

For Health



**- A REVOLUTIONARY
STRUGGLE**





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INTRODUCTION

The National Health Service represents the pinnacle of what social democracy can achieve - the ultimate reform within capitalist relations of production. Never let us forget that our health service was not 'given' to us by a benevolent ruling class, but was won by the organised working class and by the health workers in particular. The working class has fought for health because, like education, it is a measure of their dignity and strength.

As long as the ruling class needed healthy workers, the NHS, paid for and operated by the working class, was convenient. But a gain under capitalism is not safe. The ruling class is in crisis, and the strength of the organised working class has been the main cause of that crisis. Industries everywhere in Britain are shedding manpower, while capital is exported abroad to seek quicker and easier profits there. Not only are healthy workers no longer required: a dignified working class that claims the right to an effective and freely available health service is anathema to those who seek to destroy our skills and our industry, and with those our being.

The cuts announced in the White Paper on Public Expenditure, February 1976, and in the 'emergency package', July 1976 - with of course the threat of more to come - together with the proposals outlined in the 'consultative' document, 'Priorities for Health and Personal Social Services', signal nothing less than the wholesale destruction of the health services in Britain. Unless we fight every cut, hospitals will close, doctors, nurses and other health workers will join the dole queues, waiting lists will grow and so will the unquantified misery of untended ill-health. Our children and future generations of our class will be denied even the most basic health care service.

But we must also face up to the implications of our refusal to accept the cuts. It is no use pretending that we are merely looking after our own. If we make sure that our health service is kept fully manned, fully operative, this is not simply a fond action of defence by the working class of one of its offspring, it is an offence against capitalism, an injury, a taking of territory. It will lead to greater conflict, with more at stake; it will raise the question of who rules in this country.

This then is the key to fighting the cuts. Any victory won by us in the struggle to keep the NHS going will be in jeopardy until we achieve the final consolidation - socialism. The whole working class must take up the battle for health.

BEFORE THE NHS

The National Health Service Act of 1946 was one of a series of reforms introduced during or just after the second world war. Others included the Education Act, the two National Insurance Acts and the National Assistance Act. The ever-growing strength of the labour movement during the war forced the government to adopt measures for which pressure from the people had grown steadily since the beginnings of capitalism.

In the face of the organised working class the ruling class could not afford to ignore people's poverty and disease, though they showed themselves capable of doing so when such organisation was absent. So there was poor relief and there were hospitals. The provision of health care continued to be dogged by the spirit of the infamous Poor Law.

The real germ of socialised health care was born within the working class itself. Through innumerable organisations: trades unions, friendly societies, even pubs, working people were setting up their own collective sickness insurance schemes. A few (e.g. miners in South Wales) were able to build and run their own hospitals; most could not afford this but aimed to pay doctors' bills and give financial support to those who lost income through sickness. Many local doctors ran their own 'clubs'.

The health service as it stood before the second world war (i) did not cover everybody adequately and (ii) was extremely haphazard and uncoordinated - totally inefficient given even the inadequate resources available. Pressures for reform and rationalisation came from the working class. The leading role was played by the Socialist Medical Association, working through the Trades Union Council and the Labour Party. They drafted a programme for the extension and re-organisation of health care on a centralised basis in 1933, and it was adopted as policy by the Labour Party in 1934.

The advent of war in 1939 forced the government to recognise the faults in the existing services which were quite unable to deal with war casualties. An Emergency Medical Service was set up, and un-

der this scheme about 65,000 extra hospital beds were provided. Surgical and other hospital facilities were upgraded, and specialised treatment centres were developed. There was the beginning of organisation on a regional basis, with London and the Home Counties divided into three 'zones' to deal with casualties.

More important, however, was the increasing proletarianisation of the doctors. Many served in the armed forces and returned home, accustomed to salaried employment, and sharing the aversion to a return to the old ways. In referenda organised by the BMA in 1947 the majority of doctors voted for the NHS.

NEVER A COMPREHENSIVE HEALTH SERVICE

The NHS was supposed to establish "a comprehensive health service; . . . designed to secure improvement in the physical and mental health of the people . . . and in the prevention, diagnosis and treatment of disease". It is not, however, and never has been a complete preventive health system. In this society it acts more as a safety net for the injured or crippled, and cannot compensate for bad diet, bad housing, ignorance or callousness. It cannot, for instance, compensate for the appalling increase in rickets amongst our children since the withdrawal of free milk in schools.

Successive governments have shown their contempt for the health of the people, except insofar as capitalism needed reasonably healthy workers to exploit. Prescription charges were first introduced by a Labour Government, and dental fees have increased so that for many a visit to the dentist is a luxury they can hardly afford.

Governments have continued to starve the health service of essential funds. Buildings, staffing levels, facilities and equipment have always been inadequate, notoriously so in the 'unpopular' departments of medicine, such as psychiatry, geriatrics, mental handicap, which care for the most vulnerable of our class.

Even in the 1950's the ruling class was trying to reduce the cost of health care. In 1956 the Committee of Enquiry into the Cost of the National Health Service made its report. It was asked to advise the Government on ways in which the cost of the health service could be decreased, or at least to suggest some 'rationalisations'. The Committee was forced to conclude: "We have found no opportunity for making recommendations which would either produce new sources of income or reduce in a substantial degree the annual cost of the

Service. In some instances - and particularly with regard to the level of hospital capital expenditure - we have found it necessary, in the interests of the future efficiency of the Service, to make recommendations which will tend to increase the future cost."

HEALTH WORKERS ARE PART OF THE CLASS

Health care under the NHS has become increasingly socialised. The development of medical treatment has resulted in an increasingly collective approach to illness. No doctor can work in isolation now, either from the other doctors, or from the nurses, technicians, therapists, social workers, involved in patient care.

The achievements of the health service have been largely at the cost of the health workers themselves. Since 1948 while the number of beds has decreased the number of in-patients treated each year has almost doubled. Britain's expenditure on health as a percentage of gross national product has always been among the lowest in Western Europe; despite this, standards of health care in Britain have been the envy of the world. Understaffing and inadequate facilities, long hours and low rates of pay have long been the norm in the health service. The dilemma that workers in this field are both employees and the providers of an essential service held back the development of trade union organisation. The apologists of capitalism have tried to confuse the issue further with cries of 'professionalism' and 'vocation'.

In recent years, along with many other public sector workers new to struggle, health workers have realised the need for organisation. Their own exploitation had contributed to low standards of care, and 'dedication' was no substitute for struggle.

In 1973 the hospital ancillary workers fought a gallant battle for a living wage and in defence of the health service, conducting their struggle well. The odds were against them for, although they received support from other hospital workers, including doctors and nurses, the working class as a whole paid mere lip service to their struggle, and practically no material support was forthcoming from other trade unionists. They retreated faces to the enemy, and the Government's victory was at best a pyrrhic one. The material gains were slight but the leap forward in organisation and consciousness were gigantic.

The many other groups of health workers began to realise, in the

words of the chairman of the national Radiographers Action Committee, "We have no choice but to unionise, there is no room for divisions; we have to fight hard." Throughout 1974 action was taken by many sections of health workers in support of their demands for improved wages and conditions. Pharmacists, radiographers, technicians and ambulancemen were among those workers who turned to struggle to win their demands. Union membership increased, and the guerrilla tactics of fighting where you are strongest were employed. The strongly organised hospitals led the weaker, bans on overtime were imposed, departments took strike action in rotation. They were supported by the rest of the working class, and workers in other unions respected the picket lines.

Like all other workers, this dedicated and humane section of our class learnt the viciousness of the ruling class's attack when they demanded a decent standard of living. The employers used every tactic of delay and moral blackmail: no demand, however just, has been conceded without a struggle.

NURSES AND DOCTORS IN STRUGGLE

Doctors and nurses have problems similar to other sections of health workers - long hours of duty, understaffing, poor career prospects and a salary which does not reflect their workload. They have always been reluctant to take drastic action because of the humanitarian aspect of their work, but they too have realised that to get better pay and conditions they must fight for themselves - nobody else can do it for them.

Nurses are in the front line of patient-care and are accorded the respect of the whole working class. While in training they are often left in charge of wards and teaching at ward-level is often non-existent as all hands are needed to provide basic practical care, the level of trained staff is so low. Once qualified they must run a ward or a department without sufficient back-up.

With the action they took in 1974 in response to which the government was forced to produce the Halsbury Report nurses took a tremendous step forward. Trade Union membership increased as never before. They organised massive demonstrations, one-hour walkouts and bans on overtime in support of their claims. Lessons learnt then are not to be forgotten.

More recently, hospital doctors have been successful in two dis-

putes with the government; the first to gain recognition and nominal payment for overtime, and the second to ensure the implementing of the agreement. Most doctors now realise the need for collective strength, and the BMA is now a fighting union. Unity with fellow health workers is also developing. By virtue of their skills and the long hours worked, with the respect that accrues, doctors are, like nurses, in a position to advance tremendously the struggles against the rundown of hospitals.

THE CUTS ARE POLITICAL

It is because the working class has never ceased to struggle - in fact more and more sections of the class have been drawn into the battlefield - that the bourgeoisie is making an all-out attack on everything that the class has created, our skills, our organisations, our education and our health. The arguments presented by the government in favour of dismantling the health service, along with the rest of the social services, are not of course in this vein. They claim that cuts in public spending will increase investment in industry and 'save the country'. What lies - they are deliberately destroying the industrial base of the country, while investment abroad continues to increase.

'Redistribution of resources' is the government's latest cry. The reasoning is on the surface seductive. The 'poor relations' of acute medicine have been too long ignored, and scarce resources must be diverted to improving care for the young, the elderly, the mentally handicapped, the psychiatric services and to 'preventive care'. The funds allocated to the NHS will not cover a fraction of these needs, while the acute services will decline rapidly.

New 'priority areas' in health have suddenly been discovered. Funds will be switched to them from those equally new discoveries, the 'privileged' areas, such as Hackney, Stepney and Bow! Did any health worker or patient in these 'privileged' areas know that they were over-provided with health services before the government pronounced this to be so? There will be no increase in health service provision in the 'priority' areas; only decline at a slower rate.

A new system of budgeting has been introduced, that of 'cash limits'. This means that if a health authority spends more than the money allowed it during one year that sum will be deducted from the following year's budget. Long term planning has thus been discarded at a stroke in the frenzy of balancing the books for the end of the year.

But the bourgeoisie want no long term planning. A memorable phrase in the Consultative Document declares, "People not buildings!" What cynicism! NHS buildings are among the worst and most neglected public buildings. Over a third were built in the 19th century and many have been due for demolition for over a decade. Capital expenditure - the money available for hospital building - will fall by almost half between 1974 and 1980 (costed at 1975 survey prices). New hospitals just being completed were originally commissioned 10 - 15 years ago, and the £150m a year cut from the hospital building programme is money that should have been invested in the future. There will be no more new hospitals.

OUR JOBS AND OUR SKILLS TO DISAPPEAR

The attack on the working class as a whole in terms of health care is equally an attack on those sections of the working class employed in the health sector. In every area of the health service the cuts are greatest in terms of staffing levels. Like all the assaults on our class it strikes at the root of our existence, our skills and our knowledge; it is a political attack, with the ridiculous excuse that since over 70 per cent of the health service budget is spent on staffing it is there that the greatest economies must be made. Those who remain will be expected to work harder.

In concrete terms the level of services is being reduced in every possible way. Vacancies are frozen in every section, and there is no doubt that unless we refuse to cover for vacant posts, demanding that they be filled, massive redundancies will ensue. Wards are being closed, even Accident and Emergency Department and Intensive Therapy Units are closed for days at a time, because of 'staff shortages'. Porter and domestic services are run on a skeleton staff. Clerical and administrative posts are regraded at a lower level or combined so that one person must do the work previously done by two! The hospital secretary responsible for the running of a single unit is fast disappearing. One administrator may have to travel between two or three different sites, too rushed to get to know any hospital really well and doing his job properly at none of them. Reduced staffing in Medical Records departments means that the staff left can no longer cope with the work load. Apart from the resulting chaos in clinics and out-patients departments, you need accurate records and statistics in order to plan the future pattern of health care. But ca-

pitalism's plans for the future are already clear - plenty of patients but no health service.

The essential support services are being reduced drastically. Catering budgets are being cut so that the quality of meals for both staff and patients is poorer. Cuts in catering staff mean that other hospital staff are unable to get meals when they are working at nights or at weekends. A vending machine is no substitute, and in some hospitals there are plans to close the kitchens completely and hive off the work to outside firms. The works departments, employing builders, engineers and other skilled craftsmen, painters, plasterers, carpenters, electricians, have so few staff and so little money that even essential maintenance programmes are being shelved, let alone the undertaking of new building programmes. Buildings and wards are left in a dilapidated or even dangerous condition - in one Brent hospital part of the maternity block is roped off with a sign, "Danger - keep clear." Meanwhile skilled men join the dole queues.

The recommendations of a Medicines Inspectorate to improve the facilities in hospital pharmacy departments are being ignored. No funds for new buildings are being made available, and much of the drug manufacturing potential in Britain's hospitals is being closed, while the drug firms are glad to supply their own products and increase their profits.

Pathology departments provide vital back up services to medical staff. The standard of this service will inevitably be lowered when technicians are working under pressure with outdated equipment and in inadequate conditions. One mistake could make the difference between life or death to a patient, yet even here when laboratory staff leave they are only replaced after determined action by the remaining staff. The cuts in the NHS are now demanding that some technicians pay for their own education after qualifying at the basic grades - in-service training would become a luxury, Technicians are fighting to preserve and advance their skills.

Doctors are now facing massive unemployment. The number of medical students continues to rise while the closure of departments and hospitals means the loss of posts at every grade. Experienced doctors are forced to remain the junior posts, and on present estimates by 1985 30 per cent of the medical students who qualifying will be unable to find a job.

Almost overnight capitalism in its determination to destroy our health has managed to change the chronic shortage of nurses into a 'glut'. There has been a significant rise in exam failure rates, and newly qualified nurses are not being offered jobs. Student nurses are protesting and all health workers must fight with them to keep them in the health service. Our class cannot afford to lose these skills that capitalism would waste and destroy.

ACUTE SERVICES

It is no coincidence that the acute hospital services have been singled out for attack for they are the most expensive to run and are the core of the whole health service.

Already many patients are condemned to second-class care as acute services fail to keep abreast of technological advances and new methods of treatment. Some patients with end-stage renal failure are denied the possibility of life-saving treatment. Others, will be denied the best treatment for diseases that are common in our society - coronary thrombosis, strokes, lung, bowel and breast cancer - because of lack of money. The EMI scanner, a British invention, is revolutionising the management of strokes and head injuries, but only a handful of NHS hospitals have the equipment, while export sales soar.

The waiting time for some surgical operations can be as long as two years and in some specialties an emergency only service operates. The reduction in acute beds means that clinics will be bigger, operating lists longer, and ward work must increase with the more rapid passage of patients through hospital. For patients on the waiting lists with minor problems there will be no treatment until complications arise - strangulation in hernia, acute retention in an enlarged prostate - inevitably associated with higher mortality.

As Accident and Emergency Departments in the small hospitals close, under the pretext that a better service can be provided when facilities are concentrated on one district general hospital site, ambulances taking desperately ill patients to the care they urgently need within minutes will have to travel many more miles. For less ill patients it means longer journeys, higher fares.

OUR CITIES TO BE ABANDONED

There is always a heavy burden of sickness and social deprivation at the centre of big cities. Additional resources and more hospital beds are needed to meet people's needs, particularly the lonely bedsitter population and the elderly. Apart from the heavy demands made on the medical and social services, those services are themselves more expensive to provide simply because they have to be provided in the expensive urban environment.

The effects of the cuts in acute services will hit all city hospitals, whose staff are already over-burdened. But a particular blow has been dealt to the metropolitan health regions, centred on London. A complete standstill has been imposed on growth in these regions, which with inflation has resulted in most of the health authorities 'overspending' by hundreds of thousands of pounds. These regions are accused of being overbedded - what nonsense! The only time you can ever say that a hospital is overbedded is when there are no waiting lists and the beds are still empty, not because there are more beds than some mythical 'norms' say there should be.

Although at present there are 150 hospitals in London the aim of the government is to reduce the number of district general hospitals to 20, and for the others to close or become geriatric hospitals.

In the North East Thames Region alone more than 20 hospitals in Essex and in north and east London are planned for closure, with a reduction of 4,600 hospital beds and a loss of 4,500 jobs. These include Brentwood, St. Faith's, Victoria, City of London Maternity, National Temperance, New End, London Jewish and the Metropolitan.

Teaching hospitals too are under attack. For example in the North West Thames Region the Middlesex, Charing Cross and Westminster Hospitals, St. Mary's Hospital, Paddington, the Royal Postgraduate Medical School, Hammersmith, and the Clinical Research Centre, Northwick Park, are all under threat. These hospitals treat patients from all over the country, and train the future generations of doctors. If one of these hospitals or units closed their specialist skills and knowledge could not be replaced elsewhere.

In Brent Health District, one of the most deprived in the country, widespread changes and closures have already occurred. Although the waiting list at the end of 1975 was 2,875, of whom 120 had waited for more than a year, 295 beds have been lost, including 200

acute medical and surgical beds. The District has lost an ophthalmic unit and an infectious diseases unit. Willesden General, once a busy acute general hospital, has closed and been reopened as a geriatric unit, taking patients from a unit closed elsewhere in the District. Of three Accident and Emergency Departments in the District, one has shut down completely, one is closed at nights and weekends, and even the unit at the main hospital, Central Middlesex, is frequently shut for 'economy reasons.

Closures such as these, and that of the Elizabeth Garrett Anderson Hospital where a now fully unionised staff forced the Area Health Authority to delay removing the equipment from the hospital, are test cases both for us and for the ruling class. Resistance from the class must be strong enough to prevent them from lowering the high standards of the 'best' hospitals, prevent them from depriving people of the treatment they can obtain locally at present; otherwise, what is planned for London this year will be in store next year for the rest of the country.

WHAT FUTURE FOR OUR CHILDREN?

The cuts in maternity care are the most dangerous: preventive health begins with the care of the unborn child. The argument put forward by the government that these cuts are justified by a fall in the birth-rate of 27 per cent over the last five years is ludicrous when they equally forecast that the birthrate will rise by almost as much in the next five years! In any case this would be the ideal opportunity for real improvement in maternity care, not for slashing services.

The ruling class does not want our children to grow up healthy. Perinatal mortality is the number of babies dying at birth or in the first week of life. It is a profound index of the health of a nation. It is higher in the north than in the south (Oxford 7.9 per thousand births, Leeds 17.9 per thousand births) and it is worse among the poor than the rich (7.5 per thousand births in social group 1 and 27.6 per thousand births in social group V* - 1970). It is worse in Britain than in most other industrialised countries.

*Social groups 1 - V' are crude definitions unrelated to class. In general group I consists of jobs for which a university degree is usually needed (e.g. doctors, accountants, architects) and group V; consists of 'unskilled' manual jobs (e.g. labourer, cleaner).

Much of perinatal mortality can be explained by low living standards, poor diet, bad housing. These are not dominant factors, and can be overcome by high standards of care. At St. Mary's Hospital, Paddington, an inner city hospital surrounded by poor housing, the perinatal mortality rate has been reduced from 30 per thousand births to 12 per thousand births in six years since the introduction of refined techniques of foetal monitoring during labour.

The Consultative Document talks glibly of giving priority to the handicapped while more money spent on maternity services could prevent handicap and save more babies. Spina bifida, for example, is a common and crippling disorder in this country, and children with spina bifida impose an enormous burden upon their families. Important research has developed a technique for screening for spina bifida in early pregnancy. For cost reasons it is unlikely that such a screening programme will be made generally available. Putting aside the emotional burden on a family with this problem, a vulgar 'cost analysis' condemns this policy. The cost of rehabilitating a spina bifida child, with multiple operations, and months or even years in hospital, is about £18,000 a year - the cost of detecting each case in pregnancy, £800.

Death is not the only enemy awaiting the new born: the number of children born with cerebral palsy (spastics) has been shown, repeatedly, to be closely related to the quality of maternal and antenatal care. A government proposing, and causing, a deteriorating level of such care is attacking the future of our nation.

'RETURN TO THE COMMUNITY'

Carried out properly, the government's proposals to keep people out of hospitals and institutions and the care for them in their own homes would be a good thing. To do this, it would need more money for hostels and sheltered units; more trained people working in the community - GPs, health visitors, social workers; and more support and education for the community who will be caring for them. Needless to say, this not happening - rather, the government has interpreted this as a means for transferring responsibility for these people to untrained staff or to no staff at all.

These proposals will mean vastly increased caseloads for health visitors and home nurses. These services are already understaffed, there is no intention of spending money to recruit enough nurses to cope properly or to provide them with adequate clerical support. They will have no time for preventive work, so there will be more

neglected children and a slump in the immunisation rate. The elderly and physically handicapped will not receive the skilled nursing care which is their right: their families will have to cope with the increased burden alone.

The same problems apply to the idea of returning mentally disturbed people to the community. Despite the advances in medical treatment and the development of concepts such as group and community therapy, the chronic lack of funds and staff shortages in psychiatric hospitals will reverse any advances made away from the repressive custodial system. As the cuts affect these hospitals the number of trained staff on a ward is reduced to a bare minimum, and the most vital parts of psychiatric treatment, the occupational and group therapy, are the first to go - to capitalism they are expendable frills.

The government's directive for community care provides a rationale for running down mental hospitals without providing alternative facilities. The basic skills of psychiatric nursing are being destroyed, and no additional training is given to the GPs and social workers who will be expected to cope. Increasingly people with psychiatric problems will only receive skilled treatment when their problems have reached crisis point.

There can be no return to a community that is being destroyed.

PREVENTIVE MEDICINE

The Labour Government is currently talking a lot of rubbish about preventive medicine - they just mean cuts.

Capitalism cannot even countenance implementing preventive medicine in its widest sense. Many industries, mining and construction for example, are still dangerous places for workers because the ruling class won't spend money to make them safer. The diseases attendant on poverty, poor housing and nutrition will continue as long as we allow capitalism to remain.

Preventive medicine is an aspect of medicine which a socialist society would greatly expand, since it means a general increase in the health of the people by avoiding accidents and diseases which can be prevented from ever occurring. Immunisation of children against polio and other illnesses, public health measures against infectious diseases, safety procedure at work - this is preventive medicine. Preventive medicine also means increasing the level of education and

knowledge among the people about their health.

This is the kind of preventive medicine we must demand, in addition to - not instead of - the expansion of facilities for looking after sick people.

WHO IS THE MAIN ENEMY?

With its usual cunning the Labour Government has seized on and perverted issues of concern to the class. The struggle against the employment of agency staff is the fight for organisation and the maintaining of standards of care; but the government would remove these staff without replacing them - we will only win this struggle when they are taken on as permanent staff. Standards of medical care must be maintained, but it is only since they didn't want doctors because they didn't want a health service that the government has suddenly shown such concern that foreign doctors cannot speak English well enough.

We must not allow the government's choice of private beds as a major issue to influence our priorities. They propose to abolish pay beds without making up the loss of revenue to the NHS. To their mutual discredit, doctors' organisations fought against it and ancillary workers' organisations fought for it - effectively delaying the day when all health workers can unite to defend, and ultimately assume control of the NHS.

The British ruling class are past masters of the divide and rule policy and nowhere more so than in the health service. The idea of scapegoats for the state of the service has been ardently fostered in the media - a few years ago the doctors, now the administrators. We must have no truck with this. There is now, and always has been only one enemy, the ruling class. No section of our class is unnecessary, and an attack on one is an attack on all. No cut, no reduction in service, no redundancy is 'less bad' than another. We are all under attack, and can only gain strength and advance through united action.

Capitalism is the main enemy.

THE NEED FOR A REVOLUTIONARY PROFESSIONALISM

In its old sense, professionalism in the health service is dead, simply because its social basis has disappeared: those who used to work independently as individual craftsmen in competition are now part of our class.

But one enduring aspect of professionalism is the traditional laying down of standards for medical and nursing practice. This determining of standards comes from the workers involved, nobody else. It is one of those totally autonomous activities of the working class that hint at socialism, not imposed and not to be taken away. This privilege of calling our own tune in the way we work must be actively defended - by implementing those standards in the face of a system that has decreed their decline. The words of the President of the Royal College of Surgeons are a start: "No doctor should, for whatever compelling political or economic reason, be required to do less for the care of his patient than he knows to be necessary and possible."

Professionalism can be nothing if it is not revolutionary. We have always exercised great responsibility in the running of our health service. We must not settle now for accepting the task of dismantling it. In every area the only people who are willing to take the burden of responsibility are the workers on the shop floor. The ruling class tells us to take risks in order to save money. Dangerously low staffing levels, boilers left unattended at night and weekends, antiquated equipment breeding infection - "Only accept the situation, and we will take the responsibility," they say. Responsibility! This is the worst travesty of it. It falls to us workers to take up the burden of responsibility and with it the right to rule in the place of those who have so manifestly forfeited that right.

CONCLUSION

For both health workers and the class there are two stark alternatives. Either we allow the ruling class to destroy our health service and with it the health of generations to come, or we fight every cut, every redundancy, every lowering in standards, every hospital closure. There is no 'middle path', no return to an illusory 'status quo' Capitalism is in absolute decline.

As the bourgeoisie more and more abandon the health service, the scope and necessity for our intervention will increase. The tactic of closing wards is not new; now we must seriously consider the tactic of opening wards. The name of the game has changed from throwing spanners in the works to get what we want to taking the works over because that's what we want anyway. Whatever the minutiae of any struggle, even when we don't achieve a formal victory, underneath goes on the essential battle of ideas, and our real gain lies in advancing the idea that now only the working class is fit to run society.

By saying no to all cuts we are saying no to capitalism. To fight for a truly comprehensive health service our fight must be revolutionary. We must fight for socialism.



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