ENGLAND -THE NHS

"the National Health Service is a hotch potch of local and national interests, of old charity and modern welfare attitudes, of old professional habits and new patient's demands, all carried out without much overall knowledge of what is happening and why."

The National Health Service (NHS) employs over 1 million people and spends 12 billion pounds per annum. It is one of the cheapest (5% of gross national product, by comparison with 10% of GNP in the USA.) and the best medical service in the western world. Only 1/15 of people have private health insurance; the other 14/15 of people are completely reliant on the NHS.It provides UK citizens with the entire spectrum of medical care, from false teeth to heart transplants.

However, it provides these services in a way that discriminates against poor, working class, black and asian citizens. It is undemocratic, dominated by medical professionals and under the general influence of a high-tech, private profit ethos.

Over the past 20 years it has also been under attack from governments which have tried to curb its growth and cost, without any coherent attempt to equalise its coverage, set appropriate goals, make it democratic or reduce its dependance on private enterprise.

A QUICK HISTORY OF HEALTH AND MEDICAL SERVICES.

Between the 17th and 18th centuries, Britain changed from an agricultural economy to an industrial and trading empire. Vast numbers of people moved from the land to the mines, cities and facto-

ries. As the working class grew larger, it became politically organised. The Trades Unions and later the Labour Party, its parliamentary arm emerged. With increasing strength it won improvements in living conditions and health improved as a result.

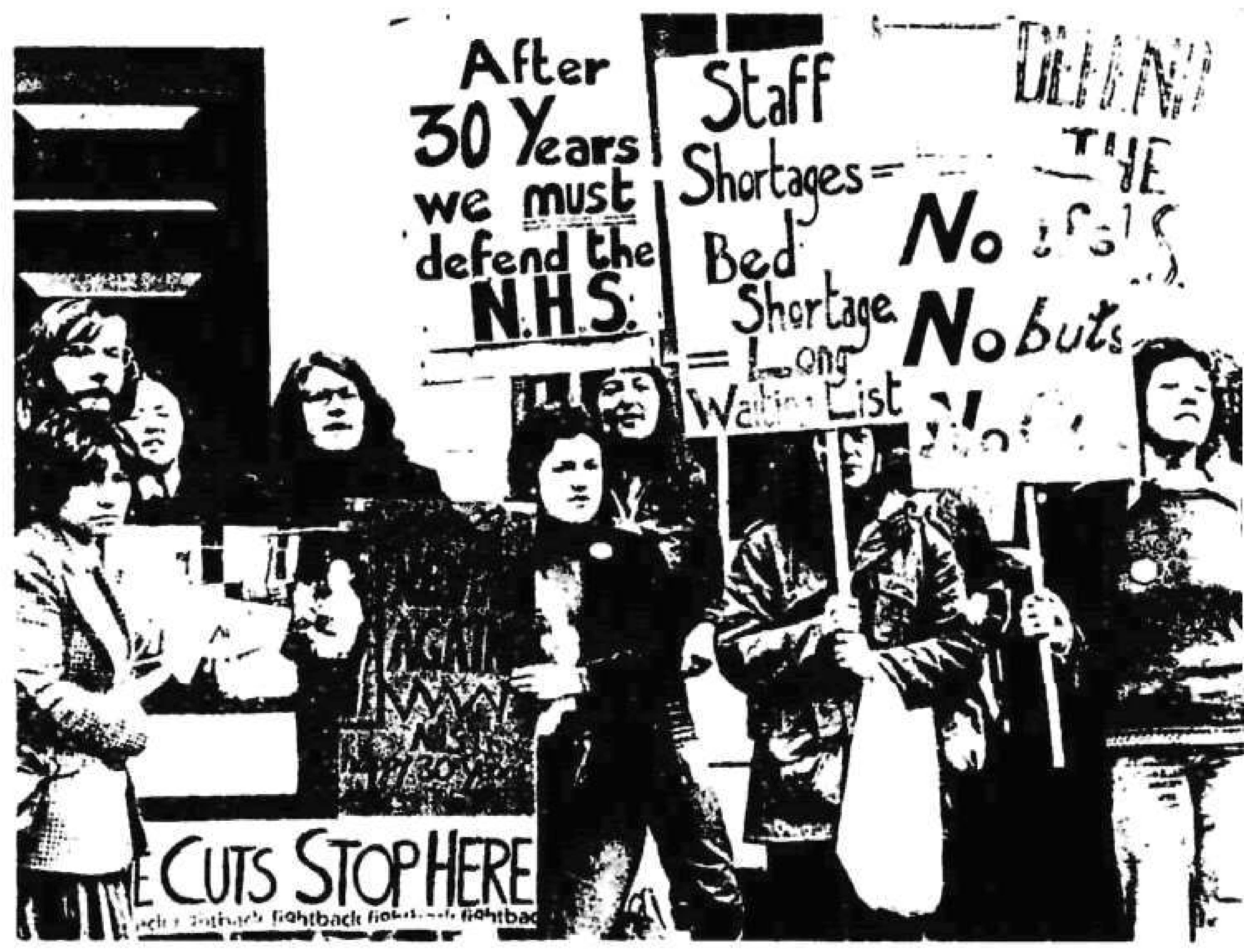
Britain was affected by several epidemics of plague and cholera, as well as endemic diseases such as scarlet fever, whooping cough, pneumonia and gastro-enteritis in children. Tuberculosis was the commonest killer of adults. All of these diseases hit the working class hardest, and the earliest interventions by the state in medical care and public health were aimed at preserving the rich from the diseases of the poor. Medical science had little to offer, and the early efforts were all sanitary. Improved water and sanitation together with rising wages, improved the health of the population substantially.

Between 1850 and 1911, medical understanding developed and with some delay was translated into medical services. The local authorities introduced a maternity and child welfare service with immunisation against several diseases like diptheria, and hospital or isolation facilities for venereal diseases, scarlet fever, smallpox and TB. Many of these advances were introduced under pressure from the Trades Union Council and organised womens' groups.

The state did not provide curative medical care, other than to declared paupers who subjected themselves to the humiliation of the Poor Law work-houses. This was the period during which the medical profession developed and organised itself into the British Medical Association. Its' higher status members, often specialists who developed their skills free consultants at the growing "charity" hospitals, saw to the needs of the rich , while the lower status general practitioner sold their services to anyone who could afford it.

Many working class people could not afford these services and under pressure from this group the state introduced the 1911 National Health Insurance Act. This used tax payers money to pay GP's to take care of workers who contributed to the fund. Although it did not cover the unemployed, the families of the workers or the lower middle class, it was a step forward, in that the insured had access to medical care when they neededit.

In many ways it was the rehearsal for the NHS, which was to be established after the second world war.Like the NHS it was established under pressure for reform and improved living conditions of the population. Like the NHS, it did not challenge the power or control that the medical profession had over the nature of medical care, and like the NHS, it did not come under control of the people it served. It was under control of the state and private enterprise in the form of the insurance companies, and to a lesser extent under the control of the medical profession.



During and after the First World War there were some serious conflicts between the working class and the poor on the one hand and the state and private enterprise on the other. With the Great Depression barely over, and the Second World War begun, it was clear to the government of the time that the population would not be wholeheartedly committed to fighting the war, unless they knew that life would improve substantially for them afterwards. In 1942 the Beveridge plan for a social welfare system for Britain was presented. It was based on a belief that every citizen has the right to a humane standard of living, which included free education, access to health care, housing and a source of income if there were no jobs. The National Health Service established in 1948,was described as the "the jewel in the crown" of the Labour Party government which took power after the war.

NHS Anatomy For Beginners.

The NHS provides medical services, and co-operates closely with local authorities in providing social welfare services. Broadly speaking, it has two parts; the hospital service and the community service.

The community service consists of general practitioners, dentists, pharmacists, optometrists and local authority services such as community nurses, child welfare clinics, a school health service, home domestic help services, social workers etc.

The GP's, pharmacists and optometrists are self employed and are not under the direction of the NHS. If the NHS wants them to do anything, it negotiates with the professional body concerned, offering inducements which are usually financial. It cannot simply issue instructions.

GP's do not charge a fee for their services, but are paid a fee by the state through their professional body according to the number of patients they have on their lists as well as for other services they provide.

Pharmacists, dentists and optometrists are paid by the state for certain services, but the patient is responsible for others. For example, optometrists test eyes at no charge to the patient, but there is a charge for spectacles, unless the patient is a pensioner, a child or very poor. The same applies to dentistry and pharmacists. Local authority services (equivalent to our municipal services) are free.

A hospital visit is free to the patient, and is paid directly out of taxes. There are about 400000 nurses who are salaried NHS staff, and 40000 doctors of whom about 1/4are qualified specialists or consultants. Several thousand of the consultants are part-time NHS staff, and are entitled to earn a portion of their income treating private patients. This is often in NHS hospitals, using NHS equipment and nurses, for the patients pay. This concession was the price the NHS paid in 1948 to win the consultants' support for the NHS.

The house officers and registrars are full time, salaried NHS staff.

This would seem to be an ideal system, however the NHS has been criticised from all sides. What follows is an analysis of some of the problems with the NHS.

SOME CRITICISMS OF THE NHS.

Patients' experience of the NHS.

These are likely but hypothetical scenarios.

Mrs. D,71, pensioner, widow of a bus driver needs a hip replacement because of severe arthritis. She

can't have one because she doesn't rank anywhere on the 7 year long waiting list in her Manchester District hospital, for this operation.

MED A 9

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births, Deaths and Marriages Regulations 1968)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths

Registrar to enter No. of Death Entry ....

Name of deceased NATIONAL HEALTH SERVICE

Date of death as stated to me 6 day of JUNE 19 83 Age as stated to me 35

Place of death UNITED KINGDOM

Last seen alive by me 26 day of JULY 19 48

1 The certified cause of death takes account of information obtained from post-mortem.
(2) Information from post-mortem may be available later.
3 Post-mortem not being held.

a Seen after death by me.
b Seen after death by another medical practitioner but not by me.
(c) Not seen after death by a medical practitioner.

CAUSE OF DEATH

These particulars not to be entered in death register. Approximate interval between onset and death

I
Disease or condition directly leading to death† (a) CONSERVATIVE GOVERNMENT
due to (or as a consequence of)
Antecedent causes. Morbid conditions, if any, giving rise to the above cause stating the underlying condition last. (b) A THOUSAND CUTS
due to (or as a consequence of)
(c) MONETARISM

II
Other significant conditions, contributing to the death, but not related to the disease or condition causing it. RACISM & SEXISM
MEDICAL DOMINANCE

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature POLITICS OF HEALTH GROUP Qualifications as registered by Medical Council NONE

Residence c/o BSSRS, 9 POLAND ST, LONDON W1 Date 12 & 13 NOV 1983

*Please ring appropriate digit and letter.
†This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc.; it means the disease, injury, or complication which caused death.

SEE BACK

Mr George P, 71, a retired banker, also needs a hip replacement for severe arthritis. He can have it done because he can afford private health insurance. It will be done by the same surgeon who would have operated on Mrs D had she have been on the hospital list.

Annie A is 19, unemployed and has one child which she did not want. In her area, the senior gynaecologist feels that working class women like herself are to blame if they don't understand their contraceptive well enough to prevent pregnancy. His department put very little money or staff into the abortion service therefor the waiting list was too long and Annie was not a priority on that list. She could not afford a private abortion and so she quietly becomes depressed in her flat on the 19th floor of a tower block in a bleak housing estate. When she sees her overworked GP, he prescribes tranquillisers.

William B was a 50 year old stevedore who died of cancer of the lung. He was a smoker, but his GP was too busy and never saw it as his job to motivate Mr B to stop smoking.Who is to blame? Mr B? His GP? The government which spent 1 million pounds a year on health education and let the cigarette company spend 80 million pounds on advertising ? Perhaps it was due to the asbestos he used to off-load at the docks.

If any of these people, rich or poor, was hit by a bus and needed emergency care, they would be assured of the best the NHS could offer. This is also true for people who have interesting diseases, as the academics in the hospitals would like to treat them.

In fact we find that the the NHS has inequalities in it that favour the rich, the services are inadequate, it is undemocratic and private health care is undermining the NHS.

Inequalities in the NHS.

There are about 25000 GP's in Britain and they are not evenly distributed to serve the entire population. As with all the services, the maldistribution is to the advantage of the middle and upper classes.

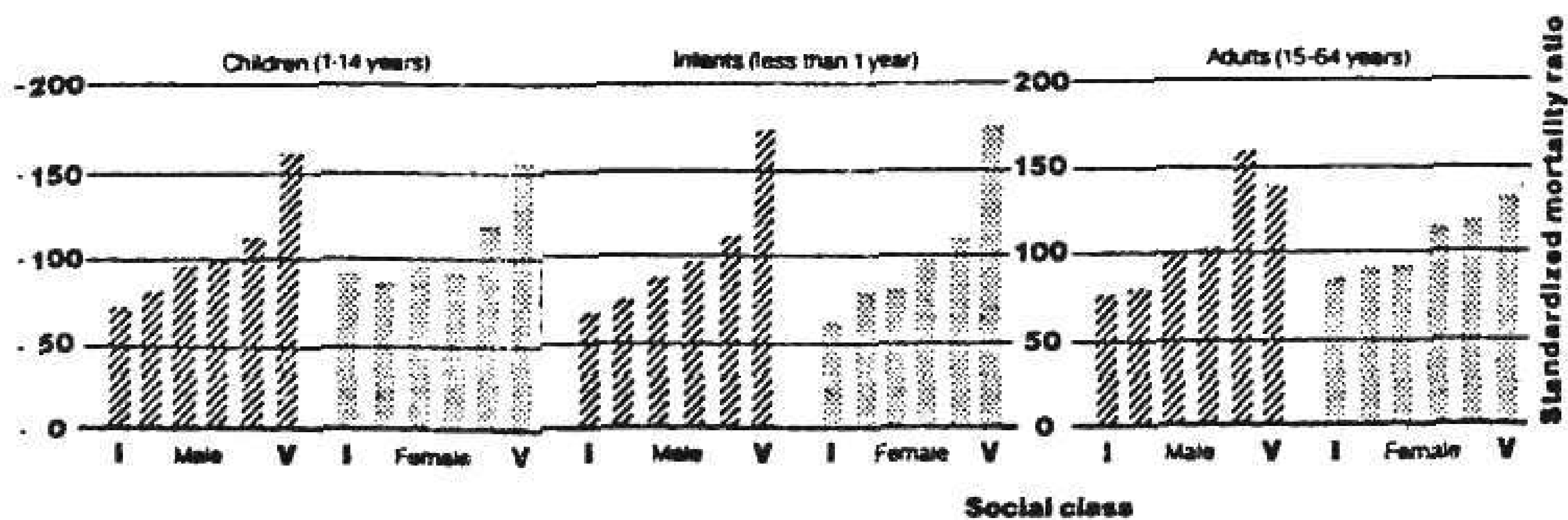
> In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas; and hospital doctors shoulder heavier case loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up as the Inverse Care Law: that the availability of good medical care tends to vary inversely with the need of the population served.
>
> J Tudor-Hart, Lancet 27.2.71.

Over the last 100 years the mortality rates for all age groups up to 55 have fallen by 90% with a substantial increase in life expectancy. This improvement has not been equal for all regions, race groups or classes. It has almost always improved less for the working class, the poor and the ethnic minorities.

> If you are an unskilled,low paid, manual worker (social class 5) - you are two and a half times more likely to die before you retire than if you are in the the professional and high income bracket (social class 1). The class inequalities in health have not been erased by thirty years of the NHS.

NHS-Condition Critical; Cis report no. 26

Below are some graphs which show that no matter your age if your are in a lower social class you are more likely to die younger.



Mortality by occupational class and age. Relative mortality (%) is the ratio of rates for the occupational class to the rate for all males (or females). (Source: Occupational Mortality 1970–72, *HMSO, 1978, p. 196)*

<u>Policies are inappropriate to the health needs of the people.</u>

There is no national process of setting goals for health services, allocating resources in order of priority, evaluating the result and making required modifications.

Instead the goals and functions of the NHS are influenced to different degrees by several distinct interest groups. These are; the medical profession, the state, private enterprise, private doctors and the people themselves.

<u>The medical profession.</u>

The medical profession has as its' goal the self interested development of the profession as a whole, in terms of skills, power and wealth. This is not surprising, since that is the goal of every organised group of workers. However it becomes pro-

blematic if the group concerned is the most most powerful determinant in setting national priorities, in this case health services.

The leading figures of the profession see its aim as the understanding and treatment of diseases, particularly interesting (rare) diseases by interesting (expensive, high technology) methods. Under the approving eye of private enterprise, and with the co-operation of the state, it has been the medical profession which has exerted most influence on spending and priorities in the NHS.

The State.

Contrary to popular belief Britain has low levels of social expenditure relative to other European countries. In 1977 Britain spent 123 pounds per person on health care, in France the annual expenditure per person was 280 pounds and in Sweden it was 450 pounds. (Black report HMSO 1980) This spending is being cut further in order to reduce taxation on the rich. It is argued that this will stimulate the private sector. Thus the economy is being managed in favour of big business.

State policy is thus to cut NHS costs in any way possible. This will obviously affect those sectors least able to resist; for eg. care for the aged and chronically ill, mental health services and small non teaching hospitals. Indeed it is just these kind of services that have been closed already.

Private Enterprise.

The goal of private enterprise is profit, achieved by selling more drugs and equipment and preferably more expensive drugs and equipment, irrespective of effectiveness and efficiency, to anyone who can be persuaded to buy them. In Britain this is the state, under direction of the medical profession, who are in turn under the influence of the companies selling the drugs and equipment in the first place.

Buying drugs accounts for 10% of NHS expenditure. It has been estimated that the drug companies alone make 300 million pounds profit from the NHS per year, and that 170 million pounds of this could be saved if the the NHS introduced generic (non brand name) prescribing. Instead the Department of Health and Social Security enter into secret negotiations with drug companies.

Private medical care.

The usual argument is that by permitting some private practise draws additional resources into the health sector for those who can afford private health insurance.

There are 3 problems with this argument. Firstly paying beds (private patients paying for beds in the NHS hospitals) are still subsidised by taxes. Furthermore nurses and doctors trained in the NHS work in the private sector yet the private sector does not carry any of the cost of training these personnel.

Secondly private medicine results in queue jumping which means that non private patients experience even further delays.

Thirdly and perhaps the most important consequence of the existence of private medicine is its indirect effect on policy making. As long as most politicians, medical professors and other influential members of society receive their health care from the private sector they will be unaware of the true conditions of the NHS and unmotivated to demand improvements in it.

The people.

The people are the least influential in influencing health in the disorganised state they are now in. Obviously there are many different interest groups and they have never spoken with one voice. Nevertheless, it was pressure from the people which

It's a RIP OFF

Did you know doctors who have private patients can make use of NHS facilities at cut-price rates?

Just look at the charges for a residential private patient who could have paid to jump the queue. In a general hospital in a non teaching district the charge is £91 a day. It may seem a lot for food and accommodation but not when you consider it is meant to cover the salaries of NHS staff looking after the patient, all treatment and any operating theatre costs.

Even in an NHS exclusive hospital - a London Postgraduate Teaching hospital - the charge is only £135 per day.

The daily charge is not adjusted to meet the full cost of the patient's treatment. The balance is met by the tax-payer - most of whom cannot afford private medicine.

Doctors treating non resident private patients get an even better deal. The charges vary according to what type of hospital provides the service. If a private patient goes to a general hospital in a non-teaching district, the charges are as follows:

Pathology: (Blood samples) - any number of tests on a single specimen	£5.00
Barium Meal: (for tracing stomach ailments)	£17.70
Radiotherapy: superficial treatment in any one day	£5.50
other treatment in any one day	£11.50
Physiotherapy and Remedial Gymnastics: for single treatment in any one day	£3.50

resulted in the formation of the NHS in the first place. It will have to be the same force which restores the NHS to its original principles of improved and equal health care for all.

The NHS needs more funding, control must be democratic with the people who use the service having control over it. The role of private medicine needs to be re-evaluated. At the same time however the re-orientation of the NHS from a mainly curative to a mainly preventative service needs to occur.