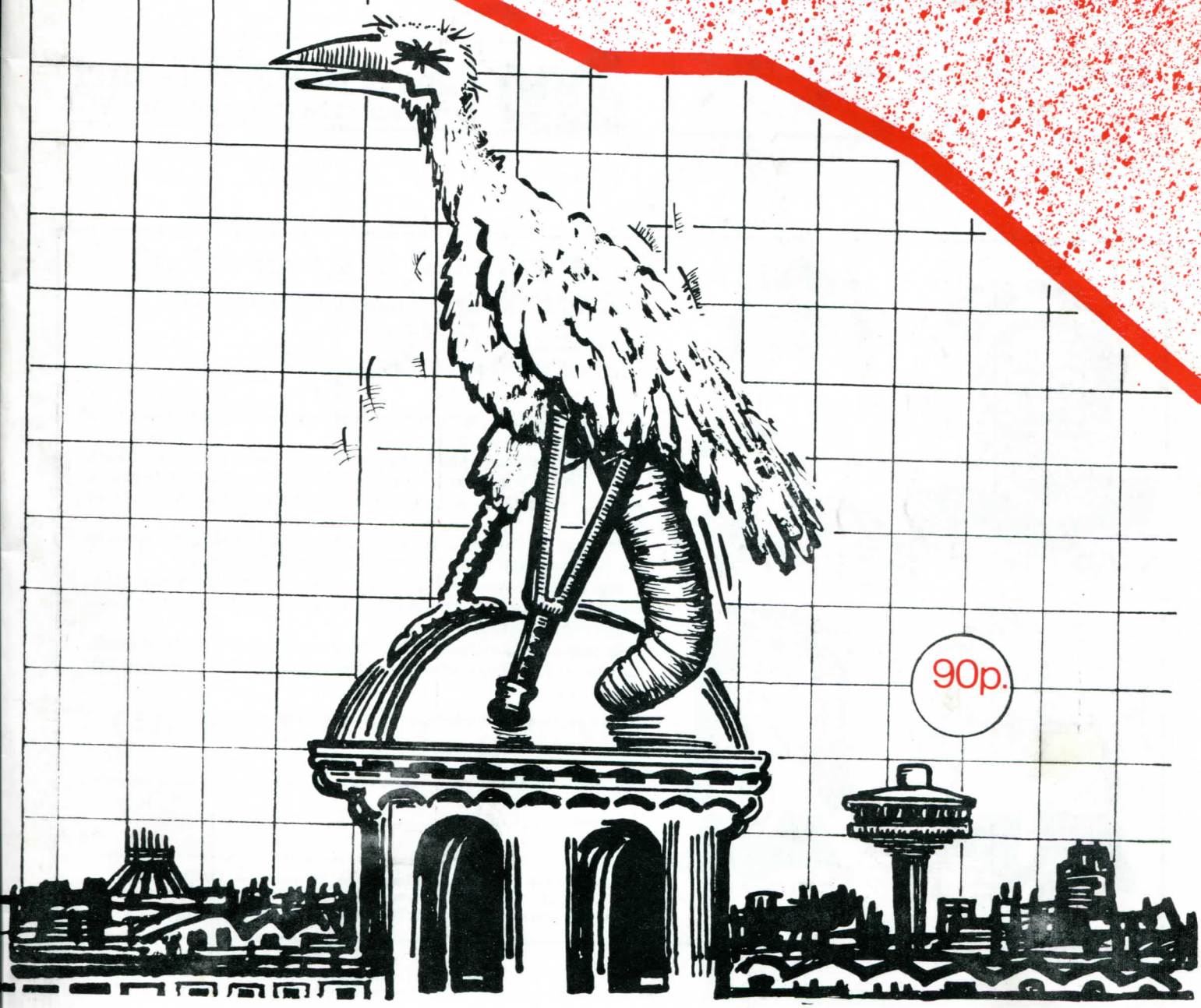
LIVERPOOL'S STATE OF HEALTH



90p.

LIVERPOOL'S STATE OF HEALTH

MERSEYSIDE COMMUNIST PARTY

EDITED BY KATY GARDNER AND STEVE MUNBY

90p.

ACKNOWLEDGEMENTS

This pamphlet was originally conceived as an update of a previous edition published by Merseyside Communist Party in 1980. In the process it has grown considerably and many people have contributed ideas, time and energy.

It would have been quite impossible to produce without this collective imput from members of the Communist Party, Labour Party, Socialist Health Association and trade unions, health workers and consumers. Given the numbers involved we will not try to express our thanks by listing them all.

However we owe a particular debt to Robin Cope, Chris Stocking and Julia South for wrestling with the illegible writing, dreadful style and lack of imagination and efficiency of the editors. Any deficiency in the final product are our responsibility not theirs.

While we hope that all the information contained in this pamphlet is accurate, this is probably wishful thinking. During the time we have been writing it there has been a General Election, a change in the leadership of the City Council and further cuts in the health service. Nor do we claim to be 'experts' on the local health service. We hope that you will read this pamphlet with a critical eye, but also find it a stimulus to discussion and activity. We welcome any further comments or suggestions you may have to make.

Contents

1) INTRODUCTION

This pamphlet was first published 3 years ago by the Merseyside Communist Party. At the time we said that "there was a need, not only to outline some of the problems of our Health Service in Liverpool, but also to start to make a fightback for the conception of a Health Service that was modern in the best sense, and stressing the need for health education and preventive medicine." We hope this edition will play a similar role.

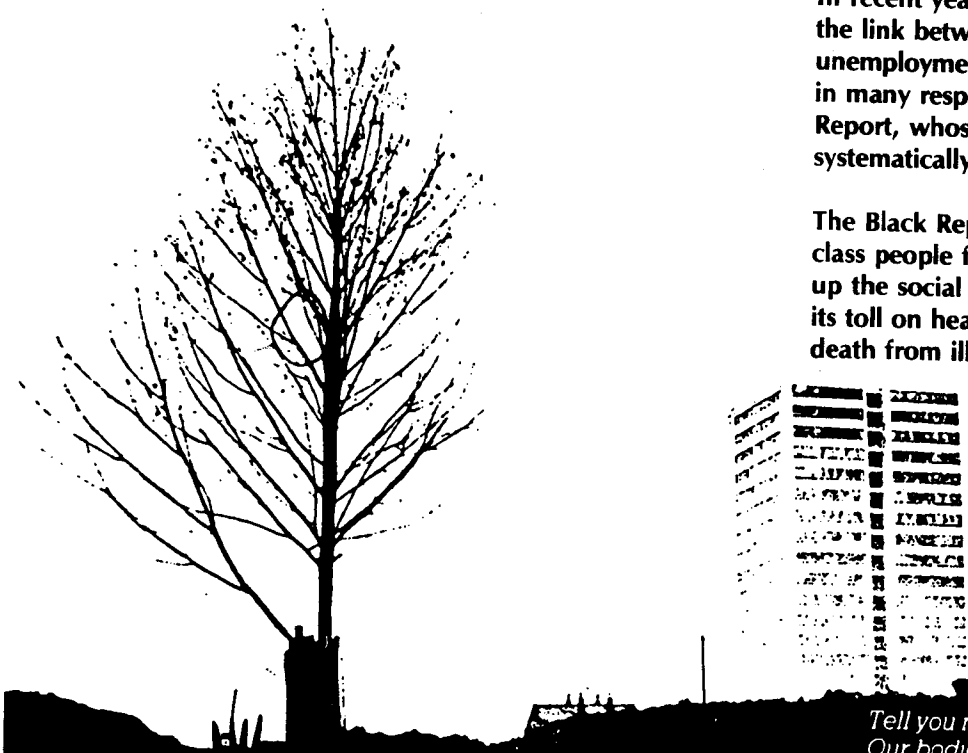
We believe that health is fundamentally a social issue. Poor health stems from a range of factors — social and economic — as much as biological. Health care should mean promoting good health and preventing illness — dealing with the causes of ill health — rather than just treating its effects. In a decent service, community care, health education and decent living conditions are as important as hospitals, technical expertise, drugs and machinery.

Health is something that concerns everyone, not just specialists, whether they be consultants, administrators or researchers. The NHS is a public service, which we all rely on and pay for, but it is deeply undemocratic. Basic decisions about health care are made by a very small group of people — both at a local and a national level. We believe that the health service should be more accountable to the population at large, both the people who use it and all those who work in it. We believe this is right both as a principle and to ensure a decent standard of health for everyone.

Liverpool's situation generates a whole range of distinctive health problems, which places a big strain on resources. Many of the effects of poor social conditions are not understood. They are seen as seperate from their social context and treated as a range of different, unrelated health problems, such as depression and alcoholism. The result is sometimes to blame the victim of ill health for leading an unhealthy life style, rather than the underlying causes of poverty.

In recent years there have been many studies showing the link between broader social factors, such as unemployment, and poor health. The best known and in many respects the most significant was the Black Report, whose findings and proposals have been systematically ignored by the present government.

The Black Report showed that in every way working class people fare worse than their counterparts higher up the social scale. In addition unemployment takes its toll on health in terms of depression, heart disease, death from illness and suicide.



A Worker's Speech to a Doctor

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

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 more weight
You might as well tell a bullrush
Not to get wet

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

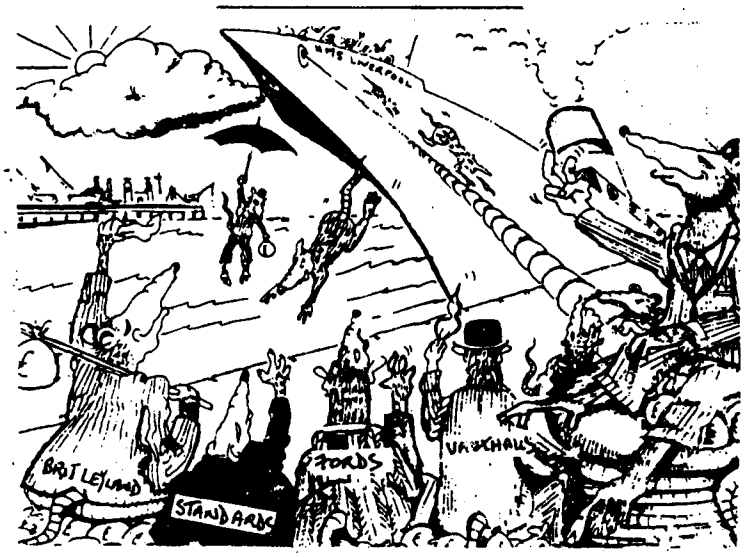
You'll no doubt say
You are innocent. The damp patch
On the wall of our flats
Tells the same story

Bertold Brecht

a) Unemployment

Liverpool's health services operate in a city that's become a symbol of urban decay. Long term industrial decline has led to mass unemployment.

In the 50's and 60's many multinational firms moved to Liverpool to take advantage of government grants. Soon after they shut up shop leaving even higher unemployment.



"It's not the leaving of Liverpool. . .

Between 1978 and 1982 unemployment in Liverpool rose from 12.8% to just over 20%. Much of the unemployment is long term. Nearly half the people unemployed on Merseyside have been out of work for over a year.

Only 7% of Liverpool school leavers last summer obtained jobs.

The 1981 census showed that unemployment in the four inner city wards of Abercromby, Everton, Granby and Vauxhall was running at around forty percent. If we take account of the many young people on temporary schemes and the married women who don't bother to register for work then the figure will climb even higher. Many of the outlying districts such as Croxteth, Netherley and Speke face similar problems.

All this has a great impact on the demands placed upon the health service.

b) Housing and Planning

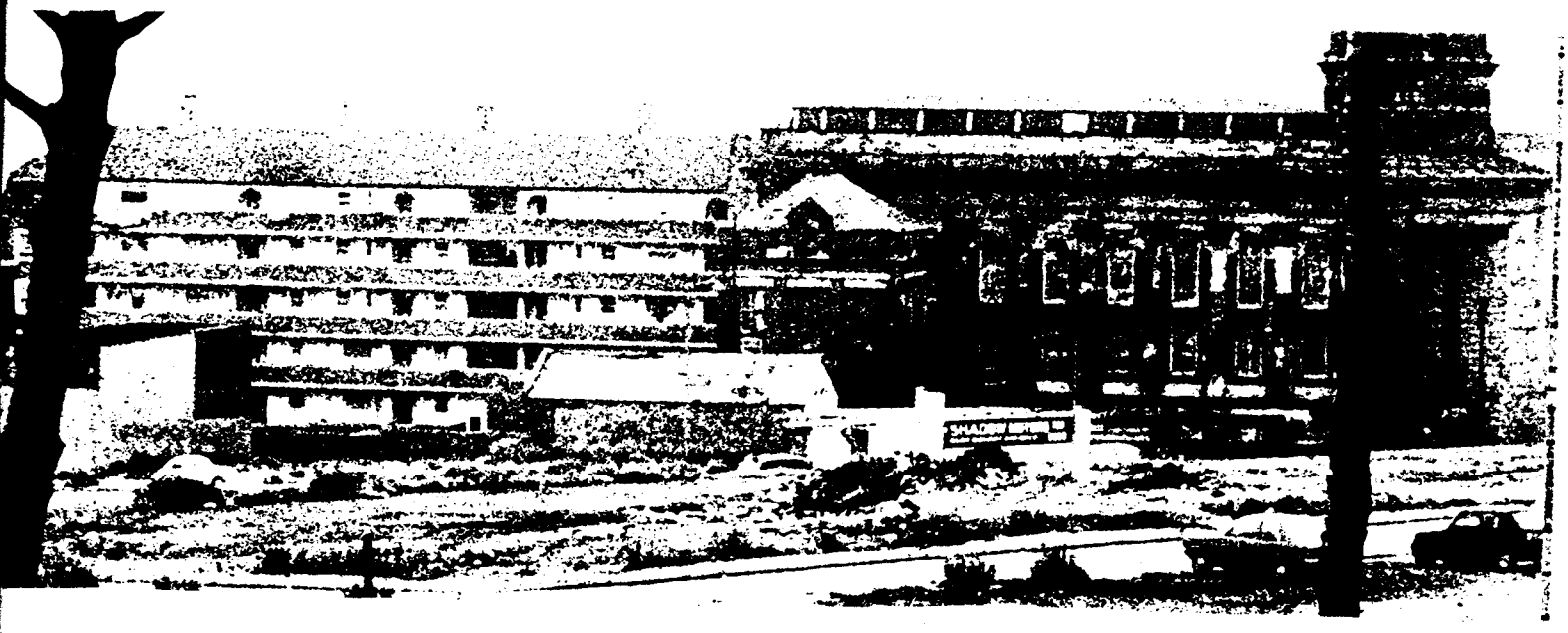
Against the background of persistent mass unemployment, a devastating range of social problems mark out Liverpool, even from most other big cities. The slum clearance programme of the 50's and 60's remains a monument to bad planning. Its legacy is a combination of vast open spaces in the city centre, with tower blocks and perimeter estates in areas like Speke, Croxteth, Netherley and Kirkby, which are some of the worst examples of concrete jungle in the UK.

The reaction against the major building programmes of the past has been almost as damaging. Left with a large and deteriorating stock of council housing, the recent ruling coalition of Liberals and Tories called a complete halt to new council house building, ran down the council's direct labour force responsible for construction and maintenance of council housing and encouraged the sale of council houses to tenants. Inevitably the only takers for this were tenants in the better stock of housing. Meanwhile thousands were left living in appalling conditions.

In the past people have taken to destroying flats in desperation to be rehoused e.g. the 'Piggeries' and parts of Netherley. A more positive innovation has been the emergence of housing co-ops, which have provided tenants with some opportunities to control and change their housing conditions.

The newly elected Labour Council has pledged itself to a major programme of council house building and a package of repairs and improvements in selected priority areas. This is welcome. But sadly the Labour Group have shown few signs of wishing to involve the people in deciding on what the priorities are and how council housing should be built and managed. Their decision to cut back on funding to housing co-ops suggests a lack of interest in opening up planning to local people. Indeed there are worrying signs that some of the old 'boss politics' attitudes of the 50's and 60's still operate — and that would be a recipe for disaster.

The attempts of central and local government to cope with the problems have been cosmetic at best and more often disastrous. The combination of inner city partnership funds devoted to environmental improvement with a battery of MSC schemes has turned into a sick joke. Generation after generation of young and not so young people have been employed planting trees, laying turf and concrete in an absurd ritual which has given Liverpool more trees and less jobs than any other major city in Britain.



c) Population

One result is that many people have moved out and the population has fallen rapidly. This tends to break up traditional family and community ties. Many young couples have moved to the suburbs only to encounter the same problems again.

Liverpool	*Population*
1961	*745,750*
1971	*610,113*
1981	*513,722*
1991	*456,500 (projected)*

The drop in numbers conceals important changes in the overall population structure. By and large it is the more affluent sections who move out, while the poorer and older sections of the community remain.

There has been a steady rise in the proportion of older people in the population. The 1981 census showed that there were:

* *90,000 pensioners in Liverpool*
* *4 out of every 10 households contain at least one pensioner*
* *the number of households consisting only of pensioners has doubled in recent years.*

Future predictions estimate a continuing rise in the proportion of elderly people in the population, especially in the over 75 age group.

When planning health services, estimates of future population are important. If the future population is *underestimated* this can lead to serious underfunding of health services. There are reasons to believe this could happen here. There were 15,000 more people in May '83, living in Liverpool, than predicted by the 1981 census. If this continues the 1991 figure could be a serious underestimate. There are several reasons why the fall in numbers might slow down:

* *nationwide unemployment means there are no jobs to move to*
* *the decanting of people to new towns like Kirkby and Runcorn has come to an end*
* *people are beginning to move back into the city from outlying areas.*

Whatever the reasons it matters to the local health service. 20,000 more people could mean several million extra pounds are needed during that time.

This introduction sets the scene for this pamphlet. There are no magical solutions. We need to fight against the social causes of ill health in Liverpool. Elsewhere the Communist Party has put forward policies on issues such as housing and employment, which we believe could begin to tackle these problems. In what follows we focus on the 'narrower' dimension of health in Liverpool, set against this wider social background.

Some indicators of the problems facing Liverpool from a report to the City Council by the Director of Social Services.

INDICATORS — all figures are percentages	*LIVERPOOL*	*MERSEY REGION*	*ENGLAND & WALES*
Unemployment male	*21.6*	*14.8*	*10.2*
Unemployment female	*8.9*	*6.2*	*4.5*
Overcrowding (more than one person per room)	*5.6*	*3.7*	*3.4*
Lacking/sharing bath	*5.1*	*3.1*	*3.2*
No car	*61.8*	*43.4*	*38.5*
Pensionable age	*18.5*	*16.7*	*17.7*
Over 75	*5.9*	*5.3*	*5.8*
Pensioners living alone	*30.4*	*29.5*	*29.1*
All population living alone	*9.0*	*7.4*	*6.6*

2) HEALTH CARE PRIORITIES

Hospitals dominate the Health Service. They get most of the money — 60% of NHS spending goes to the hospital sector, while less than 10% goes on general medical services. They also get the attention and the prestige. Within the hospitals the 'high tech' medicine and specialities get a disproportionate share of resources. People will give their last penny for appeals for lasers and body scanners (there is a big profit for someone in these). Meanwhile conditions on geriatric wards are often dire.

The hospital domination is particularly true of Liverpool. It is a 'Teaching Authority' — doctors are trained here — and there is a concentration of specialist facilities in the city. Patients come to Liverpool from a very wide area for treatment. As a result Liverpool is seen as a 'wealthy' area in health terms — 'overbedded' and 'overfunded'. Meanwhile a range of basic needs go unmet, despite our reputation for relative affluence in health facilities.

Money and the NHS

The cost of the National Health Service has become an important area of controversy in recent years. Increasing demands for health care have come up against government attempts to cut public expenditure. One result is major financial pressure on the Liverpool Health Authority.

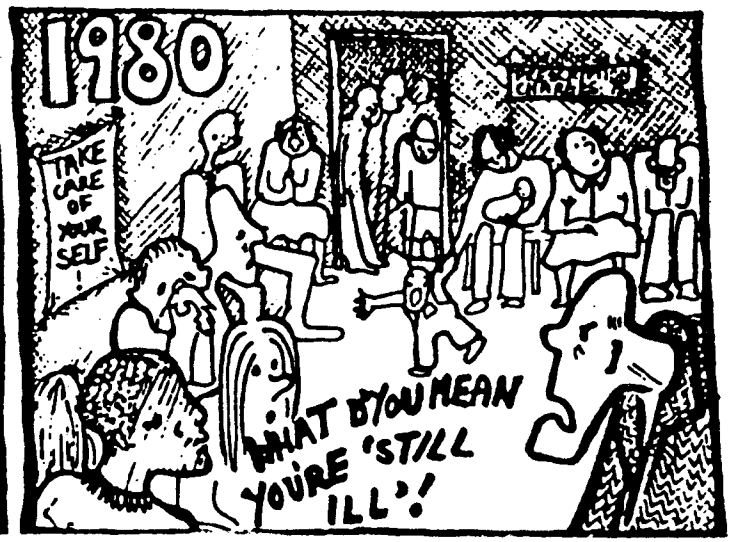
In fact, the debate within the NHS has not focused on how much the service should get as a whole but on who gets what and where.

One attempt to try and share out the national cake on a more equal basis was set up several years ago. It was called the Resource Allocation Working Party or RAWP for short. It tries to assess an area's needs, looks at the resources available and then allocates the cash RAWP has hit Liverpool hard.

RAWP measures needs on the basis of an area's population and the number of deaths (mortality). The general level of ill health (morbidity) is not taken into account. The RAWP formula also ignores factors like social class, unemployment and poor housing.

Liverpool has a relatively large hospital sector — which weighs in the balance against it — despite the important gaps in other areas of the local health service. In short the social problems of Liverpool and the artificial effects of being a Teaching Authority do not figure adequately in the final reckoning.

Apart from the conflicts over funds between different Regions and Districts, different sections of the health service are potentially in conflict over funds. Over the last 10 years or so different governments have made a commitment to channel more resources into health care



There has been an increasing demand for health care ever since the NHS was founded. Higher standards of health mean that people demand more than they would have done in the past — a question of rising expectations. Improved health and general living conditions mean that people live longer. In particular there is a rising proportion of people over 75. These and the elderly in general place extra demands on the health service.

Finally there are pressures inside the health service for higher spending. Advances in medical technology such as transplant operations lead to pressure for new expenditure in 'high tech' fields. Those placing these demands — highly placed consultants and specialists are more likely to get their demands met because of the influence they wield in the NHS and their 'clout' with public opinion.

in the community as against hospital care. This commitment has tended to remain one on paper. There are various reasons for this. The structure of the health service creates problems, since many services affecting community health are run by local councils not the NHS. So local health authorities make loud noises about the importance of community care, but do little about it, using the council's inaction as their alibi. Similarly the local council will blame the government or the health authority for shortcomings in community care.

Apart from the structural problems of transferring resources to community care, there are important institutional obstacles. As we indicated above, the most powerful lobbies over finance in the NHS tend to be senior hospital consultants and specialists. GPs, health

visitors and social workers wield relatively little power in the heirarchy of the NHS. The result is that finance stops short at the gates of the hospital.

Last, but in many ways most important, is the national context. It is no accident that community care became a popular phrase in Government circles at the same time as major spending cuts were being introduced. In many instances, professed support for care in the community, has simply served as an alibi for cuts in the hospital sector and forcing families, i.e. women, into looking after sick relatives.

This is particularly the case under the present Thatcher Government. A climate of financial stringency and cuts is not a favourable one for negotiation over a major shift in resources. As far as the right is concerned, they prefer talking about community care to providing it.

3) WHO RUNS THE NHS

We pay for the NHS. As a public service it is meant to be run in the interests of the people and to be accountable to us. But we will argue that local services are run by organisations that are both undemocratic and unrepresentative.

The DHSS is responsible for national control of the NHS. Local decisions are made by Regional Health Authorities (RHAs) and then lower down the scale by District Health Authorities (DHAs). The consumers' role is taken by the Community Health Councils, but these have little power.

Let's look at the Regions first. These are split into a team of full-time officers who are subject to the decisions taken by the Authority's lay members. But these members are not chosen democratically. They are directly appointed by the DHSS nationally and tend to consist of a mixture of senior medical staff, local political worthies and businessmen.

A (small) minority of places are given to councillors and trade unionists. Local people have no control at all. The key decisions tend to be taken by the full time professional team as the lay members bow to their 'experience' and their 'judgement'. These full time officers are part of the same group, the same class, of hospital doctors and specialists who wield large power in the NHS.

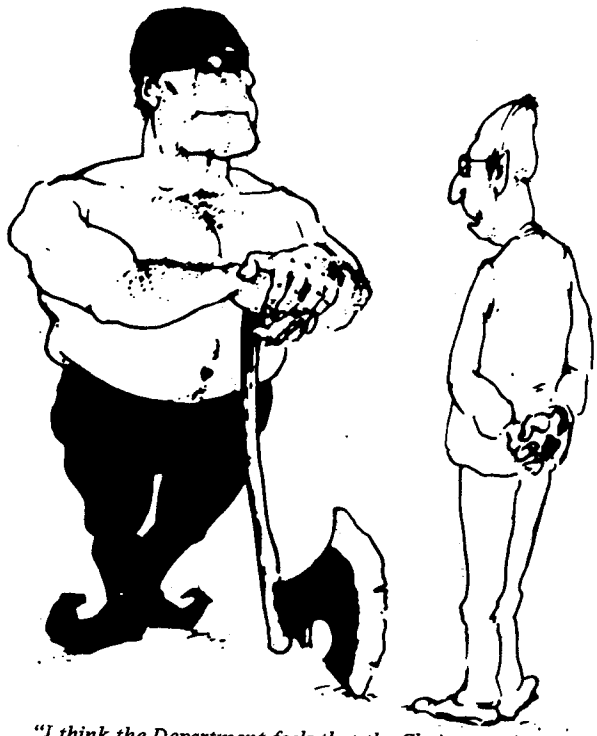
The District Health Authorities follow a similar pattern a full time professional team advising a group of lay members. This time the Region directly appoints the lay members. A case of the appointed making their own appointments in their own image. Once again a minority of places are reserved for four representatives of the City Council and one from the TUC. The Chairperson is paid and appointed by the DHSS.

In Liverpool, the Chairperson of the DHA lives on the Wirral and is a former Chairperson of the Wirral Conservatives. Only about half the members live in Liverpool and hardly any in working class or inner city areas.

It is a fairly secretive body. Ironically, because the members are unused to the glare of publicity and the pressure of public opinion, it is susceptible to a degree to being influenced by protest and argument. Meetings of the Liverpool DHA takes place on the fourth Tuesday of every month at 4.30pm, in the Senate House, Liverpool University, Abercromby Square.

This present structure of the NHS was settled in 1982 when the government said it was scrapping a layer of bureaucracy to bring the health authorities closer to the people. The undemocratic nature of the health service made a mockery of this claim. It merely gave the government the chance to weed out 'radicals' from health authorities and introduce more acceptable nominees.

It also meant a disruptive administrative re-organisation as boundaries were changed and management shifted around. In Liverpool the outcome was disastrous.

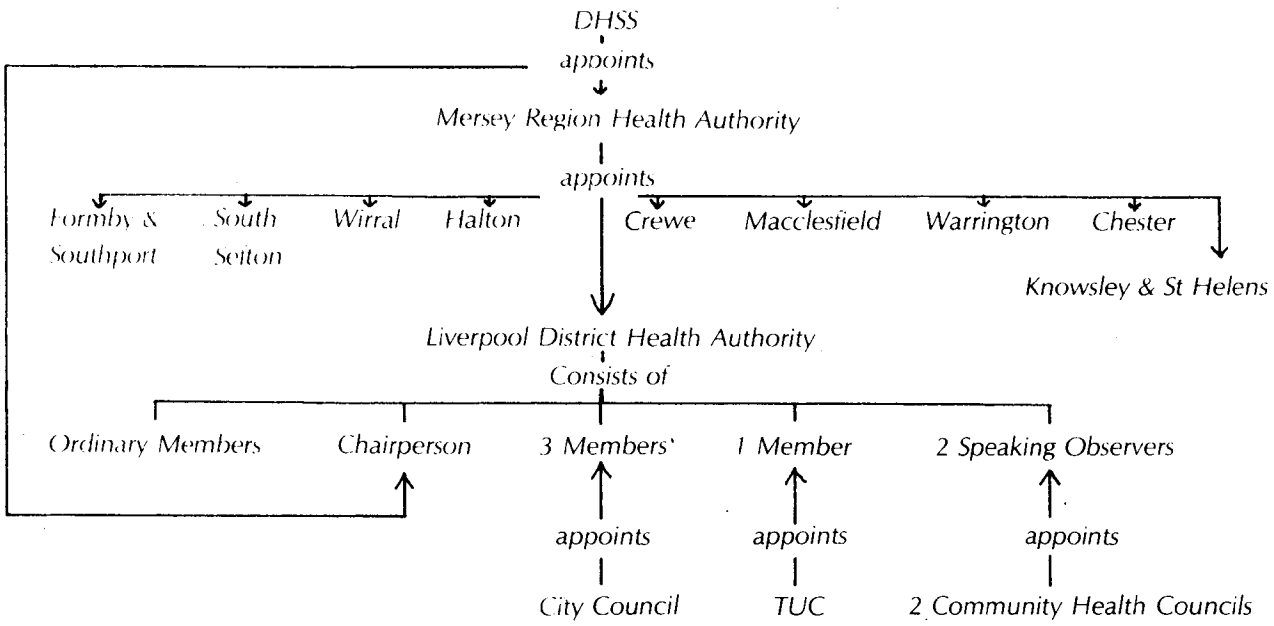


"I think the Department feels that the Chairperson's job requires a less distinctive uniform."

The city now has one set of lay members but two sets of officials. One team of professionals looks after the Eastern part of the city, another team the centre and southern parts of the city. The unnecessary bureaucracy remained.

In the North end it becomes even more ridiculous. Here the health services are in two districts at once. The Liverpool district looks after community services ... another district is responsible for the hospital sector. In fact nowhere on Merseyside do health boundaries coincide with those of local councils. This obviously means more and more officials have to take part in every attempt at joint decisions.

Power in the NHS



4) COMMUNITY HEALTH COUNCILS

Given the undemocratic nature of the NHS, bodies which can represent patients are especially needed. The most important of these are Community Health Councils (CHCs).

The CHC is a starting point for individuals who wish to complain about their treatment. But they are much more than this.

They are the major focal point for consumers when the NHS is under attack. They are in the unique position of watching health service developments on the consumers' behalf. The DHA decides when and how money should be spent, but they have to consult with CHC's about any changes in the service. So far as hospital closures are concerned — if the CHC doesn't agree — then the DHA has to go to the Secretary of State for permission. A good CHC won't just react to proposals from the health authority it will be busy working out its ideas for future developments within the service. Liverpool CHC's have been involved in many campaigns for new services. They're also an important source of information. CHC's receive a great deal of information and documents that can't be obtained from other channels.

Who Serves On The CHC?

The Secretary and his/her assistant are appointed by the Health Council; they are the only paid staff. As the CHC is funded by the Regional Health Authority, it can take an independent, critical view of the District.

The CHC is made up of 22 members, these being a combination of appointed representatives of Liverpool City Council and some elected by voluntary organisations and the TUC. Meetings are usually held monthly at the CHC premises and are open to the public.

Liverpool Community Health Councils

Liverpool Central/Southern CHC, 57, Whitechapel, Liverpool 1, Tel. (051) 236 1176.

Liverpool Eastern CHC, 648, Prescot Road, Liverpool 13. Tel. (051) 228 5139.

Liverpool Central and Southern Community Health Counci

Photo: "Health Matters", Liverpool Central & Southern CHC.

5) PRIMARY CARE - COMMUNITY HEALTH SERVICES

Primary care is the patient's first point of contact with the health service. This is more likely to be a GP a health visitor or a District Nurse, but there are other professionals, who now make up what's called the Primary Health team. These include physiotherapists, occupational therapists, psychologists and social workers.

At present primary care and community health services have little muscle and only a small share of the NHS financial cake. We would like to strengthen primary care teams by making them the focal point of the health service, reaching out into the community and providing a broad range of services. In cities like Liverpool, health centres could provide a basis for this kind of care, incorporating many community health services (see below) and being seen to be accessible and available to the community.

However, health in the community involves far more than just health services. It involves everything that goes to make up that state of mental and physical well being, described by the World Health Organisation:

> *World Health Organisation Definition of Health;*
>
> *"A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."*

There are some striking shortfalls in community health services. Liverpool has, for example, a poor record of dental health. Fluoridation is still a thing of the future. It could save millions of teeth from decay and has done in areas such as Birmingham where it has been introduced. Little effort is still being made to increase basic knowledge of the causes of decay and gum disease and to involve people in their own dental care. There is a case for every health centre and child welfare clinic to have its own dental hygeinist, if not dentist, as part of the health care team.

Chiropody is in short supply, with waiting lists of over six months for those desperately in need. Indeed it is only available free to the elderly, pregnant women, disabled people and children. The situation becomes more serious as the proportion of elderly people increases.

Health Education in the official sense, is virtually non-existent, if we compare it with the lively and imaginative schemes run elsewhere by Health Education Departments. For example Fulham has just run a health week in a local factory with films and discussions provided in the lunch break and in work time. In Edinburgh, the Health Education Department runs a shop front in a main street and recently helped organise a Women's Health Fair in the city.

The Primary Care Team

Health Visitors

The job of a health visitor is concerned with preventive medicine. They visit the young, the elderly and those with young children to monitor their well being. Their aim — more than that of any other health worker — is to reach those who do not necessarily use the health services. They are vital in the bid to encourage ante natal care, immunisation for children and supporting the elderly or families under stress.

It is the elderly who tend to miss out when health visitors are in short supply and this will become an increasing problem. At present Liverpool Health District has 18 health visitors/100,000 people. The national average is 19/100,000 and the target for the UK is 30/100,000 although this seems unlikely under the present government.

The health visitor's work tends to be very much on an individual one-to-one basis. This is partly due to the reluctance of many older GPs to work as a 'team', but also to the traditional view of health care as being an individual thing. There is a need for a more collective approach, and where groups have been set up, eg for post natal depression, they have been shown to be valuable in overcoming isolation and promoting self confidence among clients.

Happily even in Liverpool, which seems to be rather backward, there is an increasing tendency for primary health care workers to be based under one roof at GPs' surgeries or Health Centres. Only by encouraging health workers to work together in this way can real communication be established between them. In addition, since much of these workers' time is spent visiting people, there must be incentives in the form of the means to do this, and to do this safely, wherever they may be. This may mean cash, insurance, etc.

General Practice

A simmering crisis looms over General Practice in Liverpool:

Up to one third of Liverpool's GPs may retire in the next ten years and many practices are single handed and situated in decaying premises:

OCTOBER '82 PERCENTAGES	LIVERPOOL	MERSEYSIDE
Single handed GPs	*17*	*12*
GPs in groups of five or more	*11*	*15*
GPs over 55	*47*	*30*
GPs over 65	*15*	*8*
GPs over 75	*5*	*2*

At present Liverpool GPs have less hospital experience, and less access to GP beds than the national average. They have no access at all to GP maternity beds, a facility that may be crucial to attracting young, keen doctors in the future.

Practice premises too are a problem and the Health Authority has no control over their standard. A watchdog committee of GPs (the Local Medical Committee) has power to inspect them, but actually getting doctors to renovate their surgeries ... even to put in washbasins and toilets, can take years! This is a national problem which will have to be remedied if the standards of General Practice are to be raised.

Too many GPs rely on the deputising services (Liverpool Locums) as a matter of routine. This goes against the idea of the personal and continuing care which GPs are supposed to provide for their patients. And the deputising doctors are themselves often overworked hospital doctors trying to make more money.

Much of the postgraduate training of GPs is funded by drug companies for lack of any other provision. This may be good public relations for the drug companies but tying doctors to drug companies might not bring long term benefits to the health service.

On the bright side some GPs are making efforts to provide a patient-centred service and even to involve patients in the practice (see later). However this is still on an individual basis, with no incentives from the Government or Health Authority.

The Communist Party favours a salaried service for GPs. While such a change could not be introduced overnight, there is a good case, NOW, for a well paid, attractive, salary option in inner city areas of towns like Liverpool. Such a measure is immediately practical and could be linked in with the General Practice Department at the University.

Health Centres

There are now 8 health centres in Liverpool District: Great Homer Street, Bousfield Street, Netherley, Princes Park, Toxteth, Old Swan, Vauxhall and Abercromby (which has recently opened). Edge Lane is nearly completed, as is the new health centre at Belle Vale. Pressure from the local community has produced a mini health centre in Nelson Street, funded by Inner City Partnership money, which is also due to open in the near future.

Even with these developments, the proportion of GPs working in health centres is far from the national average.

Percentage of GPs working in Health Centres

LIVERPOOL	*12*
CHESHIRE	*18*
ST HELENS & KNOWSLEY	*27*
WIRRAL	*31*
UK	*24*

Why is this?

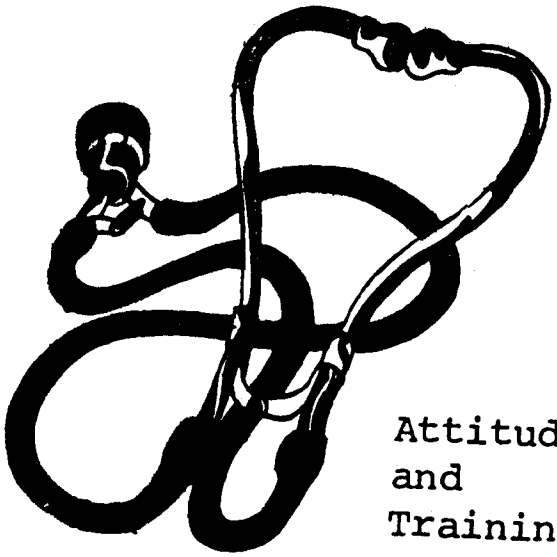
1) **Many older GPs appear unwilling to go into health centres and work with others as part of a team.** This is perhaps because of the traditional idea of the GP as an independent contractor. When the NHS was set up, the only way GPs would accept it was on the understanding that they could have contracts with the Family Practitioner Committee, rather than be salaried employees of the Health Authority. We are still paying the price for this. Traditions die hard. When the Vauxhall Health Centre opened only 3 GPs moved in, although facilities were excellent and there was room for 5 doctors.

2) **There is a relative shortage of funds for health centres,** made worse by the fact that the Tories have abolished the seperate pool of money for health centre building, which means that health centres have to compete with all the other sectors for funds.

3) **There has been a lack of strong initiatives by the Health Authority.** In order to encourage GPs to move

into new premises these must be made as attractive as possible, with the provision of community services within them. GPs should be involved at the earliest stage in the planning and design of the Health Centre. Of course it is VITAL that the local community be also involved and the CHC. So far, despite pleas from local people and the CHCs, this has not happened with Health Authority health centres. An important asset of health centres should be the provision of a resident caretaker. This is no longer the policy of Liverpool Health Authority, which may prove to be a costly mistake.

4) **GPs who have gone into health centres are feeling the pinch of the Tories via reduced spending.** It seems that it is easier to get money from other sources such as Inner City Partnership to build an extension onto a centre than to get a new coat of paint or a decent wage for Health Authority employed staff.

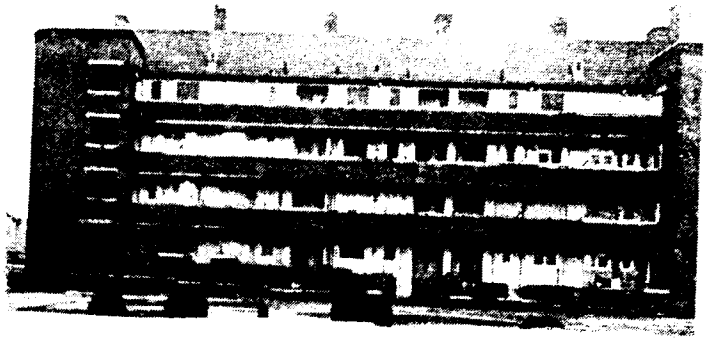


Attitudes and Training

Of course buildings alone are not enough. There has to be the will and the enthusiasm to work in a health care team. If we do not educate young, locally based doctors to work in this way, then the outlook is grim. If the doctors are not encouraged to work in the inner city then they are likely to opt for nice country towns where health centres and group practices are thick on the ground.

The same applies to other members of the team. Help with accommodation and transport is necessary. Equally important is that caseloads (the number of clients per worker) should be lower in high problem areas, since there will be more demands on time and emotions than in other more affluent areas. Rising unemployment, poor housing, etc are difficult to cope with, not only for those directly affected, but also for people working with them.

To change ideas fundamentally we need to introduce student health workers from the start to the idea that primary health care, community services and prevention are at the core of health care. Here again Liverpool has a poor record. Until recently most of the teaching of medical students about General Practice was done by a dedicated few GPs, and only in Summer '83 was a Chair of General Practice approved at Liverpool University. Nurses get no experience in the community in their



basic training. Happily too the tiny Department of Community Medicine has just been expanded and is starting to make some impact.

At present, medical students spend two weeks out of five years doing a community project and two in general practice. There have been grave problems simply in finding enough decent practices for them to go to. Most Liverpool Graduates do not go into General Practice and those that do, while they may stay in the Region, tend not to go into practice in Liverpool.

The selection of medical students needs looking into. In addition there is still an enormous gap in aspirations. Often working class people do not believe that they can become nurses or doctors. Racism, sexism and class politics still operate in the medical profession.

Pharmaceutical Services

The role of the local chemist in primary care is all too often overlooked.

Chemists have an extensive training in how drugs work. They are often more highly trained about medicines and their impact than doctors. To prevent chemists becoming isolated and to lessen the pressure they feel from drug companies we should take a new look at their skills.

We need an improved service for the public and greater accessibility. Chemists' services should be planned to ensure an even spread across Liverpool. As doctors team up in health centres or group practices, chemists' services follow this concentration and there is less prescription trade in outlying suburbs. Sixty per cent of prescriptions are dispensed in shops near doctors surgeries. Many community chemists shops are becoming unviable and yet they are essential for the elderly who receive repeat prescriptions by post, people with minor ailments and general advice to the public.

At present there is no restriction on new chemists leapfrogging to set up near a new health centre or group practice, thus poaching business from a more established shop in an outlying area. The increasing tendency for large chains to run chemists shops also militates against planning because these big chains see a planned service as running counter to their interests. We need to consider the effect on pharmaceutical services whenever new health centres are planned. Local authority planning bodies should intervene to ensure vital services are maintained.

COMMUNITY HEALTH INITIATIVES

Since the first edition of this pamphlet there have been some exciting developments in health related initiatives from the 'consumers'. Many examples of this are mentioned elsewhere in the pamphlet but two will be discussed here: Well Women Clinics and Neighbourhood Health Worker Projects.

Well Woman Clinics

There are now 10 Well Woman Clinics in Liverpool and one more (at Abercromby Health Centre) is in the pipeline.

The campaign for Well Woman Clinics, which has been going on all over the UK for the last 12 years, has had a lot to do with the rise of feminism and with women feeling they wanted a better deal from the health service. What has been important about this campaign is that women all over the country have learnt from each other, have made it their business to become informed about health, health care policy and the services available. They have therefore been able to put demands on health authorities in an informed way and have used official and unofficial channels effectively. Sadly the situation in Liverpool is still far from ideal. A hope was that the clinics would be a place women could go and not only be screened for cervical cancer, breast cancer, etc, but also feel that they could talk in an informal and unhurried atmosphere about their problems. In some areas, eg Manchester, clinics have lay health workers (women from the community) who can accompany women through the clinic, put them at ease and direct them to local self help groups and services if necessary. In Liverpool this does not happen.

The situation was made worse by the way health workers were recruited to work in the clinics. Some health visitors, while basically sympathetic, felt they had been 'dragooned' into working there. No guidelines were given to workers as to what the aims of the clinics were and where they could refer for help if necessary.

A conference in November 1982, with over 80 women present, discussed these problems, and the two CHCs have set up a subcommittee to which the Health Authority promised to listen. At the time of writing it is proving extremely difficult to obtain the co-operation of the District Medical Officer. It seems the Authority, having given women their clinics, cannot understand what all the fuss is about! Happily a group of health visitors working in the clinics is now meeting to discuss how best to make the clinics responsive to women's needs and feelings. Local women from Croxteth, Speke and Vauxhall are pressing in their respective areas for a say in the kind of services that are provided. There is also a strong campaigning group on the Wirral and in other areas of Merseyside, for Well Woman provision.

Well Woman Clinics in Liverpool

1. **Dovecot Family Health Clinic**
   Longreach Road, Liverpool 14. Tel: 228 3846
   Monday p.m. fortnightly. Dr E Heller
2. **Vauxhall Health Centre**
   Limekiln Lane, Liverpool 5. Tel: 207 5571
   Monday p.m. fortnightly. Dr E Heller
3. **Queens Drive Family Health Clinic**
   Queens Drive, Liverpool 4. Tel: 525 1522
   Tuesday a.m. weekly. Dr. I O'Malley
4. **Norris Green Family Health Clinic**
   Townsend Avenue, Liverpool 11. Tel: 256 9273
   Tuesday p.m. fortnightly. Dr R Singer
5. **Old Swan Health Centre**
   St. Oswald Street, Liverpool 13. Tel: 220 9191
   Wednesday a.m. weekly. Dr I O'Malley
6. **Rose Lane Clinic**
   1, Rose Brae, Liverpool 18. Tel: 724 3422
   Thursday a.m. weekly. Dr I O'Malley
7. **Belle Vale Family Health Clinic**
   36, Lulworth Road, Liverpool 25. Tel: 487 7072
   Friday a.m. weekly. Dr Gaba
8. **Toxteth Health Centre**
   256, Mill Street, Liverpool 8. Tel: 708 6366
   Tuesday a.m. fortnightly. Dr E Sandeman
9. **Garston Family Health & School Health Clinic**
   Clifton Street, Liverpool 19. Tel: 427 7426
   Monday p.m. fortnightly. Dr D Manning
10. **Speke Family Health & School Health Clinic**
    South Parade, Speke, Liverpool 24. Tel: 486 3572
    Tuesday p.m. fortnightly. Dr E Sandeman

Appointments can be made by ringing the clinics or the Family Planning and Cytology Section, Liverpool Health Authority on 227 4300 x 245.

Extract from a Health Authority leaflet advertising the new clinics:

The following services are offered at Well Woman Clinics:

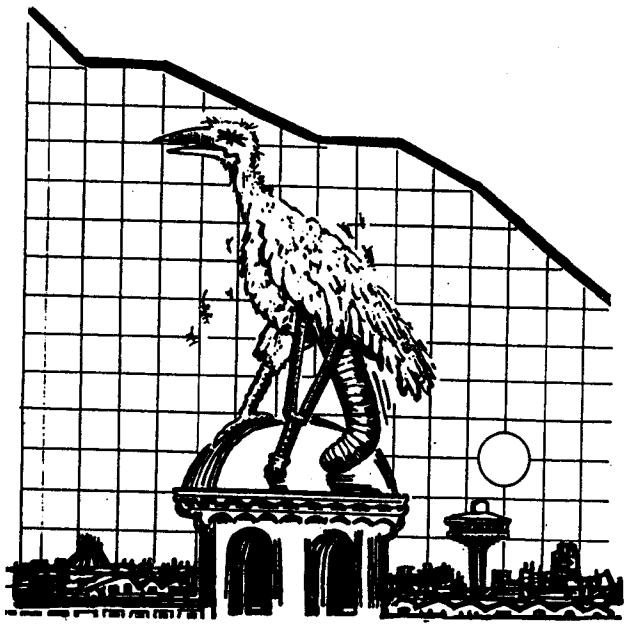
1. *Full medical history will be taken*
2. *Weight check*
3. *Haemoglobin — check for anaemia*
4. *Rubella screening — for women of childbearing age, and immunisation given*
5. *Urinalysis*
6. *Blood pressure checked*
7. *Physical examination — heart, chest, abdomen*
8. *Breast examination — instruction given on self examination if desired*
9. *Full pelvic examination with cervical smear*
10. *Advice on family planning, emotional and sexual relationships. Any problems arising are discussed and if further action is needed, eg referral to family planning clinic, psychosexual clinic, GP or social worker, this will be arranged.*

Neighbourhood Health Projects

Although the idea of lay health workers is not a new one, in the last two years projects have been set up in the Vauxhall area and in Liverpool 8. Links between local people and health workers produced applications for Inner City Partnership money, which were accepted. In Vauxhall work is being done on antenatal services and handicap, and a creche has been organised in a local health centre. In Liverpool 8 the workers are based at Home Link, parents' education centre. They will be working to explore the links between health and the social and economic environment in the area, which is mainly multiracial, working class and has a high rate of unemployment. Hopefully such workers can help the community express their feelings about health care and services provided, and become more confident in using existing services effectively.

Patients' Committees

Another way of people taking a more active role in their health care is by forming a Patients' Committee. Several practices in the Region have them, eg. Maghull, West Kirby and Runcorn. These are basically users' groups, who meet and discuss the workings of the practice from the consumer's point of view, as well as planning educational activities, helping the elderly use the



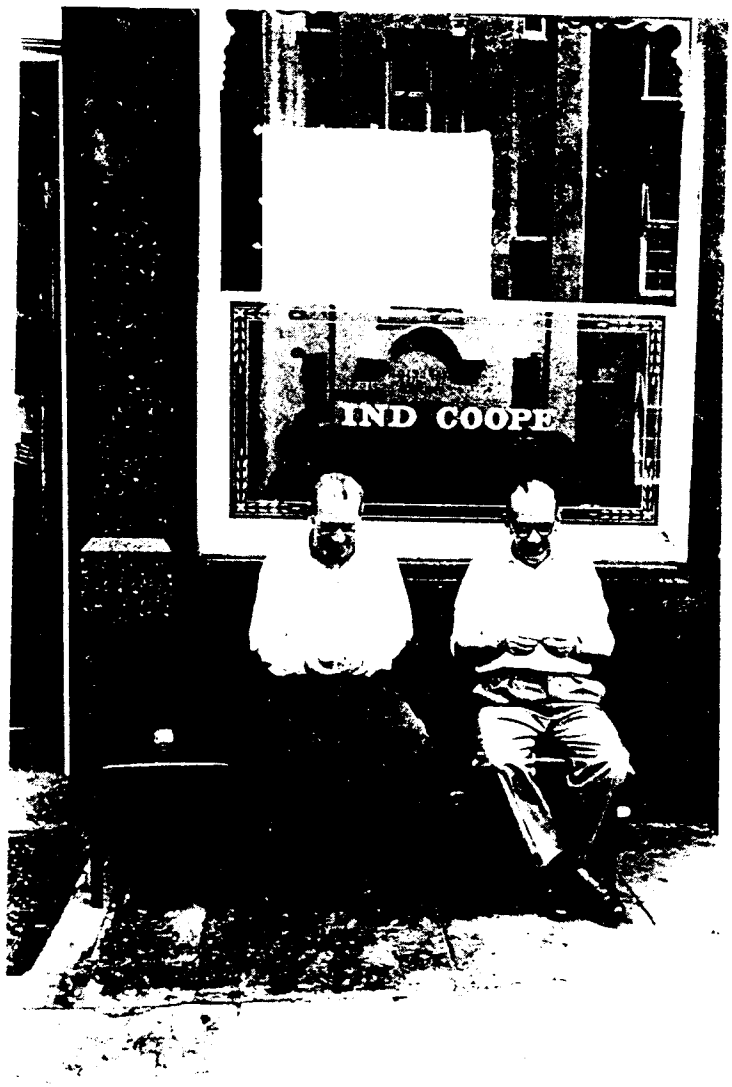
practice effectively, producing or encouraging the practice workers to produce an annual report for all patients, etc.

They also have a role to play in arguing for better secondary care, eg reduction of waiting lists, in conjunction with CHCs. Unfortunately, because people tend to defer to doctors and be anxious about challenging them, these committees are slow to get off the ground. Usually, when they do, there is a great commitment from doctors in the practice.

6) THE ELDERLY

As we said earlier, the rising proportion of elderly people within the population is placing added pressure on the health service. It has coincided with attempts by Government, Regional and District Health Authorities and local councils to cut spending. The elderly are likely to be on the receiving end of much of this. The continuing debate over the need to transfer resources from the hospital sector to community care comes sharply into focus here. Lacking any adequate mechanism to achieve this, the results are likely to be cutbacks in hospital care, with no equivalent expansion in community services and primary care.

Health care for the elderly is described as 'geriatrics' in the NHS. Where problems of mental health occur at the same time the term used is 'psychogeriatrics'. We deal with the latter in the section dealing with mental health.



Current Plans

2 reports have recently been produced by Liverpool Health Authority with major implications for the elderly. The first of these was the **Geriatric Working Party Report.** The second, which effectively supercedes (and ignores) the former, is the District Health Authority's **Long Term Strategy.**

The Geriatric Working Party made some attempt to assess the scale of the problem and propose a comprehensive response to it. It failed to tackle adequately the relationship between hospitals, primary care and community services, but it did propose a number of concrete measures, which, while falling well short of a solution, would have represented a distinct advance.

The Long Term Strategy however was based on the central premise of securing a cut in expenditure of £5.5 million over the next five years and saw the area of hospital provision for the elderly as one of the best targets for cuts. It virtually ignored the proposals of the Geriatric Working Party and failed to present a comprehensive strategy for health care.

a) Hospitals

The major proposals of the strategy with regard to geriatric care are as follows:

** A cut in geriatric beds of 107 over the next five years, from 707 to 600*
93 of these beds are used by South Sefton DHA. What the effects of this will be are unclear without knowing the Long Term Strategy for South Sefton. So it appears few geriatrics beds will be lost in Liverpool. However ...

** General Medical Beds will be cut by 265 — from 634 in 1981/82 to 369 in 1991/92. Between 50 and 70% of these beds are occupied by people over 65.*
** A tendency to concentrate services in the two District General Hospitals, Broadgreen and the Royal Liverpool Hospital (RLH), including a major expansion in geriatric provision in the former*
** Closure of Newsham General and Princes Park hospital*
** Transfer of the bulk of non-geriatric beds out of Rathbone and Sefton General Hospitals. Transfer in of geriatric beds from other hospitals being closed.*

The next effect of this is to contradict many of the Geriatric Working Party's proposals on reorganisation of hospital geriatric services. These included:

** commitment to rationalise services between different districts and the boundaries of different specialities, eg geriatric and psychogeriatric services*
** retention of existing hospitals with a mixed range of beds*
** expansion of geriatric day hospital places*
** expansion in numbers and transfer of GP hospital beds to more accessible hospitals*
** increased consultant staffing levels*
** transfer of contractual beds to NHS hospitals*

The decision to close Princes Park and Newsham General and to concentrate geriatric provision in Rathbone and Sefton General is a mistake. Our first concern must be the welfare of existing patients and the longer term effects on health care. As the Rossendale Enquiry showed, moving long stay elderly patients can

have a devastating effect (the Enquiry revealed that two thirds of the patients died within months of the move).

There is little evidence that Rathbone and Sefton General will be able to provide significantly better care, either in the narrow medical sense, or in terms of general environment. While there are serious structural problems at Newsham General, Rathbone (or Sefton General) can scarcely claim to be the most modern or best designed of hospitals. In the case of Princes Park, patients could lose the benefits of increased attention which a small hospital can offer, access to a garden and the fact that it is fairly handy for buses, so relatives can visit more easily. Since many relatives are themselves elderly, a move could well affect the rate of visits.

Concentrating geriatric provision in Rathbone and Sefton General could lead to serious problems. Rathbone would function as a long stay hospital leading to segregation of the elderly from other patients and will rapidly and rightly become seen as a 'dumping ground' for elderly patients. The same danger exists at Sefton with the withdrawal of acute services. Both will lack the necessary support services for the increase in geriatric beds. Staff in Princes Park and Newsham General face very difficult decisions in the face of the threat of closure. Quite rightly they will be concerned about its effects on their jobs and working conditions. But they are more aware than anyone else of the importance of its effects on both present and future patients. They have both an opportunity and a responsibility to give a lead to all those concerned about the care of the elderly — patients, relatives, other health workers, pensioners' organisations and the community at large. A campaign against closures initiated by staff and their trade unions could rally a wide range of support in opposition to closure and force an about turn on the health authority.

The Geriatric Working Party recommended that Geriatric Consultant staffing levels should be brought up to the level laid down by the DHSS. At present they are only about half this:

GERIATRIC CONSULTANT STAFFING LEVELS:

DHSS Norm 1980:	*10.5 consultant w.t.e*
DHSS Norm 1988:	*9.2 consultants w.t.e*
Current levels:	*5.8 consultants w.t.e*

As we make clear elsewhere we do not hold the view that health care revolves around senior medical staff such as consultants. All health workers have a crucial role to play. But the facts of life in the NHS at present are that consultants enjoy (relatively) considerable power and influence. The status of geriatrics as a second class citizen in the NHS is likely to be reinforced (given the present power structure) by a position where consultant staffing levels are well below acceptable levels.

As against the Long Term Strategy we propose:

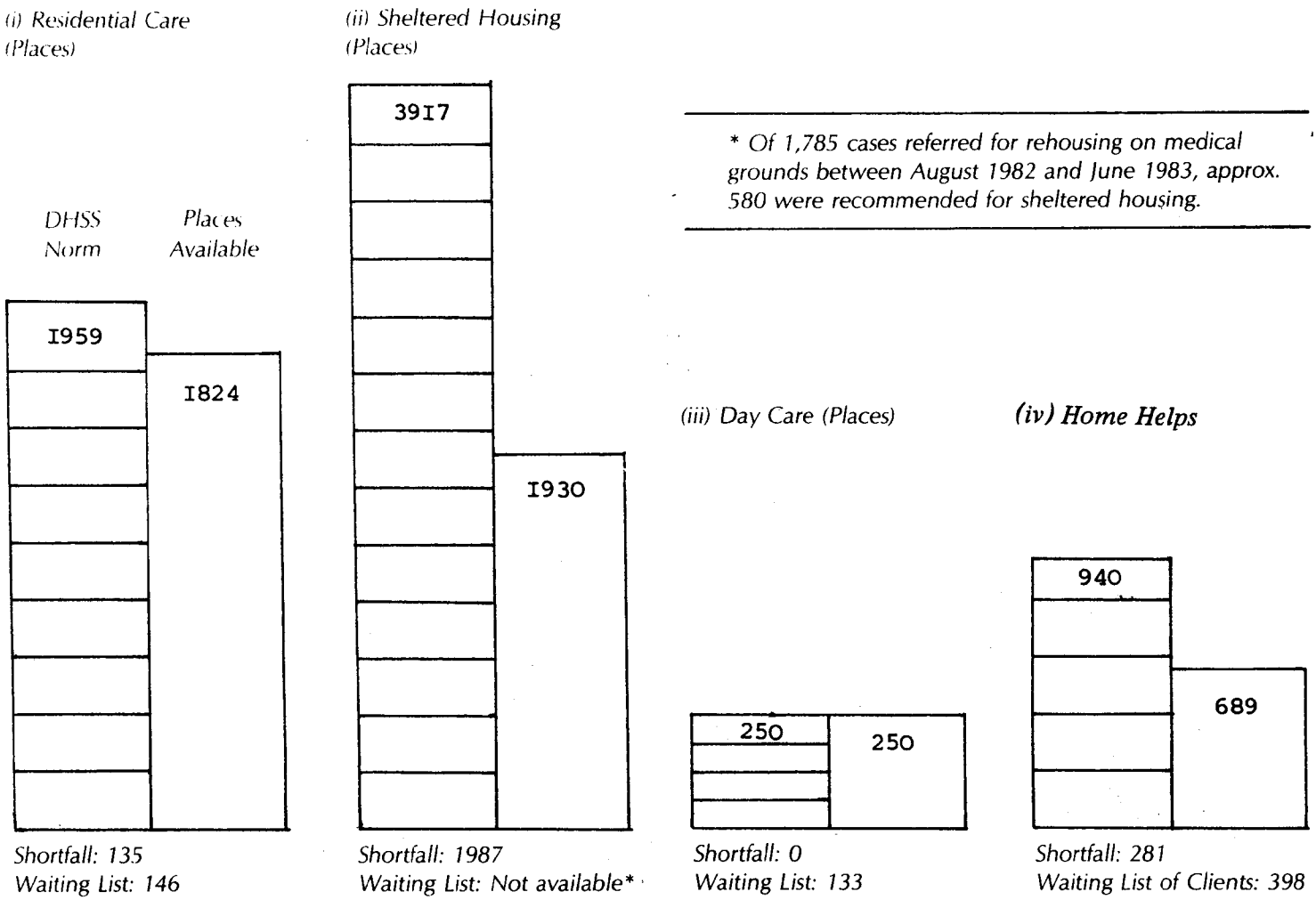
* *retention of mixed provision at Rathbone and Newsham General*
* *existing long stay provision at Princes Park should be retained*
* *expansion at Sefton General should take the form of increased geriatric and psychogeriatric day places and the development of GP beds*
* *to reach the levels laid down in DHSS guidelines, there should be an increase of 60 geriatric day places, of which 51 should be provided in Sefton General as indicated by the Geriatric Working Party*
* *the overall number of GP beds should be increased*
* *consultant staffing levels should be bought up to full strength*

b) Community Care

Both the Geriatric Working Party and the Long Term Strategy recognise the need to expand community services, both to cope with the growing health care needs of the elderly and to accompany the changes in hospital provision. But no indication is given of what resources are allocated to this expansion or how to secure an increase in local authority spending in essential services for the elderly.

The Geriatric Working Party revealed a serious shortfall in local authority services for the elderly. The same point is made in a recent report by the Director of Social Services to the City Council. The tables below from the report give some idea of the problem:

DHSS NORMS FOR SOCIAL SERVICES COMPARED TO LIVERPOOL'S PROVISION:

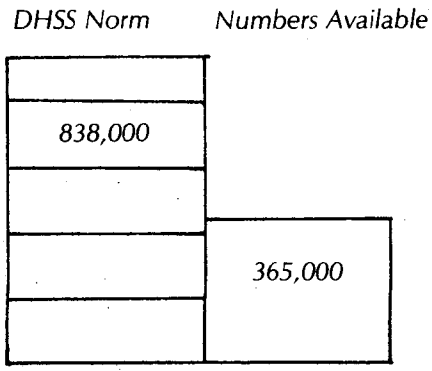


* Of 1,785 cases referred for rehousing on medical grounds between August 1982 and June 1983, approx. 580 were recommended for sheltered housing.

There is an old Liverpool saying that you cannot get a home help if you have a relative living North of Watford. The figures above show you why!

The same problem effects the Meals on Wheels service, the bulk of whose clients are elderly:

MEALS ON WHEELS IN LIVERPOOL 1981/82:



In recent years the City Council has introduced charges for each meal. Opinions differ as to whether this is an unacceptable cut or a gesture of respect for people's independence. What is both wasteful and unacceptable is the frequent practice whereby meals are taken back if payment is not immediately forthcoming. There is also considerable scope for improvement in the nutritional value of meals. There are various reasons for the poor level of local authority provision. The first and most important is that the Government has seen the area of personal social services and housing as priority areas for cuts. This has imposed major burdens on local councils trying to provide adequate services. The pressure is made no easier by the fact that the same government has repeatedly stressed the importance of 'community care', while failing to provide the necessary finance.

Nevertheless it is too easy for a local Council to use central government cuts as an alibi for inaction. The previous Liberal/Tory administration was fond of dramatic protests about the situation, while going along with the logic of cuts. The new Labour Council seems more willing to face up to the problem, both of central government cuts and the potential effects of the Long Term Strategy. However the Council's own approach could lead to Social Services and the elderly taking second place. There is a clear tendency to make housing and job creation the overriding priorities and as a result other areas become at best marginal and at worst irrelevant. A good example of this was the reluctance to back several projects aimed at improving community care (including schemes for the disabled, the elderly and the mentally handicapped) for partnership (and EEC) funding.

Both existing shortfalls and the lack of any provision for

improvements show the completely unrealistic assumptions on which the Long Term Strategy is based with regard to community care for the elderly. A major transfer of resources to community care would require a big increase in government spending. But it would also require a change in the structure and planning of health and personal social services. The fact that these services are split between two bodies — the council and the health authority creates problems.

The Geriatric Working Party (Section 8.6ii) refers to a City Council resolution carried in 1978(!) which states "that in future social services should depend increasingly upon agreed and joint planning of other services within the community, by both the Social Services Committee and the Health Authority ..." The Working Party's rather poignant comment is "we support and recommend the implementation of this policy."

Now the City Council is having to cope with the implications of the Long Term Strategy drawn up by the Health Authority. But this is not just a problem requiring goodwill, better communications or common sense, but of the structures within which people are forced to work. Because the scope of this issue extends beyond the area of health care and the elderly, we deal with it in a later section.

Despite its limitations the Geriatric Working Party made a number of positive proposals for innovations in community care. These include:

Geriatric Teams

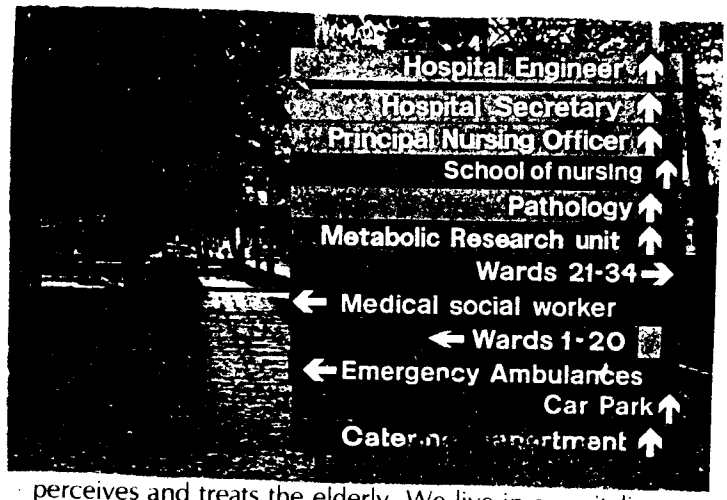
The idea is to bring together hospital staff and community health workers to assist in the transfer of patients from hospital to home, identifying needs and "either provide or mobilise appropriate services and resources." Insufficient stress is given to the need to involve patients' GPs and other members of the primary care team.

Well Elderly Clinics

These would be responsible for screening the mental and physical health of the elderly. The Report merely recommends a pilot scheme to assess the effectiveness of the idea. To have a chance of success these clinics would need to be based in general practice and would require an effective call up system and back up services.

In addition if problems were found such as a need for chiropody or meals on wheels, then the solutions must be available also. To be effective transport would have to be organised for the many who are not mobile and provision of a home visiting service. Unless this is done such clinics could prove counterproductive by segregating the elderly and failing to use the knowledge of the primary care team. As with Well Women Clinics — perhaps more so — there should also be a place where the elderly can come and feel able to discuss their problems freely, both on an individual level and collectively.

At the heart of the problem is the way that our society



perceives and treats the elderly. We live in a capitalist society whose essential motive is private profit not public need. As a result people tend to be valued for the contribution they make to the production of profits through work. Those who are unable to work through ill health or unemployment are relegated to the status of second class citizens — an unproductive burden on society.

The effect of recession and government policies has been to deny certain groups the option of working — women, the young and the elderly. While some attention (if not action) has been devoted to the first two groups, little concern has been voiced about the effects on elderly people of early retirement or changes in the social security system, which has been aimed at forcing the elderly out of the labour market. This is not to argue against such measures as lowering the pension age, but to stress that such moves should be designed to create alternative options, not to marginalise and ghettoise the elderly.

We make these points to stress that many of the problems affecting the elderly, with which health and social services aim to assist, are not primarily biological in origin, but arise from social causes — poverty, poor housing, social isolation and attitudes. This should be obvious, for example the increase in the numbers over 75 suggests an improvement in **physical** wellbeing, but it is often neglected.

So when the government is now discussing reneging on the improvements in pensions planned for the next few decades, we must recognise the implications for health care. But most important it means seeing the elderly as a potentially active and articulate force using the health service, with a right and need to be involved in and consulted with over the process of planning and decision-making.

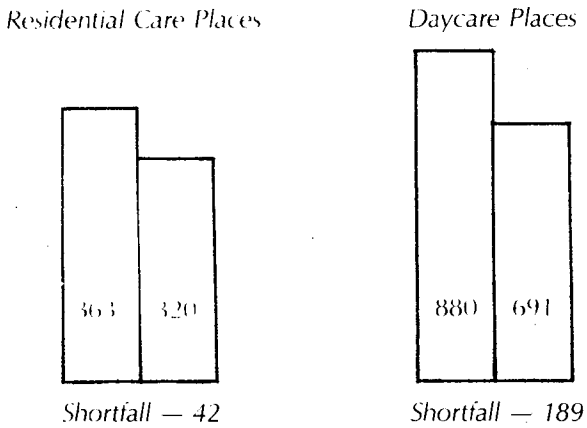
Voluntary bodies such as Age Concern have an important role to play in pioneering and developing new ideas and forms of care. But they must not be seen as a substitute for statutory provision. Their key role should be in involving people in the services. Most important is the need to involve and strengthen bodies which directly represent the elderly, such as the Federation of Old Age Pensioners and the British Pensioners Trade Union Association. At the end of the day it is the elderly who experience how the services work and rely on them. Surely they know better than anyone else what is needed?

7) MENTAL HANDICAP

Various reports published by the DHSS in the late 70's stressed the need to increase services for the mentally handicapped. As in other fields the necessary finance has not been forthcoming from the government.

Weaknesses are apparent in a range of areas, but neither the council or the health authority have come up with any clear proposals to improve the situation. There is a shortage of beds, hostels and group homes for mentally handicapped adults. If anything there are too many hospital beds for children and some at present have adults in them (eg at Olive Mount). But on the other hand there is a shortage of local council hostel places for temporary or permanent care of mentally handicapped children. As a result children who do not need hospital care can end up there for the lack of alternatives.

DHSS NORMS FOR SOCIAL SERVICES COMPARED TO LIVERPOOL PROVISION FOR THE MENTALLY HANDICAPPED



There is a need to improve home support facilities (such as holiday relief for relatives), hostel provision and adult training centres and for more day hospital places and training workshops — especially given the level of unemployment.

More support is needed for parents keeping their children at home. It is known that children in general do better at home, while attending special schools during the week. There has been a move towards encouraging mentally handicapped children to attend ordinary schools in recent years. This is welcome. But unless this is properly planned with the provision of adequately trained staff and extra facilities, it can become just one more economy measure and create more problems for all concerned. We should aim to make the lives of children as 'normal' as possible and educate others about mental handicap.

Financial assistance in the shape of state benefits for the handicapped is limited. Even in the limited range available there are serious problems. Eligibility for some benefits turns on definitions of health in narrowly biological or physical terms. This can exclude the mentally handicapped. Here again we see the importance of arguing for a broader view of health, relating to the general ability of individuals or groups to participate fully in social life. The recent successes of Liverpool Welfare Rights Advice Centre in fighting for the eligibility of the mentally handicapped to mobility allowance are significant, since the argument has turned precisely on the issue of a broader definition of handicap.

As part of the Long Term Strategy the Health Authority plan to reduce beds for the mentally handicapped by 43 over the next decade. It is not clear however where the people from these beds are to be transferred to. It is proposed to transfer 48 patients from Rathbone to Olive Mount. This is supposed to provide improved care. However no details are available of what will be spent on improving either the buildings or health care eg occupational therapy and physiotherapy. 75 beds in community units are proposed. But it is still not clear when these will come into operation. With no clear indication of how the transfers and reductions in beds will be managed, there is a strong suspicion that the new units could end up being used to cope with the problems which might arise. This should be resisted.

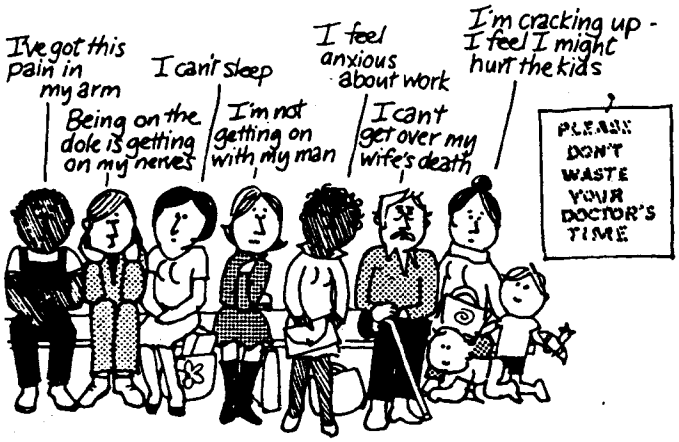
---

8) MENTAL HEALTH

Liverpool has a special need for progressive psychiatric service because of the effect conditions here have on people. Unemployment and general social problems encourage people to drink and excessive drinking leads to family breakdown, further depression and more drinking. Britain has over a million people with a drink problem. 300,000 of them, at least, are 'addicted' to alcohol. Less than 1% are in treatment. Meanwhile the government collects millions of pounds in alcohol taxes — it has a vested interest in alcohol.

Solutions to mental illness are all too often seen in terms of token occupational therapy or drug treatment. Of all illnesses, mental illness is the most bound up with social values and conditions. Take the fact that twice as many women as men are said to be psychiatrically ill. Is this due to women's inborn tendency to depression? Is it that male doctors tend to diagnose dissatisfaction with being a wife, houseworker, low paid homeworker as 'depression'? Is it that women become depressed with their lot? In one survey 40% of working class women with children under 5 were depressed (Brown 1975). — WHY? Is the solution more drugs or more nurseries? Britain has the lowest number of nurseries for under 5's in the EEC and Liverpool among the lowest in Britain.

There are over 100,000 attempted suicides per year



(and the rate is rapidly rising). There are over 4,000 successful suicides per year. Attempted and successful suicides always increase at times of high unemployment and recession. Anyone reading the papers over the last few years will be only too aware of the number of suicides of unemployed people. And the reported cases are only the tip of the iceberg.

a) Psychiatric services in Liverpool

1978 saw the opening of the new Royal Liverpool Teaching Hospital, a hospital which was supposed to provide the ultimate in health care for Liverpool's long-suffering patients. The Royal was supposed to be a centre of excellence for such specialities as surgery, medicine, gynaecology and psychiatry (!).

To provide this service has cost millions of pounds and has seriously distorted the budget of the local health authority. In the previous edition of this pamphlet we expressed our doubts about the need for such a hospital in Liverpool. But like it or not the Royal Liverpool (RLH) is here to stay, and as a result many, much needed services are likely to suffer from shortage of funds. One such service is psychiatry. Psychiatric services in Liverpool are afflicted with a social illness called poverty. For too long psychiatry has been the cinderella of the National Health Service, and this is especially so in Liverpool.

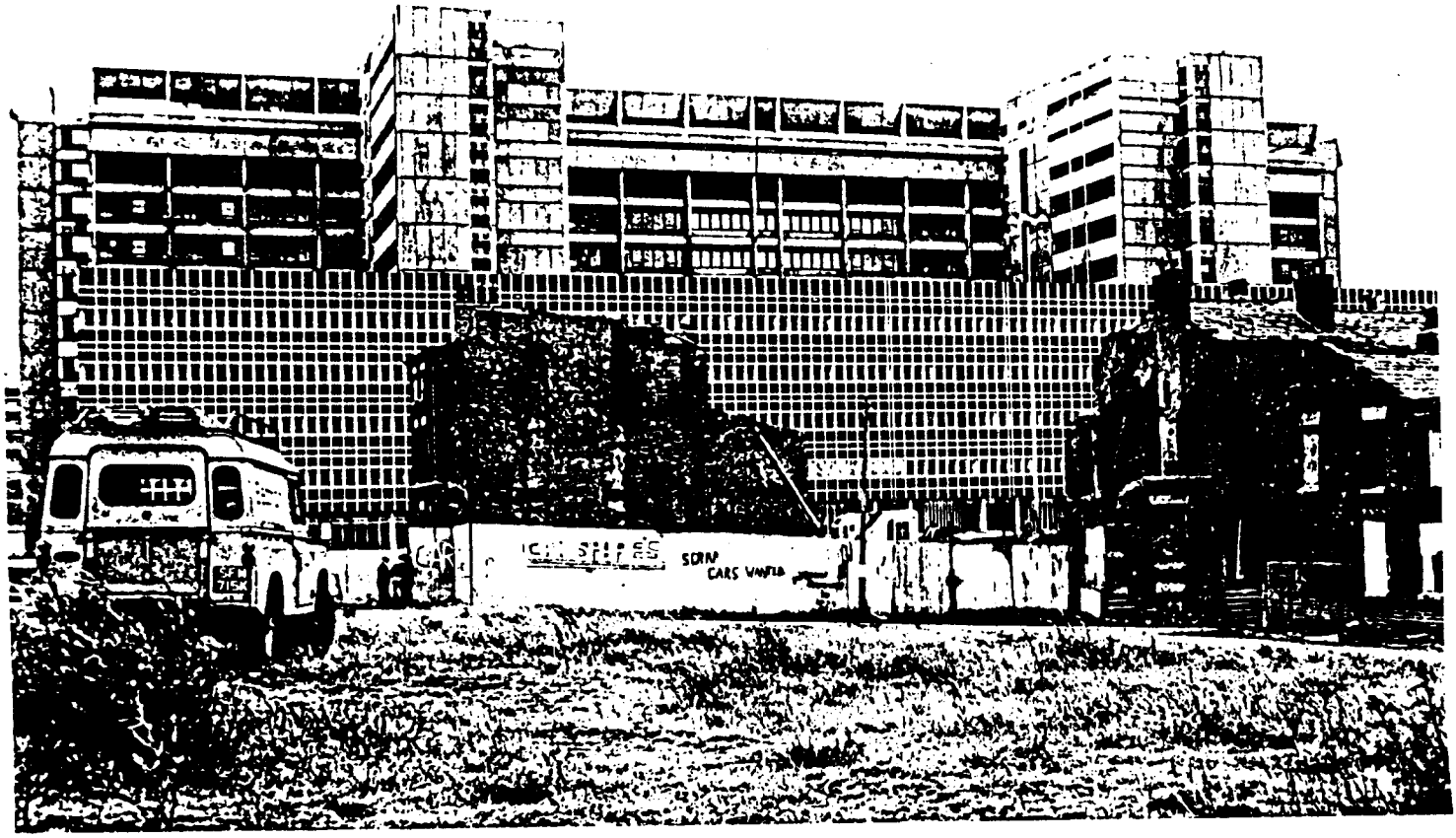
At present the great majority of psychiatric and psychogeriatric beds are concentrated in two hospitals — Rainhill and Sefton General, with more limited provision in the RLH, Park Hospital and Mossley Hill.

Rainhill Hospital

14 miles from the city centre this is a large purpose built 'mental hospital', which provides a wide range of therapeutic services for the mentally ill. Recent years have seen many changes in the care of psychiatric patients. Rainhill has rightly gained a reputation as a forward looking hospital which has improved the quality of life for its patients. However its geographical isolation means that it tends to be isolated from the problems and experience of Liverpool patients and many patients feel themselves to be cut off. Many people still feel upset by the reputation that Rainhill has had in the past. There is obviously a need for a more locally based comprehensive psychiatric service. But to provide such a local service and improve or maintain existing care at Rainhill would present the Health Authority with a difficult task.

Sefton General Hospital

This has been the other main hospital providing psychiatric beds as a unit within a general hospital. It has suffered from overcrowding and lack of funds in the past, and has enjoyed a poor reputation. The General Nursing Council will not recognise it for training purposes because of low staff/patient ratios, overcrowding and hazardous conditions. Some doctors and nurses are unwilling to work there. 'Psychiatry' is at a minimum level, most of the care is custodial. To quote one consultant, "we provide beds — literally beds. It is a casualty service only." Ward 30, a new rehabilitation ward, is



not working out as planned.

In many parts of the country, including other districts of Merseyside, community psychiatric nurses are therapists in their own right, responsible to the consultant, but working with people in their own homes or in groups to affect change — not simply to give injections. This is not only more sensible for patients but also brings more interest, initiative and job satisfaction into the nurses' work.

The Long Term Strategy aims to reduce beds at Rainhill by 273, although the rate of this would depend on how quickly patients can be discharged or die. Initial plans to transfer further beds to a new unit at Broadgreen and upgraded beds at Sefton appears to have been shelved for the moment. While a move to more local care would be welcome in principle, a number of serious questions would arise in practice. Would new provision maintain existing standards of care and provide the range of back-up services in the community to make such a change more than a matter of administrative convenience and rationalisation for the health authority?

The big reductions in beds will throw a considerable strain on existing day care and community services — both of which, as we go on to argue, are already under pressure.

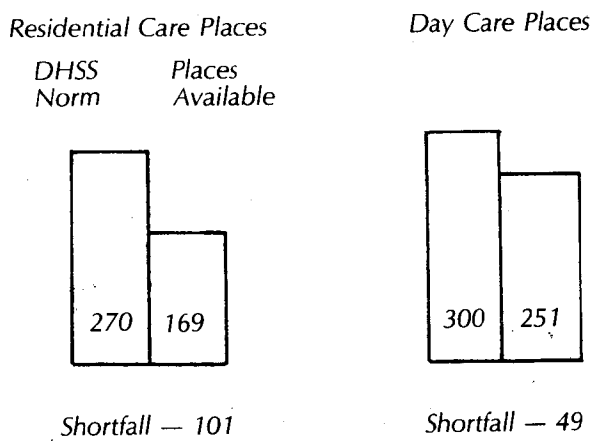
Day Care and Community Services

Acute psychiatric day care services in Liverpool can be summed up as pathetic. The purpose of a day hospital is to provide a therapeutic service in a setting other than that of a psychiatric in-patient hospital, to treat the patient in a community setting on a daily basis as an alternative to in-patient treatment.

In Liverpool at present there is a shortfall of 93 mental illness hospital day places. The Long Term Strategy makes no definite proposals to overcome this deficit. So patients who would benefit from day places to enable them to function in the community, end up being treated with drugs by their GP and when a crisis comes along, are admitted to an expensive hospital bed, perhaps taking such a bed from a patient who would really benefit from in-patient treatment.

Existing day places are often not utilised properly and not located close to the community eg one is tucked away in the RLH — completely removed from the community at large. In addition there is a serious shortfall in local council provision:

DHSS NORM FOR SOCIAL SERVICES COMPARED TO LIVERPOOL'S PROVISION FOR MENTALLY ILL PEOPLE:



We are not only concerned with quantity but quality as well. Very little in the way of group therapy and psychotherapy is available in Liverpool and there is no prospect of the situation improving in the immediate future.

b) Psychogeriatric services (elderly mentally ill)

In the past Liverpool has lacked any comprehensive service for its psychogeriatric patients. They have tended to be placed in either geriatric or psychiatric wards and when these are full, put in valuable acute beds. As a result psychogeriatrics is seen as a'problem', is blamed for 'blocking' acute beds and patients have been given a raw deal.

The original Long Term Strategy proposed an increase in beds of 180, from 30 to 210. However in the latest document an increase of 116 beds is proposed. How far this represents a real increase is doubtful. Much of the increase appears to arise from redesignating beds from psychiatric to psychogeriatric use. When we take into account the plans to reduce general medical beds the net result could be a decrease in service. The plans involve concentrating provision in Sefton General, Park and Mossley Hill hospitals. The problems we pointed out earlier with concentrating geriatric provision in certain hospitals, apply with added force to the area of psychogeriatric care.

Psychogeriatric Day Care

At present Liverpool is seriously short of Day Hospital provision:

	Existing Places	***Total Places Required***
Central & Southern	*20 (interim)*	*84*
Eastern		*73*

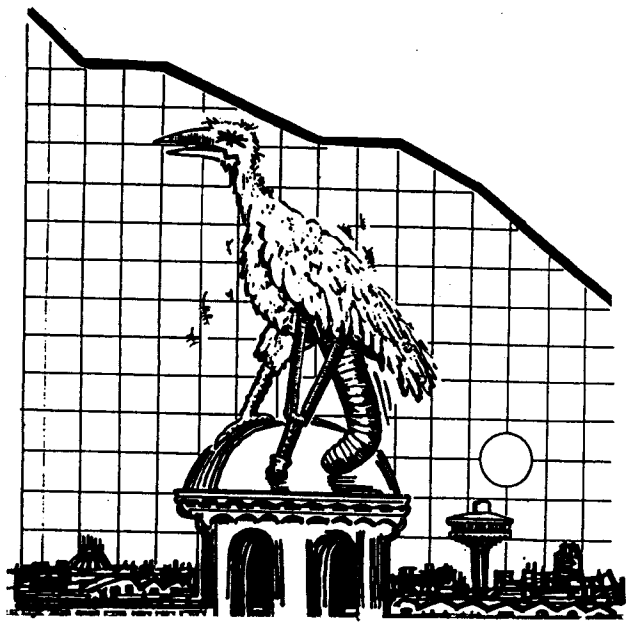
The Regional Health Authority has agreed to fund 50 place Day Hospitals at Mossley Hill and Park hospitals for 1986/87. This will still leave a deficit of 57 places. Day care should provide the first line of treatment. Adequate day care provision would lessen the pressure on in-patient services. More important it offers people the opportunity to retain their independence and dignity in their own homes and remain part of the community.

One good initiative is the Intensive Domiciliary Scheme run by Age Concern. This is a development of the Good Neighbour Scheme and offers a 24 hour/7 day home help service for the elderly mentally ill. It has worked very well and should be extended.

c) Addiction

There is a serious shortage of specialist services for drug addiction. There is a long wait for Liverpool's only Drug Addiction Clinic, at Sefton General, and doctors there have complained of being out of their depth through overwork. There has been a substantial increase in the number of registered drug addicts between 1979 and 1982. Plans are afoot to set up another Liverpool Drug Unit and a group has been meeting under the auspices of the Regional Health Authority. Merseyside Drugs Council are also planning to set up a voluntary unit in the community.

A similar pattern emerges with alcoholism. There is a lack of after care accommodation for alcoholics. The Windsor Unit at Rainhill is a bright spot for treatment, but there is a lack of locally available follow up service for discharged patients.



1982 saw the opening of Henry Cohen House in Central Liverpool, run by the Merseyside Council on Alcoholism and funded by Urban Aid. This provides a day and residential programme of treatment and rehabilitation. Clients must be 'dry' on entry and are assessed by MCA before commencing. The unit is non medical and is a light on the horizon for those people for whom hospital admission is unacceptable.

The unit also has a community team attached, running a prevention programme in the neighbouring community, which is a pioneering and much needed project considering the increase in alcoholism, especially among women.

9) MATERNITY SERVICES

In crude terms maternity care aims to produce a live healthy baby and a well mother. The news is good on this score for Liverpool parents, but less good on quality of service (see later).

In the past Liverpool has had a high level of stillbirths and babies who die within a week of being born. The number of these deaths among every thousand children born is know as the perinatal mortality rate (PNMR). There has been some improvement in PNMR since our previous review of the city's health services, but a wide variation still exists on Merseyside.

LATEST PERINATAL MORTALITY FIGURES:

Year	*Liverpool*	*Mersey Region*	*England & Wales*
1978	*15.1*	*15.2*	*15.5*
1979	*14.7*	*15.5*	*14.7*
1980	*14.8*	*13.7*	*13.3*
1981	*11.1*	*12.4*	*11.8*

PERINATAL MORTALITY RATES FOR DIFFERENT DHAs IN MERSEY REGION, 1981:

Liverpool	*11.1*
Chester	*9.5*
Halton	*15.1*
Wirral	*12.5*
St Helens & Knowsley	*14.8*
South Sefton	*15.0*

Part of the improvement is linked to the introduction of specialised services for new born babies (neo natal services) and better care for problem pregnancies and labours. A significant step was the installation of a regional neonatal intensive care unit at the Liverpool Maternity Hospital (LMH), to care for small and sick new babies.

It is possible that we are now reaching the stage where sophisticated techniques are proving useful, but do not have to be used as a matter of routine for every pregnancy. However the amount of techonology used in antenatal care and in labour, still varies greatly between consultants.

Poverty and Perinatal Problems

Although there are welcome improvment, with fewer stillborn children and more babies surviving the first week of life, problems remain. Liverpool still has high numbers of children who are bron weighing less than two and a half kilograms ('low birth weight' babies). Low birthweight is linked to social and nutritional factors. In much the same way, the Black Report revealed the links between perinatal mortality and social class — the poorer you are, the more likely your child is to be stillborn or die in the first week of life. There are many factors that could explain Liverpool's low birthweights. For example:

*** High unemployment.**
*** Women having children on their own with no support.**
*** The lack of advice on the harmful effects of smoking.**
*** Births in households where everyone relies on supplementary benefit.**
*** Inadequate dietary advice about nutritious foods that may be expensive, difficult to store and unattractive to the woman who is pregnant.**

Although the maternity grant has recently been extended to all pregnant women, the twenty five pounds on offer is virtually meaningless today. Women on supplementary benefit are often unaware of the range of benefits which they can claim and to which they are entitled. The County Council's 'Claim It Now' Campaign was a welcome step, but low staffing levels and attitudes within the DHSS mean many pregnant women face long delays and difficulties.

Countries like Sweden have had a low PNMR rate for many years . . . mainly because of a drop in the number of low birthweight babies. The reason appears to be the general rise in Swedish living standards. The fight against poverty is a vital part of the struggle for better maternity care in the 1980's.

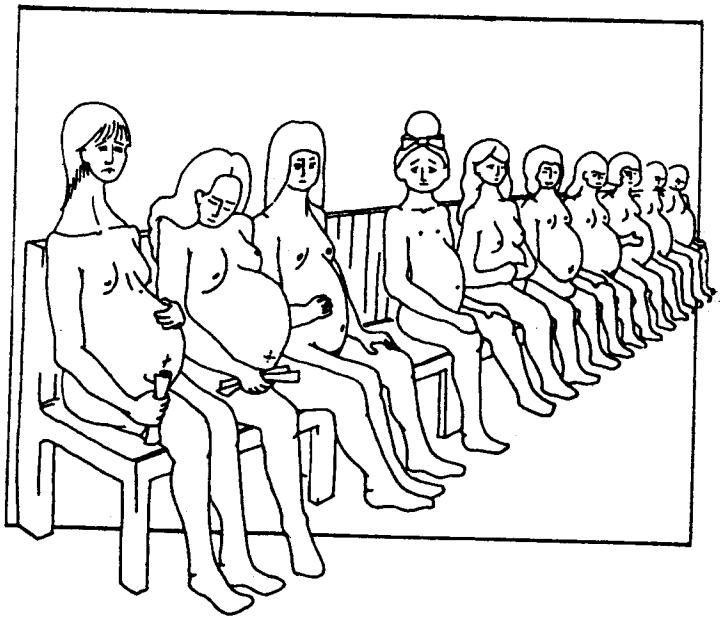
The Care of Women During Pregnancy (Ante Natal Care)

There are several clear problems in Liverpool's antenatal services.

LATE BOOKING INTO HOSPITAL
Late booking is associated with higher levels of illness and death for women and their babies. The position has improved recently because there is now a deliberate policy of implementing screening tests during the fifteenth and sixteenth weeks of pregnancy.

OVERCROWDING
Liverpool's maternity hospitals still have large clinics for over a hundred women and this is likely to persist for several years. The problem is particularly acute at Mill Road. There is also a shortage of beds because of a recent unexpected rise in the birth rate after the closure of maternity facilities at Broadgreen and Sefton General hospitals.

WAITING TIME
A survey by the city's two Community Health Councils showed that waiting time in Mill Road was excessive. The survey, which was carried out in January 1983 showed that forty per cent of the women attending, waited more than an hour for an appointment. Thirty per cent of the women waited more than two hours from the time they arrived until the time they left. This may throw some light on the high number of women who did not turn up during the week of the survey. Nearly one in five women failed to keep their appointment, but we are left to ask whether their attendance would not have stretched the already excessive waiting time. Women may also be discouraged from turning up because in addition to a long wait at the clinic they may face a long journey and not have the money readily available to pay for their fares (refund later on may come too late).



OVERBOOKING AT THE LIVERPOOL MATERNITY HOSPITAL
In the past women from all over Merseyside have been able to book into the LMH. There have been recent attempts to get the consultants to operate catchment areas, but the hospital remains overbooked. The LMH also houses the intensive care unit for new born babies and that means women

from all over Merseyside who have 'at risk' pregnancies may end up at the hospital. The combination of these factors means that women from Central Liverpool who book late may be turned away and have to travel to another hospital.

In 1982 more than 320 women were refused booking at LMH and were either referred to another hospital or back to their GP. In fact it is just these women booking late who may be 'at risk' for reasons of poor nutrition and poverty.

CONTINUITY OF CARE
This means the women seeing the same doctor or midwife at each visit, which at present is much more likely in the community setting (GP clinic) than in hospital. There is still little continuity of care for women seen in hospital antenatal clinics, both at Mill Road and at the LMH. A study in Aberdeen suggested that some 'routine' antenatal care may be irrelevant. The important factor appeared to be spending time with women, listening to their feelings and problems: in short treating women as people.

One answer put forward by the study is to cut the number of visits but to allow more time for women to talk to the midwife or doctor when they have an appointment. A policy aimed towards this might cut overcrowding, while improving continuity and quality of antenatal care.

One problem associated with continuity of care is the role of the midwife. Although there are some exceptions, in many clinics midwives often act as little more than the handmaidens of the doctor (see below for some possible solutions).

LACK OF INFORMATION
Women are often not given the right information in the right way. One example is Spina Bifida (SB). Merseyside has one of the highest rates of SB in the country and now some consultants have introduced regular blood tests to screen for the disease. These tests which are carried out between fifteen and sixteen weeks of pregnancy are fairly accurate. Yet until recently the leaflet on SB for women attending the LMH was incomprehensible. Fortunately it has

now been changed because of strong criticism by the Health Authority's working party on the health of women.

Recent research has shown that the women who are most at risk of having babies with Spina Bifida — women with poor diets, women with a family history of SB, and those who already have children with it — can greatly reduce this risk by taking certain vitamins before they become pregnant. All the more reason then why women should be adequately informed about the problem and the solution.

CRECHE FACILITIES
There are no creche facilities at the Liverpool Maternity Hospital or at Mill Road. Even the staff creche at the LMH is threatened with closure.

ANTENATAL AND PARENTCRAFT CLASSES
There are attempts being made to co-ordinate antenatal and parentcraft classes. But while some efforts are also underway to inform women about these steps, it may still be difficult for women to find out about them. This is especially true for women whose GPs do not work closely with community midwives. Many women also face a problem in finding the courage to attend these classes or the money to get there. More must be done to fix classes at a time when both working women and men can be there.

ALTERNATIVES

One consultant at the LMH has started a new policy for the care of women with low risk pregnancies. After an initial visit to the hospital, to book in, the woman sees only her community midwife or GP throughout pregnancy, with either one or two check ups at the consultant's clinic in late pregnancy.

The policy has meant shorter queues and more time per woman at the consultant's clinic. It also improves working relationships, and staff have described the clinic as 'a joy to work in.'

Another important boost is to the role of the midwife. Under this new regime they now see low risk women in their own right. This is a crucial step forward. A regional report published last year, recommended that "In hospitals, the midwives should be responsible for all other antenatal care in low risk cases."

COMMUNITY ANTE NATAL CARE
Women who attend their GPs' surgery regularly can get to know their community midwife and health visitor before the baby is born, which helps greatly towards their support post natally. However many of the city's older GPs are simply not interested in providing this service and the Health Authority has just turned down a plan for a community clinic run solely by midwives. It is vital that there should be more community antenatal care to improve the morale of midwives, to encourage the younger GPs to work in Liverpool and primarily, to increase the wellbeing of women and their babies.

Delivery

Recent years have seen a decrease in the high technology approach to delivery, with less inductions of labour and routine monitoring than in the 70's. Women's wishes are taken into account with regard to position and conduct of delivery and both LMH and Mill Road have birthing chairs. However, once again, if a woman does not ask about procedures she may never find out what is available.

A 'domino' 24 hour delivery scheme has recently been adopted by some consultants. Here the woman sees her midwife and GP throughout, is accompanied by the midwife to hospital when in labour and returns home after delivery, all being well. This is becoming increasingly popular with women, and has been acceptable to some women who otherwise would probably have refused all pregnancy care. If however all consultants used this scheme there would be a shortage of community midwives. The Authority has just rejected the idea of employing two extra community midwives to

cope with the current increased workload in the community due to pressure on beds, partly arising from early discharges, and partly generated by the domino scheme.

In fact the number of Liverpool community midwives is under par as it is. This is said to be due to the lack of job applicants. One cannot hlep wondering whether the decrease in midwives independence and involvement

with delivery out in the community is discouraging midwives from applying. Liverpool also has a total absence of GP delivery units and GP involvement in delivery.

Home Confinements

We believe home deliveries are here to stay, no matter what alternative are offered. The reluctance of many consultants to back women, midwives and GPs wanting them is still a problem. Some Districts have abolished flying squad emergency back up services completely and this could be extremely dangerous. We must ensure that this does not happen here.

HOME CONFINEMENTS IN LIVERPOOL

1976	*1977*	*1978*	*1979*	*1980*	*1981*
86	*45*	*73*	*71*	*72*	*58*
				+ 1 still birth	

Post Natal Care

Support for women and men who have young babies is far from adequate. The loss of extended family networks means that people can easily become isolated as they care for young children. Breast feeding is not a common practice in Liverpool and women who have given birth at the Liverpool Maternity hospital often report confusing advice. Overworked health visitors do not have time to spend advising women about the issue early in pregnancy.

Two good ideas on post natal care in the city came from the Working Party on the Health of Women. They recommended the use of local radio to inform women and men about antenatal and post natal services and to advise about coping with a small baby. The proposals was approved by the Health Authority but never acted upon.

They suggested a twenty four hour crying baby service for parents with young childre. It is a scheme which allows parents to ring a number that is staffed by health visitors. It is a service to parents reaching the end of their tether and has been successfully adopted in other areas. The service would need to be funded, but the return, in terms of saving distress and avoiding crises could be enormous. The Authority turned it down.

THE FUTURE

In 1983 the government published a report on maternity services that recommended many of the things we have been discussing. But, being what they are, they made no provision for extra cash.

Every District Health Authority is now to have a Maternity Services Liason Committee. Liverpool's is currently reviewing antenatal services. Although the Liason Committee is made up only of members of the Health Authority and professionals, the public may be able to put its views through the city's two Community Health Councils. It is hoped that the public will make use of the CHC's and that the committee will listen.

We support all efforts by local communities, by women's groups and by other groups such as AIMS and the National Childbirth Trust to make antenatal care more accessible to women.

We would also like to see an increase in GP and midwife antenatal care, an extension of the domino scheme and GP's eventually involved in delivery. Many of the positive changes in recent years have been the result of informed demands by the women who use services. We hope the Maternity Services Liason Committee will take this into account.

cpf

10) CONTRACEPTION AND ABORTION SERVICES

There is a high rate of teenage pregnancy in Liverpool. This reflects a lack of knowledge among teenagers about where contraceptive advice and pregnancy counselling is available.

Young people often have well founded fears about the reception they'll get in some clinics. In 1981 the Health Authority closed down its popular city centre family planning clinic and dispersed the service to more inconvenient centres throughout Liverpool. The threat of closure is also facing the Brook Advisory Clinic. This is due to move from Gambier Terrace to the new Trade Union and Unemployed Centre in Hardman Street. Although the Brook caters especially for teenagers, the Health Authority will not fund the service because it feels there is 'no need' for a young people's clinic. There is a chance that the Brook might be able to provide its sensitive and sympathetic service from the city centre if the Health Education Council provides the funds.

The morning after pill (post coital contraception) is now well recognised as safe and effective. But although the Health Authority's family planning doctors have been told they can prescribe it, the Health Authority has deliberately refused to advertise its availability.

We must continue to press for a co-ordinated contraceptive service that caters for the need of all ages and that provides not only a post coital service but also early, and accessible free pregnancy testing.

Abortion

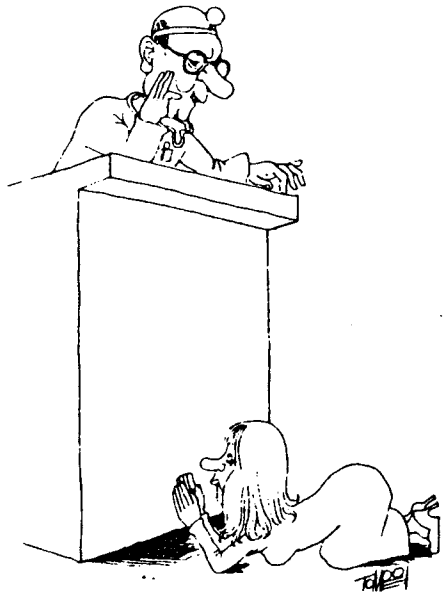
The Communist Party believes that women should be able to choose whether to become pregnant or carry on with a pregnancy. In October 1981, only 29% of Merseyside women could obtain an NHS abortion and then only by waiting several weeks and facing the distinct possibility of being turned away by either GPs or consultants.

Yet women on Merseyside are still dying from septic and illegal abortion — the risks of abortion are much increased after 12 weeks of pregnancy.

Deaths from Abortion in Mersey Region 1971-82:

Total Deaths	—	*5*
Illegal	—	*2*
Probably Illegal	—	*1*
Legal	—	*2*

Today most Merseyside abortions are carried out by the NHS at a Day Care Abortion Unit. It is called the Bedford Clinic and it operates from the Women's Hospital. All the abortions at the Bedford are carried out before the twelfth week of pregnancy when the operation is simple and safe. The unit caters for the whole of the Mersey Region so its money comes from the Regional Health Authority although it is run by the District Health Authority.



The Bedford is the direct result of long and continued pressure by Merseyside women. The Central and Southern Community Health Council played a leading role in the campaign with the backing of the labour movement. The members of the Merseyside Abortion campaign had a strong involvement. They joined the fight to save the Women's Hospital from closure in 1980 and it was partly as a result of that fight that the day care unit was sited at the Women's.

But setting up the unit has not seen an end to the problems. There have been difficulties at the unit. The four counselling staff who were originally intended to guide patients through their stay at the Bedford have all left. Two have resigned and taken their case to an industrial tribunal claiming constructive dismissal. Their case is that their jobs became impossible because of the atmosphere in the clinic. A working party has been ordered to look into the problems. But the result is that women can not now get skilled non medical advice at the unit.

This is important because it is essential that women make the right decisions about their pregnancy for themselves and for their future. An important feature is the availability of someone who has time to listen to questions and talk round the issue. In a busy unit nurses and doctors cannot always cope adequately with the questions from patients. The Bedford also suffers from delays because of the pressure from demand. On occasion the waiting list from referral to operation has been two weeks and this is simply not good enough.

The struggle for better abortion facilities didn't end with the opening of the day care abortion unit. Some women still face obstruction from their family doctor in their efforts to obtain an abortion. Others are pressured into abortions they don't want. The struggle continues.

11) CHILD HEALTH SERVICES

The trend within the NHS is to treat more children in the community and fewer in hospital. To help this continue we need to improve on the existing community services. This means updating many of the child health clinics. And when we build new health centres we must ensure there is adequate space for children to play, as well as adequate waiting areas.

There is great scope for positive health education while patients and children are waiting to see their doctor or health visitor. The dangers of smoking, dietary advice on sweets, advice on fats or fibre or fluoride all need more positive responses from the medical profession. There is also a need for a health authority policy on providing fluoride for children. Fluoride can be obtained free on prescription for young children but how many families know about it?

There is an increasing problem of child abuse. This does not just mean battered babies, but also children who suffer from emotional as well as physical neglect. The problem is likely to grow worse as unemployment rises and social services are cut. If we are to stop child abuse we need to look at a range of solutions. We need more nursery places. We need more support for isolated women who may be trying to overcome post natal depression and we need better education in the community about the problem. These are specific needs but in general we need a more imaginative approach to child care and parent support. The Family Service Unit and CHUM can open up new areas of work in this field.

There is also a need to improve the communications between the different sectors in the Child Health services. Child Health Clinics and School Health services don't liaise adequately with GP's. This can lead to frustration for medical and nursing staff and is not in the interests of the children. The Professor of Paediatrics has made attempts to try and improve the position and to encourage hospital paediatricians to venture into the community, but the success has been limited.

There is one successful area in the service where GP's and health visitors run their own child health clinics. It is here that the close links between child health services and general practice could show the benefits of cooperation. Take the example of immunisation. Immunisation rates in Liverpool are the worst in England and only by tracking down those who do not attend can we solve this problem.

% of children born in 1980 vaccinated by the year 1982:

	England	*Liverpool Health District*
Measles	*58*	*43*
Polio	*84*	*78*
Diptheria	*84*	*72*
Tetanus	*84*	*73*
Whooping Cough	*53*	*40*

The Future

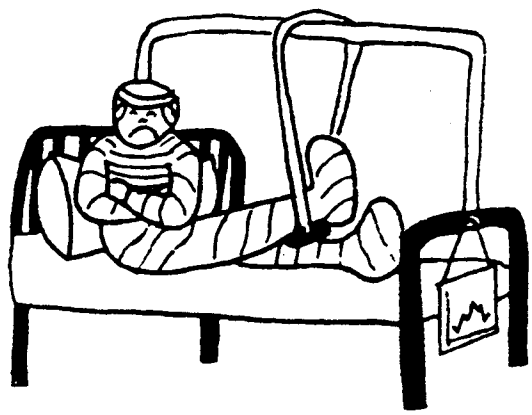
A major document on the future of Child Health Service will soon be produced with the Report of the Health Authority's Working Party on Rationalisation of Paedeatric Services. The Long Term Strategy proposed a cut of 105 paedeatric beds — the where and how will not be known until the Paedeatric Report comes out. It seems likely to present the Health Authority with various options, which makes it even more difficult to assess the future. Some points to watch out for might be the following.

Myrtle Street *— a reduction in size is almost certain with the accident and emergency services being transferred to alternative sites.*

Alder Hey *— will continue to develop as the site of all the major regional specialities. However a question mark hangs over some acute services there.*

Heswall *— The Working Party was almost certain to recommend its retention. The combination of pressure within the health service to keep it open, with the support of the extremely influential, local, Wirral, Conservative lobby made it a difficult target for the axe. However the most recent package of cuts (see later) means it is now likely to face closure.*

Community Services *— ritual gestures in this direction are likely, but again there seems little prospect of any substantial funding.*



12) DISABILITY

The main aim of services for the physically handicapped should be to allow them to live as independent and normal a life as possible. Voluntary organisations play an important role in this sphere. They are pressure groups that remind society of the need to consider such issues as access to buildings, the need to adapt housing and provide employment opportunities.

The Liverpool Association for the Disabled serves as an umbrella organisation for the physically handicapped. It was set up over fifteen years ago and gets an annual grant from the council that's running at just under £22,000.

One important new initiative is the Greenbank project. It is run by the disabled for the disabled. The project aims to teach skills that are valuable for finding work. There are courses on computing and printing. There is also training in the design and building of aids for the disabled and a variety of accommodation on offer for the students.

13) ALTERNATIVE MEDICINE

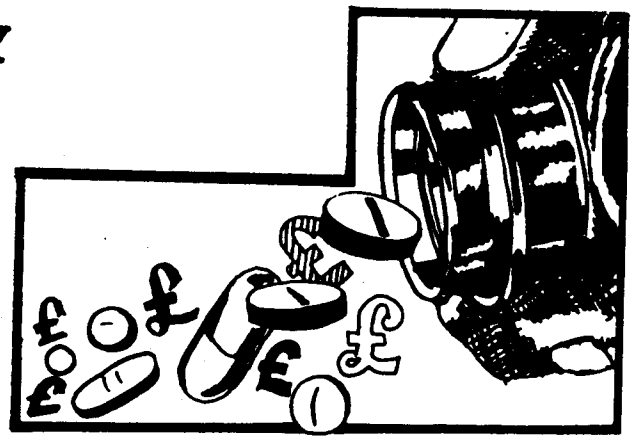
In drafting this pamphlet feelings ran high over this section. Recently the subject has received considerable public attention including from such an august body as the British Medical Association.

One source of problems is that there are really several different issues at stake. The first question is whether so called alternative therapies are effective or not. In many cases there is no proof that they are. This is not so much a question of whether an acceptable explanation of the healing process can be provided. We still hardly know how aspirin works, yet it does and we use it. A health service committed to helping people should look seriously at all techniques which might be of value, test them and if necessary incorporate them properly. Ignoring them exposes people to the risk of quackery.

Another problem is the anomolous position in the NHS, where some 'alternative therapies' are available and others not. This frequently owes little to the merit of particular techniques but much to the prejudices of the affluent and influential. So the Royal Family's fondness for homeopathic medicine gives it an acceptable status. We have the homeopathic department at Mossley Hill, which is there by virtue of tradition. But the effectiveness of homeopathy remains to be proved. On the other hand skills such as osteopathy remains outside the NHS, but in the USA osteopaths are recognised as trained doctors!

Finally, a failure to incorporate some techniques leaves patients open to commercial exploitation. This is not just a risk with private, unqualified practicioners, but equally within the NHS itself. Doctors providing a skill in short supply within the NHS, such as acupuncture, can exploit its scarcity value. They can encourage patients to see them for extra, private consultations. Such practices are not unknown in Liverpool.

14) THE DRUG INDUSTRY



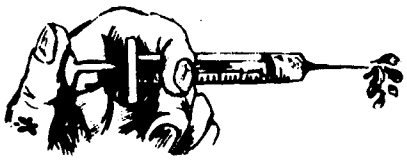
No analysis of the health service in Liverpool or any other city can ignore the damaging effects of the drug industry. Modern drugs have brought undoubted benefits in the fight against disease and ill health but the price has been too high. The position is now out of control and it is no exaggeration to say that we are being cured to death!

The aims of the NHS have been thwarted by the big pharmaceutical companies. And they have been supported in doing this by an unholy alliance with the medical profession. Armed with the dubious banner "Freedom to prescribe" the professionals have become a willing and essential link in the gravy train which we keep well and truly oiled through the tax system.

Profiteering, price fixing, promotion of ineffective and dangerous goods, high pressure sales techniques, questionable advertising, suppression of information, ferocious rivalry leading to monopoly trading — surely we can not be talking about an acitivity dedicated to combating sickness and saving lives? Yet each of these features is well documented.

For example, in 1983 the Italian multinational Carlo Erba invited Liverpool doctors to sample the "opulent splendour of the 1930's on board Henry Fords yacht." The doctors were kept comfortable and well fed as they listened to the company's sales pitch for its new wonder drug to help arthritis. The second example is the former arthritis wonder drug Opren. Opren had to be withdrawn but only after nine people in Britain had died. It is ironic that the industry charged with the honourable purpose of relieving suffering exhibits the most piratical features of modern big business.

The present volume of drug production has reached overkill. On promotions alone it has been estimated that the industry spends fifteen million pounds a year to circulate the twenty six thousand family doctors with the journals or comics they use to push their products.



There are simply far too many drugs being produced. Most of them are expensive copies of an original drug produced for a specific disease. The main costs for the research and development of these "me too" drugs is spent on finding ways around the patent laws. The head of the World Health Organisation has estimated that ninety five per cent of the drug responsive problems could be dealt with by two hundred drugs. But doctors have to choose from 30,000 different products and the cost to the NHS is astronomical The millions of pounds the drug companies spend promoting their products each year is recouped a hundredfold.

Even the Daily Telegraph has been drawn to comment: "Millions of pounds annually are being added needlessly to the NHS drug bill by mass prescribing of expensive brand named tablets which are available more cheaply under other names. Thirteen brand leaders among the most widely prescribed drugs, and also available more cheaply under other names, added at least £25 million to the 1978 drug bill of £723m . . ." 27/10/79.

In a more recent scheme doctors and chemists at Abbots Langley in Hertfordshire co-operated in prescribing and dispensing unbranded or generic drugs. They showed that for 30,000 prescriptions using twenty six varieties of the sixteen most frequently used drugs they could save £6,000 a year at one pharmacy. If we extrapolate this figure it means a total national saving of about £40 million from a total drug bill of £1.2 billion.

There is therefore an urgent need to bring sanity back into this particular market place. One aim must be to remove the NHS from the market place altogether. This must be done by developing a comprehensive nationalised drug industry that serves the country's needs.

In the short term much can be done to curb excesses. We welcome the Greenfield report on effective prescribing. This report includes a call for generic substitution by the chemist of a limited list of expensive branded goods. This simply means that where doctors prescribe an expensive 'branded' drug the pharmacist would replace it with the cheaper equivalent. This would produce considerable savings to the NHS and we must campaign effectively to see that it is put into effect.

But there's a need to go further than Greenfield. In Australia one system that works well is to introduce a limited list of drugs which doctors must stick to for prescriptions.

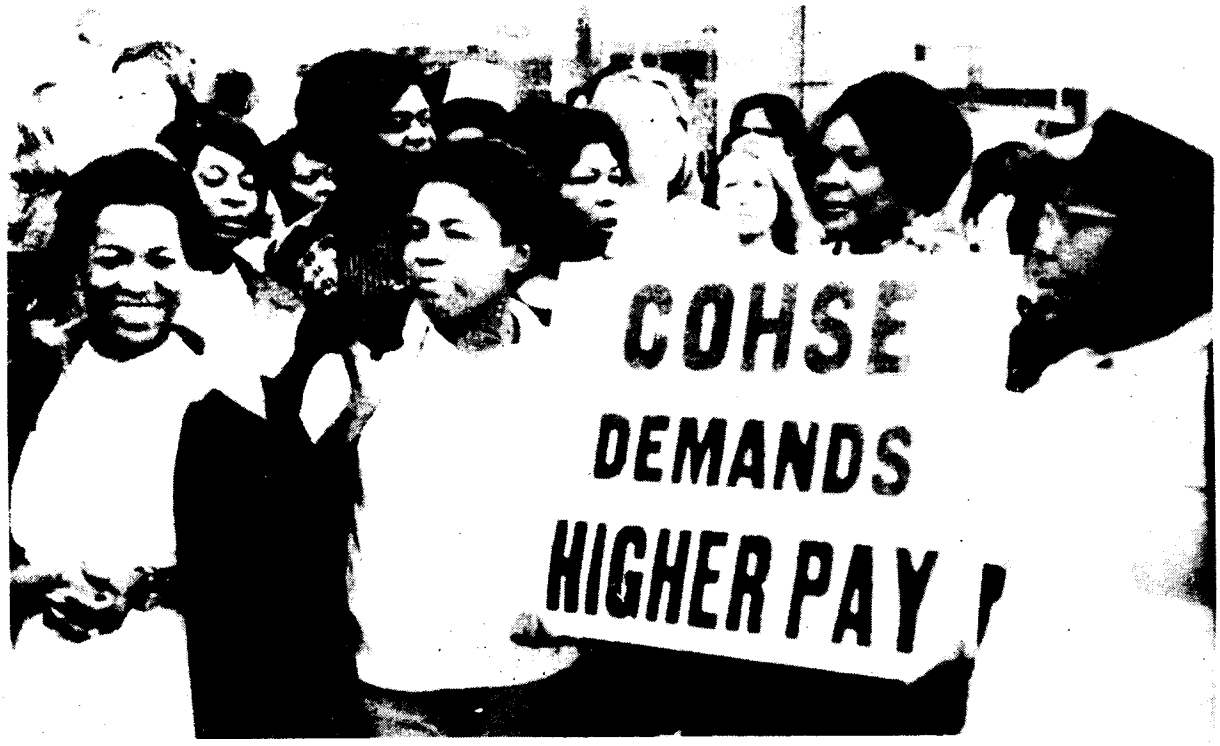
The drug industry is resisting these measures strenuously. The big companies are using all kinds of spurious arguments including the impact of such measures on their export earnings. If the promotion and sales of their products in the third world are anything to go by then it is high time they were curbed and brought under public scrutiny. Oxfam's excellent Rational Health Campaign has highlighted the horrendous activities of these companies in the developing countries.

It is in everyone's interest to make this industry publicly accountable for its actions, both here and abroad. Not only are we at the receiving end of the industry's products, we also maintain its profitability through our taxes.

15) THE RACIAL POLITICS OF HEALTH

Racism pervades our society — both its institutions and the conscious and unconscious attitudes of the people who inhabit them. Since, as we have argued, issues of health must be related to a broader social context, the pervasive character of racism has important implications for the health service. Racism affects both health service workers and the health service consumers. In turn this affects the way black people experience and relate to the NHS.

This area has recently been the subject of an important new book — "The Racial Politics of Health — a Liverpool Profile", written by Protazia Torkington and published by the Merseyside Area Profile Group, Sociology Department, Liverpool University. This covers the subject far better and at greater length than we could hope to achieve. We would highly recommend it to anyone reading this pamphlet. So we will keep our remarks relatively brief.



Racism in the NHS

Racist practices and attitudes are widespread in the NHS. A recent and disturbing example is the introduction of new hospital procedures for checking how long patients have lived in Britain. This has been blatantly used against black people and has lead to increased harrassment and humiliation. The Communist Party believes these procedures should be immediately ended and health authority trade unions should instruct their members to refuse to operate them. A similar approach by unions in the DHSS has forced the Government to delay the introduction of ethnic monitoring of claimants.

Employment is another area of concern. Despite popular myths black people are seriously underrepresented in the Liverpool hospital workforce. In September 1982 one Liverpool teaching hospital was training 170 student nurses on a three year course for state registered nurses. Only two of the trainees were black. The Health Authority is reluctant to supply figures or to admit that racism exists. It has adopted an Equal Opportunity Employment Policy, but this has proved remarkably ineffective.

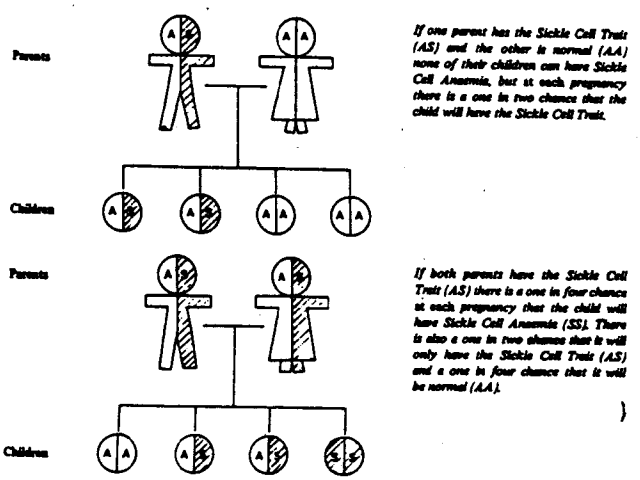
This is partly through a failure to positively encourage the employment of black people and partly by failing to confront the way many selection procedures effectively exclude black people. There is also the persistence of unconscious racism in many people responsible for selection and employment policy. One example related to us concerned a Nursing Officer in a City Hospital, who was introduced to a nurse and said: "Oh! You speak English!" She was asked in turn if there was any racism in her hospital. The answer: "Oh no, I don't think so!"

A working group on the health needs of ethnic monority groups has recently been established by the Central and Southern CHC and the Community Relations Council. This has recommended a number of positive initiatives. The working group called for two projects — one dealing with sickle cell anaemia, and the other a research programme on black people's health needs.

Sickle cell anaemia is an inherited blood disease found in people of African, Mediterranean, Asian and Middle Eastern descent. The disease is fairly rare but can be very severe. However carriers of the sickle cell trait — people who have one gene for sickle cell disease — are common and liable to problems during dental, obstetric, or surgical anaesthesia. Men and women who are both carriers have a one in four chance of having a child with sickle cell

anaemia.

The Group proposed establishing a monthly screening clinic for sickle cell anaemia in conjunction with the Department of Haematology at the RLH. An initial application for Inner City Partnership funds failed, but a second approach has been successful. However a two year research programme for two workers has been turned down twice. This was intended to look at the wider health needs of ethnic minority groups. It would also develop proposals to improve health education and the take-up of health services by black people.



Perhaps the primary effect of racism is to reinforce the problems which affect the young, the elderly, women and working class people. There is a danger of treating the health problems of black people as somehow entirely distinct from those facing the rest of society. One result can be to blame black people for their health problems. This is present in some approaches to health education and literature 'put out' for black people. These tend to be highly limited and selective, concerned only with diet, ante natal care and birth control. This is insulting and reinforces racism within the NHS.

A good example is the approach to rickets, which appears to be more common in Asian children and women. The main response in the NHS has been to blame diet and clothing, rather than to consider fortifying certain foods with Vitamin D. For some reason the DHSS finds it acceptable to fortify margarine, but not chapati flour!


Joyce A. Agee

RACIAL EQUALITY & EMPLOYMENT IN LIVERPOOL

	BGH	RLH Royal Lpool	M. St RLCH (City)	Olive Mt.	AHCH Alder Hey	LDH Dental	Womens	LMH Mat.	Mill Road	SGH Sefton	Pri-nces Park	M'Hill Mossley	St. Pauls	NGH New-sham day	Park & Park	R'Hill	Rath-bone	Total in Area
Medical & Dental	14	76	—	9[1]	—	2	2	2	5	12	—	3	6	12	—	7	—	159[2]
Nursing	10	N/A	12	16	18	N/A	3	28	12	25	10	2	5	21	10	31	1	200[3]
Ancillary	3	35	1	1	3	1	2	13	—	11	5	—	2	3	—	—	—	80[4]
Admin. & Clerical	—	—	—	—	1	—	—	—	—	2	—	—	—	2	—	—	—	5[5]
Prof. & Tech. 'A'	1	1	—	—	—	1	1	—	—	2	—	—	—	—	—	—	—	6
Prof. & Tech. 'B'	—	1	1	—	—	—	1	—	—	3	—	—	—	—	—	—	—	6
Pharmaceutical	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Optical	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Works Staff	1	2	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	5
Total number of non-caucasians per unit	29	115	14	17	13*	4	9	43	17	56	15	5	14	38	10	38	1	471
Total number of staff at 31.3.81 in each unit	1567	1734	543	269	1211	174*	254	562	454	881	154	218	283	963	252	1748	2000	11487
% of Total Workforce	1.85	6.63	2.59	6.32	2.56	2.30	3.54	7.65	3.75	6.36	9.74	2.29	4.94	3.95	3.97	2.17	0.46	4.10

*These figures exclude nursing staff

The Total number of Staff employed by L.A.H.A. (T) is 15,688
Total number of Non-Caucasian Staff employed by L.A.H.A. (T) is 471
% Figure for overall L.A.H.A. (T) is 3.00

[1] The 9 Medical and Dental Staff are included on Alder Hey's figures
[2] This Medical and Dental total includes 9 on Community
[3] This Nursing total includes 6 on Community Nursing
[4] This figure includes 1 domestic on Community
[5] This figure includes 1 Admin. and Clerical grade at Area Headquarters

From "The Racial Politics of Health – a Liverpool Profile" by Ntombenhle Protasia Khotle Torkington.

16) TRADE UNIONS IN THE LIVERPOOL HEALTH AUTHORITY

When the NHS was first set up, most negotiations between trade unions and management took place at a national level. The national forum was the Whitley Council which decided issues such as grading and pay. Local union activity consisted mainly of monitoring agreements reached at a national level and representing members in such matters as disciplinary hearings and grading appeals. As a result union activity was fairly marginal to the NHS. More recently the impact of low pay and the cuts has changed the position dramatically. There has been an increase in union membership and activity. In the 1970's a combination of national union initiatives with growing militancy at the grassroots lead to a series of industrial disputes mainly over low pay. Only a few were successful. A major factor was the Labour Government's incomes policy, which was supposed to help the low paid, but had the opposite effect. Nevertheless the experience had important consequences.

Increased union membership and activity brought forward stewards who were not content to leave everything to national leaders. At first they were severely restricted by the structure of ineffective consultative committees. These were based on staff groupings, not trade union structures. There was no way for staff to mandate a delegate and receive reports. They were too large, with every selfish, professional viewpoint demanding to be heard. In Liverpool in 1978, a majority of the TUC Affiliated unions withdrew from the old Consultative Committee and demanded that the Authority recognise them as a joint TUC side. The Management agreed. By 1980 the constitution was agreed and in 1983 all TUC affiliates were participating (bar the small Health Visitor's Association). The result has been that staff interests have been far more effectively represented, despite the various financial crisis that have hit the Health Authority. Indeed one result has been to virtually eliminate industrial action within the Health Authority. The old Consultative Committee, now almost entirely devoid of TUC affiliates, exists only as an irrelevance.

It is important however to realise the limitations of this joint TUC body. It looks at problems primarily from the viewpoint of NHS workers. This is correct. But problems tend to be looked at almost solely from the viewpoint of employees, and this is wrong. Ways must be found of bringing together the voices of the employee and the patient (or future patient). Hospital closures tend to be looked at in turns of job loss rather than patient care. The job issue will generally be resolved if guarantees are given on no redundancies or transfer of employment. But the issue of patient care can only be safeguarded by maintaining the number of beds. Another alternative would be to change the type of health care provision to one that is more community based.

Some would argue that is unrealistic for trade unions to change from organisations defending their members' direct interests to organisations fighting for a better health service. But such a transformation is impossible. Firstly because trade unions have shown some inclination in that direction. Secondly because of the present position on pay bargaining.

One example of changing attitudes in trade unions is the role they played in the fight to keep Liverpool

Health Authority as a single Authority. This campaign brought together trade unions, CHCs, the City Council and medical opinion, as well as the Liverpool Health Authority.

The second example is the recent NHS pay dispute. Here, trade unions fighting for a decent wage found themselves involved in what was widely seen as a battle over the future of the NHS. Because of this they enjoyed considerable public support. It was possible to win support from unions organising members outside the NHS. An improved, albeit limited, offer was wrung out of a reluctant Government. Here in embryo is an alliance between NHS workers and patients. Support for NHS workers from trade unions outside the health service needs to be encouraged on a much more extensive basis. Out of this alliance can come changing attitudes.

The NHS unions can become the champions of a greatly improved NHS. There are real problems. There was a certain amount of exhaustion and disillusionment in the aftermath of the pay dispute. The Pay Review Board set up for certain categories of staff opens up the danger of divisions and a return to more sectional bargaining. However the threat of privatisation seems to be evoking a new mood of militancy, particularly when accompanied by the latest round of job cuts.

The latest package of Health Authority cuts make such a role for NHS unions even more imperative. If we are to reverse the cuts and win an alternative approach from the Long Term Strategy, NHS workers and their unions will need to give a lead, both in their own actions and in their willingness to work with other forces.

17) THE HEALTH AUTHORITY'S LONG TERM STRATEGY

Liverpool District Health Authority has recently issued plans for health services in the city over the next ten years — its 'Long Term Strategy'. These plans include:

*** the closure of Princes Park and Newsham General**
*** bed reductions in many other hospitals**
*** a concentration of resources in the two District General Hospitals — Broadgreen and the RLH.**

Beds will be reduced by 694 and staff numbers by the equivalent of 769 full-time jobs. The reason for this reorganisation is essentially to cut expenditure.

Why the Cuts?

The Regional Health Authority has issued long term financial guidelines. In Liverpool's case they argued that, under the RAWP formula, we were overfunded in terms of beds and revenue. The result is a demand for Liverpool to accept a £5½ million cut over the next five years.

The District Health Authority has accepted this and worked out the Long Term Strategy with this end in view. The first draft aimed at both job and bed reductions by the closure of two or more hospitals. In October 1982, the draft Plan was unveiled at a Health Authority meeting to a packed public gallery of health workers and trade unionists. The public gallery tried to get members to throw out the plan and force the Regional Health Authority to reconsider its demand for cuts. Instead, out of a number of options, the District hit on one which involves the closure of Princess Park and Newsham General. Further investigations on its implementation were called for.

The decision attracted considerable publicity and was attacked by health service unions, the CHCs and city councillors. The City Council, CHCs and the trade unions offered to go with the Health Authority to the Health Minister, to explain the effect of the £5½ million cut and ask for a reversal of the decision.

However the District Health Authority refused. They said there was no point in pressing for additional funds until they could show they had tried to make economies and were using resources effectively.

Why it is wrong and will not work

We are opposed in principle to planning services on the basis of attempts to cut expenditure. This has been the approach to planning the welfare state adopted by right wing Labour Governments and the Thatcher Government. We recognise that infinite resources are not available. However the way we allocate them should be reversed. We should define needs first and on that basis, plan services and finance.

Even within the logic of central government cuts, the Region's argument that Liverpool is overfunded is mistaken.

Population

The past fall in Liverpool's population and its future projection are major factors in assessing how much money the city needs. As we said in the introduction, there are good reasons to believe estimates of future population are serious underestimates. An overall drop in population can also conceal major areas where demand for services will increase. The 1981 census showed that while total population had declined, the drop is most marked among young to middle aged adults. The proportion of the very young and the elderly — who place the biggest demand on the health service — has increased.

Again RAWP pays no attention to such questions as the general level of ill health and the impact of broader social factors. We have already pointed out how Liverpool 'enjoys' a combination of devastating social problems and generally poor health.

Overbedding

One reason it was argued Liverpool was overfunded was the relatively high number of hospital beds in the city. The DHA argued that more efficient use of beds could enable substantial cuts without harming services.

Is Liverpool Overbedded?

Most Liverpool residents in General Medical Beds stay in hospital longer than people from other areas using Liverpool beds.

LENGTH OF STAY IN LIVERPOOL HOSPITALS:

Liverpool 1981	***Liverpool Residents***	***Non Liverpool Residents***
Hospital	***Average length of stay***	***Days***
Sefton General	*42.5*	*19*
Royal Liverpool	*16.5*	*11.7*
Broadgreen	*11.5*	*10.7*
Newsham General	*36*	*30.4*
Rathbone	*57*	*38.1*
	—	—
	18.5	*12.9*

A comparison of Liverpool's performance in various specialities with other provincial teaching authorities gave the following results:

- In 5 out of 8 specialities Liverpool had high occupancy levels
- In 7 out of 8 specialities Liverpool had long lengths of stay
- In 5 out of 8 specialities Liverpool had low throughput
- In 7 out of 8 specialities Liverpool had above average beds

What this suggests is that while Liverpool may have more beds than other Districts, in practice this is negated by other factors. One factor is the higher level of demand for care from local residents. This reflects broader social problems and weaknesses in community services — provlems effectively ignored in the Long Term Strategy. Another issue is the inefficient use of beds. This was considered in the Strategy and forms a key element in the argument for cuts. However the proposals adopted could aggravate the problem rather than improve it.

Bed Use

A major problem in hospitals leading to inefficient use of beds, is over-occupancy. This occurs where there is a shortage of beds and different specialities are fighting amongst each other for bed space. To avoid the risk of losing beds consultants tend to keep patients in longer than necessary. Then if a bed becomes vacant before it can be filled another specialist can not step in and take it over. This leads to an effective reduction in the number of beds through over occupancy and therefore increased expenditure.

There tends to be greater over occupancy in the biggest hospitals, where competition between the specialists tends to be fiercer. The DHSS guidelines for bed occupancy rates is 85%. The RLH bed occupancy rates in many specialities exceeds 100% (i.e. more patients re-

quire urgent admission than the hospital is able to cope with). This creates overwhelming pressure to keep hold of beds. The overall bed occupancy rate at the RLH is 93%, higher than any equivalent hospital in the country. However a major element in the Long Term Strategy is to concentrate resources in the two District General Hospitals, Broadgreen and the RLH, where the pressure towards over occupancy is at its greatest!

Centralisation

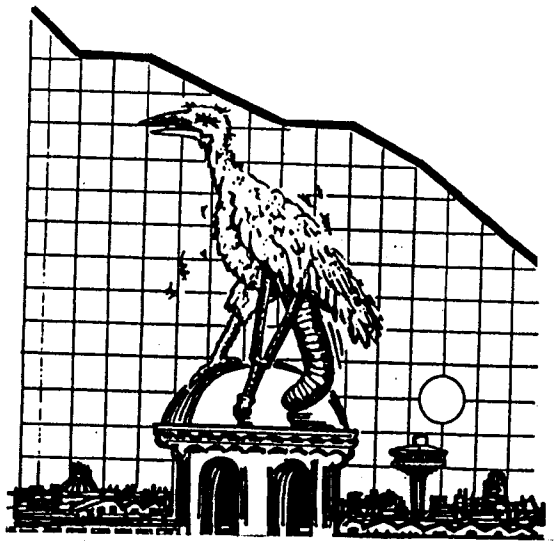
The centralising of resources in the two District General Hospitals raises broader issues of health policy. In the previous edition of the pamphlet we observed that "in the past, centralisation of services, in the RLH and elsewhere in the country, has often lead to more problems not less, to more expense in spite of less beds, and has not necessarily produced a better service." This is equally true today.

Apart from the more impersonal character of large hospitals for both staff and patients, it removes them even further from the communities in which people live. The major expansion for Broadgreen planned, could give Liverpool a second white elephant alongside the RLH. The criticism of other local hospitals — two of which are scheduled to close — that they are old, difficult to run, decaying and poorly designed for modern needs, could equally be applied to Broadgreen with its picturesque flying butresses! Indeed its present reputation as a more caring and friendly hospital than the Royal, could well be lost as the result of a badly conceived expansion programme.

If the health authority wants to make more efficient use of beds, it should look at the length of time many patients are required to stay in hospitals before and after operations. A range of operations now involve patients coming in days before they are due for surgery. They are also given general anaesthetic. In the past **and** in other areas, local anaesthetic and a shorter waiting time would be involved. But the authority appears prepared to leave such policy issues to the arbitrary decision of consultants, under the guise of 'clinical freedom'. The result is not just increased expenditure, but a greater strain on patients who could otherwise be at home.

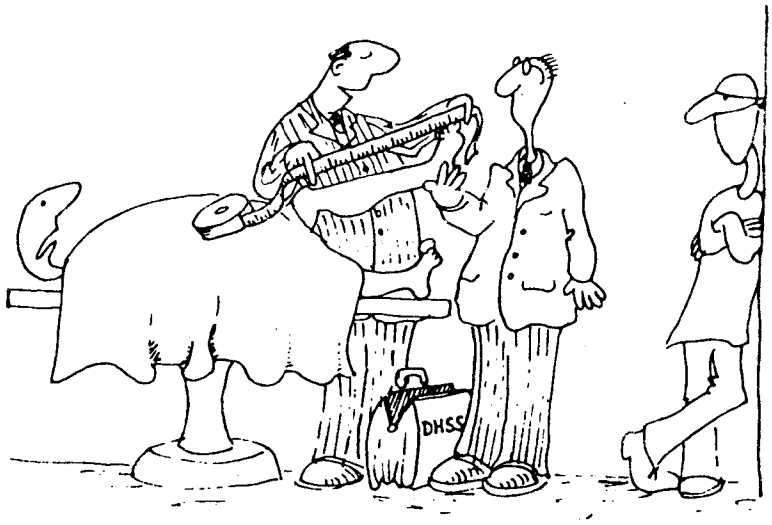
Why the Long Term Strategy should be Rejected

The underlying approach of both the Government and the Regional Health Authority in demanding a £5½ million cut should be rejected. The proposals submitted to achieve these cuts are misconceived and likely to lead to a serious deterioration in health services for local people. The Authority's argument that cuts can be made without services suffering is, as we have shown, untenable. One area of health care seriously affected is geriatrics. The elderly are to pay the price of government attacks on a free health service.



Another assumption of the Long Term Strategy is that an expansion in community services can compensate for cuts in the hospital sector. We are committed to a major shift of resources from the hospital sector to community care. But the Strategy contains no serious commitment or perspective for this to be achieved. The inevitable result if the Strategy is adopted will be a further decline in services to local people. It will also mean more people, mainly women, having to care for elderly or sick relatives at home, with little support.

All these concerned about health care in Liverpool should be pressing for rejection of the Strategy. We need a campaign for increased resources from the Government and the Region. We also need a new approach to health care in the city. It is not enough to simply 'oppose cuts' and defend existing provision. We need to develop alternatives as part of our campaigning. It is with this aspect that the final section of this pamphlet is concerned.



I think we can confidently recommend a 5% cutback.

18) CUTS MARK 2

Even as the District is considering the implementation of the Long Term Strategy, further cuts are taking place. The Government is demanding a 1% cut in every Health Authority's revenue. As a result, Liverpool has been faced with a demand to cut £2¼ million over the next two years. This is being forced through at a lightning pace.

At a special meeting in September, the District Health Authority began to implement the cuts. These came in two annual packages. For the first round 1983/84, the District Management Team suggested two alternative areas for cuts. The first of these — a reduction in posts of 400 — was deemed unwise because of potential trade union opposition. The second which was adopted, involved cancelling major maintenance and improvement programmes and delaying or cancelling various capital projects.

It was argued that this was acceptable because it "would not affect patient care". However if the object of the exercise was to save money the package was peculiarly misconceived. While short term savings may be found the long term result is likely to be incresed costs! Measures such as the energy conservation programme (effectively scrapped) or urgent building maintenance are likely to save money in the future.

The plans for 1984/85 have a more stark effect on health care, with cuts in beds, staff and facilities. The package involved:

- Closing and selling off the Robert Davies Nurses Home
- Reducing headquarters, ancillary (catering and switchboard), technical and medical staff
- Women's Hospital — temporary closure of a ward (waiting list of 490)
- Alder Hey — reduction of cleft palate and plastic surgery services and closure of a 24 bed, paedeatric (orthopaedic) ward (waiting list of 75)
- Newsham General — closure of a ten bed geriatric ward for female, long stay patients and temporary closure of a 16 bed orthopaedic ward
- St Pauls Eye Hospital — closure of an 11 bed adult ward (waiting list of 275)

Moves to close a 6 bed ward at Sir Alfred Jones Memorial Hospital (Garston) were referred back for further consideration. Also a move to impose a total freeze on vacant posts was resisted. The word 'temporary' in front of closure is used flexibly. The virtue of temporary closures for the authority is that these wards can be closed rapidly, bypassing the lengthy consultation process involved in permanent closures.

In fact many are unlikely to re-open. Part of the package involves speeding up the introduction of the Long Term Strategy, for example the cuts at Newsham General. The overall effect is to continue the process of gradually dismantling the NHS.

Despite arguments from councillors, trade unionists and

CHC representatives the Authority has endorsed the cuts package. While it expressed "great reluctance, dismay and regret at the necessity of making reductions" it has nevertheless made them. On a few issues, mainly relating to ward closures and cuts in medical services, some medical members of the authority voted with the City Council and trade union representatives against the District Management Team. But the overall package was agreed.

It was very clear that most authority members found the presence of members of the public extremely uncomfortable. Indeed agendas seem to be prepared to deal with controversial items at times when few are likely to be present. This makes even more important the task of gaining the maximum publicity and protests against the cuts so that the members of the authority are faced with both public anger and a challenge to their decisions.

CUTS MARK 3 ...

On top of the revenue cuts have come demands from the Government to reduce staff. Mersey Region is being asked to cut staff by over 500. Throughout the recent round of cuts both the Mersey Region and the Liverpool District Health Authorities have failed to make even token protests against the Government's plans. Mersey is the only Region not to have publicly protested against the latest round of cuts. One result is that while other Regions have forced the Government to revise its demands, Mersey Region is still facing the same problem.

19) CONCLUSION: WHAT KIND OF HEALTH SERVICE?

It would be neither possible or desirable for us to try and conclude with an alternative blueprint for health services in Liverpool. We have tried to raise a number of issues in health care. We have put forward some concrete alternatives. We indicate some directions to aim at.

A central theme of this pamphlet is that health care is not just an issue for professionals, administrators or politicians, but for everyone. For just that reason we do not claim to possess a set of definitive answers. However it is necessary to point to some key issues, a general direction to move in and how we could go about achieving change.

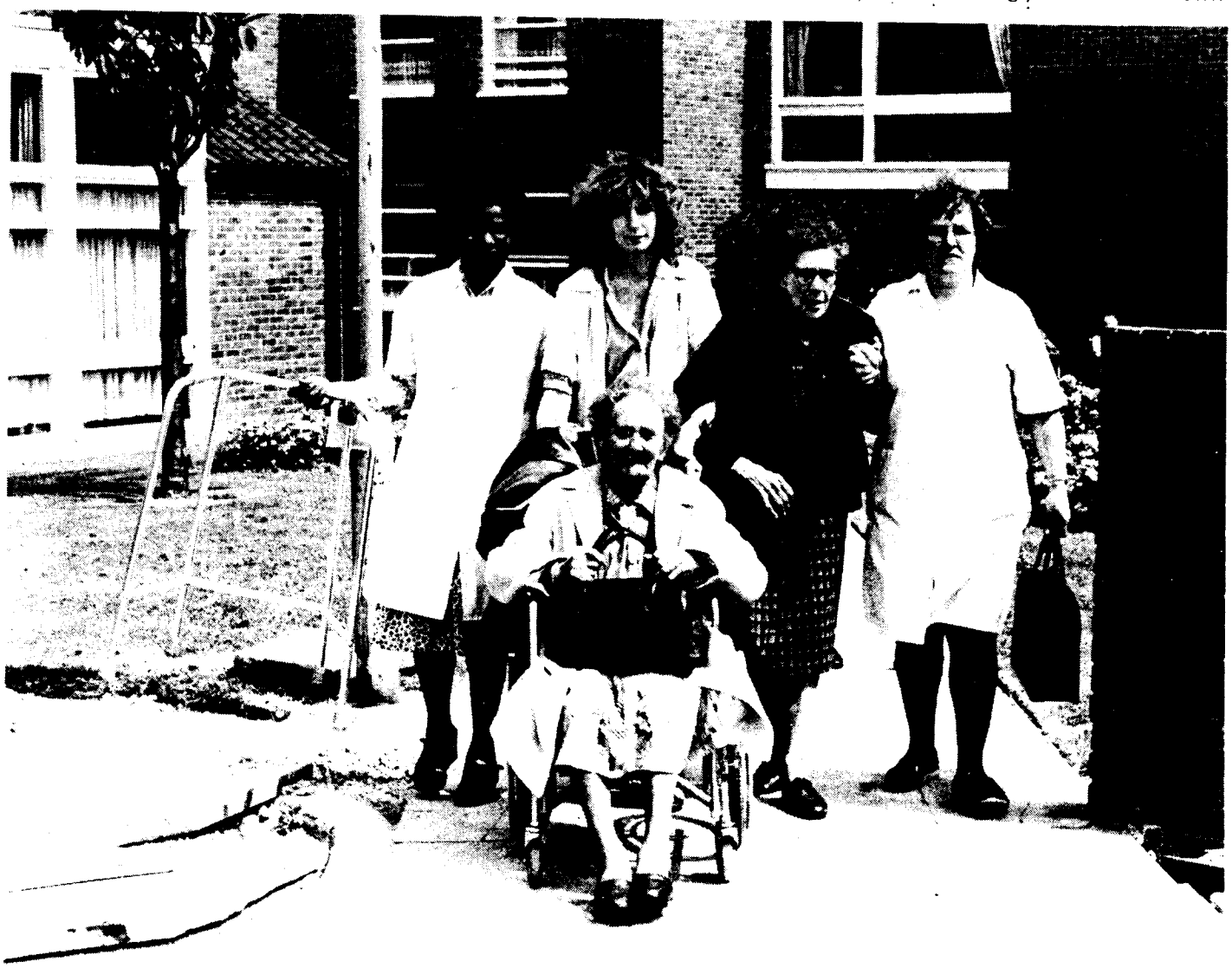
Problems and Possibilities

There are a number of areas of health care where problems are emerging and struggles being fought which are central to the future direction of the health service. The list below is not intended to be exhaustive.

Health Care for the Elderly
Geriatric care is assuming a central position in debates about the health service. The growth in demand for services from the elderly raises questions both of overall funding and of the balance between hospital care and community care. It challenges the notion that resources for the NHS can be planned simply on the basis of financial imperatives. If a growing need exists for certain kinds of service this has to be recognised, accepted and planned for, it should not be relegated to the status of a fiscal problem.

This is not just an abstract question but affects here and now the lives of millions of people and immediate plans for Liverpool's health service. Equally important it forces us to think of health care as concerned with promoting good health, not simply 'treating illness.' The writers are aware that we are hopefully the elderly of the future.

Women's Health
In this area more than any other, the consumers have begun to challenge the 'prerogatives' of the medical profession. Women have increasingly asserted their own



demands and needs as the basis for health care. Many of the struggles which are now underway, offer a model for opening up the health service as a whole to the consumers.

Privatisation
The present Government is clearly committed to a major shift away from a public health service, free at the time of need. This needs confronting at a number of levels. A major task is to challenge all elements of private health care based on the profit motive. This includes private health insurance schemes, health charges, pay beds and the insidious grip of the drug industry.

The drug industry is especially important. It offers the chance to argue in favour of forms of public control and ownership, which are in the interests of patients' health and can save money. A range of opinion, well beyond the left and the labour movement can be won to support changes in areas such as prescribing practices.

However saving the NHS from Tory attempts to move us towards a US style system is unlikely to succeed if conducted solely on the basis of defending existing services. The undemocratic dominance of 'professional' elites in the NHS, creates many problems that affect ordinary people.

Professionalism and Democracy
Despite the avowedly public character of the NHS, the definitions of health care and the running of health services are still effectively in the hands of a small minority of elite professionals. Substantial changes in the character of health care will require major changes. These should undermine the dominance of doctors as an elite grouping, in particular, senior consultants, as well as open up the health service to wider democratic control.

Knowledge is power
Democratic structures are no guarantee that people will become involved in decisions about health care. People often lack the confidence to challenge what is seen as the superior knowledge of professionals. An important aspect of many community health schemes has been the way in which local people have gained the confidence to ask for information as a result they have acquired knowledge which gives them the confidence to challenge decisions.

This requires professionals with access to information, making their knowledge and skills available to local people. What is involved is a dual process of education. In this way local people can develop their understanding of health care and the ability to make decisions. The professionals can learn how to work collectively and gain some grasp of democratic ways of working.

Which Way for the NHS?

We can suggest five major directions for NHS:

1. To redefine health care as the promotion of good health rather than its narrow definition of coping with illness.
2. A major shift in resources from the hospital sector to community care.
3. Expansion and change in health education for both health workers and consumers. This should reflect the different view of health care expressed above. It should encourage popular understanding of and involvement in health issues.
4. The elimination of private profit from the health service, linked to the creation of a free, public service. Short term measures could include forcing doctors to prescribe from a limited list of drugs or offering a salaried GP service in inner cities. Long term measures would mean taking drug companies into public ownership or establishing a salaried service for all GPs.
5. Shifting control of the NHS from an elite minority to the people. This would mean creating democratically accountable health authorities.

Democracy - a Strategy

A number of ideas have been put forward to create a more democratic health service. Three main alternatives have emerged. The first has been put forward by the TUC and would mean keeping essentially the same structure of Regional and District Health Authorities. But the representation of trade unionists, health workers and local councils would be substantially increased. The second option is to have directly elected health authorities. The final alternative is that the health service should be bought under the control of local councils.

There are good arguments in favour of each of the positions. As an immediate step we support moves to increase representation of trade unions and local councils on health authorities. However this will not tackle the central problem which is to bring health under the control of ordinary people. The representation would still be at several stages removed even from trade union members.

There are very powerful arguments in favour of directly elected health authorities. However a number of objections can be made. One which we do not accept is that it would be open to domination by right wing elements on a populist tide, for example, anti-abortionists. One of the prices of democracy is that people often make decisions which you do not agree with. This is an uncomfortable fact of life, which the left, including some communists, often find as difficult to accept as the right. More to the point is the fact that equally good

arguments exist in relation to a range of public bodies or services, such as the police, housing and education. If we adopted the same principle throughout, we could end up with a vast plethora of organisations. The result could be that public interest and involvement in elections would diminish. Finally a health authority that is seperate from local councils would still face the problem of the division in responsibility for key community services.

This division in responsibility has proved a major obstacle to redirecting resources from the hospital sector to community care. For this reason we favour the third option of bringing health services into the orbit of responsibilities of local councils. This has the advantage of providing a framework for popular debate and control and of bridging the gap in responsibilities.

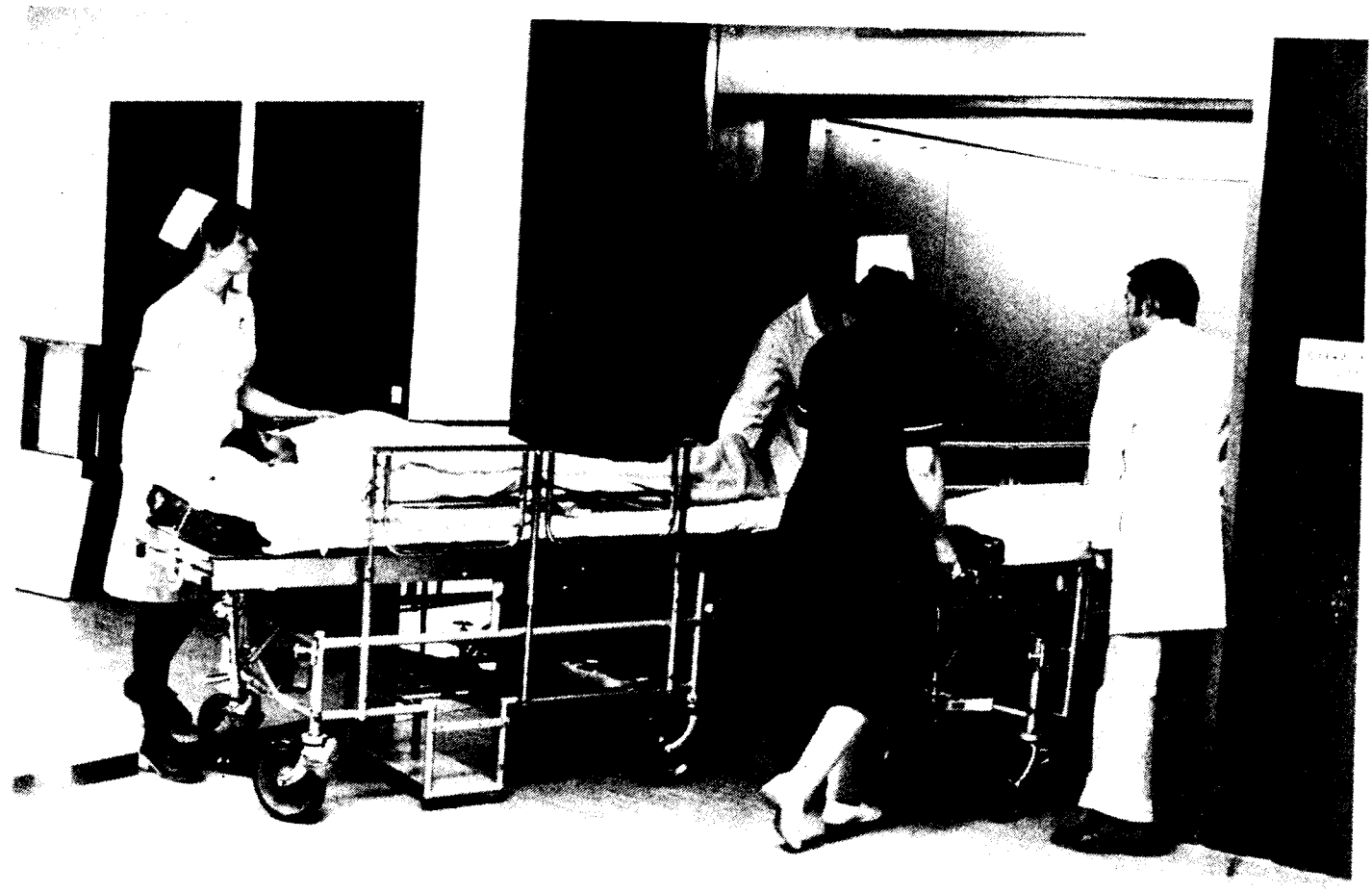
It would not be without problems. The mechanics of such a change would require considerable planning. More to the point, local councils are often a poor model of openness and accountability. But they do provide the opportunity for such a process.

Clearly the bodies directly responsible for running these new health districts should not be solely composed of councillors. It would be crucial to secure wide representation of patients' organisations and health workers. Indeed there would be a strong case for a built in majority of non-councillors on such bodies. This last proposal may seem anathema to the more conservative elements in local government. But it is already the practice in many councils' committees. Evidently the whole scheme requires considerably more debate and detailed consideration.

The Present

The politics of the present government mean that many of the ideas we have discussed are unlikely to come about in the immediate future. This does not mean that no effective advances can be secured now. On a number of ocassions in this pamphlet we have referred to gains which people have secured by working out their ideas, organising and pushing for them. Simply because the current health authorities are not of the form we would like does not mean we should refrain from pressing ideas and issues on them.

A key factor will be the degree to which we make the issue of health one on which people at large feel able to express opinions and become involved in discussion and action. The last ten years have seen a welcome growth in organisations embracing both health workers and the general public, campaigning for changes in the health service. These include the Socialist Health Association, Community Health Councils, health workers' trade unions, women's health groups and the various independent pressure groups which have emerged. These can all play a major role. We need to work for the maximum unity between these various forces. This should be on the basis of an equal relationship and to ensure that they themselves reach out to draw in wider sections of the population.



New flow of patients to occupied hospital

Morning Star Reporter

DOCTORS are beginning to admit patients again to the Hayes, West Middlesex cottage hospital which is being occupied by staff.

Hillingdon district health authority closed the hospital on Monday but it was still working normally yesterday and the 17 in-patients were receiving all the care and attention they needed.

Local support is also growing, including gifts of provisions. People passing the gate have been handing over pound notes for the fighting fund.

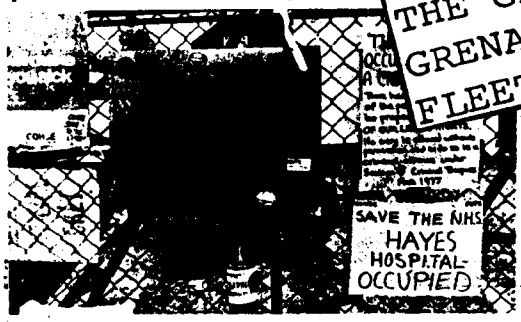
Some 25 nurses and 16 ancillary staff are keeping services going in the 32-bed hospital in which general practitioners treat their own patients.

A health authority administrator who tried to enter the hospital on Monday was refused admittance by pickets.

A delegation from the Charing Cross hospital where staff have been involved in a campaign against cuts was visiting the hospital yesterday and GLC leader Ken Livingstone was expected to visit to give his support.

The oc[illegible] cial backi[illegible] union NU[illegible] ers' unio[illegible] members a[illegible] action to [illegible] open.

Hospital staff maintain a picket against attempts to end their oc[illegible]

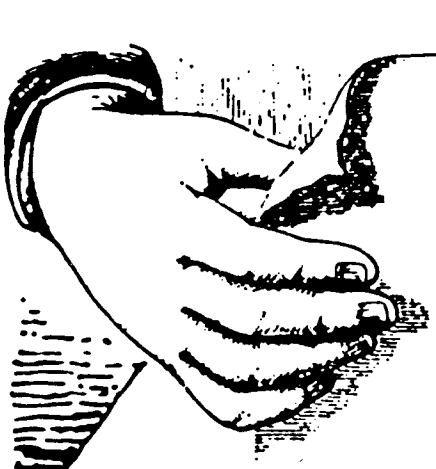


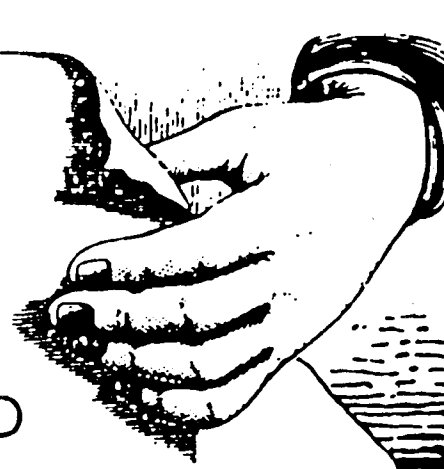
The high standard of care at the occupied Hayes cottage hospital is being maintained as usual for two of the older patients, Mrs. Dearing, 99, (far left) and Maud Ashley, 85, (also seated). With them yesterday was one of the ancillary workers fighting to keep the hospital open.

Hillingdon Health Emergency Campaign secretary Steve Clare told the Morning Star: "We are getting stronger and stronger and our support is growing among local residents.

"We have really had very good support from outside. Residents calling to give support to the pickets at the gate are leaving firewood for the brazier and sending in food for those in occupation."

Many donations are being placed in the collecting tin hanging on the gate (above).





LOOKING FOR SOMETHING TO DO AFTER FINISHING THIS PAMPHLET?

What will you do after reading this pamphlet? Take a cold bath to dampen down the shock of such a stimulating experience? Stay up all night waiting for Breakfast TV? Try to read Capital in a weekend?

Well! this offer is just for you. Work off your excitement by finding out more about the party that's working to put into practice the ideas expressed in here - the Communist Party

Send to

John Blevin
39, Shaw Street
Liverpool 6
Tel. 05I 207 0280

Gordon McLennan
I6, St John Street
London ECI
Tel. OI 25I 4406

I wish to join/wish to know more about The Communist Party/The Young Communist League.

Name _____

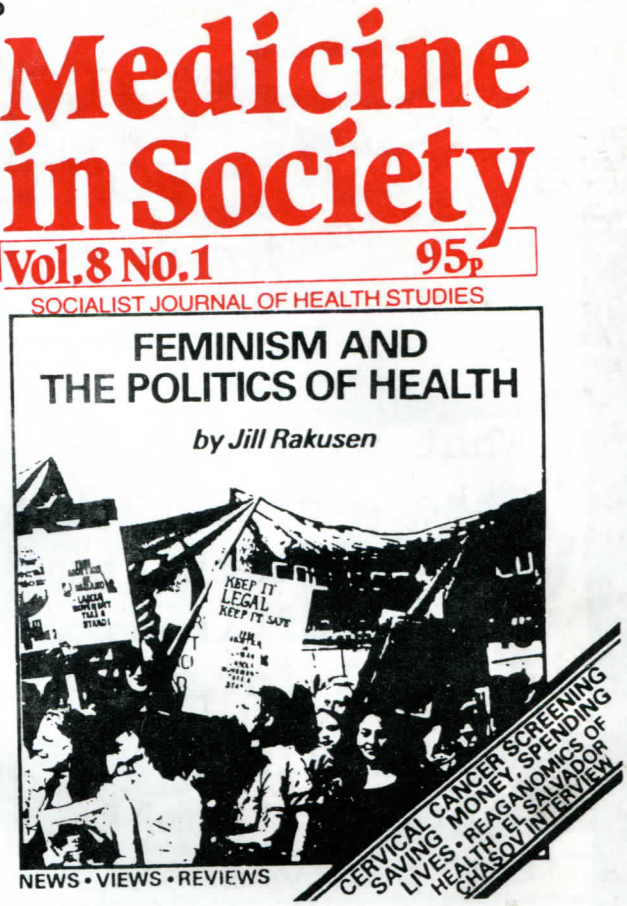
Address _____

_____ **Phone** _____

Typeset by Impact. Printed by Whitechapel Press. Cover Design by Pete Betts.

'It must be clear, however, to everybody in the Labour movement that we are not going to obtain from the National Health Service the best results possible except by the utmost vigilance on the part of the whole socialist, co-operative and trades union movement.'

Aneurin Bevan
Tribune
July 2nd 1948



Vigilance has been in short supply, and the "best results possible" have evaded the labour movement...but the politics of health are on the agenda again. The facts, arguments and analyses needed to understand the issues are available in MEDICINE IN SOCIETY, a socialist health journal for the labour movement.

WHY NOT SUBSCRIBE?

Subscriptions £5 from Periodicals Department, Central Books Ltd., I4, The Leathermarket, London SEI 3ER.

I wish to subscribe to Medicine In Society

NAME.....

ADDRESS.....

.....