Sally Ruane (Leicestershire campaign)

Most of the reconfigurations so far have been either the closure of big hospital departments like A&E or maternity services or small units, and the centralisation of those services into fewer, bigger units. Or where services are transferred out of hospitals altogether and into community settings.

This will typically involve the loss of hundreds of hospital beds on the one hand, but more care being given at home on the other hand, at a time when social care itself is being cut.

This is often been presented to us as being driven by desire to achieve person-centred, integrated care. But it actually represents a shrinkage of the hospital sector at a time of growing need. It's often presented as locally driven. In fact it's going on all across the country.

In Leicester, we have been told that they want to close 427 beds. This represents 22% of our total bed capacity, at a time of demographic growth.

The evidence for this is somewhere between mixed and flimsy. There are ideological reasons behind reconfiguration. I am sure there are those in government who believe that a good state service crowds out diversifying providers.

Certainly it's easier to privatise services through reconfiguration. It's easier to privatise services when they are in the community rather than privatising an entire general hospital. It's also making it more likely that over time NHS beds will increasingly be supplemented by and replaced by beds provided in the private sector.

The driving factor for reconfiguration is finance. There simply isn't enough money coming into the local health economy. In fact we are a financially challenged health economy.

We are looking at the closure of over one-fifth of our acute beds because we can't afford to have them. In stark contrast to this, the Nuffield trust projects that between 2014 and 2022, England will need an additional 17,000 beds – yet across the country, beds are being closed.

OECD figures show the average number of beds per 1,000 population in developed countries is something like 4.8, whereas in the UK it is 3.8: we are not over-bedding our health economy.

The chronic under-funding of the service is one of the threads that's underpinning the issues discussed here. The Treasury is aware that while the NHS has been given 1% increase per year, actually the service needs 4% a year. The Treasury is aware of what the meaning of that 3% gap per year means.

The funding policy is deliberately being used to lever other policy changes in health service. It's being deliberately used to lever a shrinkage of the hospital sector and a general shrinkage of the health service and it is being used to provoke failure in the service.

The Trust Development Authority is now demanding that NHS trusts drive their staffing levels down, despite the fact that only a few years ago the Francis Report following Mid Staffs insisted that staffing levels should increase. Failure now almost seems to be a matter of policy.

The NHS and social care are both perfectly sustainable services. In an economy of about £1.7 trillion you only need a few extra billion every year to keep those going at the proper rate.

As campaigners we should be pushing the funding of our services up our campaign agenda, partly because funding is such a critical aspect of creating the crisis in the service in the first place but also because it is something that is relatively easy to explain to the public.