Tories pump-primed their "reforms". (Then the extra finance was swallowed up by red tape as the service to patients deteriorated). And it should

not be forgotten that health spending in New Labour‘s first term rose by less than the average under John Major and subsequent increases have first to overcome this accumulated shortfall.

Tony Blair's stated aim is to increase Britain's health spending to the current European average of 8% within a few years. The increases announced will not achieve this as even if the spending pledges are met there is a shortfall of £26 billion. In any case average spending in Europe will actually be 10.72% of GDP by 2006. The NHS would require another £45 billion annually to meet this target (BMJ 2002: 324;502). Still less will Blair be able to bring spending up to the average of the richer G7 countries.

And of course all bets will be off when a new recession occurs. At present Gordon Brown plans to increase overall government spending by 3.3% a year. The Institute of Fiscal Studies estimates that Browns plans have a £7.4 billion hole in the first place (assuming an unambitious annual economic growth rate of 2.75% annually over the next five years), The problem for Brown is that he will not achieve even this economic growth. The economy has grown by only 1.6% in 2002, and will struggle to achieve 2% in 2003, on the most optimistic scenario. It is quite possible, or even probable, that an actual recession will develop. Brown admits that he faces a budget shortfall of £16 billion in 2002 and £20 billion in 2003 and that he will need to borrow £20 billion to keep his spending plans on track.

Others are less genuine than Brown and some economists are predicting shortfalls of up to £40 billion annually over the next four years.

The reason for the squeeze on the public coffers is the sharp fall in tax receipts as the economy slows. In October 2002 the Inland Revenue were raising 13% less than a year earlier. Corporation tax fell by a massive 27% over the same period. So far healthy consumer spending has prevented an even worse deterioration in government income but this will not last for much longer.

Brown hopes that the world economy will pick up in 2003, that the UK economy will avoid outright recession, and that tax receipts will pick up in the medium term. The problem for him however is the evidence that the healthy tax receipts of the late 1990s were a one-off phenomenon related to the stock market bubble.

In the circumstances that are now unfolding Brown will not be able to deliver on his promises for public spending in general, or for the NHS in particular. He plans to borrow more in the short-term and hopes that he will be able to repay these loans in the next few years. A more prolonged slow-down in the economy, by far and away the most likely prospect, will mean that increased borrowing now will store up problems for the future.

Brown has already increased indirect taxation. When New Labour came to power the tax burden totalled just under 35% of GDP, now it is around 37%. In the spring of 2003 national insurance contributions will rise by 1% for both employers and employees. Even then the total tax burden will remain below the 39% of GDP it reached in the early years of the Thatcher government.

Despite his protestations to the contrary Brown is clearly contemplating further tax rises. Rises that hit business will be resolutely opposed by the capitalist class. Rises that hit ordinary workers will be difficult for New Labour to impose given its weakened position now that the unions have now moved into action. In addition, increasing taxes at a time of economic slow-down or outright recession, is very dangerous for Browns’ overall strategy. Such a move would tip the economy further into recession, and for this reason, will only be reluctantly taken by Brown.

Thus there are three alternatives open to Brown. Increased borrowing, increased taxation, or cuts in services and spending plans. Given the difficulties outlined above, Brown will inevitably fail to

deliver on his promises of increased spending, and introduce cuts in the NHS and the education sector.

New Labour have given the private sector a massive boost by guaranteeing that operations repeatedly cancelled in the NHS will take place in private hospitals. In the year to November 2001 64,000 such operations took place. The private sector will have made a profit on each and every one. Tony Blair has also announced that he will open 7,000 new hospital beds. Most of these are to be "intermediate care" beds, allowing patients to convalesce between a stay on an acute ward and going home. What Blair didn't reveal is that the majority, if not all, of these beds will be provided by the private sector.

From October 2001 the NHS has met the cost of nursing care for nursing home residents, but charges will be levied for personal care (e.g. meals or having a bath). Intermediate care will be provided by the private sector under the same rules. This means that it is possible that there may be charges for hospital admission for the first time ever. Patients may pay when they go into hospital and the private sector will profit. The NHS will cease to be a universal, comprehensive service, free at the point of delivery. Bairbre De Brun has not indicated that she intends to introduce similar measures locally but equally has she not said that she will not do so.

Most recently New Labour has announced plans to establish “Foundation Hospitals”. These elite establishments will attract increased funding, and will be allowed to borrow money and to set their own pay rates. This will lead rapidly towards the development of a two-tier health service.

New Labour has announced plans to expand the numbers of doctors, nurses and other health staff. By the end of their first term in office, however, little had been achieved on this count. There were 22,000 vacancies for nurses and 1214 GP posts were unfilled, mostly in deprived urban areas. In 1997 there were also hundreds of vacant physiotherapy and social work posts and 510 dentists jobs were unfilled. Even if their plans come to fruition we will still be a long way short of other countries. Germany has 341 doctors per 100,000 population, France 303, Sweden 280 but the UK only 175. Britain has fewer nurses per head of the population than the South of Ireland, Germany, New Zealand, the US, France or Italy (Britain has the least at 5 per 1000, the South the most at 15 per 1000). The NHS has 0.6 GPs per 1000 population, France has 1.5. Nurse training places fell by 26% in the first half of the 1990s.

Conclusion

New Labour has not saved the NHS, nor has it reduced poverty or inequality to any significant extent. Under Tony Blair, the problems of the health service have deepened. The New Labour solution is increased privatisation and the closure of smaller hospitals. Alan Milburn, the current Health Secretary, has announced his intention to encourage major international private companies – such as Kaiser Permante and United Health Care from the US, Germedica from Germany and Capso from Sweden – to invest in Britain. “I expect to see a growing number of these new providers in place, beginning later this year. Like NHS use of existing private sector providers, this is not a temporary measure”. According to Milburn: “The new providers will become a permanent feature of the NHS landscape” (Guardian, 25/5/02). “Foundation Hospitals” are to be given so much commercial freedom that they will practically opt out of the NHS.

New Labour are destroying the NHS as a national, co-ordinated, public service. They cannot deliver on their promises of increased funding. What is the alternative to the approach of New Labour and how can we mobilise to defend and extend the NHS? We will consider these issues in Chapter Six.

CHAPTER SIX

THE ALTERNATIVE TO HAYES

Introduction

As we can see the assumptions underlying the approach of the Hayes Report can all be challenged. The true situation can be summarised as follows:

1. Demand for health services is finite and measurable and in fact not everyone will come forward to take advantage of health care from which they would benefit. Demand, far from being infinite, is less than real need.

2. Demand can be met within the resources available in a modern industrialised economy. All that is required is the necessary political will to distribute resources in such a way that the NHS is adequately funded. The fact that it is not adequately funded is due to the constraints of the capitalist system. Within the system we can fight for increased resources but ultimately only the socialist organisation of society will guarantee the future of the NHS.
3. Change is required, but not the change that Hayes and every Western government assumes. Rather we need increased funding and the democratisation of the NHS.

4. There is little evidence that large, centralised hospitals are safer or more cost effective. Larger hospitals are more expensive to run, are more impersonal and less "patient friendly", and are less accessible, particularly for the poor and those who live in rural areas.

5. Privatisation is dismantling the NHS. It has further impoverished hundreds of thousands of ancillary workers and handed hundreds of millions in profits to the private sector. The implementation of the PFI will complete this process at a huge cost. The private sector is more expensive and less effective than the NHS.

Of course it is necessary to do more than answer the arguments of Hayes. We must propose an alternative and we must explain how real change can be achieved.

Focus on the Key Issues

To be successful any campaign must take on Hayes on the key overarching issues and must avoid setting one area against another. The key issues are chronic under-funding, accessibility to acute services for all, the privatisation of the service, and the continuing and scandalous lack of any democratic control over the NHS.

The Hayes Report has drawn essentially the same conclusions as earlier reports drawn up by the various Health Boards and by Direct Rule Ministers. Whilst the members of the Acute Hospitals Review Group spent many months considering the evidence, and have loudly proclaimed their independence and impartiality, there are grounds for suspicion that the conclusions of the Report were largely predetermined.

"Experts, "consultants", "the great and the good" - in short, the people who receive invitations to sit on government bodies - nearly always accept the constraints of the system. In health terms this means accepting that "resources are finite" whilst demand is "infinite". It means accepting as established fact that big hospitals are better than small hospitals. It means that a high premium is

placed on "affordability" and low priority is given to the wishes of patients and potential patients.

The Hayes Group did not sit down with a blank sheet of paper. Those who accept the system as given, as the only reality, seldom realise that their thought is constrained from the outset. The correct approach for a real review of Northern Ireland's health service would be to begin with an accurate assessment of the health needs of the population. Then the necessary resources should be sought. And the resources are there.

Simply taking back the huge sums handed to the rich and to big businesses by both Tory and New Labour governments over the last twenty-five years would transform the finances of the NHS. The socialist organisation of society would generate untold wealth and pave the way to solving the health problems associated with poverty.

We must have a rational debate on the way forward. It is logical to concentrate certain highly specialist services in one place. Not every service can or should be provided in every hospital but it is imperative that the NHS provides safe, effective and accessible treatment to everyone. Despite the need for the centralisation of some treatment, there is no justification for the removal of all acute services, especially Accident and Emergency provision, from local hospitals such as the Mid Ulster, the South Tyrone or the Downe.

Some genuinely believe that safe treatment can no longer be provided in the smaller hospitals. A key factor in their thinking is that a few consultant surgeons and physicians carry too much of the burden, effectively working 80-100 hour weeks for all of their working lives. There is no doubt that the introduction of more reasonable working hours for junior doctors, and the desire of many consultants to work in larger centres where they are on-call less often and have more support, is placing pressure on the smaller hospitals.

Obviously something has to change. The doctors, nurses and other staff who have shouldered the burden of keeping the small hospitals open can no longer be asked to do so. Hayes is proposing a 50% increase in the numbers of consultant surgeons and physicians and similar increases in the number of other staff however and such increases would allow us to adequately staff all of our smaller hospitals.

The present hospital network can only survive with substantial investment, in particular a massive increase in investment in people. Ultimately we need to double the number of hospital consultants to the level in Germany and to more than double the number of nurses. Nurses can take over many of the roles of junior doctors. New staff and extra training for existing staff can make sure that all our hospitals continue to provide excellent treatment, with only minimal rationalisation of services when it is absolutely necessary.

This debate is ultimately about resources. The powers that be argue that there is not enough money to go around. They can see no way out except by cutting in one sector to give to another. The new plan is posed in this way - money has to be saved now to allow investment for the future. As already outlined the reality is that we can have high quality hospital service and a properly resourced community service. It is only the way that our society is organised that prevents such a desirable outcome.

Can We Rely on the Assembly?

In 1998 Health Minister John McFall gave his approval to a plan to reduce the number of acute hospitals in Northern Ireland. He proposed a three tier hospital system with regional centres, such as the Royal Victoria providing specialist services (neuro-surgery, cancer treatment, etc), second tier hospitals providing most services (including a casualty department and a full range of medical

and surgical treatment), and a number of smaller hospitals which would not operate as acute units - including the Mid Ulster in Magherafelt, the South Tyrone in Dungannon and the Downe in Downpatrick.

McFall recommended the plan but left it up to the Assembly to implement it. Unsurprisingly every Assembly member spoke up to defend their local hospital. They then deferred any decision and created the Hayes Review Group. Hayes has promptly came up with McFall Mark II.

Assembly members who accept the financial constraints of the budget devolved from Westminster can only defend their local hospital at the expense of others. By implication they will be arguing for somewhere else to close. The result of such a sterile debate may well be paralysis, the Assembly unable to agree anything. That this is the case is most clearly seen in the debate over the future of the Tyrone County in Omagh and the Erne in Enniskillen. The Fermanagh Hospital Steering Group assert that "Hayes Got It Right – Support the Erne" and recommend that the Hayes Report should be implemented "as a matter of urgency". In other words, close Omagh as an acute hospital as "a matter of urgency". The Steering Group includes Sinn Fein MP Michelle Gildernew, Ulster Unionist MLA Sam Foster and multi-millionaire businessman Peter Quinn.

In opposition the Hospital Campaign for the Rural West has drawn up counter-proposals which favour Omagh. This group includes Omagh District Council Sinn Fein chairman and MLA Barry McElduff amongst its members and concludes that Hayes "barefacedly ignored the evidence on accessibility, sustainability and the clinical evidence".

One thing that we cannot do is sit back and wait for the main Assembly parties to deliver. For the first time in a generation the political parties have lost the luxury of criticising from the sidelines without proposing an alternative. Now they must put up or shut up. They have largely chosen the latter path. All accept the constraints of the system.

The "Programme for Government" agreed by the Assembly in early 2002 states that the private sector is the "motor of economic development". All parties are behind a policy of increasing reliance on the private sector. In Sinn Fein's West Belfast newsletter, MLA Alex Maskey has argued "we will need to fund an even greater portion of our public sector capital building programme using PPP". He goes on to state that "private sector finance can help accelerate building and investment" and concludes that "we will need to take responsibility for some difficult decisions and rhetoric will not help when the reality hits us that we need to find billions to invest in restructuring our hospitals or our railways".

In a recent speech, Sinn Fein Minister Barbre de Brun made her case (and her excuses) in a way that any other Minister would echo - in Stormont, the Dáil or Westminster. "I have to be realistic because resources are tight...I will not promise to do things that we cannot afford but for me 'resources permitting' is not a get-out clause but a statement that there are limitations to what can be achieved". Francie Molloy, Sinn Fein health spokesman, has stated on Talkback the he is not opposed to private medicine "on principle".

An all-party assembly committee on the PFI, chaired by Molloy, concluded: "while the preferred source of finance is public finance… Other sources of finance, including Public Private Partnerships, are likely to play and important role". Martin McGuinness of Sinn Fein and Carmel Hanna of the SDLP are presiding over a massive expansion of the PFI in the education sector. In March 2002 McGuinness announced a number of new PFI projects (seven schools in total) and also decided that school staff other than teachers should be privatised along with their schools. Mark Durkan was, and Sean Farren is, a Finance Minister in Gordon Brown's image (and shadow). DUP Ministers are introducing PFI's into road building and both the UUP and the DUP have long records of voting for Tory economic and social policies at Westminster.

The controversy over de Brun's decision to close the Jubilee maternity unity at the City Hospital in favour of the Royal Maternity illustrates the other profound difficultly in relying on the Assembly to defend our health service. On what basis did the Assembly health committee, the MLAs and de Brun decide to come down in favour of one unit or the other? There are reasonable grounds for suspicion that some voted on sectarian grounds for either the hospital based in a mainly Catholic area or in a mainly Protestant area. No one appears to have raised the possibility that both units could stay open.

Fighting Back

The health and welfare of ordinary people always has and always will depend on their own strength. Marching feet and raised voices can make a difference. The Rural Hospitals Campaign, which brought together local campaign groups in Omagh, Enniskillen, Mid- Ulster, Downpatrick and Dungannon, has demonstrated well what is required. United and determined action to secure increased funding for our NHS is the only way forward. Now the campaign must be broadened, involving campaigners and trade union activists in Belfast as well as in rural areas.

The Socialist Party proposes a moratorium on all cuts and a determined campaign to force Westminster to increase Northern Ireland's budget allocation significantly. This is entirely achievable. If it is explained that the money is there, that it has been stolen, that it can be wrested back, the support of working-class communities will be over-whelming.

In Dungannon, Downpatrick, Omagh, Enniskillen and elsewhere tens of thousands have come onto the streets in recent years to defend their local hospitals. Fifty thousand marched through Downpatrick several years ago, a mobilisation of almost every adult in the area. Twenty thousand rallied in Omagh in October 2001. A turnout of this nature on a working day (a Monday), in some cases against the wishes of local employers, had the character of a local general strike.

Relying on “the force of public opinion” and spending large amounts of money on commissioning reports from “consultants” will achieve little. Both Conservative and New Labour governments have long track records of ignoring "public opinion". A petition with 1,000,000 signatures did not save the accident and emergency department at St Bartholomew's in London. The Edgware Hospital in Middlesex closed despite the fact that the local Tory MP resigned the Conservative whip before the 1997 election and the prospective New Labour MP promised to keep it open. It is action that will achieve results, not words.

It is possible to fight back through the electoral system of course. Raymond Blaney was elected to Down District Council in June 2001 on a platform of defending acute facilities in Downpatrick. Two other campaigners failed to win seats but gained respectable votes. Their campaign was met with fierce derision from the established parties, in particular from the SDLP.

In England hospital campaigners in Kidderminster won a parliamentary seat at the last election. New Labourite MP David Locke had promised to campaign to keep the Kidderminster Hospital open before his election to parliament in 1997 only to renege on his promise in exchange for a few crumbs from Blair's table. As a result of his betrayal he was unceremoniously ejected from his seat and Dr David Taylor romped home with a 17,000 majority.

Kidderminster Health Concern have been contesting elections for some years. In 1999 they won seven seats on the district council. In 2000 they won eight more and four Labour councillors defected to their cause. In 2002 they won further seats taking the total to 21 and gained control of Wyre Forest District Council. They also won six county council seats.

Kidderminster Hospital served a population of 135,000 before its closure. Local campaigners argue that it had to close to make a new PFI hospital 20 miles away in Worcester more profitable. During the period 1996-1999 the projected costs of the new Worcester Hospital doubled and during this period the decision to down grade the Kidderminster (built in the 1960's) was taken. In February 2000 John Jones was driven past the closed Kidderminster in an emergency dash to Worcester. He never made it, a heart attack carrying him off. Two years earlier he had written to Tony Blair begging him to prevent the downgrading of the hospital. We will never know if the Kidderminster could have saved him.

In the last general election in the South six TDs (members of the Dáil) were elected on a health platform. Recently a newly formed "Health Party" won 23% of the vote in one area of Sweden standing on the issue of closure of maternity hospitals.

The Role of the Unions

The NHS was not an overnight creation, nor was it the brainchild of one brilliant reformer. It was the end product of a long and complicated social process. Over centuries the ruling -class provided various forms of, usually rudimentary, healthcare for the poor. They did so to preserve social stability and to provide a healthy population for their factories and their wars. Some individual members of the ruling-class did act for reasons of philanthropy but in the last analysis, as argued by US health care analyst Vincente Navarro, "class struggle was indeed the main force" behind the development of state health care.

Indeed understanding the rhythm of the class struggle is the key to understanding the development of the NHS. When those who control society sit down to discuss their options they do not have the luxury of doing so in a social vacuum. They must calculate the degree of pressure from the working class, expressed through the trade union movement and working class political parties. This pressure means that at times the ruling class concedes temporary measures to buy social peace. This is the case with the NHS.

There would be no NHS today if it were not for the trade union movement. It would not have been created but for the struggles of generations of trade unionists before 1948 and it would have been dismantled by Margaret Thatcher if it were not for the resistance of rank and file activists up and down the country.

The unions will be key in the struggle to defend and rebuild our NHS. In recent months workers in Northern Ireland have shown their strength, emerging victorious from a number of significant disputes. Fire fighters forced management to sway from attacking their terms and conditions after a ballot which went 100% in favour of strike action in early 2000 and in late 2002 are now again engaged in struggle. Social work staff in North and West Belfast won a significant increase in staffing levels for childcare services after a solid campaign of industrial action in April and May 2000 (including non-completion of court reports, strict adherence to a 37 hour week, and non-completion of administrative work).

This dispute was centred around the scandalous under-funding of childcare services for some of the most deprived communities in Europe. The workers involved were fully prepared to talk and to argue their case but in the end it was action that won the day. The ballot was well over 90% in favour of action. Management eventually conceded and created ten and a half extra posts in child-care and agreed a review of the service.

It is difficult to argue with the conclusion of dispute organiser and Socialist Party member Kevin Lawrenson that, "the traditional method of struggle, with the union taking on the employer with industrial action, is without question the most effective, and the success of our dispute completely

vindicated our approach". Social workers who work for the Foyle Health and Social Services Trust followed the lead of those in Belfast and have also organised industrial action on the same issue. Now the issue has been taken up be social workers across the North.

Most significantly school term time workers- mainly secretarial staff and classroom assistants - won a long battle to be paid over the summer and other breaks after a magnificent yearlong campaign. This group were supposedly almost impossible to organise. They responded to a militant lead (with Socialist Party members in key positions) by joining the public sector union NIPSA in their scores and taking part in dozens of pickets, lobbies, street stalls and meetings and ultimately organising to take industrial action. They achieved victory despite foot-dragging by the then right-wing leadership of NIPSA and opposition from Martin McGuinness. Since then the leadership of NIPSA has swung to the left, partly as a result of the victory of the term-time staff. The left group "Time for Change" now has 13 members on the 25-member executive. Six of these thirteen are Socialist Party members. In November 2002 socialist Party member Carmel Gates won 39% of the vote in the election for a new General Secretary for NIPSA standing on a" Time for Change" platform.

The giant public sector union UNISON in particular, with 1.3 million members many of whom work in the NHS, is key to the future of our hospitals. Defending Northern Ireland's health service and resisting the implementation of the PFI here will depend on the rank and file of UNISON for victory. A number of other unions are also important organisers in the NHS including NIPSA, AMICUS and ATGWU. All unions, those who organise NHS staff and those who organise workers in other sectors, have an important role to play.

The present right wing leadership of UNISON are tied hand and foot to New Labour and the policies they have borrowed from the Tories. They have criticised the Private Finance Initiative but in reality do little to resist its implementation, instead relying on New Labour promises to ameliorate its worst effects. In the NHS the UNISON leadership are relying on the introduction of a national framework for terms and conditions despite the fact that it clearly allows the continuance of the right of Trusts to introduce local variations.

Recent elections in UNISON have demonstrated that the left is making real gains and winning the arguments on the best way forward. Roger Bannister, Socialist Party member and candidate for the Campaign for a Fighting and Democratic UNISON (CFDU) gave the right wing a real run for their money in the last election for the General Secretary position. Prentis, the right wing candidate, gained 125,584 votes (or 55.9%), Bannister 71,021 votes (31.65%) and Malkiat Bilku, a second left wing candidate, 27,785 votes (12.3%). The combined anti-leadership vote totalled 44%. Last year the CFDU doubled its representation on UNISON's NEC to six, including three Socialist Party members Roger Bannister, Jean Thorpe and Ralph Parkinson.

The swing to the left in UNISON has since been replicated by left victories in a number of unions. Left-wing candidates (though some are more left than others) have taken the helm in the RMT and ASLEF (rail-workers), the PCS (civil servants in Britain), and the NUJ (journalists) and in AMICUS (representing workers in both the private and the public sector). These victories are of vital importance. There may be a real need to take industrial action to defend the NHS in the next period, in particular to defeat privatisation.

Democracy in the NHS

The NHS has never been run democratically. In the early years hospital consultants had a disproportionate say. Under Thatcher managers came to the fore. Most recently General Practitioners have seen their role expanded. In theory we all have a say through regular elections with elected politicians deciding on the overall strategic direction and financing of the NHS. As with much else in society however, the reality is somewhat different.

Elections every four or five years may or may not replace one government with another but the rules by which they govern do not alter. Thus a new government may tinker around the edges with the NHS, or any other area of policy, but little of substance changes. Big business, through their absolute domination of modern capitalist economies, ultimately decide on policy.

The main political parties in Britain or Northern Ireland do not diverge in their positions on the key political issues. The market is king, unemployment is a price worth paying for economic stability (stability for the owners of the factories, not for those who work in them) and the welfare state is essentially unaffordable and unsustainable. This unaffordability means that social policy, and health policy, has become a constant exhortation to keep down costs, to cut waste, to streamline and to centralise in the interests of efficiency. Any political party or individual that rejects this approach is derided as not living in the real world. Any real challenge to this political status quo would meet fierce resistance from those who really control society.

Ordinary working class people are perfectly capable of understanding their own health problems and their health service. They can work with NHS staff to improve their health. Doctors, nurses and social workers do not have to issue judgements from on high to a docile population. Patients are not "consumers", an odious Thatcherite concept, which reduces us all to being what we consume. Julian Tudor Hart has proposed that staff and patients should work together as "co-producers". Together we produce a desired outcome, improved health.

It is important to assert that people deserve a real say in their health service. The way forward is through co-operation at every level. And genuine co-operation means genuine democracy, a real say for everyone. This requires both locally elected bodies, representing the community and NHS staff, which will decide on local priorities, and a national body to agree a strategic plan for the future, properly funded and accountable. Services must be equally available to all, regardless of where we live, whether or not we own a car or whether we can afford private medicine.

Inequality and Health

Whilst the NHS is well worth defending this doesn't mean that it is not open to criticism. Fifty years after its inception it has achieved much. In particular, it is very good at dealing with acute (or sudden) illnesses and with accidents. It also helps to lessen the suffering caused by chronic illnesses which are, at this time, "incurable". The NHS has been much less successful in implementing a strategy for prevention of ill health. Indeed, its emphasis on acute illness has earned it the sobriquet "National Sickness Service" from some.

At the end of the day however, prevention is much less about what a doctor or nurse can achieve and much more about how society is run. Much ill health is related to poverty and unemployment. Even so-called "way of life" factors, such as smoking and excessive use of alcohol, are often directly linked to the stress of living in poverty. The NHS cannot remove poverty and unemployment, only a revolutionary change in the way society is run can do so.

The NHS's failure in this area, or more accurately the failure of society to seriously tackle its social ills, is the reason behind the greatest health scandal of our time, the damming fact that inequality in health has worsened dramatically over the last 30 years. Whilst the population as a whole has seen its health improving, when measured on such factors as infant mortality and life expectancy, the rich have benefited disproportionately and the poor have lost out. Every year between 22,000 and 100,000 people die prematurely because of their class in Britain. If this was an epidemic of influenza or measles it would be tackled resolutely by every known method. Why isn't the death toll of class tackled? Surely a "civilised" society would not tolerate such a waste of human life? And perhaps a society that does is not " civilised" in any real sense of the word**.**

All measures necessary to tackle ill health must be on the table, and we must place new emphasis on tackling the single most important factor, inequality. Then we will have a new kind of health service.

What is Necessary

The Socialist Party fights for the following programme.

1. The Socialist Party stands for a fully comprehensive, publicly funded and free at the point of access health service. It resolutely defends the NHS but also fights for changes that will deliver better health for all. Good health is not just the absence of life-threatening illness but "a state of complete physical, mental and social we-being" (World Health Organisation 1965).

The WHO has recently re-defined health, arguing that because of the inevitable rationing of health care on a world wide scale, we must restrain our ambitions and target serious illness only. The Socialist Party rejects this approach. It is not enough to spend money on disease once it arises. A proper Health Service seeks to prevent disease arising in the first place.

This does not mean preaching at people about smoking and drinking. The greatest causes of ill health in this society are poverty and unemployment. Genuine prevention means taking measures to wipe out poverty and unemployment and ending inequality, the greatest killer. This requires a 35-hour week with no loss of pay, full employment and a £6 an hour minimum wage as a first step towards £8 an hour (the European Decency Threshold).

2. In order to avoid health care shortages there must be a massive increase in spending on the NHS. It is only by providing adequate resources that health care problems can be tackled. The proportion of GDP spent on health in the UK is 6.9%, a lower figure than in nearly every other advanced country. NHS spending needs to double. The wealth already exists in society to provide the necessary resources. Taking the 150 largest companies into public ownership, under democratic control, would generate billions of pounds for increased social expenditure. A socialist economy would create new wealth which would enrich everyone's lives and make scarcity a thing of the past.

3. There should be an immediate moratorium on any further hospital closures. A closure is only acceptable if it can genuinely be demonstrated that it is in the interests of patients and the local community. As such a case has not been made we must fight for all current acute hospitals to remain open and plan the way ahead on this basis.

4. For this to happen there must be an increase in resources, in particular human resources. The fifty per cent increase in consultant doctor numbers, as proposed by Hayes, and a similar increase in the numbers of nurses and other health professionals, will allow each hospital to continue functioning. Ultimately we need to double the number of nurses, doctors and other staff. The necessary increase in resources will only be won by determined campaigning, spearheaded by the trade unions, genuine community groups and groups representing patients and carers.

5. We must reward all those who work in our health service with decent wages and conditions. As a starting point, all NHS staff should be on national terms and conditions, should receive at least £8 an hour (the European Decency Threshold), all forms of Performance Related Pay should be abolished and no-one who works for the NHS should receive more than four times the pay of the lowest paid.

6. Many of our hospitals require extensive rebuilding programmes. To use the PFI to fund this rebuilding is ludicrously expensive. Instead the finance ought to be provided by central

government. A direct labour organisation (building workers, architects, etc directly employed by the NHS) should be established to rebuild our hospitals. There should be no profits in ill health – for building companies or the banks.

7. All privatised services must be brought back into public ownership, including all nursing homes, residential homes and ancillary services. This would save the NHS money as there would no longer be the need for profit for the private companies involved. It would also allow the staff to be brought into the NHS, to be paid a decent wage and consequently improve their health.

8. We must complete the task unfinished when the NHS was created in 1948 and bring all areas of health care into public ownership. The pharmaceutical industry (drug companies) make £1.5 -£2 billion profit from the NHS every year. The pharmaceutical industry tops every league of profitability. In 2002 US company profitability fell by 53% overall whilst the profitability of the drug companies rose by 32% (from $28 billion to $37 billion). The drug companies make a profit of 18.5 cents on every dollar invested compared to only 2.2cents in every dollar invested for the average US company. The high street chemists (pharmacies) and the medical supplies industry also make hundreds of millions from the NHS. It makes no sense to hand over these huge sums. The pharmaceutical industry, the pharmacy chains and the medical supplies industry should be brought into public ownership and integrated into a new democratically controlled NHS.

9. The New Labour government plans to spend £50-£100 million each year on paying private hospitals to carry out operations for the NHS. Instead we should bring the private hospitals, including the two in NI, into public ownership. All private beds (pay-beds) in the NHS should revert to the public sector. Then we could utilise the beds available in the private sector without the expense of creating profit. Private medicine should be outlawed as a form of discrimination (it discriminates on the basis of class).

10. At present General Practitioners are effectively self-employed and huge sums are squandered each year on administering a complex system of payments. Dentists and opticians are also paid per item of work. Primary care, dental and optical services should be fully integrated into the NHS, with all practitioners becoming salaried NHS employees.

11. Community care must be expanded. The Socialist Party is in favour of caring for as many people as possible in the community. This can only be done with adequate resources. Developing community care must not be a back-door method of closing beds in hospitals or privatising services previously provided by the public sector.

12. Genuine democratic control should be introduced into the NHS. The Trusts must be scrapped. The service should be overseen by local and national bodies representing health service unions, the wider trade union movement, patient groups, carers and elected local and national politicians. Managers should become administrators, responsible to elected bodies.

The NHS in Northern Ireland should be run by local committees, made up of one third local councillors, one third of members representing the staff of the local service (elected through their unions) and one third of members representing community groups, voluntary groups and patient groups in the area. These bodies should elect two thirds of the representatives to a regional body which will oversee the NHS across Northern Ireland, and which also has seats for representatives of central government. There should be similar democratic accountability at all levels in the NHS.

Capitalist society makes ordinary people feel powerless and makes them feel that they must hand over control of their health to experts. Under a new NHS everyone can have greater knowledge and greater education about their own health. We can all be co-producers of our own health, alongside health professionals.

13. There needs to be a new emphasis on the prevention of ill health. Ultimately there is only one way to finally to tackle the toll of health inequality – through the democratic socialist organisation of society. This requires the public ownership of the large companies that dominate the economy, and the utilisation of the resources of the economy in the interests of all.

Conclusion

The assumptions underlying the conclusions of the Hayes Report are just that, assumptions. There is no robust evidence to back up its main conclusions, that more hospitals and beds must close and that the private sector must be given further opportunities to make a profit from ill health. A revolt by ordinary working people can stop all of this in its tracks.

We want a moratorium on further closures, a determined campaign to wrest increased funding from Westminster and a NHS run openly and democratically in the interests of everyone. Rallies and marches, and ultimately strike action, both of hospital workers and other workers, will be necessary to ensure that this campaign is a success. The excellent initiative taken by Raymond Blaney and other hospital campaigners in Down may be only the first such. Hospital Campaigners across the North should consider standing candidates in the Assembly elections , if they occur, and in the next local elections.

In the 1970s patients and staff occupied a number of hospitals in London to prevent closure. There was a fierce struggle around the future of the Elizabeth Garrett Anderson Hospital in particular. The idea of occupation should now be on the agenda in Northern Ireland. If moves are made to close a hospital such as the Downe, in an area where a strong campaign exists, the staff, patients and local community should refuse to accept closure. If they occupied and prevented management removing equipment this would have an electrifying effect across the North. Such a move would clearly also provide the spring board for an electoral challenge on the issue of health.

This is a rich and sophisticated society. There is no need for anyone to lie for hours on a trolley in casualty or to die prematurely because of their class in the early years of the twenty-first century. We can sweep away all the rubbish of the past and create a new service we are truly proud of. The resources and the technology are there. All we need is the will.

Publications

This pamphlet is produced by the Socialist Party in Northern Ireland as a part of our campaign to develop public services. We regularly produce our monthly paper, *Socialist Voice*, and our quarterly journal, *Socialist View*.

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Information:

Should anyone feel the need to check the actual Hayes Report, here it is:

http://www.dhsspsni.gov.uk/publications/2001/ahrgrep.html