Preparing for the wounds of war . . . without the NHS

Some MPs and doctors feel disquiet at billions of dollars being spent on developing American war hospitals in Britain, seemingly in secret, such as at Little Rissington, above, while cuts are being made in the NHS. Peter Davies looks at the background to this situation

WHILE British and American tanks churned through West Germany in Nato's 'Operation Lionheart' exercises in September, a 1,500 bed hospital in a quiet Cotswold village was playing a part too.

During four days it received more than 400 simulated casualties — all American — from seven cargo flights returning from Germany to RAF Fairford, escorted by three American B-52 bombers. Three hundred and fifty medical personnel, mostly from Wilford Hall, the United States Air Force's biggest medical

Simulated casualties . . . real hospitals

centre, at Lackland Air Force Base in San Antonio, Texas, had been flown to Britain to meet the casualties. This was 'Operation Cold Fire', the 'live air portion' of the Lionheart exercise.

The hospital is Little Rissington, the largest and first to be completed in a network of 14 'wartime contingency hospitals' built by United States forces on Ministry of Defence property in Britain. They are mostly swathed across southern England from the West Country to East Anglia.

The USAF has nine, at Bicester, Bordon, Feltwell, Kemble, Newton, Nocton Hall, Upwood, Waterbeach, and Little Rissington. The US Army has four, at Colerne, Cosford and Tidworth. The US Navy has one at Locking and a second earmarked for an unknown site.

Others are planned for Spain, Portugal, Turkey, Italy and Crete, but most are for the UK, where they will have a total of 8,000 beds, costing £300 million.

Official information about the wartime contingency hospitals has been scant and contradictory. Their implications for NHS civil defence planners remain undiscussed. When American Defense Department officials were asked at a Congressional sub-committee hearing why the hospitals were necessary, their reply was deleted from the record. But clearly the US Government feels that NHS resources are too meagre to cope with war.

When the sub-committee questioned the need for the US Navy's standby hospital 'requiring $5 million to $10 million in military construction', it was told: 'The Government of Great Britain is not capable of providing medical support for the numbers of estimated naval casualties which would be incurred in a European war. The UK can provide site preparation contractors and some non-medical maintenance workforce assistance.'

The sub-committee proceedings also record that: 'Host nations are being asked to provide support in the medical area. However, it has not been possible to achieve all that will be required to deliver even minimal wartime medical support to US Forces through Host Nation Support negotiations.'

Their verdict implies that the NHS could not cope even in the event of a conventional war. All the hospitals are designed for use in a non-nuclear conflict.

According to a USAF spokesman at Upper Heyford, the typical wartime contingency hospital will consist of three converted RAF aircraft hangars. One, with laboratory and diagnostic facilities will be used to sort casualties as they arrive. Another will be equipped with operating theatres for casualties needing surgery and intensive care. A third will provide intermediate care.

Most will be kitted with a standard 500-bed package, described by Lieutenant Colonel

Equipment . . . will not be used in peacetime

Douglas Kennett — of the USAF base at Mildenhall as 'a 1984 version of a M*A*S*H* hospital'. Once in place, the equipment will 'just stand there' and will not be used in peacetime.

Little Rissington will be the largest of them. It will have an 'aero-medical staging unit' in addition to the standard package. This will be used by special teams skilled in extricating casualties from aircraft, Lt Col Kennett explained.

Information on who maintains the hospitals in peacetime is contradictory. A

letter from Lt Col Kennett last November to residents of Little Rissington concerned about developments at the base said: 'Once the hospital sets are in position, they would be maintained and managed by a small cadre, most likely British civilians, who could make the facility ready for the arrival of medical personnel from the United States in a relatively short time period.'

A spokesman at Upper Heyford said that a 27-person team from the USAF hospital there looked after Little Rissington.

In the week of Operation Cold Fire, the 350-strong medical team from the USA arrived on the Tuesday and received their first 'patients' on the Friday. The spokesman explained that in the event of war, the 'game plan' was for the USAF to bring these personnel from Wilford Hall, Texas, to Little Rissington, while their place in the United States was taken by medical reservists.

At present, Little Rissington could treat 700 to 800, though only 190 of its 500 beds were used in the exercise. Wilford Hall personnel had reported that the exercise had gone better than expected, the spokesman said. All problems had been minor. Some staff had had difficulty with the British telephone system. In future they would provide more hand-held radios for doctors. And they would introduce standardised medical reports to cut down the time doctors spent writing patient evaluations.

Cheltenham health authority, in whose district Little Rissington lies, knew nothing of these manoeuvres. The deputy district medical officer Dr Charles Shaw had heard nothing about the exercise. 'It came as a surprise only a couple of months ago to learn that the hospital at Little Rissington was there,' he said. This is despite the fact that Dr Shaw is responsible for the authority's civil defence plans.

Government policy appears to be to play down the existence of the wartime contingency hospitals. Perhaps it fears that at a time when the NHS is coping with cuts, such lavish military provision is provocative. The policy is working. Few are aware that the hospitals are being built. During the European elections the Medical Campaign against Nuclear Weapons wrote to several candidates asking for their views on the subject. Those who replied had no knowledge of the hospitals. Further inquiries by Richard Balfe, elected MEP for London South Inner, were answered only skimpily by the Under Secretary of State for the Armed Forces, Lord Trefgarne. He said '. . . we have agreed to make available sites for the erection by the Americans, should they prove necessary, of prefabricated buildings and also some existing buildings surplus to our own requirements.'

An earlier inquiry by the campaign's chairman, Professor John Humphrey, to the then Home Office Minister, Douglas Hurd, received an equally perfunctory reply from a Ministry of Defence official.

Opposition defence spokesman Gavin Strang was told in Parliament last May that security forbade the naming of the hospital sites, though at that time details were freely available in the United States from the Congressional sub-committee proceedings.

The *Journal* was initially told by the USAF that 'no details were releasable' concerning wartime contingency hospitals, though later enquiries met a more forthcoming response.

Details of the cost of the hospitals project are among the information available in the United States. The eight USAF hospitals funded in fiscal year 1984 cost $66.3 million, the Navy's $29.9 million, and the army's $13 million. American suppliers will provide the equipment. There will be no cost to the British Government, according to Lord Trefgarne's letter, though the Congressional sub-committee was told: 'We have asked the UK for extensive medical support at all levels.'

Lt Col Kennett's letter says that: 'While the United States is funding these standby hospitals, they would be available to any NATO casualty, regardless of nationality.'

He goes on to describe the terms of the lease. 'The facility will remain for as long as your Government and Nato wish it to be there. I might also point out ancillary advantage to the facility. Should there ever be a major natural disaster requiring its use, we should stand ready to open it upon request from your Government.'

In the event of war, the USAF will bring medical personnel from Texas to the contingency hospital at Little Rissington.

Apparently the hospitals are not designed to withstand a nuclear attack. 'All the military strategists in Nato think it would be a conventional war,' Lt Col Kennett told the *Journal*. 'We are greatly outnumbered in conventional forces.'

The Department of Health's draft circular on civil defence in the NHS appears to take this line too. But it says: 'Even a limited conventional attack could conceivably produce damage to property and result in casualties on a scale which could put great strain on local hospital facilities.'

Its proposals to set up first aid posts and casualty collecting centres 'in selected premises offering the best available facilities' contrasts with the sophisticated network of wartime contingency hospitals for military personnel.

Dr Jeffrey Cundy of the Medical Campaign against Nuclear Weapons would prefer to see resources diverted into the NHS, rather than being spent on equipping hospitals just to leave them empty. 'A lot of doctors would say, why not just increase NHS facilities to the same degree,' he said. 'I feel that if there are hospital facilities in this country they ought to be used.' He suggests they could help reduce orthopaedic waiting lists, for example.

The USAF already uses NHS facilities to some extent. Personnel based at Fairford have been treated at Cirencester Memorial Hospital when their own limited facilities cannot help them.

The lack of information about the wartime contingency hospitals angers the Medical Campaign against Nuclear Weapons. Even Dr Stuart Horner was unaware of them, though he was a member of the British Medical Association's working party on the medical effects of nuclear war, and until recently chairman of its central committee for community medicine and community health, which was asked by the DHSS to comment on the draft circular.

The campaign also believes that the Cabinet has discussed the proposal that American military casualties would take priority over British civilians in NHS hospitals in time of war. The Department of Health denies knowledge of this, and it has not been communicated to health authority officers responsible for civil defence planning. But the draft circular contains some ominous hints: 'The DHSS is responsible for the allocation of casualties to NHS facilities and will advise health authorities of the reception arrangements.' And it adds: 'The district medical officer . . . might have to enforce strict priorities for the admission of casualties to limit the strain on hospital resources'.

Dr Horner was not aware of the supposed Cabinet discussions, but said: 'If the Government decides that the forces must take priority, it is a perfectly legitimate decision for the Government to take. I neither endorse nor condemn it. I would just say that the Government has a responsibility to see that people understand that it has taken that decision, and the reasons for it.'

The Medical Campaign against Nuclear Weapons has drafted a series of Parliamentary questions for MPs to elicit more information in the coming session. Until the Government comes clean, health authorities will have little incentive to draw up plans, based on incomplete information, and which they hope they will never need anyway. As Cheltenham's Charles Shaw comments: 'Many districts are so overwhelmed with planning for this year, next year, cost improvement schemes, manpower cuts, strategic plans, and operational programmes that they tend to put civil defence on a back burner anyway.' □