

THE NHS IS 60

undervalued, under-funded, undermined



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Introduction

by Alan Woodward

This booklet, published by Radical History Network of NE London, attempts to see clearly through the manufactured euphoria which will undoubtedly emerge around the 60th anniversary in July 2008 and provide a more realistic view. Of course the UK National Health Service is still to a certain extent "The Envy of the World" [Caldwell – the author's reference can be found in full in the Sources/ References section]. With its provision of medical care, for even the poorest, with no extra payment on delivery, despite the attacks, open and hidden, the NHS is a tribute to the million or so staff who daily work hard to provide services.

However the hard reality is that the NHS is at present undergoing consistent sabotage from within. The government, or more precisely the Department of Health, has been conspiring for some years to substitute a commercial healthcare market for the existing health service. A considerable portion of the increased government expenditure has gone to the so-called "independent sector treatment centres", or more plainly, the private sector. Their plans are to copy the USA version of health care, and the agencies involved are the profit obsessed "health management organizations"; moreover, the plan is being realised on a wide front, in virtually every area in the country. Cleverly disguised by rather grand schemes like that of Lord Darzi, big business is attempting a mass take-over. Its pursuit of doctors' surgeries is only the start, but serves to awaken resistance.

This will be a money based system, with private insurance as the entry point. We know from news seeping from the market dominated countries, of people dying on the streets, of the insurance exclusions. The film SiCKO exposes this as a warning we would do well to learn. Unless we stop this scandal, we will soon have a national wealth service.

The content of articles

We start where the imposition of a central state organisation on a provision that had been partly voluntary or municipal for decades exposed it to the limitations of all such bureaucracies. A

more local service, with its popular control more in the libertarian style of elected area bodies, would have made it more conducive to social pressure. But this was to be “the path not taken” by the welfare provision despite the glowing example of, say, the Peckham Centre. Liz Willis looks at alternatives.

Regardless of this, one huge gap was apparent from the outset – the exclusion from the thousands of workplaces in the country. There was to be no unified Occupational Health Service, despite the high percentage of ill health created by work. The demand for a comprehensive funded OHS became the policy of many unions, of the TUC, and even appeared in Labour Party election Manifestos, unfulfilled of course. The Hazards at Work movement prefigured later environmental concerns. Alan Woodward examines the consequences for employees and the movement for change.

With the continued existence of the “workhouse” philosophy – and its heritage – low pay, expenditure cuts and under-funding have been inevitable. This has produced growing conflict with the dedicated staff, as well as patients. The consequential rise of health service trade unionism in the 1970s and 1980s makes up another chapter in our narrative. The middle period of the 70s and the 80s was marked by resistance to low pay, cuts and hospital closures. The first of many “re-organisations” showed government verbal promises, but actions that introduced the reverse of progress. As well as union organisation, we also saw the establishment of organisations to co-ordinate this such as the London Health Emergency, plus local Health Emergency groups. Lesley Fisher, Terry Burton and Dale Evans tell of some fragments of the resistance by health workers.

These years also saw a new event – hospital occupations, usually organised by nurses. Factories, mines, depots and such like had seen workers taking over the premises, expelling reluctant managements and setting a collective model for a future society. We reprint extracts from this document, published originally by LHE and re-published recently by the libertarian libcom.org.

Within the health service itself, provision for mental health has been the poor relative. Tales of mistreatment and disorder abound and the users of treatment have a strong loyalty to each other. As usual we have seen cuts. Peter Sartori records the experiences of just one group of users, and their success.

The extremely narrow approach of orthodox medicine, with its universal panacea of commercial drugs, is believed by an increasing number of patients to be too rigid. Of the many alternatives, herbal medicine, tested not by modern science but by centuries of social practice and found, by this pragmatic experiment, to be beneficial in prevention as well as treatment, is growing in popularity. Melissa Ronaldson looks at the practical case for the holistic approach.

In the last two decades a new danger has once again been added to the long-standing problems of adequate provision. This is privatisation. Starting from peripheral functions, under Thatcher, such as cleaning, the Blair/Brown administration has introduced the wholesale transfer to American-style multinational companies, the so-called “health management organisations”. The horrors of the US health care system with its tens of millions excluded, or under-financed, patients, are becoming well known. Keep Our NHS Public analyses the hidden problems of health conspiracy by the Department of Health.

Lastly

Those seeking further information can consult the Directory of organisations, general reference list of publications and websites, and short book reviews at the end of the booklet.

Items not covered

In the planning stage, we identified a range of subjects which could illustrate our idea but which we have been unable to follow up. These included a particular aspect of neglect, that of preventive health. Despite a nominal commitment to tackle the problems before they began, even with the later additions of screening, this remains an outstanding exclusion [Tudor Hart]. A second concern, hospital created disease, like MRSA and *C.diff* currently, is a hidden dimension and spoken of as a temporary blip. But some commentators have articulated the experiences of the many sufferers for decades from iatrogenesis or hospital/doctor-created disease, mainly in the USA [Illich]. A UK book re-emphasised this for home territory [McTaggart]. Further work remains to be done in these areas.

Perhaps the last omission is the greatest. Despite the valiant efforts of many members of unions in the past to resist commercial and vested interests, the present conspiracy for privatisation by the government has been accepted passively by the national union structures. Their loyalty to the Blair/Brown administration blinds them to the consequences. A study of this betrayal is long overdue.

Where we come from

Our initiative is penned from a perspective, not of a neat theoretical basis but from the experience and thoughts of those on the receiving end of social institutions. Hence our accounts could be prone to alienation, material poverty and a not-always-finalised set of ideas, but readers must judge for themselves. The overall political context is examined below and looks at the long term politics of health. For now, we would emphasise that the document makes no claim to be disinterested or academic about the national health service, though there is a preference for a libertarian welfare society (which is considered in our first contribution).

Some of us view the workers' councils, examined here, of Spain – and those of Germany, Italy, France, Algeria, Russia, the Ukraine, Iran, Ireland, etc. – as inspirational and the most likely models for a new society [Woodward].

Hence our theme will be the celebration, but also radical criticism, of the manifestation of the British welfare state as it has developed. We take this from a concept of a welfare society which gives a form of direct provision with a collective organisation. Our story could be subtitled “The Path Not Taken”, as in Colin Ward’s memorable expression of the libertarian alternative to present social institutions [Ward]. In this powerful article he traces the hidden existence of working class organisations in the recent past, and their creative potential, a key concept for us.

Who we are

Radical History is mainly defined by negatives. We are not from the recesses of the traditional political left and its disputations. Instead we are motivated by a firm faith in people’s capacity to organise in their own best interests, both in stable periods and in interludes of revolutionary type change. We reject the role of the interventionary party at all levels and in all forms. Electoral activity, for municipal and national parliaments, we regard as definitely ancillary and a special method only.

Our organisation reflects this choice –

- the NE London branch meets monthly
- those attending are nearly always ex-something or other

- the subjects discussed are decided by those present
- most are active in campaigns for local control, anti-racism and anti-war, for a greener world and generally doing-it-ourselves.

Of course we are vigorous in the movement to keep the NHS out of the clutches of private ownership, an object the last four governments have been very active in conspiring for. This is not too strong a word. We strongly support Keeping our NHS Public, and opposing the Darzi Plan, and other camouflage for mass privatisations, as outlined in the relevant contribution.

The political context

A final note is necessary about ideas and action in general within capitalist society. Clearly these are dominated by the economic market which gives priority to the production of goods and profit – not just because of personal greed but so that the surplus money can be re-invested to produce more profit, and then more investment and so on, in an ever-tightening cycle. This is the crazy dynamic of market control – present cuts and poverty so that profits can accumulate for the future!!

The market, as it existed in the first historical phase, had no place for the welfare of people like workers and their families – all that taxation could be more fruitfully re-invested. Only a few philanthropists thought differently. Medical treatment for the vast majority of those that preceded us frequently depended on charity schemes or institutions, a chancy business, with a high failure rate.

Improvement came on two fronts: firstly from the establishment of friendly societies of one form or other which functioned on the basis of weekly contributions in return for a minimal medical service. This grew to cover millions of the population by 1911. An authority on friendly societies comments that every district of every town and city in the country had a society making social provision for the poor, available nowhere else [Green]. The same author looks briefly at workplace based provision, a consequence of union organisation, our second item, and we also pick out one such scheme for more attention, the Tredegar Medical Aid Society in South Wales. David Green, it should be noted, advocates non state provision from a free market standpoint and his writings should be approached with caution.

A “welfare” state

Friendly society provision pre 1911 catered for around 8 million of the estimated 12 million people included in the National Insurance scheme, provided by doctors as medical officers, with a minimum of statutory assistance [Green, p 95]. The estimates vary about exact figures but the fact of friendly society success cannot be doubted.

It attracted the attention of the growing powerful commercial insurance industry which feared its competition. Despite the rhetoric used by Lloyd George, the resulting legislation gave a clear run to this despicable branch of capitalist enterprise and the new scheme, copied from Bismarck’s state run German style model, severely wounded the friendly society provision. Now some “approved societies” managed to hold on until the parliamentary representatives of “Old Labour” killed them off in 1948. An awareness of the political inheritance of the whole provision – a widespread and deeply felt libertarianism in South Wales especially – no doubt swayed their minds.

Revelling in its triumph, the “Combine” of commercial interests shared its power with the doctors’ national organisation, and the state bureaucrats. Compulsory state taxation rather than voluntary payment funded the exercise. In two stages we had a consolidation of power away

from working class bodies like friendly societies, and towards the institutions of capitalism, the privileged monopoly of doctors and institutional structures. We exist now under this mixed economy of welfare, but are about to witness, under Blair/Brown, a second shift of power and money towards the profit making insurance companies.

Sources of resistance

Opposition to the pervasive influence of capitalist control has always been a feature of the labour movement. Over the twentieth century, we can discern the growing influence of the political ideas of a broadly marxist or reformist nature. We are speaking of course of the organisations known for the complicity of trade unions in social democracy, or the Labour Party in Britain, and Russian style “communism” of various descriptions, including leninism and trotskyism. We cannot provide a complete political analysis here and can only note that these twin souls of socialism were originally the source of hope against naked capitalism but their ideas and structures have been corrupted and become distrusted. Their role has now expired into being part of the problem not the solution.

The libertarian approach

Our main consideration is another set of ideas which benefit from the growing present recognition of the limits of the state centred philosophies – that of libertarianism. This idea is based on the self activity of workers, their families and miscellaneous self-managed organisations. Such a movement lacks the central coherence of the Party run structures and shows an alarming – to some – display of contradictions. There is likely to be extremely uneven development. These “weaknesses” can also be seen as strengths, as they avoid the gross errors of the all-pervasive State and do not replace one hierarchy with another.

Mutual aid, voluntary bodies, friendly societies, federal structures, etc., are the hallmark of libertarianism, notwithstanding the occasional minor deviations of organised anarchism. This very basic “democracy”, not the dissolute parliamentary version, is the core of the movement – workers’ control, members’ rights, elected and fully recallable leaders, a minimum of full time staff and total accountability, are the watchwords. This is real hidden history, as Colin Ward identifies it. We would locate ourselves within that movement.

TWMAS

Within the present context, we can only snatch a glimpse of the best provision of friendly society non-state institutions. One well-publicised example originated from the Tredegar Workmen’s Society and Institute (TWS&I) of South Wales in the old century. For our enquiry, the best product of this vigorous friendly society was the Tredegar Workmen’s Medical Aid Society (TWMAS). Based on the steel workers’ and miners’ union organisation in the Welsh pits in 1890, this collected 2d or 3d in the £ [old pence, old money] in exchange for which the workers and their families got medical services [Foot].

By 1946, the TWMAS, in collaboration with five other medical aid societies from the South Wales and Monmouthshire Alliance of Medical Aid Societies, provided a panel of doctors, a surgeon, two pharmacists, one physiotherapist, a dentist and assistant, and a district nurse. Glasses could be obtained for 2s 6d and false teeth for less than cost price. Artificial limbs were free, as were injections, patent foods, drugs, wigs and X-rays. For those who had to go to hospital, a car was provided to the railway station and first class rail fare provided. For 4d a week, free hospital treatment was also available. The doctors were paid an average of £380, dependent on their patient list size. [Green p 165, 172]

The TWMAS was significant as its whole set-up was extremely well known to the 1948 Heath Minister, one Aneurin Bevan. Born in the area to a mining family, he had worked for the TWS&I for many years, mainly on the provision for the townsfolk of the magnificent municipal Library. Bevan was able to spend £300 [old pounds] a year on new purchases. Thus this famous left wing parliamentary leader did his duty, along with attacking housing squatters elsewhere, to destroy the fruits of working class initiative – should the Blair events surprise us?

A second view on the TWMAS can be found in A J Cronin's celebrated autobiographical novel *The Citadel*. This book examines the working of the MAS Committee in an unusual portrayal of working class democracy in action. Cronin's account of the fictitious society, drawn from his experience, is a rare description of a lost treasure. A last comment from an old activist from the Valleys. He said that in 1948 "We expected the creation of a whole nation of Tredegars, but got something different". You could say that again.

Conclusion

The topics we raise in this little publication will not be solved in the short term; progress will only follow the effort of direct action, not delegation to political representatives.

We urge all to participate, as the struggle goes on!

A Libertarian Alternative?

by Liz Willis

(member of the Editorial Board of *Medicine, Conflict and Survival*, a designated journal of MedAct: for further information see www.medact.org – Publications)

Over the centuries there have been many critiques of established or orthodox medicine, from within the profession as well as from people who tried to find ways of helping and with luck when necessary healing themselves and each other, whether through rejection of established practice or by force of circumstances. Some of them, the most relevant to our discussion, have been consciously radical, even revolutionary in intention, seeing collective efforts at mutual aid as pointing a path towards a different organisation of society.

Traditional histories of medicine in Britain, which now look distinctly old-fashioned, used to paint a picture of inevitable progress, overall, towards 'scientific' medicine, and the supposedly universal access to a health service provided by a benevolent state; historians who were often doctors themselves paid homage to the great men, 'fathers' of this and that advance or specialism. By the later 20th century this view was being challenged from various perspectives: theoretical (Illich, McKeown); feminist (Boston WHC); humanitarian (Abse); and ethical (Kennedy) which will not be recounted in great detail here. Of course there were also critics of the critics, and the debate continues.

Individual expedients

While aspects of such writers' analyses may have been new, there are many earlier literate and literary examples articulating the ambivalent, uneasy or openly hostile feelings people have possibly always had about medical 'magicians' – we need them, almost inevitably, sooner or later, but can we trust them...?

Sometimes rules were imposed on them by legislation, indicating the desire of the ruling groups in society to keep them under control, while the moderately affluent often resorted to self-help. Do-it-yourself domestic medicine and regimen (supposedly healthy life-style and routines), self-administered for the preservation of health, do not, however, necessarily imply a rejection of orthodox medicine. For many centuries it was accepted that those matters were not the province of the physician but of the well-to-do householder, who would at the same time provide similar or modified routine health care for dependants. The extremely rich (royals at any rate) would have their own domestic medics.

The attitude of the lower classes is more difficult to find expressed in their own voices. Paying physicians, resident or not, was for much of history far out of the question for the mass of the population, for whom reliance on the local individual or exchange of anecdotal experience with anyone they knew were the first and only resorts. In ancient Babylon, the historian Herodotus related: 'They bring their sick to the market-place, for they have no physicians; then those who pass by the sick person confer with him about the disease, to discover whether they themselves have been afflicted with the same disease as the sick person, or have seen others so afflicted; thus the passers-by confer with him, and advise him to have recourse to the same treatment as that by which they escaped as similar disease; or as they have known to cure others. And they are not allowed to pass by a sick person in silence, without enquiring the nature of his disease.' (Garrison)

Self-help and mutual aid, up to a point, but such a system would clearly be inappropriate in cases of severe or infectious disease or acute trauma, not to mention the issue of personal privacy. Unscientific too – but then so was every other type of medical practice for many centuries. In those circumstances the idea of trying something that seemed to have worked already was not irrational, and no doubt resulted in some successful outcomes. The underlying principle continued to carry conviction. In medieval times, a number of manuals appeared on gynaecological, obstetric and similar subjects, written for women, in an attempt to spread the accepted knowledge of the time, as practical solutions to down-to-earth problems. A holistic approach is discernible, combining the roles of social worker and psychiatrist with that of family doctor; disorders for which ancient cures were offered included family discord, indifference of men to their wives, and the barking of dogs.

Criticism from inside and outside

Another outbreak of publications written for and popular among the middle classes occurred in the 18th century, which was also a time of widespread satire and scepticism about medical practice. John Moore, himself a Glasgow physician and surgeon wrote in *Medical Sketches*, 1786: 'The difference between a good physician and a bad one is certainly very great, but the difference between a good physician and no physician at all, in many cases, is very little.' He advocated the 'healing power of nature' as against 'being teased to swallow drugs... a species of distress to which the rich are more exposed than the poor, provided the latter keep out of hospitals.'

The pressure for reform continued to build. An outspoken critic of doctors in the early 19th century was Richard Carlile, a radical, free-thinking printer, bookseller and writer who was repeatedly sentenced to imprisonment because of his consistent refusal to pay much attention to the law. He could justly claim that some of his best friends were doctors, notable among them Thomas Wakley, the first editor of the reforming medical journal *The Lancet*, but he did not like the surgeon of Dorchester Gaol, where he was confined in the 1820s. He wrote to this character in 1825, asserting the right to his medicine of choice (in this case an unfortunate one, crude mercury) and took the opportunity to criticise medical education, but explicitly not all medical

men, 'the majority of the more intelligent part' of whom he counted among his sincerest friends and supporters.

The less intelligent part he compared unfavourably with their 'wiser medical predecessors, the old women': 'Like those old ladies, with you, it was hit or miss, every case an experiment: if the patient is killed, the fault is the disease; if he recovers, wonderfully clever doctor! There is much less chance of being killed by an old woman for a doctress, as she will not be so rash with her experiments [...]' (Brook)

Collective Solutions and State Take-over

Later in the 19th century ordinary working people were beginning, or continuing in a different way to take matters into their own hands and organise collectively in case they should fall ill or meet with an accident, forming friendly societies and medical institutes that enabled them to have access to effective affordable medical care. Colin Ward, the anarchist writer and theorist, has described how 'the tradition of fraternal and autonomous associations' sprang up from below and flourished until displaced by a system of 'authoritarian institutions directed from above'.

Eventually 'the great tradition of working-class self-help and mutual aid was written off, not just as irrelevant, but as an actual impediment, by the political and professional architects of the welfare state' and 'the social principle' was subordinated to 'the political principle'. (Goodway)

The process is analysed in detail in David Green's book on *Working-Class Patients and the Medical Establishment*, which identifies the National Insurance Act of 1911 as another 'Path Not Taken' (in Ward's phrase). This Act he sees as giving government backing to a more unequal doctor-patient relationship. It also affected the future role of Medical Officers of Health:

The locally based Medical Officers of Health argued that their knowledge and geographical structure would be the obvious delivery system [for a national health service]. However, the adoption of the German model of social insurance in Britain through the National Insurance Act 1911 made the creation of such a system impossible, and they found that their work was dominated by managerial responsibilities rather than their old investigative and community-based activities.

– The Annual Report of the Chief Medical Officer of the Department of Health 1997

In Green's view the 1948 creation of the NHS (under a Labour government) was in keeping with the spirit of 1911 (as part of the Liberal reform programme). Political parties in power and in opposition all focused on a government-led 'statist' way of organising, with whatever variants and modifications, as did many non-governmental groups, comprising a 'sinister alliance' of Fabians and Marxists. (Ward, Goodway)

Medicine for All

Of course there were voices for a more people-centred approach, with good intentions and some good ideas. In 1943, when the shape of the NHS was still under discussion, not a foregone conclusion, the debate was opened up to a wider public by the Penguin Special, *The Future of Medicine*, by Dr David Stark Murray. The author was a founder member (1930) of the Socialist Medical Association (SMA) and later its President (1951-70), who continued his agitation for what he saw as a truly socialist health service long after 1948. (The SMA re-named itself in May 1981 as the Socialist Health Association "to reflect a shift in emphasis to the prevention of illness through the promotion of good health. The SHA now engages primarily in public education and lobbying on health issues" – see Directory.)

He insisted that medicine should not be the exclusive business of experts and favoured a free, comprehensive, universal service under democratic control, based on local Health Centres, so that he became increasingly concerned over what he saw as inherent weaknesses in the NHS, especially its undemocratic administration and lack of such health centres. His outlook included the idea that the discoveries and methods of science could provide models for social reorganisation, that science and medicine are deeply integrated with wider society, and that environmental surroundings and the general standard of living are crucial determinants of individual and national health. (Oxford DNB) Because of the complexity of modern medicine he also believed in teamwork and in the role of the GP, supported by close contact with specialist services.

A Different Approach

For a more thoroughly radical alternative we have to consider anarchist or more broadly libertarian viewpoints, expressed not just in criticism of the status quo but in constructive efforts. Medicine is one of the areas which are sometimes said to be necessarily authoritarian and hierarchical, beyond the scope of a self-managed society based on workers' control because of its complexities and the specialised knowledge required. Yet there have been a number of noted libertarian doctors who were highly competent, even eminent in their professional lives while believing their expertise should be demystified and health should be everyone's concern, and subject to people's control: in late 20th century Britain, Alex Comfort, Chris Pallis, John Hewetson (GP and editor of *Freedom*) and others; in 1930s Spain, Isaac Puente, Felix Martí Ibañez, Amparo Poch y Gascon.

And anarchists could point to examples, limited and impermanent but significant, where an alternative was tried out and achieved a degree of practical success: the Peckham Health Centre in London, the Spanish collectives of 1936-37.

Introducing an exhibition in 2002 on the Pioneer Health Centre, Peckham, Lesley Hall wrote that, in contrast to other initiatives aiming at positive health rather than merely avoiding disease, it 'placed the family unit and participation in a community, rather than the solitary individual, as central to a healthy life'. The Centre originated in a move to establish a birth control clinic, but soon widened its scope and was opened in 1926 to be run on lines developed by the two doctors involved, George Scott Williamson and Innes Pearse, in an experiment or 'pilot project' to study 'the living structure of society' and to try to identify ways of actively generating health. (Hall)

Later it was housed in a specially-designed building with day nursery, play area, swimming pool etc. Like a club, it had membership, open to local families on payment of a small weekly subscription, and its organisation was on the principle of autonomy; people were allowed to make their own decisions about medical treatment and members were encouraged to set up their own activities using the Centre's resources.

Wider aims

The doctors explained that the centre was not for treatment but for the promotion of health, to detect by periodic medical examination any incipient or existing disease and to advise, without directing, how to obtain treatment if necessary.

During the Second World War it was forced to close but in 1945 its organisers, members and supporters campaigned successfully to get the building back. A Petition on this 'matter of national and local importance', 'the world famous Experimental Health Centre at Peckham for the release of which EVERY member-family is petitioning', pleaded for its restoration. It pointed

out that the family and home had been the first casualty of war, and must be attended to, and that the PHC was 'not a polyclinic dealing with the sick but a Health Centre dealing with the cultivation of health'. Other localities were determined to build their own similar centres, and they argued it was also an international issue. (TNA AVIA 9/91)

Although it re-opened in 1946 and continued for a few years after the inauguration of the NHS, the Centre's respite was temporary, despite repeated efforts to secure funding and endorsement from the authorities. A Research Programme dated October 1949 tried unsuccessfully to interest the Medical Research Council in its objective: 'the unfolding of the fullest human capacities' with 'organism and environment in mutual synthesis'. (TNA FD 1/299) It did not fit in, though, on a number of counts: its focus on health not illness; the required, though small membership fee, and its philosophy of encouraging self-activity. 'It was based on autonomous administration and so did not conform to the lines of administration laid down by the Ministry of Health. This last anomaly highlights a wider problem of the general hostility in the years after 1945 from within the structures of the welfare state to any initiative originating outside and hence non-statist and libertarian.' (Goodway)

For the same reasons that it could not survive in the post-war climate it remains as a point of reference for those who argue that things have gone and could still go a different way – although obviously not to be copied wholesale in the different circumstances of the early 21st century.

Alternatives in Action: Revolutionary Spain

A reviewer in *Freedom*, the anarchist weekly (quoted by Goodway) in 2005 lamented that 'the Peckham model was rejected by the 1945 Labour government that instead created the top-down, state-controlled bureaucratic national sickness system', while urging the transformation of the NHS into 'a decentralized, community-led organization'.

In a very different context, some of its principles and a more developed version of anarchist ideas on the topic of medicine and health provision are to be discovered in accounts of the collectives established in Spain in the revolutionary upsurge that was sparked off by the Nationalist coup of July 1936. In areas where anarchists and syndicalists were numerous they experimented with new ways of providing health care among other services while struggling to survive, and to wage war.

Public health in the Republican zone during the civil war laboured under massive disadvantages and disruption; although there was a significant campaign to provide international medical aid, much of it from Britain (Fyrth) the burden in many areas inevitably fell on the local people with whatever skills and resources they had. Any success, such as the collectives' ability to send supplies to the front and to military hospitals (army doctors and nurses frequently treated civilians too, so that the help was reciprocal), was hard won.

There were doctors who supported the attempts to put theories of social revolution into practice, within the context of popular resistance to the military insurrection; some were members of the anarcho-syndicalist trade union, the Confederación Nacional de Trabajo (CNT) and in the view of at least one historian were among the best Spanish libertarian militants. (Leval)

Accounts of the collectives, often admittedly partisan but backed by evidence from witnesses and observers, praise them for having devoted much attention to medical and health services which they endeavoured to provide free of charge at point of use. Gaston Leval collated many detailed reports, based on first-hand observation of their efforts and achievements in various parts of the country:

Wherever we were able to make a study of villages and small towns transformed by the Revolution, medicine and existing hospitals had been municipalized, expanded, placed under the aegis of the Collective. When there were none, they were improvised. The socialisation of medicine was becoming everybody's concern, for the benefit of all. It constituted one of the most remarkable achievements of the Spanish Revolution. (p. 278)

New form of society

When the Civil War broke out, there was no specific doctors' Syndicate in Barcelona, but a 'Syndicate of the Liberal Professions' with various sections; he judges that the number of doctors involved must have been fairly large, by the speed with which initiatives sprang up to meet the challenge of the time. 'Individual and collective initiatives were encouraged; stately homes were requisitioned and the rooms were furnished, and beds set up all in good order.' Dr Felix Marti Ibañez was nominated director general of sanitary services and of social assistance in Catalonia.

Leval noted that new hospitals placed under a kind of governmental aegis were only the old establishments with a change of name, whereas those, much more numerous, taken over by the Syndicate were, with considerably less means, created anew on holistic, organic principles. Patients requiring urgent or special treatment were taken by ambulance or taxi to Barcelona which had greater technical facilities and specialised establishments. The sections based on specialisms were autonomously organised within the Syndicate, but this did not mean absolute independence, still less isolation from Barcelona; the plenary assembly would periodically make reappointments or modifications as required.

Within a year, Leval tells us, six new hospitals had been created in Barcelona alone, including two for war casualties, while nine sanatoria had sprung up in Catalonia. Properties were taken over, but the problem of internal equipment had to be solved by improvised means to meet immediate needs. Out-patients' departments were set up in all the principal localities in Catalonia, to which the smaller localities were attached. They had access to medical specialists and equipment which made it possible to prevent the crowding of patients in a few large centres.

Like other workers, doctors were directed to places where the need for them was felt most, and no longer disproportionately served the rich areas. When a locality asked for a doctor from the Syndicate, it would first check up on local needs and then select from its list of available members the practitioner whose qualifications were most suitable, and he would have to give good reasons if he wished to decline the posting; it was considered that medicine was at the service of the community, not the other way round. In the new clinics, operations were carried out free of charge as was treatment in psychiatric hospitals.

Attitudes of doctors to this upheaval not unnaturally varied: among the older ones, those of the formerly privileged class were far from pleased with the changes while those who had not yet achieved established status offered no resistance and even collaborated amicably; the young generally joined in with enthusiasm. There were no longer "señores doctores" receiving huge fees while other doctors lived virtually in conditions of poverty. More than half the practitioners cooperated voluntarily within their competence. Further steps taken were the general organisation of everything to do with pharmaceutical products and improvements in treatment for injuries suffered at work, with full-time medical services in large factories and workplaces.

It is on the whole a question of establishing services having as their objective to protect or restore health, on the one hand by encouraging economic prosperity and by increasing well-being, while on the other by eliminating what is prejudicial to public health: to this end the unitary Syndicates of Public Health propose the union of workers,

technicians and intellectuals, a union indispensable for public health and for the national economy.

– Feb. 1937 congress motion by the Sanitary Federations of Catalonia, the Centre and the Levante on the General and Specific Functions of the Unitary Syndicates of Public Health.

Like the Peckham Health Centre of mid-20th century London, the anarchist collectives of 1930s Spain clearly cannot supply a perfect blueprint for the future of health provision in the UK, but those, among other examples – some of which may yet emerge from historical research into the hidden areas of people's autonomous self-activity – go to show not only that a libertarian alternative is worth thinking about but that it can exist.

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Short Review (see pp. 60-62 for more of these)

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Occupational Health and the NHS

by Alan Woodward

Alan Woodward is now retired, and a regular user of the NHS. In work, he ran and took courses for shop stewards and union reps, as well as being a practising representative himself. He is a libertarian socialist.

The exclusion of the workplace from the NHS meant that the old system of medical supervision involved some hundreds of general practitioners as Appointed Family Doctors on a part time basis to make statutory medical examinations. In 1973 a more formal Employment Medical Advisory Service was begun. Even this resulted in less than 100 doctors specialising as occupational health staff. Management did appoint medical staff but also controlled their role and very few acted independently. Some did ameliorative work to the best of their limited knowledge. There was virtually no effective monitoring of health.

As a result, workplace health and safety grew steadily worse, while the general health of the population got better after 1948, sometimes dramatically so. Moreover the nature of the problem changed. From simple care against accidents, the enormous increase of new substances and chemicals now began to pollute the workplace, causing a massive range of ill health and disease, largely unrecognised until it was too late for the victim.

There were several components to this crisis in health. The owners of industry, or controllers of state institutions, had traditionally placed a minimum of regard on employees' work conditions and lives. Early attempts at regulation by officials monitoring these were evaded, by-passed on a large scale, despite progress from the turn of the century. Employees raising these issues were either promoted or dismissed, either way little was achieved but business was "as usual".

The legislation on occupational health did not cover workplaces beyond factories, offices, mines, docks and some specialised areas. Even so it was astonishingly selective in items it actually regulated. The Health and Safety at Work Act started a very slow process of modernisation in 1974, but regulation while extended was progressively weakened in terms of enforcement.

The government Inspectors had an excessively tolerant attitude towards property owners/occupiers who theoretically carried total legal responsibility. The Factory Inspectors had a pioneering role in exposing and trying to prevent the worst excesses of early capitalism, as is well known. Now they had degenerated – it was the "quiet word" approach after the breach in the law, prosecution was absolutely the last resort.

Trade unions' officials regarded health and safety as a provision for afflicted members – take court action to get compensation, never mind about preventing the human damage in the first place. The TUC generally colluded in this low level strategy. Workers were victims of the headlong pursuit of production and "efficiency" at any price. The interests of the shareholders or management came first, second, third, etc.

To rationalise this absurd situation a camouflage of excuses was erected as carefully as the ideology about capitalism itself in general: in particular, the myth of the "careless worker" Accidents and ill health had mysterious causes and therefore nothing preventative could be done – money remained the measure of everything!

The truth was more complex but simpler. All those involved were defending their own interests, while a steadily rising toll of workplace ill-health was hidden from view to all but the unfortunate. Victims of exposure to asbestos, substances such as Toluene Di-isocyanate or TDI, repetitive strain injury, long hours and stress, and those exposed to carcinogens – cancer causing agents – etc. knew only too well the consequences for their health but had little power to do anything.

By the mid 1970s the situation was ready to explode. A small number of doctors, workplace stewards, union researchers, friendly journalists, helpful academics and political activists intervened to bring about a minor revolution in health at the workplace. This meant the environment. This concern has now spread to the wider issue of the earth's environment, a problem many time greater, but arising from the same conflict over the effect of resources use for profit. For now, the revolution over health hazards at work had begun.

We can single out three elements in this success story – an organisation, an author, and rank and file union members – and their combination.

Hazards at Work, the movement

Firstly, the emergence after 1968 of the specialist group British Society for Social Responsibility in Science, better known as an instigator of the Hazards at Work movement. The BSSRS, a body of mixed parentage, looked at the contentious subject of workplace pollution by hazardous substances which could have serious or fatal long term effects on workers.

BSSRS activists set up hazards centres in cities and towns, and over the following three decades, published many valuable books. Foremost of these was ex-communist Alan Dalton's *Asbestos, Killer Dust*.

Individual hazard centres were usually linked to a network of H&S centres, usually linked to a TU H&S group. There were active groups in major centres. These included the Birmingham based Health and Safety Advice Centre, HASAC. and its counterpart the BRUSH, Birmingham Region Union H&S committee, whose secretary was a British Leyland shop steward. This operated in a much more open manner than the Coventry CHASM. It had an office, several advice workers and welcomed visitors – in short, it cut through the union bureaucracy effectively.

The London Hazards Centre, LHC, has been a constant source of books, as well as its bi-monthly journal *Daily Hazard*. It does pioneering work and capitalises on very valuable research done as part of its advice service. On this subject, I worked with various other union members to set up the Campaign Against Hazards in London (CAHIL). The Centre itself is publicly funded and cannot undertake agitational work so CAHIL does this. They provide an irreplaceable service.

It was the Hazards at Work movement that instituted the International Workers Day, 28 April, with its slogan *Remember the Dead but Fight for the Living*. This got increasing recognition both in North America where it started and elsewhere. I think the wording came originally from the legendary miners' organiser, Mother Jones, always articulate on workers' interests.

There were many supporting organisations and it is clear that the Hazards movement has been driven right from the start by activists from the bottom and in spite of the disinterest shown by the TUC and their official union leadership. There are many examples: asbestos dangers were exposed by union activists.

A final word on the overall politics of the movement. The Labour Party's policy as ever concerned making the system more efficient and occasionally slightly fairer. The Communist Party, like Labour, was made up of many excellent members. Its dual policy - pursuing a nominally radical line for the rank and file but making "arrangements" with dubious union and Labour leaders - would in the end lead to its collapse. Now it just resulted in an ambivalent role. The prevailing ideas of those who did the work were "new left", International Socialists or libertarian. As an alliance it seemed to work quite well.

Hazards at Work, the book

Our second major influence was a writer and his publication: Pat Kinnersly's influential book *The Hazards of Work and How to Fight Them*. (1973, 394pp.) This was the opening title in Pluto Press's series of "*Workers' Handbooks*", and has been called the union H&S reps "Bible". Pat Kinnersly himself was an independent writer. Pluto Press, as a small Left wing publisher, was very much outside official approval. More recently an Australian union manual on HASAW also owes its publication to them.

The *Hazards of Work* book made a powerful impact in 1973. Pat Kinnersly went on an extended lecture tour in that and subsequent years. He covered many shop stewards' committees, union branches and places where union courses were being held. The book was widely promoted by Union Rank and File groups, the National Rank and File Organising Committee, the Liaison Committee for the Defence of Trade Unions and most left political groups. In subsequent years, many union reps and political activists have found it invaluable, despite its being out of date in some legal and technical matters.

The essential thing about *The Hazards of Work* was that it changed the emphasis. Kinnersly collected a lot of evidence to show that, despite the "careless worker" nonsense, the reality is the carelessness of the employers. Workplaces are designed with no thought for H&S, layout is made to maximise production, management responsibilities are consistently dodged (including reporting accidents), tools and machines are outdated and worn out, occupational training is virtually unknown, substances are used with little or no planning, and unhealthy workplace practices like shift work are constantly being imposed.

Unhealthy and unsafe systems were built into practically every workplace. Far from being careless, most workers perform miracles to avoid accidents and ill-health, and employers exploit the very small number of examples of "carelessness" for maximum effect.

Kinnersly repeatedly said that health was now more important than traditional safety concerns. Accidents were the most "obvious" problem when most industrial processes were mechanical. However since the war, more and more technology has been used. Technology applied to workplaces means adverse health conditions for workers and the common sense rules about accidents are less relevant for occupational ill health.

Union health and safety representatives or shop stewards were becoming more aware of the epidemic of ill health from which, unlike accidents, there is no general medical recovery. A broken leg mends quickly, but in contrast, damaged lungs, heart, central nervous system, etc., either improve gradually or more likely just get worse.

Apart from the severe consequences for the workers affected, there are two general political consequences of this – the strain on the health service is considerably increased, a subject covered by Lesley Doyal in *The Political Economy of Health* (1979).

The government Inspectors have not been immune to the change. Their union, the Institute of Professional and Managerial Staffs as it was called at one stage, produced useful information, such as an Alternative Official Health and Safety Report. However they are part of the State, and as such their role objectively is to promote the interests of the dominant force in society. The H&S Inspectorate does perform these tasks in the last analysis. Some clarification regarding the role of the State ought to be one of the lessons learnt by workers in conflict with their employers.

Of course, the *Hazards of Work* book itself can be criticised from a socialist viewpoint. It is perhaps too tolerant towards government services and trade union leadership but that is another story. Here we can record the effects of its publication in improving the health of people at work.

The third influence was ground level trade union members. In contrast to the official trade union movement - TUC and suchlike - the rank and file have been consistent in their own interests. Still locked in the compensation role, national unions were slow to adapt. The process of getting money once the blood was on the floor was essentially a defensive process. It was also true that Union solicitors normally only took on strong cases, but there was a growing body of more adventurous lawyers, especially over ill health, that would deal with less certain cases. In summary it must be concluded that the union leadership plays at best a bureaucratic role in workplace H&S. It sees the issue as an opportunity for compromise and participation, with a heavy emphasis on the legal side. No change here then.

Since the 1970s, there has been a multitude of meetings, newspapers, conferences, books, research papers etc., with only limited help from the official union leadership. They have always kept their distance, perhaps because they realise they cannot directly control the hazards activity. This is the generous interpretation, but there is another that says they did not want to disturb established cosy relations with employers.

Asbestos

The situation can be explored through a case study of the dangerous dust, asbestos. Working for a building magazine, friendly journalist and political activist Laurie Flynn, from the International Socialists, had discovered that there had been a massive cover up over the fatal effects of exposure to the deadly dust in numerous workplaces, buildings and suchlike.

As a consequence, people were now starting to die in large numbers. The whole asbestos scandal broke when rank and file union members began to link the deaths of workers to the exposure to asbestos. Lagers in Glasgow and dockers in London were prominent in this. Laurie wrote a booklet, *Asbestos - the dust that kills in the name of profit* (1972, 16pp.) based on his research.

The Inspectors did virtually nothing and were severely criticised in subsequent court cases. The union leadership also did nothing and indeed the TUC played a very negative role. Its doctor sued the Hazards at Work organisation over allegations made in Alan Dalton's excellent book *Asbestos - Killer Dust* in 1979. This resulted in the technical bankruptcy of the publishers, the British Society for Social Responsibility in Science or rather the *Hazards Bulletin*. Its newsletter had to be published under a new title, *Hazards*, and a correction put in all unsold copies of the book. The uncorrected book holds an honourable place on many bookshelves.

Pretty soon the news spread. The employers set up a front organisation, the Asbestos Information Council, which did its best to spread lies that only blue asbestos was dangerous, white and brown were OK. Court cases followed. The mention of asbestos became enough to

give government Inspectors the nervous twitches, and union H&S reps were to become acutely aware of employers' irresponsibility over hazardous substances. They correctly drew conclusions that asbestos was not an exception. The general approach and the ineffectiveness of Inspectors was clear for all to see. Meanwhile hundreds did die, and continue to die, every year as a result of exposure.

By the 1990s the crisis had assumed huge proportions. The stability of Lloyds of London Insurance was threatened by the claims from the USA about asbestos cases and the huge costs of removal. Asbestos is the best case illustrating the irresponsibility of the employing class with regard to workers' health. It is now being realised that occupational ill health makes up one third of the overall total - all preventable if work were rationally organised and the money motive removed from private and public sector. Alan Dalton's important book, *Asbestos - Killer Dust* (1979, 287pp.) tells much of the early events.

In conclusion

Health while at work is still disadvantaged by the lack of regulation by those involved. Where they have the power, many workplace unions act as defenders of workers' interests. State regulation, under-funded and frequently ignored, plays an insignificant role, despite the intentions of individual Inspectors.

The problem, and the solution, remain essentially the same – more workers' control.



Haringey Health Workers get Organised

by Lesley Fisher and Terry Burton

Lesley Fisher is Secretary of Haringey Health UNISON branch, and works at St Ann's Hospital. Previously she was the main active member in the public employees union, NUPE. She is the National Chair of UNISON National Health section¹, a delegate to Haringey Trades Union Council, and holds other national union positions. She is a nurse.

Terry Burton is Secretary of HTUC and an "ill health retired" member of UNISON. He has worked at the Prince of Wales and St Ann's Hospitals, and Tanners End Lane Building. He was an admin worker, starting on the "1% Survey" of the health of Haringey adult residents

Their joint paper covers the early history of the union and some of the strike action of the immediate past. The problems facing unions today are looked at during the Thatcher years and currently. The writers make clear that the anti-union laws have not presented a major difficulty for them. The paper looks at the union organisation of NUPE and UNISON at workplace level at St Ann's Hospital.

The unions in the health service are a recent phenomenon, because when I, Lesley, started training in the 1960s, it was at a hospital where there did not appear to be any unions. When the first big crisis in my career occurred in 1978 and they tried to close down the Wood Green and Southgate Hospital, there were only two of us in the union. We won that and when they came again in 1982, we were better prepared.

At first it was just accidental that we were in NUPE. We wrote off to the T&GWU but they didn't reply. The branch secretary at the time said we were wrong to oppose the closure. We ignored that and went on visiting workplaces and campaigning. John C was very active in this. In the early years we did lean a lot on the full time officers, especially Mike Taylor.²

In NALGO, there was a tradition of keeping the full time officers away, but their members in the NHS who were relatively small admin and clerical sections, had few problems anyway.

In NUPE we always had a commitment to the ordinary members, the rank and file if you like. Unlike some unions in say the engineering factories, or NALGO in the public sector, which had geographical branches or separate branch executives, our tradition has been to have workplace branches. Not only that, we have tried to have section meetings for special groups and night workers, because for women, with family commitments, it was not always possible to attend evening branch meetings. We have won time off for workplace union meetings.

St Ann's: the base

In Haringey the main base has been St Ann's Hospital. We've had bits taken away to the North Middlesex Hospital, and bits added, like the COHSE exiles from Friern Barnet, but we've always tried to maintain and improve the union organisation here. Currently in this workplace, we have 80% union members and of those, 92% are in UNISON.

¹ UNISON was formed by the amalgamation of the National Association of Local Government Officers, National Union of Public Employees and Confederation of Health Service Employees.

² see *Work*, vol 2, edited by Ronald Fraser, *The Machine Minder*, for an autobiographical essay.

Today we try to keep up the workplace tradition, or linked workplaces in the health authority, but the Trusts³ are against that. They separated the North Middlesex Hospital off and the union organisation took a downturn there but it's now rapidly improving. The new branch secretary, Margaret B, is recruiting a good number of new members and rebuilding the stewards structure. This is a problem that we expect to overcome in the next few months if not sooner.

There was a powerful but ultimately unsuccessful campaign to stop the move to make the NMxH into a Trust. The campaign was well supported by staff, patients and public - it was marked by a big public meeting, a well attended march through Edmonton, and a massive petition that was signed by almost everyone to whom it was presented. The Joint Unions organised a staff vote in which over 90% rejected the Trust proposal, with a 90% turnout.

This was all ignored as the decision to press ahead had already been taken, a typical piece of "consultation".

Incomes Policy and pay

One thing that is worth commenting on in the historical sense is the question of pay and the incomes policies of the last Labour governments⁴. Pay is not the first priority of most of our members, various surveys have shown that, but Harold Wilson justified the incomes policy on the grounds that the well off car workers would be restrained, to the benefit of the low paid nurses. The Social Contract was similarly, though not so explicitly, legitimised by allegedly bringing benefits to the neglected public sector workers. So far as I recall, we didn't benefit much from either of these. Our biggest increase was from the Halsbury Review.

Thatcher

With the Tories came the anti-union laws and such like, but this seems to have had little effect locally. The NHS "reforms" from the mid eighties have created multiple problems for us but the net result has been a higher awareness of the need for the union among the members. In one sense Thatcher created strong unions in the NHS; we are certainly much stronger now than in 1979. We have lost members due to job losses and morale is low but the union has gained from the 18 Tory years. Let's look at some points in detail.

CCT

Compulsory Competitive Tendering was introduced in the 1986 as a cost cutting exercise by outsourcing services to private companies. The ancillary workers have suffered the effects of this. It was suppose to benefit the small company as opposed to the big hospitals but in fact the companies who won the contracts, here and in local government, all turn out to be part of some huge multinational company. It was the Tories helping their backers again.

The political aspect became clear when the union leaderships compromised from total opposition to CCT to trying to win in-house contracts. In 1986, we staged a one week pre-emptive strike here, and many other hospitals did likewise, but the campaign was dissipated as the leadership gave little support. Our strike was a big success. We had some bus loads of people who went to the Prince of Wales Hospital by Tottenham High Road where the health authority were meeting. We joined the picket line and had a meeting. Godfrey Eastwood, the union full time official, spoke and we won the issue here.

³ Trusts were the Tory government's method of breaking up the NHS into semi-commercial units.

⁴ Various post-war governments used formal incomes policies to restrict wages, whereas more recently spending limits do the same job.

Winning an in-house contract is better than losing it to financially driven private outfits, but it inevitably means losses in pay, hours, conditions and often union organisation.

"The Market"

"Competitiveness" really means worse conditions for those already at the bottom. It makes nonsense of Equal Opportunities policies, much vaunted by union leaders and managements, because those affected are largely women and ethnic minorities.

Later the purchaser-provider split created new problems. Nurses and health visitors were re-organised into community bases around GP units, instead of hospitals. While this can provide a better patient service, the effect on the admin and clerical grades has been disastrous. It means worse conditions like Saturday working, longer hours etc, all for very low paid staff on £8,000-£9,000.

General conditions in the NHS have deteriorated as a result of contracts. For example, supplementary leave provision, which used to give us five days for caring, doctors' visits, etc., is being monitored strictly, with targets and pressure to come in more regularly. Managers are trying to subvert long term sickness - previously 6 months on full pay then 6 months on half - for a shorter full pay period and ultimately pension pay, which is even cheaper for them. Short term sickness is, as in most workplaces, constantly monitored, with returnees' interviews and pressure to come back because of staff shortages, which are the managers' responsibility anyway.

Pall Mall kicked out

At St Ann's, the contractors Pall Mall - of Hillingdon Hospital strike fame - won the catering contract in 1996. We agitated to remove them. Because of inferior service, including the appalling cook-chill process, they lost the contract. We have partially re-instated the traditional cooking methods, rather than "ingredient technicians", by bulk cooking which is finally divided up in the wards. The staff are back on NHS conditions - all done by union organisation.

Nowadays private contractors are being protected by facilities contracts which require looser specifications. It is therefore much more difficult to apply penalty clauses and get rid of these companies.

1987 and its results

The whole question of nurse grading was the result of the successful nurses' strike and other actions in 1987. This was one of the most constructive actions of the period but the follow up was less so.

The 1988 Clinical Re-grading review had given some nurses higher grades but management would not pay for "F" or "G" grades. They simply went to departments and decided the grades they said they could afford and avoided the problem by not filling posts or advertising the same job at a lower grade. Here we had 700 appeals against the gradings anyway and we won 70% of them. The cases went on for years and we still have one not settled.

The last one to be heard was a good result. The manager just read out the management guidelines. She went on "You can't do this, you can't do that ..." The ACAS man replied, "The point is, Madam, you patently can", delivered the verdict and went off in his taxi! De-skilling was introduced in 1990 on the basis that it promoted enhancement and combination of personal skills. In practice, it's just a cost cutting exercise.

Lower levels

Dilution has accompanied de-skilling historically in engineering workplaces and the same applies here. Health visitors used to be all grade "G" but now more "C" and "D" grades are being employed. Less trained workers are doing work which is sometimes beyond them and may be giving inappropriate care.

Along with all this has gone an attack on Section 47 of the Whitley Council Agreement⁵ which safeguards pay and conditions in cases of down grading. This applied until retirement or your new grade caught up with you. Now Section 48 - a real catch 22 - abolishes protection below the age of 42 and limits it to 1 year thereafter. This protection was not costly and its abolition was a dogmatic application of "flexibility".

Market accounting

This requires that the contracts between hospitals and health authorities are required to be 3% lower every year, under the Cash Recurring Efficiency Savings scheme. This means on-going reductions on the biggest item in the budget, the staff. They just reduce numbers of the largest section, the nurses, and train fewer every year. Hence the service gets worse.

Other techniques

Flexibility is management's watchword now. Casualisation has been increased by a devious use of the "banks" which were originally set up, they say, as an Equal Opportunities measure to facilitate the re-entry of nurses after family raising. Now the banks are merely agencies for cheap and flexible nursing provision, to supplement low staffing levels.

A further example of flexibility is the introduction of rotating shifts. These are universally known as the most unhealthy and disruptive type of shifts throughout industry. We fought them off two years ago but they are coming back, with their fairy stories that this will allow day time training. We know that the effect will be catastrophic for child care arrangements and will probably cause much more ill health. It is part of their plan to abolish night shift premium and get total flexibility in working hours. At present nurses get no overtime pay premium, and may get less for overtime than standard hours, but this would be very much worse.

Consequences

Staff shortages can have a dangerous dimension especially in mental health as at St Ann's. A typical week can show up 170 patients for 110 beds. This means farming out patients but also that the amount of care is restricted. Patients who through no fault of their own are a danger to others are being left to wander around unsupervised.

IIP

"Investors in People" was introduced by the Human Resource Management Dept in 1994. It seems like a joke at first but allows management to set work objectives, through a central core brief and departmental team briefings. We opposed the introduction of Quality Circles because they were clearly a way of by-passing the union but IIP was negotiated with a strong UNISON input. For example we made sure there was no link to disciplinary procedures. There are some dangers in IIP but we think we have them under control.

⁵ Following the emergence of the shop stewards movement in World War 1, the government and the official trade unions tried to regain their power by setting up joint workplace, and national, committees on the lines recommended by the Whitley Report. These "works councils" were widely adopted in the public sector but not in the traditionally more militant private sector.

Some "Professional" associations

The attitude of some of the associations to the changes in the NHS has been terrible. The Royal College of Nursing for example has an élitist approach. I hate their insistence that nurses are a race apart and nobody else matters. One of their recruiting lines is "You don't want to be represented by someone like a porter, do you?" We have porters here who are far better negotiators not only than local RCN reps but even than their national officers - and I know them personally. We represent many special groups and grades but we defend the interests of all NHS workers. They merely try to defend their privilege as nurses.

One example is about the framework arrangements in 1994. We were trying to hold out against the worst excesses of privatisation until a Labour Government but the RCN voted against it, and persuaded the Midwives [RCM] to do so as well. It was a mistake for the RCM.

One of their problems is their undemocratic structure. Most unions - and possibly the Labour party - have a Conference that decides policy. The RCN have an Arrangement Committee that decides conference details but the RCN Council effectively makes policy, not the delegates. This is under the tight and personal control of the general secretary. Their biggest branch locally is Bloomsbury but even that has halved to 2,000 members.

For example this year, they would not negotiate because they said it would be a return to local negotiations, so we went ahead anyway. The RCN FTO was blasted out of the water by Tim L, the branch chair, who shouted that "You've no right to say anything, according to you there should be no negotiations!"

Union wins better conditions

There are even some small victories to celebrate. Back in the mid eighties, the Haringey Health Authority, then separate from Enfield, took up Community Projects in a big way. Long term unemployed were given 12 months work on an agreed project. In fact the workers got the "rate for the job", and in the NHS, they got Whitley Conditions. The attraction was that the central government paid, not the HA.

The union rose to the challenge, seeing the situation as a possible form of cheap labour. Every attempt was made to unionise the several hundred workers who were employed on a dozen or so schemes. These were based mainly at the old Prince of Wales but also at St Ann's and the NMxH. We got an average of 85-90% union membership with 100% in places.

The problem was that it was only short term, and around 1990, CPs were replaced by Employment Training. This turned out to be so-called training at £10 a week plus benefits and no employee status. Much of the "training" seemed to consist of loading and unloading lorries - we could see the people being "trained" from our workplaces.

No Closure

The campaign to stop the closure of either Chase Farm Hospital or NMxH A&E departments was a morale boosting triumph as well. There was the usual public meeting, well attended, and a massive march through Enfield. This was an HTUC initiative and was supported by many union branches, the local SWP, and thousands of the population. Closures and rationalisations are still on the agenda and we may be called into action again in the near future.

Currently

In terms of day to day practice, HHU are expanding all the time, often at RCN expense. Over the years, the role of the local union has changed somewhat. As well as collective negotiations we are carrying out a more social role. There is more union education and advice work. We spend hours helping members with DSS forms which I think are deliberately made more complicated to put off claimants. To some extent this is a return to the old friendly society functions of unions that the welfare state took over but is now abandoning.

One of the things that have strengthened the union has been the financial packages that are on offer, it seems the members want them. The convalescent homes are still popular and we do everything possible to get members in them. We advise members over loans and money management, it always seems to be the low paid that get more than their share of problems, and little help.

Whitley

A final word on Whitley which we are always defending. A local manager was tired of hearing us say that Whitley demands that, or says that. He burst out "If this Mr Whitley has so much to say, why doesn't he come to this meeting for himself?" It makes you laugh but is typical of the management today.

The struggle goes on.



'Nurses Are Worth More': The 1982 Health Workers' Dispute

by Dale Evans, NHS worker

The 1982 pay dispute was the largest strike in the history of the NHS and greatest show of solidarity across the trade union movement since the 1926 General Strike. Unfortunately this complex and often contradictory dispute that coincided with the Falklands/Malvinas War has been forgotten. Historians of trade unionism and the Thatcher era have not recorded it.⁶ This is not hard to understand, after all nurses and other women health workers rarely count in the arena of male dominated trade unionism; their disputes - because they lack 'industrial muscle' are hardly noticed. But the 1982 health service pay dispute is a great story. It was a strike that involved the workforce of the single largest employer in the whole of Europe, lasted for several months, challenged new anti-trade union legislation, gained enormous public support, received solidarity action from across the trade union movement and was the largest pay dispute of the Thatcher era.

Background to the 1982 dispute

From the beginning of the NHS in 1948 nurses' pay was regularly falling behind comparable occupations in other sectors. Nurses found themselves campaigning to catch up as their salaries were eroded by government policies on wage restraint and post war price inflation. In 1974 the Halsbury enquiry into nurses' pay awarded them increases of between 20 and 40 per cent. The severe inflationary period of the 1970s quickly undermined the gains of 1974 and a further enquiry - the Clegg commission of 1979 - awarded nurses 9% plus additional payments. The new Tory government of 1979 implemented the Clegg awards. However, by 1982 continuing inflation and limited public sector pay increases had left the nurses' pay lagging behind again.

There were other paternalistic and structural reasons for successive governments not taking the remuneration of nurses seriously. Nursing was overwhelmingly staffed by women and nursing was viewed as an extension of caring for a family, that is not a professional occupation. Nurses' pay was viewed as secondary income for families where the main income was provided by men. However nearly one third of nurses were single, and in places where the economic recession of the early 1980s hit hardest nurses became the main family wage earner. The NHS policy making mechanisms were dominated by doctors and their interests came first. On a structural level the NHS was expanding. Between 1976 and 1983 the number of nurses increased by 16% to nearly 400,000. At the same time the hours worked by nurses also decreased hence increasing the overall wage bill. In 1950 they worked 48 hours per week, by 1982 this had been reduced to 37½. Successive governments fought to contain the costs of the NHS by restricting pay increases to nurses and other non-medical employees in the NHS, by far the largest section of the NHS workforce. By 1974-75, nurses real income had increased by only 9% since the beginning of the NHS. From this peak the real value of nurses went into decline and by 1982 had decreased by 18% since the mid-1970s.

In order to redress the decline in pay for nurses and low pay for other NHS workers the unions argued for a 12% increase across the board for the 1982 pay round. However, the Tory government had already announced that public sector pay increases would be limited to 4%, but by March Norman Fowler, the Secretary of State for Social Services, issued a statement that more money was available for nurses, midwives, and the allied health professions

⁶ Colin Leys, *Politics in Britain ; from Labourism to Thatcherism*, 2nd Ed. 1989, Alan Sked and Chris Cook, *Post-War Britain : a Political History 1945-1992*, 4th Ed. 1993, Henry Pelling *A History of British Trade Unionism*, 4th Ed. 1987. [Note: Footnotes for this paper are numbered from 6]

(radiographers and physiotherapists etc.) and that an offer in the region of 6% would be made. All other non-medical staff (that is porters, cleaners, ambulance personnel, clerical staff) were to receive the 4%. To what was an obvious provocation, the health service unions had to respond.

Beginnings of the Dispute

The trade unions responded to the offer with derision; one NUPE (National Union of Public Employees) official denounced the offer as an 'unacceptable prescription which will do nothing to alleviate the problem of low pay affecting thousands of health service workers'.

In 1981 health service trade unions affiliated to the TUC had formed the TUC health services committee under the chair of Alan Spanswick from the Confederation of Health Service Employees (COHSE). The 1982 date for the pay round was April 1; for the first time in NHS all staff except doctors were to receive their annual pay increase from the same date. This gave the unions an organisational advantage in being able to organise and negotiate for all employees on the same basis from the same date. The unions believed that their claim of 12% for all NHS staff was reasonable. The rejection of this claim by the government quickly led to industrial action by the TUC affiliated unions.

All the unions were conscious of the fact that public support for their campaign was paramount; they had no wish to alienate the public as they believed the public workers' dispute had done in 1979's 'winter of discontent.' Although an all out strike was discussed most action in the course of the dispute consisted of work stoppages by nurses and nursing auxiliaries, porters, cleaners and other staff that would not endanger patients. This was the course taken by COHSE and NUPE and the other TUC unions. The first days of action took place in May. These actions were varied across the country. In some places the NHS only offered emergency services on these days, in other areas staff worked by only performing limited duties.

At a local level unions officials received support from other public sector workers. As the summer progressed the Scottish miners came out on strike in support of the day of action. By the end of June sympathy strikes had taken place with miners, shipyard workers, factory workers and staff from government and council offices all taking part. Examples of this solidarity action came from all over the UK. Shipyard workers joined a demonstration by health workers in Glasgow, 77 schools in Nottinghamshire were affected, swimming pools in Yorkshire were closed, stoppages occurred at some of the major power stations in Yorkshire, council workers in Hackney and Tottenham also took action. By July 750 hospitals had only emergency cover. In Wakefield 4 hospitals did not have any services at all on days of action. Further solidarity action saw seamen stop a ferry leaving Felixstowe for 2 days. All of this action was in breach of the 1980 Industrial Relations Act that outlawed secondary action by one group of workers in support of another. However in August the Electricians Union managed to stop the Fleet Street printing presses rolling with a 24 hour stoppage. Sean Geraghty, the shop steward involved. was fined £1300 for contempt of court after ignoring an injunction banning the stoppage. Hundreds of health workers demonstrated in his support on the day of his hearing.

In spite of the stoppages and inconvenience to patients the dispute was widely supported by the public who perceived that the nurses were being given a raw deal. Of course patient care was compromised as waiting lists soared and operations were cancelled but this did not undermine public support.

Divisions between the unions

Outside of the TUC affiliated health service unions were the Royal College of Nursing (RCN) who represented 180,000 nurses, and other smaller unions such as the midwives, health

visitors and those representing the allied health professions. These organisations were also professional bodies as well as trade unions. As professional bodies they had a regulatory role over members, provided education, and set professional standards just as the BMA (British Medical Association), and the Royal Colleges do in medicine. For these reasons the RCN did not sit easily with trade unions affiliated with the TUC, COHSE and NUPE, which had 135,000 and 80,000 nurses in their membership respectively and were also the unions representing tens of thousands of other NHS workers. This split between TUC affiliated bodies and non-affiliated unions such as the RCN was to prove crucial in the conduct of the dispute, and its final resolution.

The RCN argued that because of the public support shown for the nurses' cause it was not necessary to engage in industrial action. Indeed its president Trevor Clay later wrote:

'The nurses had the high moral ground through balloting at a time when the government were lambasting other unions about their lack of balloting and unrepresentative activity.'⁷

During the days of action members of the RCN worked normally, because strike action would have been in breach of its rules (Rule 12). The RCN had only become a trade union in 1977 and in 1979 its membership had rejected the opportunity to join the TUC. A debate in 1982 concerning amending Rule 12 came to nothing.

Throughout the dispute the RCN acted independently of the TUC health unions, often meeting ministers and engaging in talks without any acknowledgement of the need for greater unity. The RCN only paid lip service to supporting non-nursing NHS staff but made it apparent that it wanted a settlement whereby porters, clerical staff and nursing auxiliaries would receive a lower pay rise than qualified nurses. Unlike the TUC unions it was willing to support the government's idea of establishing a permanent pay review body (PRB) for nurses that would be similar to that already set up for doctors. The PRB would annually compare nurses' pay with other sectors of the economy and make recommendations to the government.

The RCN wanted to have its cake and eat it. Its President Trevor Clay genuinely believed that its position of no strike action and talking to the government whilst constantly balloting the membership of the RCN on various matters was the most productive way to settle the dispute. This of course allowed the government to split the campaign effectively into two camps, those for and those against industrial action. Norman Fowler's statement to the House of Commons on 18 October 1982 clearly thanked the RCN for continuing to work and lambasted the TUC unions.

COHSE and NUPE felt that the RCN was only gaining advantages with the government because of the strength of their action. Without industrial conflict the RCN would not have been invited to the negotiating table. Rodney Bickerstaffe, general secretary of NUPE, diplomatically expressed the differences:

'I think that the RCN linehas been that whilst they are still talking there is still hope. I don't wish to drive any more wedges between ourselves and the RCN. It's fine to say that whilst we are talking there is still hope, but less people would be hurt if we all threw our weight behind the industrial campaign to get proper talks.'⁸

For both COHSE and NUPE it was a matter of principle that all the health service workers received 12%. They had major concerns about low pay in the NHS that they felt the government should address. These unions had a different approach to striking. COHSE's 1982 conference

⁷ Trevor Clay *Nurses, Power and Politics*, London, 1987, p138-39.

⁸ Going public: an interview with Rodney Bickerstaffe. *Marxism Today* November 1982 p11.

rejected an all-out indefinite strike and supported the call for extra days of action with emergency cover only. NUPE's conference on the other hand voted in favour of an indefinite strike with only basic emergency cover. COHSE's position was strongly influenced by the winter of discontent. After that the union had drawn up a code of conduct for disputes whereby its members were expected to provide emergency cover and ensure that the dignity and welfare of the patients is paramount. Both unions rejected the idea of the government's PRB, as both unions believed in annual pay negotiations based on the principles of collective bargaining.

During the course of the dispute the RCN balloted its membership on two offers both of which were rejected by the membership. From the views of the membership it seems clear that the RCN wanted to extricate itself from the dispute as quickly as possible. The members of one RCN branch wrote to the *Nursing Times*:

'We find it distasteful that you [Dame Catherine Hall, an RCN negotiator] held a press conference without first referring the detail of your discussions with the secretary of state to the RCN labour relations committee for a vote....There is no mention in your misrepresented statement of referral back to the membership.'⁹

And another member complained

'I have just received my RCN News. Cutting through the waffle it seems that the College is attempting to sell us out for an extra 1½p in the pound.'¹⁰

Such was the divergence of views that the RCN issued a leaflet in which it fully defended its position against the accusations levelled against it.

The government also exploited the split to argue that the TUC unions had a political agenda, that is that the strike was not about health service pay but was to undermine recent trade union legislation and re-establish the former power that the unions supposedly enjoyed. On the 21 September the Health Minister Kenneth Clarke said:

'The TUC hopes to smash the cash limits of the National Health Service in order to end pay restraint in the public sector and prepare the way for bigger claims for miners and others this winter. They are taking secondary action in order to challenge the Government's legislation and defend their old immunities above the law.'¹¹

This lack of unity and the government's endorsement of the RCN's position undermined the strength and purpose of the TUC unions after the largest day of action on 22 September.

22 September 1982

22 September saw a huge show of solidarity for the NHS dispute right across the country; an estimated 2.25 million people took part in one form or another. In London 120,000 demonstrated, Aberdeen 12,000, Edinburgh 10,000, Liverpool 20,000, Norwich 2,000, Derry 3,000 - and these were just some of the many demonstrations that took place all over the country. Strikes were evident in many hospitals with only emergency cover provided. Some ambulance crews walked out and refused to provide emergency cover.

⁹ *Nursing Times* July 14 1982 p1173.

¹⁰ *ibid*

¹¹ *The Guardian* September 21 1982.

Secondary support for health workers was also very significant, 80% of the mines were closed as were 43 of 65 docks. Fleet Street workers stopped the publication of the national newspapers and many local newspapers were disrupted as well. There was some disruption to television programmes broadcast by Granada and Ulster TV. Local government services were affected with many schools being closed for part of the day. Supporting strike action was also taken by car workers at Ford and Vauxhall, and Post Offices were closed.

This day was an undoubted success and was the high point of the whole dispute for the TUC unions. Such enthusiasm would be difficult to repeat and the time for indefinite strike action had passed. The RCN was still talking to the government and seeking a way to end the dispute. And the government, very much buoyed by its victory in the Falklands/Malvinas war, took a hard line, proclaiming that the day of action had changed nothing. As many nurses pointed out the government could always find money for wars but not for funding the health service.

The fact that this historic day of action had failed to move the government left the unions in a quandary: what to do next?

The end of the dispute

Attempts to organise further days of action petered out. The dispute dragged on with only a few local actions occurring. COHSE called a delegates' conference for 14 December to discuss the possibility of an all-out strike. In reality the split in the nursing profession between the RCN and the TUC unions had undermined the possibility of further action. Most of the action had been carried out by the other health workers. As one participant commented:

'There was considerable resentment among the ancillaries about the nurses. The press had gone on about the nurses this the nurses that. The cleaners knew that they had stayed solid for months. Most of the nurses had crossed the picket line time after time. The cleaners felt used' ¹²

Many of the nurses did however recognise the contribution to the dispute by other NHS workers:

'The ancillary workers are helping us by taking action, as well as themselves... Nurses do not have the power to fight the government on their own, they need other workers' ¹³

By December the RCN was effectively leading the dispute with most of the discussion centred on the establishing of the PRB, which the TUC unions still rejected. The government improved its offer to 12.3% for nurses over 2 years with 7.5% to be received in the current year, and the promise of a pay review body for 1984. The RCN put the offer to its members, 80% of whom accepted. NUPE and COHSE tried to scupper the deal by recommending to its members 6.5% for the coming year without any conditions for future years. The membership rejected this. NUPE and COHSE also found themselves outvoted in the TUC health services committee where each member (14 in all) had one vote even though NUPE and COHSE represented the majority of health service workers between them. Furthermore the RCN and the other professional bodies such as the Royal College of Midwives had a slender majority on the national negotiating committee, the Whitley Council. NUPE and COHSE had been effectively outmanoeuvred. Ancillary staff received a 10.5 % deal over 2 years, receiving 6% in the current year. Both pay deals were only backdated to July even though the date for a new pay rise was

¹² Jonathan Neale *Memoirs of a Callous Picket*, London, 1983, p103.

¹³ *Nursing Mirror* August 25 1982 p14.

the 1 April. No doubt this was an extra punishment for a workforce that had fought for a living wage.

Aftermath

The conservative government won the 1983 general election and the PRB was set up. Nurses were awarded between 9 and 14% in 1985 and 8% the following year. Work done by ancillary workers (porters, cleaners) were increasingly privatised with two thirds of contracts awarded to private contractors by the end of 1984. This section of the workforce was reduced by 40,000 by 1988. COHSE's membership had peaked at 231,000 in 1982 had fallen to 218,000 by 1988.¹⁴ The RCN membership which had been 162,000 in 1979 reached 282,000 in 1988.

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¹⁴ Note that white collar unions and public sectors unions did not lose membership at the same level as industrial unions during the Thatcher era

Health Workers: Occupy and win!

by London Health Emergency

with Comment by Industrial Workers of the World - a union for all workers - www.iww.org.uk

This is a guide to hospital workers on how – and why – to occupy hospitals to prevent their closure. It was published first as a pamphlet by London Health Emergency in 1984.

It was later posted as a web page by libcom.org in November 2006, with minor edits. libcom commented "libcom.org have scanned and put this text online today (in November 2006) since the issue of widespread hospital closures is again sadly very pressing - though this time round by a Labour government.

N.B. *“Some of the information contained in the text is now out of date, for example some of the unions mentioned have since merged, and we now live in very different times, where occupations and solidarity strikes have disappeared from the memories of many people. However we re-publish this text in the hopes that it may provide ideas, inspiration and some practical advice to health - and other - workers and patients today on how to defend our UK health service.”*

Libcom's original posting: [libcom.org /library/occupy-win-manual-fighting-hospital-closures](http://libcom.org/library/occupy-win-manual-fighting-hospital-closures).

Introduction

The original and amended publication was 7,500 words long, very well illustrated with photos and cartoons, and packed with practical advice. The contents list was: *Why occupy? What is an occupation? Will the workers get paid? General Practitioners, Do you need to sleep in the hospital overnight? What happens in the run up to closure? Building a campaign, Building up support, Spotlight on the DHAs, How do we actually occupy? Unions, Declaring a hospital occupied, Who runs the occupation? Management: should they stay or go? Supporters, Press/publicity, Relatives/patients, Supporting strike action, The law, Why should we occupy when other occupations have not kept hospitals open? On London Health Emergency.*

Occupations can of course be used in a variety of situations. They remain a tactic of the ultimate resistance, similar to that of the workers' councils which appeared all over Europe during previous economic and political crises. Radical History looks forward to their return. We print below some extracts that may be interesting but it is best to read – and reproduce – the original.

Why occupy?

- Bethnal Green Hospital campaigners lobbied the DHSS at the Elephant and Castle in 1978; they successfully held up the closure of casualty for over two years.
- Hayes Cottage, and Northwood and Pinner hospitals were both due to be closed on October 31 1983; they were occupied, and as a result they are now still open, with a temporary reprieve.
- Thornton View hospital in Bradford, occupied since last summer, now faces the imminent danger of a raid by District Health Authority bailiffs seeking to implement the order for closure issued by Health Minister Kenneth Clarke; but had it not been for the occupation, Thornton View would already long ago have closed down, and its geriatric patients been bundled off to other hospitals.

One general rule stands out from the whole experience of fighting the health cuts: it is not certain that occupying a threatened hospital will keep it open, but it is certain that if you do not

occupy, it will close. Hospital occupations are not new. In 1922 workers at the Radcliffe Hospital in Nottingham occupied! Since the late 1970s occupations have increasingly been used to defend the hospitals scheduled for closure. Workers who have taken part in occupations have learned valuable lessons about how to organise them and how to anticipate some of the problems which may arise. With the present round of financial cuts, hundreds of hospitals are faced with closure. Since August 1983 there have been three occupations in hospitals which are still open in 1984 and many campaigns have asked for information about how to organise them.

Every occupation is different, but there are things which are common to all occupations and that is what this pamphlet is about. Good early organisation can help to ensure that an occupation is strong within a short period of time and makes it much more difficult for management to move against it at the onset.

This is not a failsafe guide or a list of easy answers. It is a sharing of tactics and strategies, learned in long, hard and often bitter struggles. It may not answer all the questions which apply to your particular hospital. Every occupation throws up new problems, new questions and new answers, but it will provide a basic framework for you to follow.

What is an occupation?

An occupation means that workers in a threatened hospital take a decision to actively oppose the closure of the hospital by ensuring that patients and equipment are not moved out and by refusing to leave their jobs at the hospital.

The main area where control is taken is in the movement of patients. A hospital can only be closed if there are no patients in it. So the main goal of an occupation is to keep the patients it has, if it is a long stay hospital, and to ensure new admissions if it is an acute general or cottage hospital.

Will the workers get paid?

This is usually the first question which is asked. The answer is yes. As long as there are patients in a hospital, the Secretary of State is legally bound under the Health Services Act to ensure that they receive treatment; there must be workers, ancillary workers, nurses, doctors, technicians etc.

Hospital doctors and particularly consultants will rarely support an occupation. This should not be a decisive factor in deciding whether or not you should occupy.

The obligation to treat the patient means that even if the regular consultant resigns, a locum must be appointed as long as patients remain. Sometimes the consultants will be hostile and deliberately try to frighten workers and the public. If a consultant says, for example, that a hospital is 'unsafe', it is potentially very damaging. It is worthwhile checking your consultants' commitments to private medicine, etc., as often they have a vested interest in a hospital closing – you can use the information in press statements to show why the consultant is not backing the occupation. Indeed the medical arguments are very often quite spurious: patient mortality during the St Benedict's occupation fell way below the national average, yet within six months of the end of the occupation 30% of the patients had died.

Despite their hostility and lack of concern it is important to try to keep a good relationship with the consultants. Keep them informed of what is going on and explain in detail what the occupation means.

Building a campaign

Occupations in Hayes Cottage and Northwood and Pinner hospitals in the autumn of 1983 were both successful in winning at least temporary reprieve. Without the action, both would have been closed. Health and Safety committees are particularly important – at the South London Hospital the Health and Safety committee forced management to make major repairs that they were hoping to leave and use later as fuel for their arguments about the hospital being in a "run down" condition.

As soon as the word leaks out that a hospital is threatened (there are dozens in London alone) the workers and local community must organise. It takes time for the implications of closure to sink in. Most workers, although they are aware that other hospitals have been closed, think it can never happen to their hospital. But all health service facilities are threatened by the Tory cutbacks: to think that if another hospital in your District closes yours will be OK is disastrous. In Wandsworth, five hospitals have closed since 1978, and now the South London is earmarked for closure. Management use the fear of closure and the false hope of saving one place at the expense of another to try to pit worker against worker.

All work necessary to close hospitals should be blocked by the unions. Stewards should oppose three and six-month contracts which make it easier to assimilate people from the hospital about to be closed. Usually a District will only issue "temporary" contracts for a whole year's run-up to closure. So, new staff are effectively sacked in order that workers from the closing hospital can be "slotted in".

The whole process undermines trade union activity and militancy and makes some workers wary of even joining a union in case they jeopardise the renewal of their contract. Workers in the threatened hospital must refuse even to discuss alternative employment with management. They should ignore any letters or demands that they get from supervisors telling them to attend meetings (usually on their own) to have preliminary discussions.

Health Service managers are now experienced in the techniques of closing hospitals. They try to do it quickly and quietly through administrative measures and intimidation. They do not like well-organised campaigns with experienced people who know their tactics.

Building up support

Once nurses see the hospital still running "normally" and caring for patients, many will give increasingly active support to occupations. The most successful fightbacks — EGA, St Benedict's, Longworth (Oxfordshire) and St Mary's — have involved workers and supporters meeting together either weekly or fortnightly. Meeting in the hospital is best, because the workers will see people coming in every week to support them and the supporters will feel part of the hospital (and know its layout).

It may seem too frequent at first; but managers work very quickly, and things can change on a daily basis. There is no need to ask for permission for these meetings; management will almost certainly refuse. Just pick a room and have the meetings. It is unlikely that administrators will make an issue of it as they do not want to provoke action early on.

A public profile is essential. Everyone in the community should know that their hospital is threatened. Leaflets, posters, petitions, pickets and demonstrations are all good for attracting interest. Workers who are a bit frightened about fighting management and are not sure about the levels of support they will get can be bolstered by seeing a large demonstration or a lot of people turning up to picket outside the hospital.

It is important to challenge management at every step of the campaign. The administrators and consultants will constantly be putting out statements about the terrible financial conditions, weeping crocodile tears that they have to close the hospital, and claiming that they really have no choice since there is no money available.

Workers should be reminded that in 1982 health workers were given the same arguments about why we could only have a 4% increase in pay. There was "no money" then; but suddenly billions were found for the Falklands War, and extra money was handed to the judges and the police. Money is available but the Tories refuse to spend it on health.

How do we actually occupy?

The main victims of government cuts and enforced closures are of course the patients; within six months of the raid on St Benedict's (above) 30% of the patients were dead. The decision to occupy is not taken overnight. There needs to be preparation. If you are thinking of occupying your hospital, contact someone who has done it. Get her/him to come to the hospital and talk to people, answering questions and explaining directly what an occupation means.

Sometimes it is only a handful of workers who decide that they will not let the hospital close. They take the initial action and bring the other staff along with them throughout the course of the occupation. This happened at Hayes Cottage in Hillingdon and also at Thornton View in Bradford.

In other occupations there have been mass meetings with ballots. This happened at Northwood and Pinner Hospital. All three have been successful occupations. Obviously the more staff who are involved the better. However, experience has shown that even when only a small number of workers take the initial action other workers will continue to come in and work and can be won over to supporting the occupation.

It is often domestic workers who take the initial action, with very passive support from nurses. But once nurses see the hospital still running "normally" as far as patient care goes, and see management powerless to stop the normal running of the wards they may increasingly give active support.

Workers will naturally be worried about being sacked, victimised, struck off or blacklisted. It is important not to dismiss these fears, but to have a frank and honest discussion with them. Nobody has ever been struck off the nursing register for supporting an occupation. Even the Royal College of Nursing has given tacit support, usually instructing its members to "stay with the patients".

The fear of victimisation is more difficult to dispel. The strength of an occupation lies in collective action. The more staff are involved, the more difficult it is to victimise anyone. Decisions are made collectively. But it would be dishonest to say that there is no possibility of anyone being victimised. Unions must be pushed to demand no victimisation, and to give assurances that they will fully back any member who is threatened, with strike action in other hospitals if necessary.

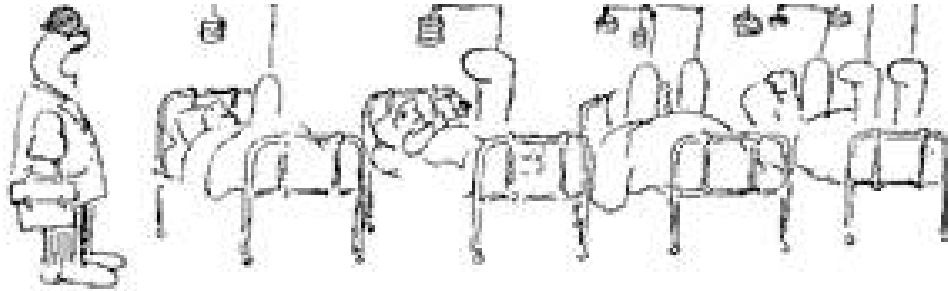
Unions

Many workers who have occupied their hospitals have not been in a union at the start of the action. It is important that the workers in the occupied hospital do join a union and that there are stewards elected on site. The union full-timers should be informed as soon as the occupation has been declared and be asked to make the action official. NUPE, COHSE, TGWU, GMBATU,

and ASTMS have policies of supporting occupations and will usually make them official immediately.

Although they will give you official support, most full-time union officials do not have much knowledge or experience of occupations. They should be pushed to provide practical support from the beginning - money for leaflets, posters, stickers, duplicators, paper, equipment, etc. You should also ensure you are able to contact an official at all times.

If you can contact someone who has had practical experience of occupations to be at the hospital for the first few days it will be an advantage.



All those in favour of this ward being closed...

Declaring the hospital occupied

When a hospital is declared occupied there are some things that need to be done immediately.

An office

It is almost impossible to run an occupation without access to an office and a telephone, or a room in the hospital to be used as a base. In planning the occupation, you should decide in advance which office is best to take over. Often it is the Administrator's or Nursing Officer's. This has the added advantage of displacing the people most likely to try to intimidate and disrupt the occupation in the first few days.

Arrive prepared to change the locks on the door. This gives you possession and means that management have to go to court to get the office back. You will need to put up a notice which informs people of your rights.

Pickets

If you are occupying a long stay hospital, lock the front gates with a padlock and put a picket there to let staff, supporters and visitors in, but to keep management and the police out until the occupation is secured. Bring the padlock and locks with you on the day you declare the occupation and make sure that there are enough people around to cover all the immediate jobs that need to be done.

A twenty-four hour picket may be necessary from the beginning. Ensure that pickets know the rules and regulations, are well-informed and have up-to-date information on who is to be let in, who is to be kept out, etc.

Make sure that someone capable of making quick decisions and who is reliable is in the office.

The staff

Get a meeting together to explain exactly what has happened for the benefit of staff who have not been involved in the planning and the timing of the occupation. Reassure staff that what they should do is continue to work as normal. It is often useful to have a sympathetic nurse on hand who has been involved in an occupation. If a meeting is not possible, go around to all the wards and departments and explain what is going on. This is essential in order to bring people who are unsure, frightened or hostile into at least passively supporting the occupation.

Prepare a leaflet for distribution the day after the occupation begins. Also prepare a press statement.

Regular bulletins for staff are essential because of the shift patterns and the impossibility of getting everyone to a meeting at the same time. It is also important to change the exterior of the hospital. Fences should be covered with posters and banners proclaiming the occupation, displayed in prominent positions. Make sure every passer-by knows that a struggle against health cuts is going on.

Who runs the occupation ?

It is the workers who must make the decisions about how the occupation will run. If there is good unionisation then the Joint Shop Stewards Committee may be the occupation committee. If, as is quite often the case, the hospital is weakly organised, then there will need to be an occupation committee set up with representatives of all departments and all staff. It does not have to be the same people all the time. As many staff as possible should be encouraged to attend. It is useful at first to have someone at these meetings who has experience of occupations and who can answer questions that arise. But any decision must be made by the workers themselves.

The committees may need to meet every day during the first week or two and then it should meet as regularly as the staff think necessary (once a week is usual).

Supporters

Occupations need a lot of help to run smoothly and to win. It is essential to get as much outside support as possible. Hospitals belong to the community and they will want to help defend their local hospital. There should be a rota set up for pickets which will include both staff and supporters. Factories and other workplaces, tenants' organisations, Labour parties and community groups all need to be approached for help.

There should be regular supporters' meetings so that everyone knows what is going on; there should be good liaison and communication between supporters and the occupation committee. Regular bulletins are good for sharing information.

An occupation diary should be kept in the office. Pickets should be encouraged to read it when they come in for their stint, and to write up details which they feel to be of use.

Get names, addresses and telephone numbers of anyone who offers help. Get them to give a regular commitment to picketing. Begin to work on developing a telephone tree, which is a system of contacting people by phone in an emergency. It usually works by three people telephoning three other people who in turn phone three people until all the supporters are contacted.

The important point for supporters to remember is that the hospital is running as normal, as far as patient care is concerned. Patients' privacy is a top priority. No supporters should be allowed in the ward areas. No drinking should be allowed on the site during an occupation. Health workers are not used to outsiders walking around hospitals. Management will inevitably play on this, trying to discredit pickets who are not staff members.

Everyone has a right to defend their hospital: that is why people come to support occupations. Staff at occupied hospitals are doing their normal job — often physically and emotionally exhausting. They are also taking an active role in running the occupation and so cannot keep the pickets going on their own. If they are women, they are often under intense pressure at home because of their increased commitment. They need support.

The labour movement was built on solidarity; and that is what occupations are about. This Tory government has no conscience about bringing in its own outsiders to run down the NHS - Griffiths, a grocer from Sainsbury's, is advising them on how the NHS should be run! Private outside contractors are looking to increase their profits by getting NHS contracts. We should make no apologies for taking advice and help from people prepared to help save hospitals.

Supporting strike action

Occupations cannot win without support. In order to avoid the kind of raids which ended the Hounslow, St Benedict's, Longworth and Etwall occupations, it is necessary to get sufficient outside support to make the District Health Authority hold back from sanctioning a raid. This has to be done by getting other workers in the District and the Region to pledge supporting strike action immediately any piece of equipment or patient is forcibly removed from the hospital.

It is not easy to get these pledges, and they must be worked for from the first day of the occupation. Management tactics are to divide and rule health workers. They know the importance of strike action, and that is why they try to exploit other health workers' fears of redundancy and cuts by threatening them that if the occupied hospital is saved, their hospital will be cut.

Such claims have to be dealt with very quickly. Every cut, every closure makes each subsequent one easier for management to accomplish. Every victory against cuts and closures makes it more difficult for Districts to make more cuts, because it encourages others to fight. That is why promises of supporting action are so essential. They break down the isolation of occupations, and make them a focus for broad resistance to the cuts.

Experience has shown that while trade unions will give quick recognition to occupations, union officials will not build for supporting strike action. In some cases they have deliberately worked against it, defusing and diverting the issue, and making the workers occupying think it is impossible to win supporting action. It is by no means easy or automatic: but it is certainly not impossible. Don't leave the work of building for supporting strike action in the hands of union full-time officials. Get stewards and workers from the occupation in every branch to raise the issue, ask for support and to explain why support from other workers is so vital.

Why should we occupy when other occupations have not kept hospitals open?

This question is always asked. There is no easy, sure way to keep a hospital open. Workers at St. Benedict's spent ten long, exhausting months occupying to see, at the end, a vicious raid by private ambulances with the help of the police, taking the patients out and closing the hospital. There had been no pledges of supporting strike action; and so management had felt confident that they could move. But the public disgust at the methods used and the closure of the hospital provoked such a backlash that it was another three years before that health district has even

suggested that another hospital should be closed. Hayes Cottage, Northwood and Pinner, and Thornton View hospitals are all still open more than six months after they were due for closure, thanks to determined occupations.

Remember, it is not certain that occupying your hospital will keep it open — what is certain is that if you do not occupy it will close. It is also certain that every time we fight a cut or a closure, the ripples are felt. If there had been no resistance to the closures in the past, we would be facing even more devastating cuts than the Tories are now proposing. Every time a hospital, ward, or department is occupied, it is a clear sign to the government that they cannot easily cut our services.

Occupations are never a waste of effort. They politicise workers very quickly. Health workers are locked into a very hierarchical system which is extremely undemocratic and oppressive. Decision-making is entirely out of our hands. Occupations give the decision-making back to the workers. A cleaner who stands at a gate telling an administrator to go away is in control. The hospital is running, under new 'management', under workers' control. The whole process of occupying shows workers that they can make major decisions about their hospital, and that when they are in control it usually runs better and smoother.

It makes us think about the reasons for the cuts and closures. Where does the money go? Why can't we keep the services for local people and cut out the vast profits that go to the drug companies and other suppliers and contractors? Why do health authority accounts have to be so secretive? Why can't health unions and other trade unionists examine the books to expose the details of how the District allocates its money?

Occupations rally whole communities around defence of health care. For the first time, ordinary people go to Health Authority meetings and see the scandalous group of non-accountable, appointed people who make life and death decisions with no thought for what we have to say about it.

People start talking about not only defending what we have, but demanding what we want. Occupations are not easy. They require a lot of hard work, a lot of commitment, and can be exhausting. The alternative is to let successive governments 'rationalise' the health service right out of existence. At the moment there are three hospitals which would have been closed in 1983 which are still open because the workers occupied. Those three could be multiplied by hundreds. The possibilities of keeping hospitals open exists. That is a good enough reason to consider occupation of your hospital.



Campaign against the Closure of the Haringey Mental Health Day Hospitals

by Peter Sartori and Paulette Case-Robinson
(service users / campaign members)

The provision of mental health day services in the borough of Haringey was dangerously sacrificed by the Barnet, Enfield and Haringey Mental Health Trust as they announced the closure of the two mental health day hospitals in Haringey, back in June 2003. Their plans to close the Day Hospitals were strongly resisted by Unison union staff members and, most importantly, the service users themselves.

These mental health units – The Kate Marsden, at St Ann's in Tottenham and at Canning Crescent Clinic, Wood Green – provided employment for 40 health and supporting workers. Haringey – a borough with all of the inner London deprivations – was to become the first London borough to have no mental health day hospitals at all!

Two unsustainable reasons were given in connection with the closure decision by the Haringey Mental Health Trust. One astonishing reason was a lack of funds to comply with the government's White Paper regarding the development of Crisis Resolution Teams. Secondly, two services were then cited by the Trust as 'replacements', namely Assertive Outreach and Crisis Intervention. The Ramsey Report, commissioned in 2002 by the Trust themselves, stated categorically that these services should run *alongside* day hospitals, and were considered to be neither remotely similar nor potential replacements.

Consequently, an extended campaign was formed to oppose the decision of the Barnet, Enfield and Haringey Mental Health Trust. This would become known as '*The Day Hospital Campaign Group*'.

Its members comprised:

- Haringey Mental Health Service Users
- Health care and local government workers and their UNISON union branches
- Haringey Trades Union Council

The Day Hospital Campaign group met regularly every week. It was attended by, among others: ex Labour councillor Kevin Hargreaves; HTUC members Terry Burton and Alan Woodward; Mental health service users Peter Sartori, Paulette Case-Robinson, Peter Johnson, Ronnie Romei and Inga Bystrom; Unison members Lesley Fisher, Zeld Barter, Tim Loveridge [health], and Pauline Bradley [local government].

Under the initial slogan 'HANDS OFF HARINGEY DAY HOSPITALS' a meeting was first called at the Wood Green Labour Club, Stuart Crescent N 22, to focus the wide public support for those opposing the closures, on Thurs 17 July 2003 at 7.30 pm. Those speaking were: Lesley Fisher, branch secretary, St Ann's Hospital Unison; Pauline Bradley, convenor, Unison Local Government Social Services; Peter Sartori and Paulette Case-Robinson – both mental health service users; Peter Lewington, assistant secretary, Unison Local Government workers' branch; with Tim Loveridge – Chair of the Unison Health Workers branch – chairing the meeting.

The mental health service users recounted their own personal experiences, both within the mental health system and from the help they had received from the Day Hospitals. (Paulette Case-Robinson made a touching personal statement to this effect at a later date – see pp. 43-45).

They all stated the case for proper consultation and a proactive plan of action, namely:

“We are calling for delay for three months of the closure decision in order that a proper working party can consult users, their relatives and staff. This procedure would allow for a reasonable period of consultation in which everyone might both have their say and be heard, allowing for a much greater likelihood of achieving a mutually acceptable solution.”

This was followed by a petition which was handed out. It read as follows:

“ If you support our case:

- ❑ sign the petition,
- ❑ take away copies of the petition to collect signatures from work/home,
- ❑ write to your MP stating your opposition,
- ❑ interview your MP,
- ❑ write to the local newspaper stating your case,
- ❑ raise the issue in any organisation you are active in,
- ❑ join us every Saturday morning with our street stalls for publicity,
- ❑ come to the organising meeting, every Wednesday evening at 6.30 pm at the Common Room, Block 6, at Ann's Hospital, St Ann's Road, N 15.
- ❑ contact Peter Sartori for further information ”

Many were now contrasting the apparent expansion of the NHS with this abrupt cut in local mental health service provision. Even allowing that much of the government money was to go to the Foundation Hospital and their private sector contracts, this action seemed to run counter to Labour policy and had already been causing ructions within the NHS.

One immediate sign of the fight back was taken when HTUC turned its entire monthly meeting over to the Day Hospital Campaign (as described above). Zelda Barter, one of the affected workers, would speak at the HTUC monthly meeting on Thursday 26 June at Wood Green Labour Club at 8 p.m. unless the issue were settled before this point.

The plan of action in the long term was being outlined. The Campaign Group requested an urgent meeting about the closure which was planned for three months' time. As such, the Campaign 'gatecrashed' several monthly meetings of the Haringey Mental Health Trust Executive. At these meetings, it stated its case using no uncertain terms. The primary question posed by the Campaign to the Mental Health Trust was “Do you know what a mental health day hospital does? Do you know what you are closing?” The uncertainty of the reply from the Trust provided the Campaign with its most powerful ally – knowledge!

Formal consultation had been announced, due to end on 1 September. Letters of protest had been written to a wide range of local medical officials and doctors. Service users would then contact David Lammy MP, Barbara Roach MP (twice), Steve Norris (Opposition candidate for London Mayor), John Reid MP (Minister for Health), Lynne Featherstone (LibDem Councillor and prospective MP).

Previous attempts at hospital closures in the borough had resulted in long union campaigns with leaflets, badges, meetings, lobbies and such like. The members were equally determined this time. The Campaign had the additional weapons of great contact with the media, familiarity with politicians of all parties plus a superior knowledge of the functions of a mental health day hospital than the service providers who were closing them!

Those anxious to help the Day Hospital Campaign were urged to:

- come to the original meeting (plus subsequent meetings)

- collect signatures on petitions
- speak out on the issue in union, public, political and other meetings
- write letters to the Mental Health Trust and everyone they could think of.

Initially, posters against the Day Hospital closures were designed by the campaign group. However, when they were put up in various mental health units (and libraries) in and around Haringey, the staff at those units were none-too-discreetly ‘threatened’ by members of the Trust to tear them down and have nothing to do with the Day Hospital campaign (for the wellbeing of their own careers)!

Later, The Day Hospital Campaign had achieved the following – it had:

- organised several well attended public meetings,
- attended several political meetings in support of the Day Hospital Campaign,
- lobbied Haringey councillors but, despite initial obstruction, identified sympathetic voices and had personal meetings with those who were on our side (from all parties),
- run very successful Saturday stalls, collecting over 4000 signatures (the second-highest amount collected in Haringey at that time). These were presented to Barbara Roche MP and copied to the Chief Executive of the Barnet Enfield and Haringey Mental Health Trust,
- had meetings with Trust officials, initially explaining to them exactly what a mental health day hospital was, and what it was they intended to close down,
- Later brought these self-same officials to task at public Scrutiny Meetings which were faithfully witnessed and recorded by the local press. (The Trust Chairman resigned shortly afterwards – coincidence?)
- Had several extensive discussions with Barbara Roche who was very sympathetic,
- Intervened at several Trust public meetings, forcing them to listen to us.
- Intervened at a Haringey Council Meeting, where their complaints over the Haringey Day Hospital closures were extensively covered by the local press.
- Maintained a regular contact with reporters on various local newspapers about their complaints, identifying the sharp practice of the Mental Health Trust in their closures without consultation. Local Newspaper coverage was empathetic and continuous, for almost two years.
- Been interviewed on BBC Radio 5 Live (Adam Brimilow – Health Correspondent) regarding life as a mental health service user.

The role and function of the units threatened with closure were officially described by The Day Hospital Campaign Group (*fronted by service users*) as follows:

“Day hospitals are neither ‘day centres’ nor ‘drop in centres’. They are a clinical area where people with mental health difficulties can receive support from a multi-disciplinary team, with assessment based upon a person’s physical, psychological and social needs, and which is person/client orientated. Time spent there is structured (a nurse would telephone a client if they failed to show). Both individual counselling and intensive group work form the basis for an individualised therapeutic package. The purpose is to enable clients to work towards reintegration back into the community. Self respect may increase as, through practical assistance, people are encouraged to make plans about their futures (this may previously have been unthinkable).

Social isolation is often a result of mental health problems. Coming to the day hospital begins to address this real difficulty. Peer support, in the context of the day hospital set-up, also plays a vital role.

Until 31st August 2003, Haringey had two day hospitals. Canning Crescent in the west of the borough, and Kate Marsden, a purpose-built hospital to the east of the borough. Both hospitals had the capacity for 80 clients (that is 40 clients each).”

(The above was given to the press and media, to explain what we were fighting for)

The Haringey Mental Health Trust's plans to close the day hospitals were destined to provide mental health day-service users with a much bleaker outlook:

Instead of the intensive yet non-intrusive, socially-orientated treatment of the day hospitals, people would be treated in their own homes on a more short-term basis. For many, this was seen as being intrusive (it may also inform neighbours of something they had been trying to keep private, thus further eroding their dignity). The constructive and on-going neutral ground of the day hospital was being replaced by these two services, neither of which could replicate it.

Staff said that the two day hospitals were vital in treating patients who would otherwise have to go to the acute mental health wards. They also provided a thorough assessment of patient needs, produced respite for carers, reduced isolation and engaged patients towards more independent living. The health workers, as professionals, worked in a client centred approach and said they were angry at the decision being taken in an autocratic way, with no discussions or consultation with patients, relatives or themselves. They were deeply concerned for their patients, as were the service users themselves.

Day hospitals were therefore a crucial part of the provision of mental health day care services and Canning Crescent had been open for less than 10 years. Its opening was widely welcomed. The official reason for the closures were that new institutions would soon be provided and that both provisions could not be afforded. Health workers asked - what would happen to the patients' interests in the meanwhile? Service users wondered if they should simply avoid having mental health problems during this time!!

Staff and Service User response

It had been impossible to follow any semblance of usual procedures, due to there having been minimal consultation offered by the Mental Health Trust. The Day Hospital Campaign Group collected over four thousand signatures of protest. Local newspapers had continuously publicised the story of the ongoing Day Hospital Campaign. The MPs David Lammy and Barbara Roche were contacted. Several meetings were had between the Day Hospital Campaign Group members and Barbara Roche, during one of which the then Chief Executive of the Trust was asked to leave the meeting, due to his intransigence!

Those with a long memory will remember the long and vigorous campaign carried out against the closure of the Prince of Wales Hospital a little over a decade ago. In the hospitals all evidence of protest has been removed by management. This was to prove more fruitful.

The Day Hospital Campaign ploughed on, unperturbed by the initial inaction, and began to make its case and pressurise the Trust, both by its media exposure, the multi-party political support it achieved, plus its presentation of a re-designed new facility. Success came eventually when, due to a continuously high public profile and very vocal public support from all three major political parties, the closure decision was revoked, in part at least, and the re-opening of one unit was announced. The reason for this is either that the core of the users gradually won their argument or the committee members proved such a hassle to Trust members – take your choice. Either way, the users were formally invited to set up a formal group to advise the Trust on a new unit. Service users from the Day Hospital Campaign Group designed the new unit themselves, after having finally being given a realistic budget from the Haringey Primary Care Trust.

A Press Release from the Campaign summarised this achievement:-

“On 7th February 2005, the “Haringey Therapeutic Network” opened at the Canning Crescent Centre in Wood Green. It is, in effect, a day hospital by any other name – the result of nearly two years of campaigning since the closure on 31st August 2003 of the two day hospitals in Haringey, namely Canning Crescent and Kate Marsden (St Ann’s, Tottenham).

This protest by the Day Hospital Campaign Group represents living proof that the voices of mental health service users in Haringey may ultimately be heard, and the difference we were able to make in this instance may serve as an inspiration to others. Also, that the 4000-plus signatures collected by the Campaign Group in support of the day hospitals ultimately helped towards this result.

The day hospitals were closed by Haringey Mental Health Trust after minimal consultation. However, after a long, initially confrontational campaign, the Primary Care Trust agreed to finance this new 12-place unit.

Sadly, one in four of us suffer from a mental health condition at some time. As such, this 12-place unit is very small, compared with the 80 places offered by the previous two day hospitals. We realise that this is not the end, but the beginning, as the east of Haringey is still without a replacement.

As to whether the ‘Haringey Therapeutic Network’ will be allowed to prosper, only future hindsight will tell. To these ends, the Campaign Group intends to keep a watching brief.”

It may seem slightly ironic now, in 2008, that the Therapeutic Network is considered by the Haringey Mental Health Trust to be one of the mainstays – if not the lynchpin – of its mental health day services – a far cry from the not-so-far-back days of 2003, when the Mental Health Day Hospitals were condemned to be closed down. In fact it is now considered so good, that it now caters for 20 places or more, and has some facilities to cover the East of Haringey, where the Kate Marsden Day Hospital once was.

Personal Statement

As a commentary on the whole episode, Paulette Case-Robinson made her personal statement about her treatment from the beginning for the Haringey Therapeutic Network launch on 23 June 2005:

“My speech is to enable you to put a face to term ‘USER’, when you are thinking about the kind of client to benefit from this service. May I add that I have a background in Nursing, Psychology and Mental Health.

When I was sectioned to Downhills ward in 2002, because my then Community Psychiatric Nurse (C.P.N.) was worried about my ability to care for myself - I wondered what crime I had committed to end up in such an inhospitable place! I felt that there should have been a sign saying ‘Abandon hope (or is it humanity) all who enter here!’

As someone who lives with depression, I have always known the meaning of despair, but during the previous two years I had vied between ‘wanting to live and wanting to leave’.

If I had had enough money, I would have booked myself into a five star establishment that offered room service and an environment conducive to peace and respite. Instead, I was in the process of booking a trip to my birthplace in Jamaica with the money I had finally been compensated for a flood in my previous address. Ironically, the trip in planning was to my ancestral home in St. Ann’s, Jamaica, where I expected loving arms to enfold me, people to listen compassionately, and a community that would accept me, unconditionally.

Instead, I was diverted to Downhills Ward, St. Ann's Hospital, Tottenham. Here, my liberty was taken away, I was cruelly pinned down by several Black, male workers and carried to a ward. My trousers and knickers pulled down to facilitate an injection in my posterior. For someone with a history of sexual abuse and already in a traumatised state, this went beyond horror. I am still struggling to overcome the indignity and trauma of that experience. For those of you not familiar with St. Ann's hospital, Downhills ward, is a female only ward - a token gesture to recognise female vulnerability, I think.

In my sometimes 'befuddled' mind - even more 'befuddled' as I struggled to overcome the effects of medication, which had the most horrific effects on my spinal column and brain - when awake I attempted to talk incessantly, about past pain and humiliations and systematic failure. That is, the whole system e.g. education, racism, bullying at work and at home, and other social injustices which had brought me to this situation. I was shouted down and when that failed, medicated. This was the cycle for about two weeks, until eventually the medication kicked in and my manners returned. That is, I recognised the futility of talking to people who did not want to, or were incapable of listening.

I decided to conform. Outwardly, I again became quiet, the woman with the ready smile and polite exterior and dressing well. Retreating further inwardly, with a few more battle scars.

Unable to tolerate the boredom of the wards and the sexual advances of my form mates, I asked Rose, the cleaner, if I could help her clean the wards and eventually, when it was deemed "safe" for me to go out unattended, as soon as the doors were unlocked, I went home every day, returning to the hospital to lay awake most of the night, waiting for morning.

My crisis still exists: poor housing conditions, debtors that do not recognise mental health problems as a disabling condition, an inefficient benefit system, the apathy of the 'generic mental health workers', stigma, etc., General Practitioners that do not listen and engage.

If the purpose of a mental health institution is to deliver one back to 'ordinary' unhappiness, then it was effective. Nothing had changed - my depression/despair deepened, and it was then I was referred to the Kate Marsden, a Day Hospital.

Here, there were compassionate workers, working to re-establish dignity, self-esteem and checking that we were safe to cross the road. Working hard to reconnect us, one to one, and to the wider community. When I heard that both Day Hospitals were to be closed, I was outraged at the treatment of not only the clients of the Day Hospitals, but also of the dedicated staff, who always came to work with their humanity intact.

To quote Hippocrates - the founder of Western medicine:

"Healing is a matter of time, but sometimes also a matter of opportunity. Hence medical practice must not depend primarily on plausible theories, but instead on experience combined with reason."

I believe that a Day Hospital presents such an opportunity, even though 12 weeks will be enough for some individuals, but not for others. There are inequalities in terms of referrals; a clear east-west split is indicated. There are critical periods in rehabilitation/recovery, where if maximum support is given, people can sustain recovery and move on.

To cite Hippocrates again: "Life is short, art is long, opportunity fleeting, experiment deceptive and judgement difficult. Hence not only the physician, but also the patient and everyone who is involved in the situation, must cooperate." A clear indication for wider consultation, especially "User" involvement. Professional carers really ought to be aware that it matters "who" gives the medicine, as the practitioner is also part of the process of "well-being".

To conclude, there are pockets of "excellence" within the NHS: nurses that act with compassion, e.g. a former C.P.N., a new compassionate G.P., Lesley Fisher, Kevin Hargreaves and other members of the Day Hospital Campaign Group, Members of the CATT, Alexandra Road Crisis unit, etc."

An emerging enterprise

The final part of this success story is that two service-user members of the Haringey Day Hospital Campaign Group have set up a community enterprise which is now an established working unit: ACTiveEIGHT. This is described by their first interim mission-statement as follows:

ACTiveEIGHT **Acceptance, Commitment to Change through Therapy or Talking**

ACTiveEIGHT (Mental Health) Ltd was officially set up and registered in the UK at Companies House as recently as late-November 2007. We currently comprise two voluntary unpaid directors: Paulette Case-Robinson and Peter Sartori.

ACTiveEIGHT: We are a Community Enterprise based in North London. We are unique in our position of being professional presenters, lecturers, course designers and business consultants. As such, we are familiar with the mindset of mental health organisations. This includes economics, power-structures and politics.

Our uniqueness stems from the fact that we are also mental health service users (patients). We have had first hand experience of these mental health services as delivered, their degrees of quality and suitability (or otherwise), plus gaps in the service.

We will respond to government agenda to engage and involve service users in mental health service design. Being service users, we also know how service users may be invited for their presence only not for their contributions. We aim to ensure that service users' views are taken fully into account, not merely acknowledged.

We have always been aware that, within many service providers and educational and research establishments there remains an overall level of unawareness of how mental health service users/patients experience their conditions. The Medical Model still prevails. ACTiveEIGHT's mission is to ensure quality of life is given higher recognition.

We joined the pan-European EMILIA Project in late-2006, contributing to the Strengths and Recovery modules. We have also taught at Middlesex University and made presentations to our local Mental Health Trust in North London.

During our early work with the EMILIA Project, we incorporated our successful campaigning work (which began with the Haringey Day Hospital Campaign) with setting up our own company. We often speak about empowerment in our presentations. However, it is only when one experiences some empowerment as a service user that we are fully reminded how disempowering life as a service user/patient really is.

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"We might be mad, but we're not stupid!"

Herbal Medicine and the NHS

by Melissa Ronaldson (practising medical herbalist)

Introduction

The branch of medicine currently used to deliver health care within the NHS is known as the 'biomedical model'. The ideas behind this particular way of approaching health and disease evolved through the industrial revolution, and became consolidated in a discipline as distinct from other approaches to medicine during the 19th and early 20th century. The model, claiming exclusive use of the word 'scientific' to describe its own method, has distilled itself into a system of medicine that uses, as its main tool, pharmaceutical intervention at the point of pathology or crisis, to the exclusion (perhaps with the exception of surgery) of other strategies. This article will focus on one of these strategies – western herbal medicine. It will raise the questions:

- Is herbal medicine as inappropriate to primary and secondary healthcare provision on the grounds of lack of evidence base and cost as medical orthodoxy maintains?
- How did one model of medicine attain the ideological monopoly so as to shape the nature of our National Health Service provision?
- Does that monopoly deliver best possible health care or serve some other vested interest?

The aim is not to argue that herbal medicine should be included within the health service above other modalities (least of all the biomedical one), but to use it as an example to explore the process, impact and consequences of other approaches being left out, and the arguments for a more pluralistic and integrated system of healthcare.

Western herbal medicine is the system of medicine from which the biomedical branched.

The earliest written records of this tradition date back to the 4th century BC, though evidence suggests people throughout the world used plants as medicine for millennia before this. 80% of the world's population still relies on herbs for their health.

A practitioner trained in western herbal medicine today in the UK may well borrow diagnostic tools from other traditions to complement and enhance her own. She will also be using diagnostic procedures and tools familiar to health service professionals – eliciting a case history, a stethoscope to listen the heart and chest, a sphygmomanometer to take blood pressure, an ophthalmoscope for looking in eyes, an otoscope for looking in ears etc. The procedure may take more time than the average health service consultation. A holistic approach will be employed that acknowledges the many different causal factors that contribute to our well being (from genetics to material reality), recognising the uniqueness of the individual; and the lack of separation between mind and body and spirit. Treatment will come in the form of advice and support with diet and lifestyle, referral to other agencies, and herbal medicines in the form of tinctures, tea, syrups, creams, ointments etc.

The question of evidence

To some extent herbal medicine and biomedicine have evolved and developed along parallel pathways over the last 100 years or so. For example many tools of the herbal tradition, the plants and the plant extracts, have been submitted to the same tests and investigations as pharmaceutical preparations. A common theme with herbal medicine research is that scientific investigations will confirm or reinforce through analysis of chemical constituent activity, the logic of traditional use. This research has revealed that, for example: St John's wort is as effective as certain pharmaceutical anti-depressants in mild to moderate depression, as well as being

specifically anti-viral to some strains of herpes¹⁵; ginkgo improves poor cerebral circulation¹⁶ as well as having anti-microbial activities¹⁷; garlic is efficacious against TB¹⁸ as well as being anti-viral¹⁹, anti microbial²⁰ and anti-fungicidal²¹ to various different micro organisms; ginger is anti-nauseant²², dilates the peripheral circulation and is anti-microbial.²³ In fact hundreds plants have been shown to have anti-biotic activity, some specific to MRSA²⁴ (footnote 24 represents only sample of studies across the world) A simply prepared infusion of *Artemisia annua* is effective against chloroquine resistant strains of malaria²⁵.

This last example highlights an important aspect of herbal medicine that is only just beginning to break through scientific consciousness. Initial research revealed that not only was the simple plant infusion more effective than the synthesized alternative, but it also worked better than the standardized plant extract. This would seem to confirm something that herbalists have argued for a long time – that plant medicine contains a complex, interacting and dynamic cocktail of chemicals which as a whole may be more effective or appropriate than the so-called ‘active constituent’ in a plant, be it extracted or synthesized.

¹⁵ Behnke K, Jensen GS, Graubaum HJ, et al. Hypericum perforatum versus fluoxetine in the treatment of mild to moderate depression. *Adv Ther* 2002;19(1):43-52. [Note: Footnotes for this paper are numbered from 15]

¹⁶ Dodge HH, Zitzelberger T, Oken BS, et al. A Randomized Placebo-Controlled Trial of Ginkgo Biloba for the Prevention of Cognitive Decline. *Neurology*. February 2008.

¹⁷ Yang X, Chen J, Qian Z, Guo T Study on the antibacterial activity of ginkgolic acids *Zhong Yao Cai*. 2002 Sep;25(9):651-3.

¹⁸ Delaha EC, Garagusi VF. Inhibition of mycobacteria by garlic extract (*Allium sativum*). *Antimicrob Agents Chemother*. 1985;27(4):485-486.

¹⁹ Tsai, Y., et al (1985) Anti-viral properties of garlic: in vitro effects on influenza B, Herpes Simplex and coxackie viruses. *Planta Medica* 51:460-1

²⁰ Sharma, VD., et al (1977) Antibacterial property of *Allium sativum*: in vivo and in vitro studies. *Ind. J. Exp. Biol.* 15:466-8

²¹ Moore, G.S. and Atkins (1977). The fungicidal and fungistatic activity of an aqueous garlic extract on medically important yeast-like fungi. *Mycologia*, 696:341-348.

²² Pongrojapaw D, Chiamchanya C. (2003) The efficacy of ginger in prevention of post-operative nausea and vomiting after outpatient gynecological laparoscopy. *J Med Assoc Thai*; 86(3):244-50.

²³ Akoachere JF, Ndip RN, Chenwi EB, Ndip LM, Njock TE, Anong DN(2002) Antibacterial effect of *Zingiber officinale* and *Garcinia kola* on respiratory tract pathogens. *East Afr Med J*; 79(11):588-92.

²⁴ Farrukh Aqil, Iqbal Ahmad, Mohd Owais Evaluation of anti-methicillin-resistant *Staphylococcus aureus* (MRSA) activity and synergy of some bioactive plant extracts. *Journal of biotechnology vol 1 issue 10*

Kabir O Akinyemi, Olukayode Oladapo, Chidi E Okwara, Christopher C Ibe, and Kehinde A Fasure. (2003) Screening of crude extracts of six medicinal plants used in South-West Nigerian unorthodox medicine for anti-methicillin resistant *Staphylococcus aureus* activity *Int J Food Microbiol*. 80(3):223-30.

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²⁵ Mueller MS, Runyambo, Wagner I, et al. (2004). "Randomized controlled trial of a traditional preparation of *Artemisia annua* L. (Annual Wormwood) in the treatment of malaria". *Trans R Soc Trop Med Hyg* 98: 318–21.

This issue of evidence is important. The question of whether a tool or a system of medicine has sufficient evidence to justify inclusion into the health service or the medical model in general is obscured by the random – or not so random – decisions that shape the goal posts for measuring what is considered to be ‘valid evidence’. An ‘evidence base’ within mainstream medical protocol does not include thousands of years of empirical use, even where analyses of constituents demonstrate properties that are consistent with that empirical experience. Lack of ‘scientific evidence’ is often cited as an obstacle to taking a more pluralist approach to health care. This obstacle becomes a cul-de-sac when you consider that the large-scale research needed in order that a process or product be considered to have sufficient evidence base, is expensive, market driven, and inherently needing the input of pharmaceutical companies who will need to justify their investment with the anticipation of significant profits associated with a marketable product .

While it might be true that some mass produced, standardized herbal preparations may well fit this criterion, holistic herbal medicine as a system of health care that emphasizes the needs of the individual and may come in the form of different solutions in different circumstances and locations, will always be difficult to push through this particular ‘evidence’ hoop.

To be clear, a service delivering provision for the community funded by the community (or the nation) has to have some system of accountability and checks and balances in place in order to determine what is the right medicine for the individual or the community within the limited resources available. However the current system of pseudo-scientific evidence base does not deliver this. It is ‘pseudo’ scientific because the process of obtaining evidence is not neutral or unattached to the outcome. ‘Evidence’ within the current paradigm is expensive. It can only be obtained through investment of large funds. And herein lies the flaw – the pursuit of evidence currently is the prerogative of drug companies who have the funds to invest in creating it with most of an eye on producing a product that can be sold for profit and return their investment. The result is health care where the goal is profit rather than health.

This brings us to the issue of cost.

Cost

If we were to decide that our health care provision would benefit from a pluralistic approach that included methods beyond the so called evidence based bio-medical model, what of the cost? There is sometimes an implicit assumption that holistic, individually tailored health care is all very well if you can afford it. Activists and community members fighting to prevent the erosion of basic provision; health visitors, nurses, midwives struggling to maintain their professional integrity against a backdrop of over-work and under-staffing, may consider the seemingly peripheral issue of which model of medicine is used, a kind of intellectual luxury miles away from the everyday reality of maintaining basic bread and butter health care in the face of huge pressure. But the rationale for the economics of health depends, as with so many other things, on the point at which you do the sums.

To consider two examples....

Scenario 1. A child has atopic conditions, asthma and eczema. The pharmaceutical option includes steroid creams and inhalers. These can work miraculously and in the short term buy the body time and space to recover its equilibrium. But if they don’t work and the condition becomes chronic, the very medicines can add to the problem by thinning and making more fragile the epithelial layer of the skin and lungs, reducing the opportunity of the tissue to heal,

increasing susceptibility to hypersensitivity²⁶. A herbal practitioner will take time to listen and find out the causes behind the atopic response. These causes will vary from individual to individual. There may be some red herrings along the way. A parent may need support to put difficult behavioural or dietary changes in place. All very labour intensive and seemingly not cost effective compared to the quick fix option. However if the quick fix option fails (and it often does) and you take into account the cost to the child and their immediate community of the condition not resolving – sleepless nights, poor concentration, exclusion from certain activities and possible hospital admissions – then the labour intensive option seems viable.

Scenario 2. An immuno-compromised individual with weak lungs and a viral cough. Twenty years ago a GP might well prescribe prophylactic anti-biotics in case the cough becomes a nasty chest infection. Astonishingly many still would today. In terms of convenience this would seem a preferable option to mucking about with specific and individual prescriptions for tinctures and herbal teas and chest rubs and dietary changes, let alone anything as messy as garlic plasters!

the cost is much greater than time and inconvenience. It cannot be measured in money. In 2000 the Director General of the World Health Organization warned of the imminent catastrophe of anti-biotic resistance. She said:

“Our Grandparents lived during an age without anti-biotics. So could our grand-children. We have the means to ensure anti-biotics remain effective, but we are running out of time.”

The imperative to use herbal medicine in conjunction with, or initially in place of pharmaceutical anti-biotics does not come from a nostalgic notion of using old fashioned remedies. There is a life or death imperative to preserve and ration the use of anti-biotic drugs so that pathogens are not continually given the opportunity to develop resistance.



²⁶ John D. Kirby, D.D Munro (1976) Steroid-induced atrophy in an animal and human model. *British Journal of Dermatology* 94 (s12) , 111–119

Biomedical monopoly of health care provision

Sixty years ago the medical profession and the policy makers could not have anticipated the issue of anti-biotic resistance. And it is fair to say that part of the answer to the question ‘How was one model allowed to attain dominance in such a way as to shape the nature of health care available?’ lies in the fact that at the inception of our health service in 1948 – and perhaps for the next 30 years or so – many people laboured from within the flush of euphoric optimism that this contemporary branch of medicine, this pharmaceutical led biomedical model, held all the keys to a virtually disease free society. These keys, it was supposed, came in the guise of miracle cure pharmaceutical products – anti-biotics and anti-virals for infections; chloroquine for malaria; chlorpromazine, Librium or Valium for mental distress; cortisones and anti-histamines for allergic responses and auto-immune diseases. Another part of the answer lies in the fact that much of this really was true. The biomedical model has indeed spawned pharmaceutical treatments that have delivered and continued to deliver dramatic and reliable ameliorations to pain and disease.

Of course it has become apparent that is not the whole story. Many emerging diseases are chronic consequences of modern lifestyles. Sometimes the drugs have not been able to deliver in a way that people had hoped – pathogens developed resistance to the anti-infectives; the miracle cures (as with those of the preceding 60 years such as mercury and arsenic) turned out to have disastrous side effects. Sixty years on, with the luxury of hindsight, we have no excuse for imagining that the solutions are so simple. However even at the time, the dominance of the pharmaceutical-led biomedical model was not achieved just by default and a naive sense of optimism. There were other factors.

The issue of profit motive has already been alluded to in the section on evidence base. It could be argued that reductionist, product led healthcare solutions are a logical response from a capitalist society. We are used to thinking of the NHS as a triumph of socialism, and that the overt push towards market led health care is a sinister post-Thatcher, post-Blairite development. In fact our health service is firmly rooted in state capitalism – despite the altruistic, community serving and collective intentions of many policy makers, commissioners and employees over the last 60 years.

The wheels of capitalism had been driving the shape of medical science for a long time before 1948. For example, when J D Rockefeller came to offload some of the millions made through his oil empire at the end of the 19th century, his intention may have been philanthropy, but the consequence of the ensuing selective targeting of resources served to promote one particular direction of research and education and to consolidate the partnership between medicine and industry (interestingly against the wishes of Rockefeller himself, who had a penchant for the Baptist Church and homeopathy). In fact the US arrived relatively late to the world of synthetic drug manufacture. But on receiving certain treasured patents from Germany in 1917 under the auspices of the Trading with the Enemy Act, it soon cottoned on to the possibilities. In 1918, a Professor Kraemer in the *American Journal of Pharmacy* noted with glee:

“...our manufacturers have seen the importance of extending their research laboratories... Never before in our country have we seen the close relationship between the scientifically trained expert and the manufacturer and between the inventor and the banker... If the capitalist can be shown that laboratory work is likely to become a commercial success, he is at once interested and his investment is certain”

A second factor has been the competitive drive towards dominance and protectionism from the medical profession, compounded by the failure of herbalists and others to unite and organize coherently in relation to this. Protectionist battles have been fought, won and lost at judicial and

legislative levels since the time of Henry VIII. The general pattern has been repeated attempts by the medical profession to push for legislation criminalizing unlicensed practice by anyone other than their own members, counteracted by some sections of the herbal medicine profession lobbying for official legal status in their own right. Generally each side failed on both counts, but records of the Association – now the National Institute – of Medical Herbalists show continuous harassment, vexation and attempted legal suppression from the medical establishment diverting all their energies and resources from the last years of the 19th century and the first decades of the 20th.

On occasions the medical profession succeeded in achieving legislation that marginalized herbalists, and ordinary people found ways around it. For example, while the 1858 Medical Act had debarred herbalists from, among other things, issuing sick notes, the Royal Commission on the Medical Acts heard how 'in large manufacturing districts there are vast numbers of people who have only Herbal practitioners for their Medical Attendants, and that Club and Benefit Societies have passed Byelaws to enable their members to employ Herbal Practitioners and do receive certificates from them'. The 1911 Insurance Act did not explicitly forbid approved societies from paying benefit on a herbalist certificate; but doctors sitting on the insurance panels made sure that insurance companies refused contracts to herbalists. Herbalists attempted to mobilize and protest against this, but just at that point along came the First World War and the issue became somewhat peripheral. (Ironically the wartime demand for garlic to use on the front line casualty stations caused the government to require tons of bulbs to be produced urgently).

In 1941 the Pharmacy and Medicines Act was rushed through onto the statute book, removing the right of herbalists to supply medicines directly to their patients, effectively making them illegal. Paradoxically herbalists were, after some negotiation invited to join the health service in 1948, on condition that they undertook expensive education schemes, received marginal income from NHS prescriptions and remained subordinate to the regular medical profession. They opted to remain outside. History has yet to reveal if this was a decision that severed access to herbal medicine for 60 years, or preserved the tradition to remain intact for future generations.

The issue of gender cannot be ignored. Healing the sick, delivering babies, caring for the dying – these tasks, historically, are associated with women. Knowledge of medicinal plant lore has always been inextricably linked with these tasks. The roles of midwife and nurse have naturally been subsumed into the health service – they are the backbone of it - but the skill and craft of these professions is often subjugated to the perceived greater authority of biomedicine. The value a society puts on certain tasks is often reflected in the wage and management structures of its institutions. Health service employees have been battling these inequalities for the last 60 years. It may seem farfetched to link health policy decisions in 1948 with the witch burnings of previous centuries, but patriarchal establishment bias against areas of expertise that are considered the province of women was, and continues to be, a factor.

And the next 60 years?

Ten years ago, the Mental Health Foundation carried out a study aimed at mental health service users. It framed the disorientating simple question: 'What works for us?' The study was extraordinary because it shifted the investigation away from measuring how subjects responded to a new drug, compared to their counterparts in a placebo taking control group – and towards exploring, from the point of view of the individual, what helped them deal with their mental health problems. The constituency of mental health service users is slightly unusual in that it is more organized, more defined than other groups. Many within it have become politicized and less deferential to the whim of medical opinion through bitter and bruising experiences of state

imposed 'health care'. For many in this group demanding diversity of provision and evolving alternatives to what the state had to offer has been less about seeking 'freedom of choice' in the privileged language of market speech, and more about fighting for survival.

In order to shape our provision to reflect 'what works for us' within the resources available, we need to search for ways of gathering, recording and disseminating evidence of what is good practice, from the ground up. Evidence must include our experiences. Not instead of, but as well as traditional scientific method. We cannot allow the viability of a medicine to be measured in terms of whether it can be patented or not. The issue of anti-biotic resistance is an example that demonstrates the urgency of this and brings to light the mantra, 'act locally, and think globally'. We cannot afford to wait for policy changes from above.

The constant 'back against the wall' struggle to defend crumbling services at a grassroots level – both by members of the public and health service employees – can often distract from the task of pursuing creative, community specific and diverse solutions. Pluralistic and integrated solutions need not be restricted to funding a wider variety of health practitioners. It may include, for example, provision of allotment gardens for schools and care homes. The culture of deference to the smokescreens of 'expert medical opinion' and 'scientific reasoning' distract and deskill in relation to the task of grappling with the complexities of meeting the changing health care needs of our communities.

Alexander Fleming actually noticed, back in 1928, that the microbe inhibiting mould he had discovered stopped working after a while. Had all factors been equal and the science of health care been pursued for its own end, medical history may well have taken a different direction. The consequences of handing over responsibility for our health and the pursuit of medical knowledge have global and generational implications. Some things are just too important to be left to the vagaries of vested interest, market forces and the hands of governments.

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The NHS: Never Under Lay Control

by Janet Shapiro

According to the accounts of Charles Webster [1] and Dr Julian Tudor Hart [2], the National Health Service was not subject to lay control at its inception in 1948.

During the Second World War, there was universal acceptance of the need for a comprehensive national health service but fierce disagreement as to how this could be organised. During the coalition government, vested interests that opposed any loss of their power severely compromised earlier plans. After the Labour landslide victory in 1945, Aneurin Bevan was appointed Minister of Health; he was young and an ex-miner from Wales, with a determination to achieve progress. He recognised the main protagonists as the medical profession, independent contractors, voluntary hospitals and municipal planners. Local authorities had made considerable progress in providing comprehensive community health care. In addition they managed public hospitals that outnumbered voluntary ones three to one, the latter being dependent on public subsidy.

Bevan anticipated that nationalisation of all hospitals on a regional basis would be accepted more readily than the alternative of municipal control, by both the voluntary hospitals and the medical profession. Nationalisation would also allow continuation of the modernisation begun by the war-time Emergency Medical Service - **but** the removal of hospitals from local authority jurisdiction created a less radical administrative structure for community care. Thus he capitulated on earlier plans for local government to have overall responsibility for health care that included the conscription of general practitioners as full-time salaried staff. The result was a complex overall administrative structure with GPs, dentists and opticians remaining as independent contractors. The big breakthrough was that the newly created NHS, funded from national taxation, provided free health care to all. It replaced the inadequate provision of the National Insurance Act, whereby workers paying the health stamp had minimal access to panel doctors, and was an enormous benefit to low-paid workers, women and children.

Julian Tudor Hart, like Aneurin Bevan before him, is Welsh, and appreciated the success of lay control and employment of general practitioners in Welsh mining areas. This had to be abandoned after the 1911 Insurance Act. As a general practitioner Dr Tudor Hart applied the same principles of community care, carrying out whole population screening with measurable health improvement [3]. In his book he advocates that patients and medical workers should be co-producers in pursuit of health improvement; he acknowledges that the spirit of cooperation for a common goal is the great strength of the NHS, transcending its deficiencies.

In 1948, 80% of GPs were opposed to the establishment of the NHS. While in open opposition, consultants recognised that nationalisation of hospitals on a regional basis was in their favour. Allegiance to the system has since grown in strength so that when 'market economy' policies threatened the service in 1979 all unions (NHS Together), united in opposition to the 'reforms', were in a position to defeat the Thatcher government's proposals. In the event, Sir Maurice Shocker made a speech for the British Medical Association (BMA) acknowledging the authority of the government. He weakened the opposition of informed unions at that opportune time.

The complexity of the NHS structure and absence of lay control as set up in 1948 excluded the public from advising on its development. Since then, intrusion of the market economy has further fragmented the service. Unions are aware of deterioration but fight battles related to work conditions so the socialist struggle is hampered. Local authorities have Overview and Scrutiny Committees that wield some influence, but in sharing health care responsibilities they get the blame without the power or funds to improve delivery.

Julian Tudor Hart is optimistic; he indicates the unified rebuff to recent attempts to completely transform Primary Care Trusts from employers to commissioners of service. He has faith in the work of Keep Our NHS Public (KONP) and cites Bevan, who said that 'government without economic power is a sham'. Bevan understood that support for public ownership should be our ultimate aim for the NHS.

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'Keep Our NHS Public' responds to Darzi

Statement, December 2007 in response to the Reviews of the NHS by Lord Ara Darzi:

“Our NHS Our Future — NHS Next Stage Review”

“Healthcare for London: A Framework for Action”

“In the proposals, there is both promise and threat for the future of the NHS. The threat — of transactional fragmentation and commercial distortion of care — could be notably reduced by recognition by government that involvement of market mechanisms including the private sector in any such development plans is totally incompatible with the conditions of mutual support, trust and cooperation that are necessary to attain these new levels of NHS performance and achievement. Without this the promise in Darzi’s plans — the release of the creative enthusiasm and the mutually supportive drivers that established the NHS — cannot be fulfilled.”

Statement by Keep Our NHS Public in response to the Reviews of the NHS by Lord Darzi

- 2 – [edited excerpts]

PFI schemes. Urgent financial intervention by the Department of Health or Treasury to address the indebtedness which has resulted from inadequately thought-through government policy is required. Now that the major rebuilding programme has taken place, further projects for new build or other capital improvements should be funded and contracted for through the traditional direct funding system, supported if necessary by the issue of NHS bonds.

The use of private providers contracted for routine elective procedures raises concerns of equity because of their selective approach to patients. They are generally averse to accepting patients who also suffer from other conditions. Should their procedures fail or complications arise, they return patients to NHS care. They typically carry no training or teaching responsibilities. Despite this, these providers are significantly more costly than their NHS counterparts and they underperform against contract. Fragmentation of provision reduces the ability to sustain a universal and equitable health service by undermining the basic principles of risk pooling and cross-subsidy. This system should be discontinued.

The split between purchasers (or “commissioners”) and providers of care was a necessary step to allow the establishment of a health-care market. Markets are not known as a means to remedy inequalities in health-care or to match resources to social need. An economic structure which sets health-care organisations in competition one with another cannot be reconciled with Darzi’s integrationist approach. This crucially requires mutual support, planning and cooperation between primary and secondary care, between different specialities, between hospitals and between colleagues.

The re-establishment of national, regional and local planning and development systems in the NHS would ensure that — unlike commissioners negotiating price and service at one remove from the operational end of health care — the planners, managers and clinical staff could work together to achieve shared purposes and agreed outcomes. Darzi recognises that it is through collaborative effort that sound outcomes can be achieved. He states “. . . *the most successful action happens when different agencies work together.*”

The introduction of Practice Based Commissioning takes the market approach further. It fragments the process of care and exacerbates competition within the system. It diverts general practice from its prime function and may introduce perverse incentives into patient care decision making.

Payment by Results also challenges the key requirement to ensure that treatment is appropriate to clinical need. Many senior clinicians report difficulties with the system. Pressure to release beds — either before completion of diagnosis in complex cases or before full recovery from an operation — occurs too readily, causing further costs on readmission. Referrals to other specialities within an institution may now require reference back to the General Practitioner (GP) or Primary Care Trust (PCT) for re-referral to claim extra income, wasting time and resource and delaying treatment. Darzi's aim to enhance patient access and to facilitate patient movement within the service is clearly incompatible with such bureaucratic hindrances and finance-driven distortions.

Darzi exposes very effectively the need to improve the present complicated arrangements for patient access to the various branches and departments of the health service. However, he fails to analyse in similar detail the potential hindrances to free patient movement within a system where access is "regulated" by a business contract culture. A harbinger of such hindrance is the introduction of so-called Referral Management Centres which have powers to divert or refuse a patient's referral contrary to the agreed wishes of the GP and the patient. This flouts the GP's authority to recommend, in consultation with the patient, the treatment and care pathway they consider appropriate.

The London Plan

Lord Darzi has already produced a detailed plan designed to address some long-standing inequalities and important weaknesses in health and healthcare in London. It deserves to be taken seriously in proposing some radical changes and seeking genuine modernisation to deliver improved health and social care in Greater London. Some of its proposals merit careful consideration; others much less so.

His proposal to develop 150 polyclinics to provide a mix of primary care, urgent care, ambulatory care and outpatient treatment may have some merits, but remains controversial even among Darzi's own team of advisors and NHS London. There are serious questions over the proposed size, cost-effectiveness and user-friendliness of single site, multipurpose services for such large catchment populations. Important concerns that polyclinics may attract further encroachment by private sector providers have been underlined by recent statements from Health Secretary Alan Johnson promoting the increased role of private sector provision in primary care. The possibility has even been raised that "healthcare silos" and provider trusts will become the ready victims of corporate buy-outs and be operated as fiscal entities like US Health Maintenance Organisations. The polyclinic model, as yet in embryo, has to date attracted opposition from organizations representing many of London's GPs. Without their involvement the scheme is unworkable.

Darzi proclaims the end of the era of district general hospitals and yet the evidence for hospital reconfiguration is based upon computer modelling and remains highly contested. Darzi's general ideas cannot be endorsed until specific and detailed proposals are put forward for consideration by staff and patients as well as planners. Similarly, proposals for large-scale investment in reconfigured specialist services must be evidence-based and Lord Darzi must explicitly identify the evidence base used. His Report has been published at a time when many hospitals and other units are facing controversial cash-driven cuts in services. This raises understandable fears that the upgrading of a few acute centres would run alongside the downgrading of busy local hospitals. Darzi accepts that no existing facilities must be lost until at least equally effective alternative provision is up and running.

These fears are amplified by the refusal of NHS London to insist on a moratorium on hospital cuts and closures while the debate on Darzi takes place, including the fact that services in, for

example, Enfield (Chase Farm), Redbridge (King George's Hospital), Brent (Central Middlesex Hospital), South West London (Epsom and St. Helier) and South East London (Queen Mary's Hospital) are currently under threat, out to consultation or already being run down in response to cash shortfalls and long-term financial pressures. Indeed, the crisis quadrant of South East London has accumulated debts of £180m.

With no credible route map for its implementation, there are real fears that the positive elements of this Darzi Report may be used as a smokescreen to divert attention from unpopular policies which threaten to undermine local access to care and which increasingly open up an ever-widening and deepening role for private sector providers at the heart of the NHS.

Conclusion

The Darzi Review for England may, despite the principled concerns set out above, have a genuinely valuable effect on the quality of care provided within the NHS. The approach he takes for England as a whole will clearly differ in a number of important respects from his London Plan which concentrates on reconfiguration of hospitals and proposes the setting up of polyclinics in primary care.

In the Darzi proposals, there is both promise and threat for the future of the NHS. The threat — of transactional fragmentation and commercial distortion of care — could be notably reduced by recognition by government that involvement of market mechanisms including the private sector in any such development plans is totally incompatible with the conditions of mutual support, trust and cooperation that are necessary to attain these new levels of NHS performance and achievement. Without this, the promise in Darzi's plans — the release of the creative enthusiasm and the mutually supportive drivers that established the NHS — cannot be fulfilled.

As a pre-condition for further effective progress with the Darzi proposals, Keep Our NHS Public calls upon government to reverse the market structure and processes that have been imposed on the NHS and to declare a moratorium on further involvement of the private sector in the provision of NHS services. Adequate resources and facilities should be provided without delay to commence pilot trials within the NHS of some of the innovative and exciting service proposals outlined in the Darzi Reports.



Short Guide to London Health Emergency, 1984 to 2007

The LHE was established over 23 years ago, as a collective umbrella organisation for local campaigns defending hospitals in the capital against closure (under the impact of the 'Lawson cuts' in the 1983 budget). It was initially funded by the Greater London Council (GLC), as were numerous local campaigns, most of which ran autonomously under the general name of local Health Emergency groups. LHE's director John Lister was appointed as Publicity Officer in the spring of 1984, and has remained with the organisation ever since.

By the time the GLC was abolished in 1986, LHE had established a central role as a resource for campaigners, health union activists and journalists from the regional and national media. As a result, LHE managed to secure continued funding from a consortium of London boroughs with the support of the Association of London Authorities (now the Association of London Government).

However this core funding has never been sufficient on its own to sustain LHE's activities and its full-time staff. Since 1987, therefore, LHE has undertaken a steadily increasing volume of research work and commissioned publicity work for trade union branches, regional and national bodies, London boroughs and councils in England and Wales. In 1988 our work with health unions on nurses' pay led to a massive 1,000-strong rally of health workers in the Camden Centre.

Our research work beyond London increased further after 1990, when we published a nationwide analysis of the first wave of hospital Trust applications, and were later commissioned to draft responses to second and third wave opt-out bids around the country.

We were central to the Hands Off Our NHS campaign which from the time of the 1989 White Paper spearheaded resistance to the government's marketising NHS reforms; LHE speakers toured meetings all over the country and our publicity material was distributed in towns and cities throughout England.

When the Tomlinson Inquiry was launched in the autumn of 1991, LHE was the first to warn that its task would be to draw up a hit list of hospital closures in the capital - and that if these closures were allowed to happen, they would also hit other cities in England, Wales, Scotland and Northern Ireland.

We were also the first to challenge the credibility of the King's Fund Commission's proposals for London, which asserted without proof that improved primary care (GP) services could reduce demand for hospital beds. This proved to be the key argument in the subsequent Tomlinson Report. Yet since then thousands more hospital beds have closed while demand for emergency admissions continues to escalate.

LHE's status as the key source for London-wide information was reinforced when we were able to leak the contents of the 1992 Tomlinson Report the day before its publication by the government. Our campaign "*Londoners Need London's Hospitals*" won massive support not only from COHSE (now part of UNISON) and other health unions but also including the *Evening Standard*, and thousands of individuals who responded by collecting signatures, going to meetings, and distributing leaflets.

LHE has been actively involved with all the principal campaigns against hospital closures over the years, including the defence of Bart's, Guy's, Edgware General, Oldchurch, Charing Cross, Kidderminster, and Queen Mary's Roehampton.

But we have also forged strong links with union branches and campaigns around the UK, with affiliates and a history of work in Scotland, Wales, Yorkshire, the midlands, East Anglia and throughout the South East. The campaign's own newspaper *Health Emergency* has always attempted to reflect national rather than simply London issues.

In addition to challenging hospital closures and rationalization, LHE has maintained a consistent and principled stance of opposition to all forms of privatisation of support and clinical services, opposition to the Private Finance Initiative as a means of privatising the NHS building stock, and opposition to all forms of market-style reforms - which have served to fragment the NHS and demoralise its staff.

LHE has worked closely on many of these issues with local, regional and national health unions, conducting extensive research for UNISON including major national studies on PFI and (most recently) Hospital Cleaning.

Our director John Lister has also found time to complete a doctorate in health policy. His doctoral thesis has now been published as a 350-page book *Health Policy Reform: Driving the Wrong Way?* (Middlesex University Press, 2005 www.mupress.co.uk). This critical guide to the global 'health reform' industry offers a readable and accessible understanding of health policies around the world, with a unique analysis covering not only the wealthiest countries of Europe, north America and Australasia, but also the poorer developing and so-called "middle income" countries of Africa, Asia and Latin America.

For the first 17 years, LHE's other prominent worker was Geoff Martin, currently chair and campaigns director of LHE, and London Region convenor for UNISON. Many other loyal supporters have served on LHE's Steering Committee, and many more activists at branch and local level have given us priceless support. Well over 100 union branches continue to affiliate each year with many sending donations to help LHE maintain its campaigning effort. We very much appreciate this support.

We are grateful to all those supporters who have stuck by us: and we extend a warm welcome to any other individuals or organisations which affiliate or subscribe now to LHE. We also welcome any links with similar campaigns or health workers' organisations internationally. LHE speakers have addressed meetings in France and in San Francisco, and we have had links with health unions in New Zealand and Norway.

LHE remains committed to an independent stance - seeking if possible to work with Labour ministers in planning and developing services to bridge the gaps in care opened up over the last 20 years, but ready to speak out as and when necessary in defence of front-line services. We think this is the only principled way forward.

There is much more to be done.

London Health Emergency's new critical history of the National Health Service

The NHS After 60 - For patients or profits? by John Lister

is published by Middlesex University Press, 2008, ISBN 978 1 904750 30 7;

cover price £25 (but see special offer at <http://www.healthemergency.org.uk/international.php>)

"Everyone should read this book, and we must get together to ensure that the privatisation it warns of does not happen." – Tony Benn

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- Hospital Worker; *The Rank and File Health Workers' Almanac* [1977, 25pp]
- Ivan Ilich: *Medical nemesis - the expropriation of health* [1975, 184 pp] later re-issued as *The Limits of Medicine - medical nemesis, the expropriation of health* [1995, 294pp],
- Pat Kinnersly: *The Hazards of Work and how to fight them* [1974, 394pp]
- Lynne McTaggart; *What doctors don't tell you – the truth about the dangers of modern medicine* [1996, 378pp]
- Michael Moore's: "SiCKO", [film; 120minutes, 2007, USA, category 12A]
- Vicente Navarro; *Class Struggle, The State and Medicine – an historical and contemporary analysis of the medical sector in Great Britain* [1978, 156pp]
- Jonathan Neale: *Memoirs of a Callous Picket* [1983, 107pp]
- Stewart Player and Colin Leys: *Confuse and Conceal - the NHS and the independent sector treatment centres* [2008, 115pp]
- Allyson M Pollock: *NHS plc – the privatisation of our health care* [2005 new edition, 319pp]
- Peter Sedgwick; *Psycho Politics* [1982, 292pp]
- SPK: *Turn Illness into a Weapon – for agitation by the Socialist Patients' Collective at the University of Heidelberg* [1993 Germany, 216pp]
- Mike Taylor: *Creating a health Workers' Democracy* [36pp] in Michael Barratt Brown and Ken Coates: *Trade Union Register 3, 1973* [1970, 296pp]
- Trade Union Congress; *The Unequal Health of the Nation – a TUC summary of the Black Report*, [1981, 24pp]
- UCH; *Occupational Therapy: The Incomplete Story of The University College Hospital Strikes and Occupations 1992 /3 /4* [1995, 67pp],
- Colin Ward; *The Path Not Taken* [The Raven, 3, 1987, 6pp], and *History and Policy* paper 55 on website as above
- David Widgery; *Health in Danger - the crisis in the National health Service* [1979, 178pp]; and *The National Health – a radical perspective* [1988, 205pp], *Some Lives – a GP's East End* [1991, 248pp].
- Alan Woodward: *The Political Economy of Workers' Socialism – a first approximation* [2005, 84pp]

Short reviews

Virginia Berridge, 'Past opportunities Labour health ministers' obsession with Nye Bevan cannot hide their failure to learn from history', *The Guardian*, Wednesday June 20, 2007.

Shows how politicians in recent years have constantly invoked 'the same narrow history' in relation to the health service history, explores reasons for this and how it happens, and suggests avenues for discussion. Asserts that 'Bevan's achievement was great in the short-term politics of the 1940s, but there were also losses that we might well consider'. Available online at: <http://politics.guardian.co.uk/labour/comment/0,,2106589,00.html> LW

David G Green, *Working-Class Patients and the Medical Establishment: Self-help in Britain from the mid-nineteenth century to 1948*. (Gower, 1985)

Argues that a great deal of success was achieved through people's self-organisation by voluntary means - the friendly societies and medical institutes that were formed and flourished in the later 19th century - in providing effective affordable medical care at least for working-class men, until the National Insurance Act of 1911 gave government backing to a more unequal doctor-patient relationship. In his view the creation of the NHS in 1948 kept to the spirit of 1911, further consolidating the professional state-backed dominance and reducing people's control over health provision. The same author has written on 'Mutual Aid or Welfare State' and his work influenced Colin Ward (see References). LW

Lesley Hall, *Positively healthy: The Pioneer Health Centre, then and now*. <
http://www.wellcome.ac.uk/doc_WTD004752.html>

Summary introducing an exhibition on Peckham Health Centre in the Wellcome Library reading room in 2002 A competent brief description of the Centre's origins, achievements and (in some respects at least) significance. Concentrates on the 'positive health' aspect of its work, not so much on its libertarian credentials, but relates it to its social and historical context, and to the present-day Healthy Living Centres initiative. Links to the Pioneer Health Foundation, 2007 and to details of the exhibition at <http://www.thephf.org/> >. LW

Frank Honigsbaum, *Health, Happiness and Security: the creation of the NHS* .(1989)

Examines the decision-making process that led to the NHS Act, challenging the accepted view of obstruction by doctors and instead holding the Civil Service responsible for standing in the way, claiming rather surprisingly that civil servants wanted a system of health care based on local planning and control (doubtful if a libertarian option is meant here); one chapter is 'Doctors reject municipal control'. Concludes by comparing influence of doctors and civil servants. LW

Jacky Law, *Big Pharma: How the biggest drug companies control illness [2006]*.

This excellent book written by someone who was previously a journalist writing for a trade magazine from within the pharmaceutical and industry details how this industry works. She shows how its power has increased through monopolisation, the use of patent rights, the methods of drug research, their influence over the medical profession, and the development of new markets across world. It is a story of exploitation and greed of the huge pharmaceutical companies that make enormous profits. In the 1980s Glaxo developed a drug called Zantac for stomach ulcers, in 1990 its sales were worth \$2.4 billion, and Law shows how other alternatives were available that were much cheaper. In psychiatry the drug companies rush to develop new cures for the new mental diseases found by the psychiatrists. On the other hand the book details the fight-backs by governments and individuals against the drug companies especially where their rush for profit has caused misery and death. Law concludes that the more active involvement of the public in the provision of health is important in holding back the power of the drug companies. DE

Michael Moore, director; *SiCKO*; [12A, 2007, USA] 120 minutes

This biting but humorous attack on the USA private health system examines the plight, not only of those millions in America who cannot afford health insurance, but also of those who thought they did have cover but found the insurance companies too devious to pay up. Moore looks at various countries – Canada, France and the UK - to find the truth behind the health managements companies' propaganda. Finally he goes to Cuba, where the inmates in the US political prison at Guantanamo Bay apparently have 100% health care, to ask for some attention for the workers who became ill as a result of clearing up after 9/11. They are refused but the Cuban health service offers them generous provision. A popular, revealing and humorous but instructive film on the disastrous consequences of private health care, perhaps over optimistic about NHS.

AW

D Stark Murray, *The Future of Medicine*. (Penguin Special 1943)

A thorough account of the state of play five years before the NHS both with regard to the existing medical provision and the options being discussed, by a doctor who wrote on medical matters for the lay public. Aims to show that medicine is 'not a mystery, the property of only a few.. but a method of restoring and maintaining health that can be learned by all.' Comes out in favour of a service based on Local Health Centres, suggests how this might be achieved and organised, and also emphasises importance of understanding the social background in which disease occurs.

LW

Jonathan Neale: *Memoirs of a Callous Picket* [1983, 107pp].

A title in the "Working for the NHS" series of Pluto Books, this short book offers a humorous but very sympathetic account of the writer's experiences working as a hospital porter, and woodwork instructor. He describes the foibles of the union branch, the activities of the rank and file at the workplace around the 1982 strike, and throws a penetrating light on the overall politics. He has since been active in the movement for a sustainable society.

AW

Stewart Player and Colin Leys: *Confuse and Conceal - the NHS and the independent sector treatment centres* [2009, 115pp]

This little book is slap bang up to date, being finished at the end of 2007. The first nine pages, Foreword by Dr Wendy Savage, Preface by Stewart Player and the authors' Introduction provide an excellent summary. Part one looks at the origins and Phase one of ISTCs; two at the very weak attempt at parliamentary scrutiny; and three examines the Dept of Health conspiracy to introduce a totally new health care market, US style, and the political context. Should be compulsory reading for NHS workers, campaigners and indeed any concerned patient.

AW

Allyson M Pollock. *NHS plc – the privatisation of our health care* [2005 new edition, 319pp]

This timely book describes in careful detail the history of the NHS since 1980. In particular it is a basic guide to the nasty world of private health care. We are introduced to Health Management Organisations from the USA, Europe, South Africa, etc., which will dominate affairs in the near future. In the last 25 years Margaret Thatcher and Tony Blair have conspired to destroy the universal public health service and replace it by a market version, run by capitalist business people, on a profit making basis. Of course the old model was far too popular – and deservedly so – and this has meant a softly-softly approach and the promotion of a whole raft of misleading ideas to camouflage their real intention – "modernisation" etc . The book is not an argument for socialism, more a passionate defence of state capitalist provision, but essential reading for all of us potential patients. The later paperback version is best.

AW

Mike Taylor; *Creating a health Workers Democracy* [36pp] in Michael Barratt Brown and Ken Coates: *Trade Union Register 3, 1973* [1970, 296pp].

The author was a union full time official and had previously written in a book about Work. This article looks at the NHS re-organisation in the 1970s, but also, in part 2, makes up a unique description of the rank and file in the 1973 strike; and lastly in part 3, assesses the degree of control from below in the existing NHS. His verdict – not much, but he proposes a National Health Service Workers Council, elected by universal vote, plus bigger and better local Community Health Councils. He correctly predicts a future conflict of the interests involved.

AW

David Widgery; *Health in Danger - the crisis in the National health Service* [1979, 178pp]; *The National Health – a radical perspective* [1988, 205pp], and *Some Lives – a GP's East End* [1991, 248pp].

These books, written by a doctor whose practice was in East London, were not materially affected by his membership of a leninist party, where he was always on the libertarian wing. There are indeed essential reading, perhaps the most useful so far in any radical assessment. Widgery writes with passion about his everyday experience but also injects a perceptive political analysis about strikes, situations and perspectives. His early death was a tragedy but his critique of the private sector shows he would be livid about the present privatisation conspiracy.

AW

Reviewers: Alan Woodward (AW); Liz Willis (LW); Dale Evans (DE)

Directory

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Disability Rights Commission (DRC) closed 2007; responsibility transferred to Equality & Human Rights Commission: 3 More London Riverside, Tooley Street, London SE1 2RG, 020 3117 0235, Email info@equalityhumanrights.com , www.equalityhumanrights.com.

KoNHSP Keep our NHS public <http://www.keepournhspublic.com/index.php>

LHC, London Hazards Centre, Hampstead Town Hall Centre, 213 Haverstock Hill, London, NW 3 4QP; 020 7794 5999, email: mail@lhc.org.uk

LHE <http://www.healthemergency.org.uk> London Health Emergency, BCM London Health Emergency, London, WC1N 3XX. Tel: 020 8573 6667; e-mail: info@healthemergency.org.uk

Mind [National Association for Mental Health] 15-19 Broadway, London E15 4BQ

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Patients Association, PO Box 935, Harrow, Middlesex HA1 3YJ; Tel: 020 8423 9111; email: helpline@patients-association.com; <http://www.patients-association.org.uk/>

Politics of Health *and* UK Health Watch www.pohg.org.uk; e-Mail: contact@pohg.org.uk; ukhw@pohg.org.uk

Socialist Health Association <http://www.sochealth.co.uk/sha_sha.html> 22 Blair Road, East Chorlton, Manchester M16 8NS. Phone: 0870 013 0065; e-mail: admin@sochealth.co.uk .

Society of Radiographers, 207 Providence Square, London, SE1 2EW, 020 7749 7200, email: info@sor.org,

Unison, 1 Mabledon Place, London, WC1H 9AJ. 0845 355 0845, email: via www.unison.org.uk.

Unite the Union (ex Amicus etc.) <<http://www.amicustheunion.org>> Head Office, Press Office, Gen. Sec., 35 King Street, Covent Garden, London WC2E 8JG; Tel. 0845 850 4242.

A Worker's Speech to a Doctor

by Bertholdt Brecht, 1898-1956

We know what makes us ill.
When we are ill
We are told
That it's you who will make us better.

For ten years, we are told,
You learned healing in fine schools
Built at the people's expense,
And to get your knowledge
Spent a fortune,
So you must be able to heal.
Are you able to heal?

When we come to you,
Our rags are torn off us,
And you listen all over our naked body.
As to the cause of our illness
One glance at our rags would
Tell you more.
It is the same cause that wears out
Our bodies and our clothes.

The pain in our shoulder comes,
You say from the damp; and this is also the reason
For the stain on the wall of our flat.
So tell us, Where does the damp come from?

Too much work and too little food, makes us feeble and thin,
Your prescription says: Put on weight.
You might as well tell a bulrush,
Not to get wet.

How much time can you give us?
We see: one carpet from your flat costs
The fees you earn from
Five thousand consultations.

You'll no doubt say
You are innocent.
The damp patch
On the walls of our flats
Tells the same story.

“celebrate our history, avoid repeating our mistakes”