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Health and Health Policy

Gillian Pascall

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Introduction: health, society, and social policy

Health is very unequal in Britain, related to key variables such as gender and race, and deeply patterned in particular by social class. What lies behind these patterns of health and disease in society? It is widely assumed that the **National Health Service** (NHS) produces health, and that improving health is a result of improving medical care. But what impact does the National Health Service have on health? The chapter will start with a discussion of health, to examine its social features, and to underpin thinking about health services and the needs they may be thought to address. By contrast to these patterns of inequality in health, the NHS appears to offer a model of healthcare that is very egalitarian, offering care—broadly—on the basis of need rather than ability to pay, membership of scheme, or contribution record. Health policy in the UK rests on the National Health Service Act of 1946, the key parliamentary Act of the postwar Labour government. The NHS itself began in July 1948. Health debates even now revolve around the decisions made at that time (see Box 14.1). These were to provide

Box 14.1 The National Health Service 1948

Was set up to provide:

- a system of medical care to individuals;
- with ideals of comprehensive service covering all health needs;
- free at the point of use, paid for by general taxation;
- nationally owned and planned from the centre, through regional and local bodies;
- on a **universal** basis, equally to citizens.

Social, economic, and political change since 1948 has challenged all these ideas and ideals. After its review of health, the chapter will take each of the key policy decisions embedded in the 1946 National Health Service Act and ask how it has stood up to these changes. How fit is the NHS for the twenty-first century? And how does it compare with other systems of health provision?

Learning outcomes

This chapter will allow readers to:

1. outline the history of the NHS and the key principles that have informed its development;
2. describe the broad patterns of health and access to health care in Britain and inequalities involved;
3. outline a variety of theories that explain difference in health and health outcomes in Britain;
4. distinguish and evaluate the main issues and positions in current debates about the finance and management of the Health Service;
5. access key sources of information about the performance of the NHS.

Health and health inequalities

'Instead of exposures to toxic materials and mechanical dangers, we are discovering the toxicity of social circumstances and patterns of social organisation' (Wilkinson 1996: 23).

Why study health inequalities?

Why do health inequalities matter? Three reasons can be put forward for making these a priority in an understanding of health that is relevant to social policy:

1. The intrinsic significance of issues of life and death, health and disability, and how these are distributed in society.
2. Relationships of health with social variables—such as social class and race—give clear evidence of the significance of society, social science, and social policy to health: health does not belong wholly to medicine, however appropriate medicine might be to people who are ill.
3. A better understanding of the ways that health relates to social disadvantage may provide a basis for better policy. Perhaps the most promising strategy for improving the national health is to improve the health of the most disadvantaged.

What are the key social features of health?

Social class, gender, and ethnicity can all be related to people's experience of health, sickness, and disability. Powerful evidence of these inequalities has been collected in the UK. A government-commissioned report by Sir Douglas Black (DHSS 1980) was particularly influential in collating, analysing, and publicizing evidence of health inequalities. The Black report also stimulated new research that has subsequently elaborated the picture it drew of social class as a key determinant of people's life chances. More recently, another government-commissioned report, Sir Douglas Acheson's Independent Inquiry into Inequalities in Health, gathered and analysed the data anew, for a New Labour government, in 1998 (Acheson 1998).

Some measures of health have improved dramatically during the twentieth and twenty-first centuries. For example, life expectancy has increased from around 45 years for men and 49 years for women in 1901 to over 76 and 80 years respectively in 2003 (ONS 2002: chart 7.1, 2005: table 7.1). **Infant mortality rates** have declined too: the chances of surviving the first year of life have become much greater (Fig. 14.1). But people have not shared equally in this improvement. For example, life expectancy at birth for social class I, the 'professional' class, increased almost six years over the last quarter of the twentieth century, while the rise for social class V, 'unskilled manual workers', was less than two years. The gap between these two classes stood at almost ten years by the end of the century (ONS 2002: 120). There is a wide gap in infant mortality too, with the rate for social class V now double that for social class I (Department of Health 2002). These measures suggest that improving health over the population as a whole has been accompanied by widening differences between experience of health, life, and death in different social groups.

Very different sources of data, using very different concepts of health and inequality, show very similar pictures of social class differences in health, illness, and death. Table 14.1 shows

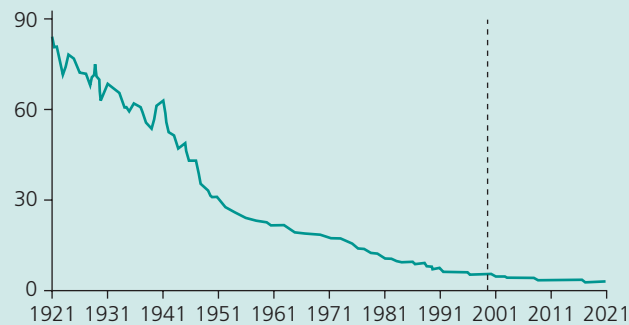


Figure 14.1 The decline in infant mortality, UK

Source: Office for National Statistics Social Trends 2005: p 98, fig. 7.5

the social class differences in **standardized mortality rates**, which are the measures generally used to compare death in different population groups. These show that for all causes of death, mortality rates for unskilled manual workers in 1991–3 were 806 per 100,000, compared with 280 for professional workers, around two and a half times higher. They also show—broadly—that each decrease in social class brings an increase in mortality: a social gradient that is widely found in data about health and inequality (Bartley 2004). The patterns are replicated across different diseases, with accidents, poisoning, and violence showing the sharpest differences between social classes. These figures also show the sharpening of differences between social classes over time, in every category of disease. A very different concept of health is found in data from the General Household Survey. This is a government-sponsored survey in which people are asked about their experience of long-standing illness and how much it limits their capacities in comparison with people of their own age. These data show men classified as routine manual reporting nearly twice as much limiting long-standing illness as men classified as higher managerial or professional or as large employers, with a similar pattern between women in different social classes (ONS 2005: table 7.4).

Gender differences in health and death can be shown too. But they are less marked than social class differences. Women tend to live longer than men: there is currently a four-year gap in life expectancy (ONS 2005: table 7.1). But women experience poorer health: longer life brings a heavy burden of chronic sickness and disability in later years, with 48 per cent of women of 75 and over experiencing limiting long-standing illness according to current General Household Survey data (ONS 2001: table 7.1).

Ethnic differences have been less well documented than class or gender differences. Health and mortality differences between ethnic minority and white groups are strongly connected with their experience in Britain. Differences in socio-economic status of different ethnic minority groups, rather than biological or cultural differences, are the key to their different experiences of health and death (ONS 1996).

Table 14.1 European standardized mortality rates, by social class, selected causes, men aged 20–64, England and Wales, selected years

All causes rates per 100,000				Lung cancer rates per 100,000			
Social class	Year			Social class	Year		
	1970–2	1979–83	1991–3		1970–2	1979–83	1991–3
I—Professional	500	373	280	I—Professional	41	26	17
II—Managerial & Technical	526	425	380	II—Managerial & Technical	52	39	24
III(N)—Skilled (non-manual)	637	522	426	III(N)—Skilled (non-manual)	63	47	34
III(M)—Skilled (manual)	683	580	493	III(M)—Skilled (manual)	90	72	54
IV—Partly skilled	721	639	492	IV—Partly skilled	93	76	52
V—Unskilled	897	910	806	V—Unskilled	109	108	82
England and Wales	624	549	419	England and Wales	73	60	39
Coronary heart disease rates per 100,000				Stroke rates per 100,000			
Social class	Year			Social class	Year		
	1970–2	1979–83	1991–3		1970–2	1979–83	1991–3
I—Professional	195	144	81	I—Professional	35	20	14
II—Managerial & Technical	197	168	92	II—Managerial & Technical	37	23	13
III(N)—Skilled (non-manual)	245	208	136	III(N)—Skilled (non-manual)	41	28	19
III(M)—Skilled (manual)	232	218	159	III(M)—Skilled (manual)	45	34	24
IV—Partly skilled	232	227	156	IV—Partly skilled	46	37	25
V—Unskilled	243	287	235	V—Unskilled	59	55	45
England and Wales	209	201	127	England and Wales	40	30	20
Accidents, poisoning, violence rates per 100,000				Suicide and undetermined injury rates per 100,000			
Social class	Year			Social class	Year		
	1970–2	1979–83	1991–3		1970–2	1979–83	1991–3
I—Professional	23	17	13	I—Professional	16	16	13
II—Managerial & Technical	25	20	13	II—Managerial & Technical	13	15	14
III(N)—Skilled (non-manual)	25	21	17	III(N)—Skilled (non-manual)	17	18	20
III(M)—Skilled (manual)	34	27	24	III(M)—Skilled (manual)	12	16	21
IV—Partly skilled	39	35	24	IV—Partly skilled	18	23	23
V—Unskilled	67	63	52	V—Unskilled	32	44	47
England and Wales	34	28	22	England and Wales	15	20	22

Note: Social Class I Professional (doctors, lawyers) II Managerial and technical/intermediate (nurses, teachers), III Non-manual skilled (clerks, cashiers), III Manual skilled (carpenters, cooks), IV Partly skilled (guards, farm workers), V Unskilled (building labourers, cleaners).

Source: Acheson (1998) Independent Inquiry into Inequalities in Health Report Tables 1 and 2.

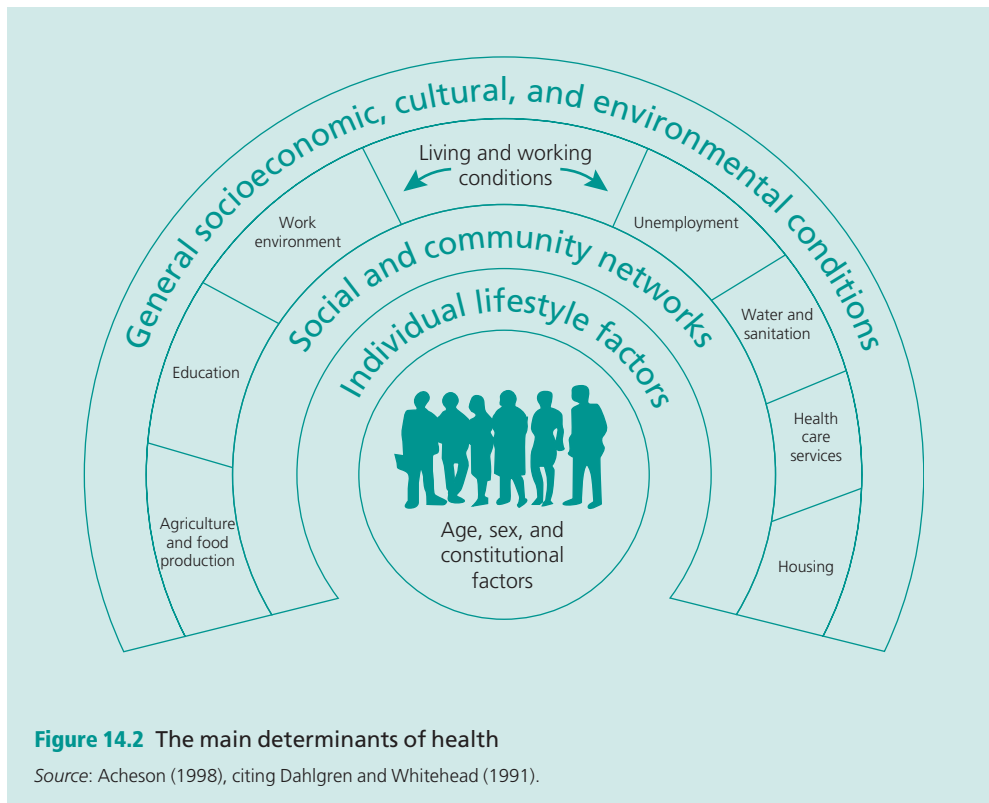
Social class does not encapsulate all variations in health. There are differences between men and women, between different ethnic groups, and even between areas—the **north-south divide**—which cannot be wholly understood in terms of class. But social class is a strong component of health variations. This can be illustrated by thinking about the relationships between class, gender, and race. For example, married women's health varies according to their partners' occupations. Despite all the changes in work and family, women's lifetime earnings are about half men's, on average. Their living standards are still determined more by their partner—or lack of one—and by the household income rather than their individual earnings: women's health is thus clearly patterned by social class. Ethnic minorities' health fits socio-economic patterns, with those highest in socio-economic terms—Chinese and African-Asian—having the best health experience, and poorer groups—Pakistani, Bangladeshi, Caribbean—having the worst experience of health. Social class is the most powerful predictor of health.

The environmental movement has made us more aware of man-made risks, produced by nuclear energy, pesticides, genetically modified food. Such risks may appear to threaten us all. Do these developing environmental threats change the traditional relationship between poverty, ill health, and early death, making us equally vulnerable? The evidence offered so far suggests not. Patterns of inequality associated with social class are persistent, even increasing. The Department of Health is targeting health inequality, and measuring progress since 1997–9. It recently admitted no progress on its chosen health inequality measures—infant mortality and life expectancy—rather that the gaps between social classes were still widening up to 2004 (Department of Health 2005: 8–9).

How can health inequalities best be explained?

It is easy to think of reasons for social inequalities in health: perhaps people have different patterns of smoking, eating, exercise, and these lead to social class differences? Perhaps health services are unequally distributed? Perhaps the tobacco companies are too free to sell damaging products? Perhaps unemployment or low benefits are the problem? It is much easier to propose theories than to decide which theories offer the most powerful explanation. And explanation is a crucial foundation for understanding policy and the failure of policy.

Mapping factors that affect health—and may produce health inequalities—is a first step to unravelling a complex picture. Figure 14.2 offers a useful aid to figuring out how different factors may fit into the picture. It fits individuals into their social and environmental context. In this figure, individuals—with their age, sex, and genetic makeup—are in the centre of the picture. A **biomedical model** of health and disease starts in the middle, with understanding disease processes in individuals. But individuals affect their own health by their lifestyle choices: asking why disease processes start might lead us to behavioural factors such as smoking and food choices. Asking why people smoke or eat unhealthy food might lead us to social and community influences. Asking why some social groups are more likely to smoke or eat unhealthily might lead us to ask about their living and working conditions. But what lies behind living and working conditions? Wider economic and political factors, such as national government policies on benefits and asylum seekers, tobacco companies and markets, international agencies such as the World Bank and International Monetary Fund, are important in the distribution of resources that are significant to health.



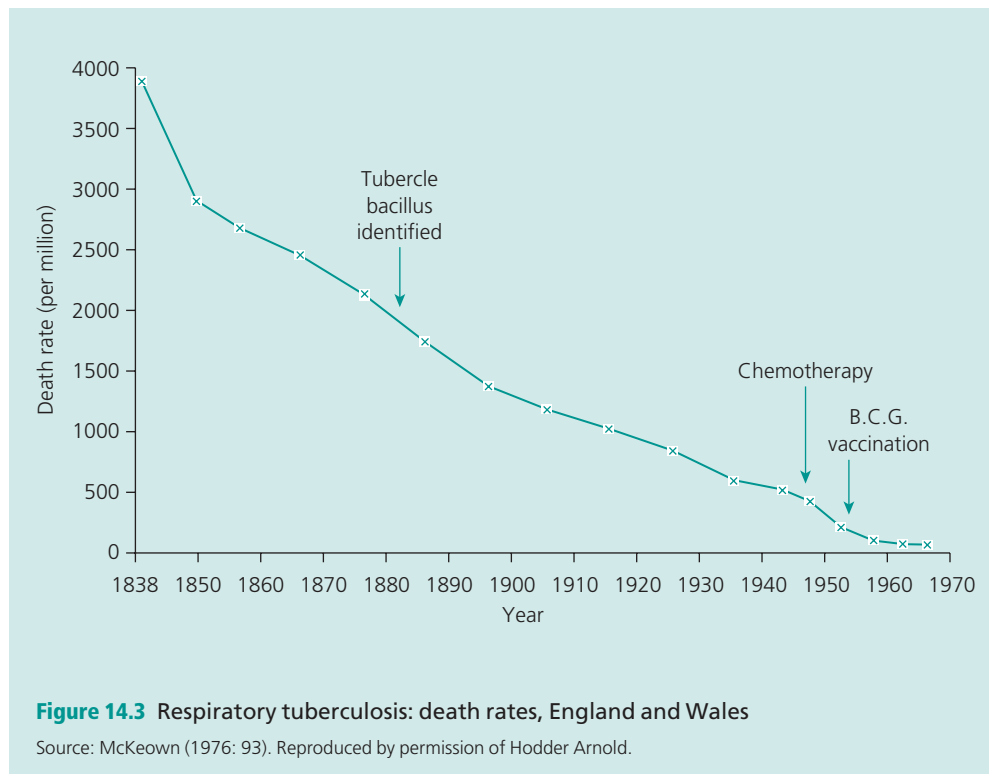
The growing body of research has provided answers to some questions, but has also raised new ones. Mel Bartley classifies current theories explaining the relationship between social inequality and health into five broad categories. First is the material explanation: individual income affects diet, housing quality, exposure to pollution, and work hazards. Second is the cultural/behavioural explanation, with differences in norms, beliefs, and values bringing different patterns of diet, smoking, and drinking. Third, the psycho-social explanation proposes that differences in status, control, and social support at work or at home impact on physical health. Fourth, a life-course explanation proposes that health and social circumstances may affect each other over the lifespan: events in crucial periods before birth and in early childhood affect people's ability to maintain health. Finally, a political economy explanation focuses on political processes and the distribution of power, which affect provision of services, the quality of the environment, and social relationships (Bartley 2004: 16).

Four of the most important questions to arise out of the debates and research on health and health inequalities are addressed below. The first question is about the relationship between health and medical care. How important is unequal access to medical care and health services in explaining differences in health? But more debates in the health literature are about how much people can choose better health by improving their lifestyles or whether health is largely determined by social and economic circumstances. Could we all equally improve our

life chances by following health advice about smoking, exercise, and diet? How much are the choices and health of people in poorer social circumstances constrained by factors over which they have no control? A third set of questions in this next section is about the routes through which social inequality affects health: should we see these as primarily material or as psychosocial, mediated through people's experience of relative deprivation? Finally are questions about policy, about the policies of UK governments and other national governments, and about what approaches to health and health inequalities may work best to improve health and reduce health inequalities.

Medical care and health First, how important is access to medical care in determining health? McKeown's thesis is a focus for debates here (McKeown 1976). McKeown argued that the biggest improvements in health in the UK took place before there were effective medical interventions to address them. He investigated population data from the beginning of the registration of deaths in the 1830s, and examined the trends for the various causes of death that contributed to the major trend of declining mortality over the nineteenth century. The example of TB is given in Fig. 14.3.

The graph suggests that TB was already in decline when records started to be collected, and shows a great reduction in deaths during the nineteenth and twentieth centuries, when no effective medical or public health interventions were available. The first scientific understanding of TB came with the identification of the tubercle bacillus in 1882. Effective drug



treatment came in the 1940s, and BCG vaccination in the 1950s. Thus, medical treatment and prevention have come rather late to give assistance to a trend that was already well established. McKeown showed that this pattern was replicated for most of the key diseases, and argued that improving health had more to do with improving nutrition and living standards than with medical interventions. McKeown may have understated the importance of public health measures in the nation's improving health—measures such as improving water supply and sanitation which were brought to Britain by the nineteenth-century public health movements (these debates are discussed in more detail in Gray 2001b: 123–130). We cannot read directly from this account of medicine in the nineteenth and twentieth centuries to the uses of medicine in the twenty-first. But these debates suggest that we should not take the importance of medicine to health for granted.

Access to medical care in the UK has not been entirely equalized, despite the NHS aim of delivering care in relation to need rather than ability to pay (Department of Health 1980). Access is more equal than in the more market-oriented service in the US—no payment at the time of use, free prescriptions for lower-income groups—and the more obvious obstacles to equal treatment are thus removed. There are less obvious obstacles—the cost of journeys and time off work. But if equal medical care could produce equal health we might expect to see greater equality of health in the UK than the statistics (Table 14.1) show at present. We might also see more differences between different diseases. The same patterns of inequality show for cancer, heart disease, and accidents: these suggest that something—perhaps to do with living conditions or social inequality—lies behind the medical situation of people dying from these diseases.

These debates suggest that medicine should take its place as one among many factors that influence health and survival.

Individual behaviour v. social circumstances? Figure 14.2 may help us to make sense of a complex set of factors and explanations and how they may fit together. But how can we assess the importance of individual behaviour and how do individual choices relate to social circumstances? There is evidence for the impact of individual behaviour on health, and on inequalities in health. The clearest example is smoking, which brings risks of heart disease and cancer and is related to social circumstances, with people in poorer circumstances more likely to smoke. Exercise and healthy eating are also related to socioeconomic patterns, with better-off people more likely to do regular exercise and to eat a diet rich in fibre, fruit, and vegetables that conforms to the government's health advice.

Should we blame poor people's health on their smoking and food choices? If so, how much of the blame for health inequalities lies here? The Whitehall study has been tracking 18,000 government employees in London—from top civil servants to caretakers and other manual workers—since 1967. It offers evidence that smoking plays a part in differences between people in different positions. But it also shows that smoking and other known risk factors can only account for a third of the difference in mortality between the highest and lowest grades (a more detailed account of this study and other studies on the explanation of health inequalities is given in Gray 2001a: 240).

Have poorer people not understood the official messages? There is research on people's knowledge of health advice. But studies have failed to show major differences in knowledge

about food between different socio-economic groups. They do indicate that poor mothers have as much desire as better-off ones for healthy food for their children.

And why have better-off people responded more and more quickly to health warnings? One key to these differences lies in the social context. People cannot make choices that are wholly divorced from their environment. There are many obvious material constraints on choices when people live in poor environments. Budgeting studies showing the difficulty of affording healthy food are reviewed by Spencer: 'Far from being able to afford a healthy diet, many members of low income families frequently go without any food, healthy or unhealthy. Children are less likely to go without food because they are protected by their mothers, but . . . 10 per cent of children said they had gone hungry in the preceding month because of lack of money' (Spencer 1996: 156). Access to fresh food may be improving for those with cars, but car-based out-of-town shopping diminishes access for those who have to add bus fares to the price of food. Food choice may be hampered by the inability to risk waste. Low incomes may also lead to disconnections of essential services of water, gas, and electricity, especially since privatization, making people vulnerable to cold, respiratory infections, and gastro-intestinal infections. Damp housing, poor heating/insulation, traffic pollution, and unsafe play spaces for children are among the problems people face trying to make a healthy environment for their children on low incomes. These add up to formidable material limitations which are the social and economic context for people's health choices. Higher incomes bring the choice of housing, avoiding many kinds of environmental threat: traffic pollution, nuclear power stations, electricity pylons, and agricultural chemicals.

A major study of health and social circumstances aimed to compare the impact of healthy living behaviours—lifestyles over which people have some control—and social circumstances, over which they do not. Generally social circumstances were found to be more powerful explanations than personal behaviours. But the study also found differences in what different social groups could achieve by healthy living. People in good social circumstances could improve their health by exercise, non-smoking, good diet. But people in poor social circumstances who made healthy choices did not gain as much benefit. There was a lower return from healthy choices, with health overwhelmed by factors they could not control. These findings may help to explain why poorer people are less likely to make healthy choices. If there is less health gain to be had from giving up smoking while living in a polluted area, then the rational choice may be to make less effort (Blaxter 1990).

Psycho-social v. material explanations Material limitations have been a dominant part of accounts of health inequalities in Britain, seen especially by the Black report as the key explanation for unequal health. But Wilkinson argues that in developed societies such as Britain and the US, increasing living standards have not increased health: material needs have been met, even for those in relative deprivation. But income relative to others marks social status and position in society: the damage lies in unequal access to society more than in unequal access to material resources. It is social circumstances that are toxic, rather than material ones. The damage of social exclusion creates psychological damage; smoking, alcohol, drugs may be used as a—damaging—refuge from social stress. Exclusion from choice in a consumer society is damaging to self-esteem. Comparisons with other societies, and between different states in the US, suggest that more equal societies and areas have lower death rates. If it is equality

that makes the difference, then it will not be enough to wait for economic growth to improve the material circumstances of people in poverty: we would need to redistribute resources, not simply lift socio-economic levels for everyone (Wilkinson 1996, 2005). In response, other researchers stress the continuing importance of objective material factors in understanding health inequality in Britain and other developed societies: people with lower incomes have to choose between social and consumer spending, healthy diet and healthy accommodation (Bartley 2004).

Policies for health and to reduce health inequalities Approaches to understanding health and health inequalities are clearly connected to approaches to policy. From the middle of the twentieth century, UK governments have tended to adopt strategies that first emphasize the distribution of medical care and second persuade people to adopt healthy lifestyles. So the NHS was developed in the 1940s to give everyone access to treatment when they became sick. When ministers of health argued for preventing ill health, they published *Prevention and Health: Everybody's Business* (DHSS 1976), stressing people's ability to look after themselves rather than the conditions that might damage health and make healthy living difficult. Research at the end of the twentieth century found that advice about healthy living tended to increase health inequalities: it was more readily adopted by advantaged people than by disadvantaged. These studies preferred policies to improve the conditions under which people lived, which would improve health directly and materially and would also make it easier to adopt healthy lifestyles and to lower psychological stress. The recommendations from this literature were, for example, for changes in housing policy to produce quality social housing and reduce homelessness, raising child benefits, and control over tobacco advertising and sponsorship (Benzeval et al. 1995; Acheson 1998).

Current UK government policy is for: 'striking a new balance . . . a **third way** . . . linking individual and wider action' (Department of Health 1999). The emphasis on individuals improving their own health remains, but governments now acknowledge the difficulties arising from poverty, poor housing, pollution, low educational standards, unemployment, and low pay, as well as the link between health inequality and social inequality. Policies across this wide agenda have in practice been uneven, but increased child benefits and child tax credits are among the most significant policy developments aimed at reducing poverty, social inequality, and the roots of health inequality.

What is to be learnt from comparison with other countries? There is a strong relationship between health measures such as infant mortality and socio-economic development. In general, poverty goes with high infant mortality rates (IMRs), which are the number of infant deaths during the first year of life for every 1,000 births. In 1998, industrialized countries had an average IMR of six deaths per 1,000 births, while low-income countries had an average of 80 deaths. But there are poor countries with good records as well as rich countries with poor records. Evidence from those poorer countries that have achieved good health suggests that going for economic growth alone may not be the best way. A UNICEF study chose ten high-achieving countries which had better health than might be expected given their levels of national wealth. These included Kerala State in India, with an IMR of seventeen, Cuba with seven, and Korea with five. The study emphasized the role of public action and balanced economic growth, spending on basic services and on education, especially women's education, and fairness

in public spending. The overarching principle was that ‘these countries did not give priority to achieving economic growth first, while postponing social development’ (Mehrotra 2001).

Comparison with countries more similar to the UK in economic development shows that the high-achieving countries in the European Union in terms of infant mortality are Sweden and Finland, where deaths of children in the first year of life in 2002 were 2.8 and 3 per 1,000 compared with an EU average of 4.5 (Eurostat 2004: 83). The policy regimes of these highest achievers in Europe emphasize high levels of government intervention to reduce poverty and social inequality and to increase social cohesion. The **social democratic regimes** of Finland and Sweden may be contrasted with the US, where governments promote a **liberal, free-market-based approach** to social policy. Here infant mortality rates are higher, at seven per 1,000, despite high levels of economic development and spending on healthcare.

Health policy

The NHS in 1948

Governments had already intervened in health and health policy, with public health legislation in the nineteenth century, hospitals under the Poor Law, National Health Insurance early in the twentieth century, and the Emergency Medical Service during the war. But the Second World War brought a qualitative difference in assumptions about what governments could and should do. It also brought experience of the confusion of existing health services and their inadequacy. William Beveridge was commissioned to make plans for social security after the war. His plan for the nation’s social security assumed that there would be ‘comprehensive health and rehabilitation services’. The wartime government did indeed plan for a major extension of health and medical services. But the first election after the war brought a Labour government to power and Aneurin Bevan to the Ministry of Health. The plans for reform acquired a more radical twist. It was already assumed in the wartime plans that the new health service would be universal (available to all), comprehensive (including all services, both preventative and curative), and free (involving no payment at the point of delivery)’ (Webster 1998: 22). Bevan’s plan also nationalized the hospitals and reorganized them into a system that would be managed on a regional basis. He aimed to **‘universalize the best’** health care, in contrast to a Poor Law, minimum-level approach which favoured means-tested services for the poor, and which stigmatized those who used it. The service would not only be free at the point of use; it would also be funded mainly through general taxation, rather than through insurance contributions. This meant that people would pay according to how much they could afford, through taxes which Bevan believed should be progressive, taking a higher proportion from higher earnings. Thus the NHS was built on explicitly egalitarian and **redistributive** principles. The NHS Act was passed in 1946 and the service inaugurated in 1948, with a leaflet, ‘The New National Health Service’, on everyone’s doormat at the start of the NHS, declaring:

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness. (quoted in Webster 1998: 24)

While the legislation and establishment of the NHS evoked fierce opposition, the service did in fact become popular, for the freedom from medical bills and the anxiety that surrounded them. Not only was the NHS popular with the public, it also gained loyalty and support from those who worked in it. More surprising, perhaps, is the degree of support it commanded from politicians of different political colours, including Conservative governments with very different ideals from those of Bevan and the postwar Labour government. There have been many opportunities to move from the principles of the NHS, to introduce market-oriented systems of healthcare, but politicians—including Thatcher and Blair—have continued to express broad loyalty to NHS ideals, if they have sometimes undermined them in practice.

Bevan's proposals for the NHS can be seen as a 'mixture of audacity and prudence' (Webster 1998: 15). If nationalizing the hospitals, universalizing the best, and funding through taxation were the audacious part, there were prudent elements in the NHS mixture. The NHS held onto systems of administration that already existed, making a 'tripartite' system whose lack of coherent planning structure revisited later health ministers. The system was also conservative in the services that it offered. The system took over hospitals and general practitioner services and drew local authority public health services under its umbrella. The appointed day for starting the NHS brought no chaos of new systems, rather the same services as delivered the previous week, albeit to far more people. 'Comprehensive health and rehabilitation services' dominated by medical services to individuals lay at the centre of this most collectivist system of health service delivery.

The next sections discuss what has become of these NHS principles (See Box 14.1) in practice over the nearly sixty years since the service began. Social, political, and economic changes during this period have made in many ways a different world. Family change has changed the assumptions we can make about how much we care for each other. Demographic change has brought a much older population, with much heavier needs for healthcare. Consumerism brings patients who have more expectations and make more demands than their predecessors. Economic growth brings new resources. Globalization brings more aggressive markets and less confidence in interventions by national governments. Technological development brings new possibilities, mainly more expensive possibilities, for all kinds of therapeutic intervention. How has the NHS responded to all these changes? And how well is it placed to adapt to the twenty-first century? Each of the following sections takes a key element of the decisions that established the NHS and asks how it has fared and whether the principles of 1948 are still recognizable in the service that exists today. The chapter also discusses the extent to which the principles of the NHS are relevant to health and healthcare today.

The NHS in the twenty-first century: contesting medical dominance?

A biomedical model of health was the dominant model at the beginning of the NHS, rooted in assumptions about the value of medical science in the treatment of individuals. Doctors' authority was central to the operation and management of hospitals, primary care, and community health, including authority over other professionals and health workers. Patients had little role in NHS decision-making, and were seen as having little role in their own healthcare. 'Alternative' practices such as chiropractic or acupuncture were not available on every high street. As we have seen in earlier sections, medicine's role in health has been challenged by social science. The dominance of medicine in the NHS has also been contested from several

Box 14.2 The NHS now: a snapshot

On a typical day in the NHS:

- Almost a million people visit their family doctor
- 130,000 go to the dentist for a check up
- 33,000 people get the care they need in accident and emergency
- 8,000 people are carried by NHS ambulances
- 1.5 million prescriptions are dispensed
- 2,000 babies are delivered
- 25,000 operations are carried out including 320 heart operations and 125 kidney operations
- 30,000 people receive a free eye test
- District nurses make 100,000 visits

On a typical day in the NHS, there are:

- 90,000 doctors
- 300,000 nurses
- 150,000 healthcare assistants
- 22,000 midwives
- 13,500 radiographers
- 15,000 occupational therapists
- 7,500 opticians
- 10,000 health visitors
- 6,500 paramedics
- 90,000 porters, cleaners, and other support staff
- 11,000 pharmacists
- 19,000 physiotherapists
- 24,000 managers
- 105,000 practice staff in GP surgeries

(Department of Health 2000: 23)

directions. We may ask whether patients have been turned into consumers, how much doctors' authority has been contested by other professionals in the NHS as well as outside—lawyers for example—and whether a more **social or environmental model** has gained ground over the medical perspective.

The development of consumerism is a key social change. If people using health services were once assumed to be patients, they may now have greater expectations of choice and control as consumers of services. Patients' groups have developed around chronic health conditions, such as Parkinson's disease; and carers' groups established to support those who have responsibility in the community. These operate as foci of information for the many NHS users who have long-term illness or impairment. The internet enhances the sharing of information

for such groups and for individuals. People now frequently choose alternative therapies rather than medicine or as well as medicine. The transformation of people from patients into medical consumers is partial: illness makes people vulnerable, and they may still be seen as patients needing expertise and services. But these social changes may be seen as bringing some elements of consumerism into relationships between doctors and patients, making the authority of medical decisions less taken for granted. They have also brought a new government agenda to the fore, with governments increasingly assuming that they can and should reform the NHS through patient choice.

The development of **new social movements** has also challenged the assumptions on which medical authority rested. The women's movement and environmental movement both developed during the last quarter of the twentieth century. The green movement has drawn attention to the environmental aspects of health in contrast to the medical ones. The women's health movement challenged medicine's masculinity and its relation to other professions, in particular nursing and midwifery. Women were denied access to medical schools in the nineteenth century, and not admitted equally with men until nearly the end of the twentieth. Nursing and midwifery were established as female professions under medical authority. Gender divisions and power relations in health work have been changed—though not wholly transformed—by the challenges of the women's movement and legislation such as the Sex Discrimination Act (1975). While medicine's relation to other professions was under scrutiny, so was its relation to women as patients. Contraception, abortion, childbirth, and new reproductive technologies such as in vitro fertilization bring issues of personal autonomy into sharp focus. In the last quarter of the twentieth century the women's movement fought for—and to some extent achieved—more autonomy for women in making decisions about whether, when, and how to have babies (Doyal 1995; 1998).

Medical authority has also increasingly been challenged in the courts, and in public inquiries. Litigation is increasingly seen as a way for individuals to gain redress when they are dissatisfied with the quality of care. An increasingly open environment—in which the media play a key role—makes public issues of medical decisions which might earlier have remained within the privacy of doctor–patient relationships. Trust in medicine has been the subject of high-profile investigations into poor-quality care, the ability of individuals to expose it, and of health systems to deal with it. The Kennedy Report into the Bristol Royal Infirmary and the case of Harold Shipman, a GP who is thought to have murdered over 200 patients, revealed failures of professional self-regulation. Changes in medical governance have followed, bringing more regulation to NHS professionals (See Box 14.3, Ham 2004: 246).

But while medical authority has increasingly been challenged, it has not died. The description of the National Health Service as a National Illness Service or a National Medical Service appears in every textbook. NHS spending has always been dominated by spending on hospitals, with primary care and public health lagging behind. Health ministers are always centrally concerned with hospital beds, waiting lists, and standards of care. If these concerns fitted with the 1948 ideas about the role of medical science and treatment in health, they may be seen as increasingly at odds with research and debates about the sources of health and ill health at the end of the twentieth century. There have been attempts by recent governments to push public health up the agenda. For example, the World Health Organization has encouraged governments to work on strategies to bring health rather than treat disease. The UK government

Box 14.3 Evidence-based medicine

Growing interest in evidence-based medicine (EBM) can be seen as one response to these challenges to medical science. Doctors and medical researchers want to ensure that clinical practice is informed by up-to-date research findings in order to preserve the credibility of medicine. Managers have an interest in eliminating ineffective treatments, in order to make the budget go further and raise the quality of care. Variations in the introduction and use of effective treatments are also seen as inequitable by patients and organizations representing patients. Systems to make sure that new research findings are implemented in clinical practice have developed from within clinical professions as well as from managers and governments.

Clinical guidelines have been produced by the professional bodies, such as the Royal Colleges, setting out agreed standards.

Government initiatives include the National Institute of Clinical Excellence, to produce guidelines on clinical and cost effectiveness of services (Baggott 1998: 56–7).

Box 14.4 NHS core principles, 2000

1. The NHS will provide a universal service for all based on clinical need, not ability to pay
2. The NHS will provide a comprehensive range of services
3. The NHS will shape its services around the needs and preferences of individual patients, their families, and their carers
4. The NHS will respond to different needs of different populations
5. The NHS will work continuously to improve quality services and to minimize errors
6. The NHS will support and value its staff
7. Public funds for health care will be devoted solely to NHS patients
8. The NHS will work together with others to ensure a seamless service for patients
9. The NHS will help keep people healthy and work to reduce health inequalities
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance

(Department of Health 2000: 3–5)

has responded with White Papers such as *Saving Lives: Our Healthier Nation* (DoH 1999) and a Minister with responsibility for Public Health. Ministers of Health and government documents, even HM Treasury, now express the need for prevention and the need to reduce health inequalities. The agenda has changed and broadened to include a health perspective as well as a medical one. The priorities in practice are more persistent. The NHS Plan set out ten core principles for the NHS (see Box 14.4) These include providing a universal service based on clinical need (1), shaping the services around the needs and preferences of individual patients, their families, and their carers (3), and working to improve quality services and minimize

errors (5). The ninth principle is that ‘The NHS will help keep people healthy and work to reduce health inequalities’. But it is the only principle that reflects the agenda of social change rather than the agenda of medical care (Department of Health 2000: 3–5).

The medical model of health may no longer be unchallenged. Consumerism, new social movements, especially the women’s movement and the environmental movement, growing litigation and public inquiries, social science research: these diverse changes in society make medicine’s authority and dominance now much more open to question than it was at the start of the NHS. But perhaps the statement of ideals in the NHS Plan, as well as practice on the ground, in particular spending, suggest these have undermined trust in medicine and trust in doctors less than may at first appear.

The NHS in the twenty-first century: comprehensive care?

If comprehensive care was part of the 1946 promise, delivering comprehensive health services brings dilemmas. The possibilities of medical intervention already seem limitless, yet they grow all the time. We have not, as a society, decided to spend more than a fraction of our resources on healthcare, and few would wish for a society and economy consumed by meeting health needs. Increasing the resources spent on healthcare would solve some problems, meet more needs, but would not meet them all. Comprehensive care, meeting all health needs, whether defined by professionals or by people as patients, parents, sons or daughters of patients, may best be seen as an ideal that cannot be realized in practice. This ideal may also be seen as a measure against which to assess what the health system does achieve and to compare it with others. These problems emerge internationally in different health systems. The NHS commitment to comprehensive care, free at the time of use, poses the dilemma in a particular form in the UK, but every health system generates debates about rationing and priorities.

Prioritizing or **rationing** in fact takes place. Some services have been withdrawn from the NHS in some areas—cosmetic operations, infertility treatment, long-term care of the elderly. Some groups of patients are less likely to receive services than others. There is evidence of discrimination against older patients, or smokers may be deemed less likely to benefit from treatment. Mechanisms for rationing include those set out in Box 14.5.

More demanding health consumers make these issues more contentious. There was never a golden age in which all possible health needs were met, but patient questioning about priorities defined by professionals has probably grown, as patients have become more ready to complain (Powell 1997: 107). The more overt debates about rationing that have ensued have

Box 14.5 Rationing mechanisms

- waiting lists
- deterrence through charges
- deflecting demand to other services
- diluting (e.g. using cheaper drugs)
- denial of some services (Hunter 1997: 22).

raised the question about who should take such decisions and how. Community participation in developing priorities is one kind of solution, scientific calculation of **cost-benefit or cost effectiveness** another. Public participation in decision-making may bring advantages, but may also tend to exclude unpopular groups/needs from health treatment. The scientific approach—calculating costs and benefits—is more defensible in comparing different treatments for the same problem than in the infinitely complex problem of making systematic comparisons of costs and benefits across different health needs. The question of which different treatment is most cost-effective for kidney disease can be addressed by accounting the costs of each in relation to the effectiveness of the treatment. But more fundamental difficulties are raised by attempting to count the costs and benefits of drugs to ease multiple sclerosis against those of, say, infertility treatments.

Central governments have aimed to diffuse the blame attaching to hard decisions, with professionals and health authorities having in practice to decide questions such as whom to treat and how much, how much to spend, what to leave out. There is therefore variation around the country in these decisions and how they are made. The accusation of ‘postcode lottery’, in which treatment depends on where you live, has brought efforts to bring more coherence to these decisions. NICE, the National Institute for Clinical Excellence, was established in 1999 ‘to provide patients, health professionals and public with authoritative, robust and reliable guidance on current ‘best practice’. Advice covers specific treatments, such as drugs, techniques and procedures, and clinical management of specific conditions (NICE 2002). NICE has reported on many contentious issues, such as the value of drug treatments for Alzheimer’s disease or multiple sclerosis. At first, guidance from NICE did not give patients the right to receive particular treatments and was therefore an aid to more coherence in the professional decision-making process rather than a new rationing agency. But in 2003 a decision to make NICE guidance mandatory reduced the discretion of Primary Care Trusts. Central government aimed to increase consistency of decision-making, while keeping responsibility for decisions at local level (Ham 2004: 258). Public participation in NICE decisions has been joined through a Citizens’ Council, with members of the general public invited to discuss the questions on which NICE will report.

Box 14.6 on long-term care offers illustration of these issues too. It shows a shift of care from health authorities to social care agencies and families which represents a shift in what is defined as healthcare. While the coverage of the NHS has in many ways widened over time—to include contraceptive services, and many drug treatments as they have become available—there are some instances of a narrowing NHS remit. Routine eye examinations were no longer provided free from 1989. Terminal care in hospices has developed partly within the NHS, but depends for half its cost on charitable contributions (Pollock 2005: 41). Dentistry has disappeared from the NHS in some areas, as dentists have refused to work under NHS contracts. In England and Wales, long-term personal care has been excluded from the NHS, while nursing needs are in principle covered. In Scotland both are treated as health needs.

The NHS in the twenty-first century: from state finance to mixed economy?

One idea of the transformation of social welfare provision in the UK during the latter part of the twentieth century is that it went from domination by the state to a more variegated mix of public, private, voluntary, informal care—a **mixed economy of welfare**. This section

Box 14.6 Long-term care

'The policy thread that binds all these official attempts to promote community care has been a concern to shift the responsibility for care from one agency to another—from the NHS to local authorities, from local authorities to families' (Lewis and Glennerster 1996: 2).

The issue of long-term care gives an example of changing policy over what should be deemed to be health needs and included as part of the health service. Policy has, in effect, changed, so that people who might once have occupied hospital beds are now more likely to be in nursing homes or residential care, or in their own homes with support from community services. Care that would have been free at the point of need within the NHS may be charged by social services or nursing homes, or may be delivered by relatives without charge or count.

The NHS inherited many long-term beds from the Poor Law, warehouses for older people, some of whom needed hospital or nursing care, but many whose need was for an alternative place to go. Movements in mental health and geriatric medicine towards enabling people to support themselves in their own homes as long as possible have contributed to this decline in long-stay hospital beds. These developments have produced a wider range of community and smaller home provision and enriched the choice for people needing long-term care. But the desire to move costs, from fully funded NHS beds to means-tested local authority responsibility, and from local authority to unpaid care at home, has been a major power behind these changes. An element of privatization has been involved, as the government has fostered development of an industry of care homes, as well as pushing costs onto families and unpaid carers.

At the start of the NHS there were eleven hospital beds per 1,000 population. By 1989/1990 this had dropped to 6.2 per 1,000 and by 1999/2000 to 4.1 per 1,000 (Office of Health Economics 2002). There are many reasons for this decline, which affects acute hospital beds as well as long-term ones: the remaining beds are used much more intensively, with quicker patient turnover, shorter hospital stay, and keyhole surgery allowing patients home. But this huge decline in hospital beds, at a time of ageing population, gives some indication of the shift from NHS to local authorities, and from local authorities to families, described above by Lewis and Glennerster.

A Royal Commission Long Term Care for the Elderly was established by the new Labour government in 1997, and published a report in 1999. Scotland decided to follow its recommendations for a comprehensive package of care for people with long-term needs. But people in England and Wales have been offered less. There is a new agreement to include the costs of nursing care within the NHS. But a new boundary has been created, which may be difficult to defend, between those whose needs are deemed to be for nursing and those whose needs are for personal care. Personal care remains outside the NHS.

examines the mix of state and private finance in the UK, as well as the mix of state and family care, to ask how true this picture is in relation to healthcare.

The question of the mixture of state and private finance has been entwined with the question of whether we spend too much or too little on health. Freedom from payment at the point of use gives rise to fears that people will demand too much. Right-wing critics have argued the need for a price mechanism to regulate demand: people may want more at the

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point of need than they are prepared to pay for in taxes. Defenders of the NHS have argued for its efficiency in keeping costs down as well as its humanity in meeting needs. As an experimental system, the NHS did overspend in its first two years, an experience which brought a long period of stringency and constraint, with spending settling at around 3.5 per cent to 4.1 per cent of GDP during the first 25 years (Webster 1998: 30–4).

Currently, both public and policy analysts are more concerned about the low levels of NHS spending—and low levels of service—in comparison with other European countries (Fig 14.4). After long periods in which governments have argued for small government and low taxation,



there is official support for higher government spending, especially on health. The NHS plan acknowledges that 'in part the NHS is failing to deliver because over the years it has been under-funded' (Department of Health 2000: 1). The Treasury commissioned a report to quantify 'the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay' (Wanless 2002). This counted the cost of many years' under-investment in NHS staff and buildings, in order to bring them up to contemporary expectations and comparable countries in Europe. In the subsequent spending review increases of 7% per year in real terms were planned until 2007/8 (Ham 2004: 79).

Increasing living standards have tended to bring higher healthcare spending. Now Turkey is spending about 4 per cent, but the US is spending nearly 14 per cent of its GDP on health. Promises to lift public spending on health and close the gap with the rest of Europe show clearly in the figures. Overall real government spending increased by 47% over the five years from 1999 to 2004. In 2003, total spending was 8.4% of GDP and just below average for the European Union, whether the EU 15 or the EU 25, including the new CEE members (OHE 2005). Current plans to increase public spending on health until 2007/8, an average annual real growth of 7.4%, should bring total health spending to around 9% of GDP (King's Fund 2005: 14).

These are unprecedented increases in Britain's health spending, and there are many debates about how these funds are being spent, whether spending is bringing value for money, and why parts of the health service are facing serious financial difficulties. More than 25% of NHS trusts in England reported financial deficits in 2004/5. Reforms are introducing a more competitive environment, which will make financial instability more serious, as hospital trusts earn according to 'payment by results' and money increasingly follows the patient. Deficits may be the result of inefficient management, but they may also have to do with the financial regime and constraints over which hospital trusts do not have control (Palmer 2005). An audit of the NHS covering the years from the beginning of the Labour government in 1997 to 2005 finds that the increase in spending is real enough. Cost pressures, such as increasing pay and shorter hours, mean that not all the extra funding goes into extra healthcare, but overall the extra spending has brought real increases in staff, equipment, buildings, and medicines, has reduced waiting times, and improved the quality of care (King's Fund 2005).

Debates about the source of payment for healthcare also persist. Bevan's ideal at the start of the NHS was for a service that would be funded through taxation, reflecting ability to pay, with an element of contribution through national insurance. Private practice would continue, but universalizing the best in the NHS would give people little incentive to pay privately. Challenges to these ideals started early, with the introduction of prescription charges proving the first crack in the ideal of a service free at the point of use. Political differences around public funding—and political change from the collectivism of the postwar era—have made more room for charging, as well as for developing alternatives to the NHS such as private health insurance: 11.5 per cent of the UK population were covered privately in 2000, though private coverage is often less comprehensive than NHS coverage. Every country shown in the graph of health spending (Fig. 14.4) has private health spending as well as public. In comparative terms, the UK's private/public share resembles the social democratic countries of Scandinavia, with very high proportions of spending coming from public sources, rather than the US, whose public spending is less than half its total health spending.

The key debate about the merits of public vs. private funding is about how redistributive the system is between different income groups. Public funding is mildly 'progressive' in the sense that national systems of taxation take a higher proportion from higher income groups than from lower. The system is less progressive than it seems at first sight because indirect taxes such as VAT hit lower-income groups harder; but overall, public funding means that funding comes disproportionately from higher-income groups. Currently the NHS is financed 80 per cent from taxation, with 12 per cent from National Insurance contributions and 4 per cent from charges (Dixon and Robinson 2002). Public funding tends to be associated with better population health outcomes. And, from the point of view of the economy, 'private health spending has no advantages over public health spending. The most obvious consequence of shifting from public to private spending is to shift the burden from the relatively rich to the relatively poor' (Normand 1998, quoted in Wanless 2002: 141).

While UK health funding remains distinctly public, the mixture of public and private within the system has grown, and changed the character of the NHS (Box 14.7). The NHS has always purchased drugs and equipment from the private sector. Contracting out hospital cleaning and catering services introduced contracting with private companies from the 1980s, and has expanded to involve agencies supplying nursing staff. The private finance initiative brings private investment capital to major investment projects in general practice and in hospitals. Contracts with the private sector to undertake operations and with overseas health services mean that healthcare itself may be contracted out. Independent Sector Treatment Centres have been developed to carry out routine elective surgery, using NHS funding and in

Box 14.7 Private finance in the NHS

The Private Finance Initiative (PFI) was introduced in 1992 to bring the private sector into public sector developments, including the design, building, financing, and operation of hospitals and other health facilities. In practice PFI started slowly, with only one major hospital development signed by 1996, to build a major district hospital in Norwich.

Labour governments have reaffirmed their commitment to the use of private-sector capital for funding major projects, accepting that 'private finance might complement public funds, as long as schemes were compatible with NHS priorities' (Baggott 1998: 171). For the government, PFI projects are a way to increase public-sector building projects quickly without big increases in government borrowing or spending. They are also seen as transferring risk to private companies.

PFI has grown under New Labour, with 105 health projects signed by 1 September 2001, worth £2,502 million (Allen 2001: 11). PFI now funds nearly all new major hospital schemes, accounting for 64 of the 68 new projects by 2005. A variant—LIFT (Local improvement finance trusts)—is being developed to build primary care premises, with one open so far and 41 in preparation (OHE 2005).

Advocates point to the rapid development of new hospital buildings and the modernization of the NHS stock. Critics point to longer-run costs, with today's public buildings costing tomorrow's taxpayers, a growing stream of public payments to private companies, and some evidence of risks falling on the public rather than the private sector when costs escalate. Finally, some critics wonder whether this is a route to privatizing the NHS.

competition with NHS hospitals. The Department of Health sees this as adding to provision, reducing waiting lists, and widening patient choice, while NHS hospitals see it as unfair competition, with higher tariffs paid to independent centres, and encouragement to PCTs to use the independent centres (Pollock 2004/5: 244). NHS contracting with private companies continues to grow.

The mixture of state and family care is another key concern. The idea of a National Health Service taking care of its citizens from cradle to grave always missed one crucial component of care: to a large extent people have taken care of each other, without intervention from governments or services. Feminist writing in the 1980s began to identify unpaid care, and women's work as unpaid carers, as a crucial component of health and social systems, albeit one that was not quantified (Pascall 1997). Counting it, understanding the work, who does it, and why they do it, has grown into a very significant body of research. This work spans cradle and grave, in its concern with parenting as well as with care for disabled people and the frail elderly. Parents' core concerns with raising healthy children, protecting them from injury, may be seen as health work; responsibility for the interface with public services—taking children to services and managing treatment—puts parents at the centre of healthcare for young children. Where children are disabled it is not unusual for parents to do specialized nursing work. And older people, especially spouses, often meet and manage each other's health and care needs.

Feminist investigation began with the gendering of care work. While parenting has become a more fashionable idea, research continues to show mothering as a more common practice. The picture of care for elderly people is more complicated, as it is common for spouses to care for each other, and such care involves husbands as well as wives. But it has become clear that women are more likely to have responsibility for heavy nursing care and to have a wider set of responsibilities, in and beyond the immediate family (Finch 1989; Morris 1990). Since feminist work drew attention to the importance of unpaid work, it has become much more common for researchers to count it, to develop accounts of time use, which include paid and unpaid work. The evidence accumulates across many countries that women's joining the labour market has not been matched by men's joining family work, though there is some convergence of working patterns between men and women (Gershuny 2000).

If one crucial argument about care work is about its distribution between men and women, another is about its distribution between state and family. Box 14.6 on long-term care looks at the recent history of health and community care for frail elderly people who may need personal and/or nursing care. There is no straightforward way to count a shift from state care to family care, but there is evidence that it has happened. First, the reduction in hospital beds—now just over a third of the provision in proportion to population that existed in 1948—suggests that some care has shifted from hospital to home. Second, the elderly population has grown, especially the very elderly, whose healthcare needs are greatest (see Chapter 15). And third, governments concerned with the numbers of frail elderly and with public finance have shifted policy to ensure that more older people, and more frail older people, are in need of support and living at home.

Does the evidence support the idea of a trend from state provision to a more mixed economy of care in UK health policy? There is clearly an increase in the extent to which governments have turned to the private sector and to the family. There has been a growth in private

insurance outside the NHS, and a growth of private-sector contracts in the NHS. There is little quantitative evidence about what families did in the postwar period, but the implications of changing policy and changing needs are that the health and care work of families has been growing, especially in relation to older people. But the UK continues some of its postwar tradition. Its NHS is more collectivist, more dominated by public spending than the more liberal US, and in this respect retains a more social democratic style in relation to health than in relation to most other social provisions.

The NHS in the twenty-first century: managing healthcare—top down or bottom up?

Who should have power over the development of health services? What kind of mix should there be between governments and professionals, service providers and service consumers, managers and professionals? And how should that power be exercised? Should central government take decisions that apply nationwide? Or should local communities participate in decision-making about local services, even if it means diversity in the way services are provided? How can health service planning be integrated with social service planning? If governments have tended—ultimately—to take the same line about public funding for a national health service, they have tended to take different lines about how to manage it. Problems of organization have sometimes taken the blame when the level of funding was a more likely culprit. The resulting organizations and reorganizations have been many: seven different diagrams are required to describe the structure of the NHS in England between 1948 and 2002 (Ham 2004).

The 1948 model was essentially a top-down one, with the Minister of Health in at least theoretical control of a health service managed through regional boards and local management committees and, to a lesser extent, local government authorities. There was a new integrated structure for delivering hospital services, but the first design for the NHS owed as much to the need to placate entrenched interests, to get a health service started, as it did to any ideals about how services should be managed. The first organization of the NHS was much criticized for its tripartite nature, with no integration of hospital, general practitioner, and local authority public health services. But the NHS in this period did develop integrated local services, domiciliary services for health and social care under Medical Officers of Health. Reorganization to make more coherent planning structures for health, implemented in 1974, created a much more difficult environment for integrating local health and social services. It also took the management of health entirely away from local government. Critics saw problems of public accountability in health services, with decision-making by non-elected authorities and a lack of public participation in decision-making.

If the 1948 model appeared to critics to be top-down, it did not always appear so to Ministers of Health. Ministers enunciated policies, to move resources to 'Cinderella' services for elderly and mentally ill patients, but spending continued in established patterns, with acute hospitals receiving more money. From the point of view of Ministers of Health it appeared that medical consultants controlled spending rather than themselves, with resources following medical decisions rather than ministerial ones. Professional networks rather than hierarchies or market competition may be seen as the real power arrangement in this period (and others) (Ham 2004: 244).

The NHS came to be criticized as a bureaucratically managed system, lacking flexibility and unresponsive to patients, protecting entrenched interests, especially the interests of professionals delivering the services. General management was introduced in 1985, as a solution to these problems: managers—never mind whether their background was in industry, financial services, or nursing—would be responsible to government for delivering policy.

This produced a radical change in the management of health services, but a more radical one was to come. Right-wing critics saw in the health service a command-and-control style of management that bore an uncomfortable resemblance to discredited Soviet systems. Markets were seen as more dynamic, with incentives and freedom to innovate, and responsive to consumers, who could take their custom elsewhere if not satisfied. After a brief flirtation with the idea of exchanging the NHS for alternative systems—especially market-based systems—the Thatcher government decided to keep the NHS but import market principles into its management. Hence the 1989 White Paper *Working for Patients*, and the NHS and Community Care Act of 1990, which introduced the **internal market** into the NHS.

The government aimed to bring the virtues of markets to the NHS while keeping the promise of public funding for a public service. The top-down bureaucracy of NHS authorities would be dismantled. Instead of authorities using government funds to provide services, purchasing authorities would have funds to buy services and providing authorities would produce and sell them and compete for a market share. Purchasers could pick and choose between providers, and contract for the best services available. General practitioners could become fund-holders, purchasing services from hospitals and other providers. Hospitals could become NHS Trusts, with independence from health authorities, and freedom to develop in their own way, subject only to winning enough custom. The internal market offered a very radical reorganization. All provider units in fact became trusts, including hospitals and ambulance and community health services. GP fund-holding also spread widely.

Critics of markets looked for inequalities in the NHS internal market. Would the service continue to offer service on the basis of need, or would some patients get turned off GP lists? Would patients of fund-holders get better service than others (Le Grand et al. 2001)? There were many other questions around the costs and efficiency of the internal market. Would the high transaction costs of the internal market, the managers and computers needed to operate it, bring efficiency benefits to outweigh their costs? But perhaps the most politically pressing issue for a New Labour government in 1997 was whether the internal market would generate the kind of inequalities that the NHS was founded to eliminate.

The incoming government offered a new solution. Commissioning by Primary Care Groups was to provide a 'third way' between top-down management and the fragmentation of the internal market, aiming to bring 'integrated care, based on partnership' (Department of Health 1997: 5). Key decision-making was devolved to local-level groups based on primary care: in 2002, these became 302 **Primary Care Trusts** (PCTs) to cover England, with 28 strategic health authorities to monitor performance and standards. Primary Care Trusts are funded directly from central government according to their population size, weighted according to measures of health need. They are planned to become broadly co-terminous with local authorities (Lewis and Dixon 2005a), which means they can work together with the staff of social services departments. They provide primary care and community health services and became the new purchasers for hospital services.

Three political tensions underlie NHS development under New Labour. First, ideas of patient choice, local decision-making, and citizen involvement are in tension with ideas about quality control, spreading best practice, monitoring and setting standards. In practice, bottom-up decision-making has been strongly regulated: local decision-making ring-fenced by central government control with—at least at the beginning of the New Labour government—‘a command and control approach that was much more directive than anything that had been attempted before’ (Ham 2004: 245). A developing agenda of choice (see Box 14.8) may now be shifting power from central government. Second is the tension between hospitals and primary care. Funds have been devolved to Primary Care Trusts to commission services, which may bring power to General Practitioner services over the development of health care provision, including hospitals. But ‘the unfolding of powerful incentives applied to acute hospital advisers’ may overwhelm primary care commissioning unless PCTs are strengthened (Lewis and Dixon 2005a: 24). Third is a challenge to the power of professional networks, with markets used to bring reform. This is likely—as did the internal market from 1990—to bring increased transaction and administrative costs and increased payments to private companies. But it also challenges the trust in professionals, which is at the core of NHS relationships.

The internal market was softened, but not abolished, by New Labour’s development of commissioning by Primary Care Trusts. The government claimed an intention to produce a more collaborative arrangement than the internal market, but contracts persist between one part of the health service and another, and with outside providers. More recent developments—payment by results, NHS Foundation Trusts bringing more independence to hospitals, a ‘patient-led NHS’ bringing more choice to patients (see Box 14.8)—have increasingly emphasized the market in the management of the NHS. If underfunding was the core challenge to the traditional ethos of the NHS in the 1980s and 1990s (bringing reduced coverage and increased opting for private insurance), increasing faith in the merits of markets may be the core challenge at the beginning of the twenty-first century.

A universal NHS in the twenty-first century: do other systems work better?

Has the NHS become out of date? Towards the end of the twentieth century it was criticized for everything, from its waiting lists to its standards of hygiene. The argument gained ground that there was something wrong with the NHS as a system, that there was a flaw at the centre of its collectivist ideals: a product of the postwar period could not meet the demands of the late twentieth century. The alternative interpretation of NHS ills was that they were mainly a product of a struggle to survive in a hostile climate. The collectivist NHS could not survive without taxation, but taxation for public expenditure was seen only as a burden. All health systems have problems, but the NHS seemed particularly deeply troubled at the end of the twentieth century.

The most different system of healthcare in a developed country is in the US. A much stronger market operates, with less than half the spending coming from governments. Private funding systems bring many problems: they tend to be ‘inequitable, regressive (those with greater health needs pay the most), have weak incentives for cost control, high administration costs and can deter appropriate use’ (Wanless 2002: 141). In the US a tiered system has emerged, with the best health services for people with occupational coverage and their dependants. There are middle tiers of people with ‘bare bones’ coverage such as Medicaid,

Box 14.8 Policies reducing the Department of Health's control over the NHS in England

Creating local purchasing power

Devolving resources from the Department of Health to local primary care trusts (PCTs)

85 per cent of NHS resources are now spent by PCTs.

Encouraging further devolution of spending decisions to GP practices The government target is for all practices to be commissioning almost all care for their patients by the end of 2006.

Reducing capacity at the centre and regionally The government target is to achieve a 40 per cent reduction in the number of Department of Health staff as well as a reduction in the number of strategic health authorities by 2007.

Introducing payment by results This is a new system by which hospitals are paid for operations or treatments only when they have done them, with the price fixed by a national tariff for specific procedures. The system is designed to encourage providers to keep costs low and make their care and facilities more attractive to patients. The system is being rolled out slowly—covering only a very small number of procedures for most hospitals in 2003, increasing to 90 per cent of hospital care by 2008.

Extending patient choice To date, choice of provider has been limited to patients who have been waiting long times for certain procedures. But from December 2005, all patients needing planned surgery or treatment will be able to choose from five providers, and from 2008 the government has promised that patients will be able to choose any provider meeting NHS standards and prices.

Encouraging a mixed economy of 'autonomous' providers

The creation of NHS foundation trusts as part of the 2003 Health and Social Care Act This legislation freed a number of NHS hospitals from direct control of the Department of Health and enabled them to borrow capital, sell assets, and retain in-year surpluses. Governed by a board that includes representatives of their local community, foundation trusts are intended to be more responsive to local needs and have more autonomy to ensure those needs are met. So far, 32 NHS hospitals have become foundation trusts.

Increasing the role of private-sector providers While still currently providing only a small proportion of care for NHS patients, the government is expanding the role of the independent sector through nationally awarded contracts (for example, for new diagnostic and treatment centres) and by enabling patients to choose any provider for planned surgery that meets NHS standards and prices.

Introducing competition within primary and community care services Department of Health guidance issued in July 2005 proposed that by the end of 2008, PCTs should no longer directly provide their own services. More details are anticipated in the forthcoming White Paper on 'out-of-hospital' care.

Establishing independent regulation of providers The Healthcare Commission was created in 2004 as an independent organization inspecting all healthcare providers and providing information to the public about the quality of that care. The Commission for Social Care Inspection provides a similar function for social care services. And Monitor is the independent regulator of foundation trusts, authorizing their establishment and, partly through Healthcare Commission inspections, monitoring their activities.

Source: Lewis and Dixon (2005b: 2–3) *NHS Market Futures: Exploring the impact of health service market reforms*, London: King's Fund.

and there is a growing uninsured population at the bottom, who have only limited access to public hospital clinic and emergency rooms. Health spending levels far above European countries omit 40 million Americans from health insurance cover. One American author advises his European readers:

First, cherish your universal coverage and relatively lower costs. You may not realize how good your systems really are. Second, cherish your commitment to solidarity and equity. Your systems may lack efficiency from the point of view of health economists who are concerned with moral hazard and cross-subsidization from the young and healthy to the old and sick, but that is the price for a sense of community and social justice. Third, be very careful about the creation of a large upper tier of people who purchase all of their care privately . . . Support for the public system could decline, and with it funding for the public system. (Kirkman-Liff 1997: 42)

European systems all use public funds as the main source of funding for healthcare. Some have tax-based systems similar to the NHS, while others use social insurance. Insurance gives a narrower base for funding, as people pay only during their working lives, and countries are shifting from this model. Comparison with European and other countries shows that, despite differences in organization and funding, a number of challenges are shared. These include: 'ensuring equity of access to health services; raising quality; improving health outcomes; sustainable financing; improving efficiency; greater responsiveness; citizen involvement in decision-making; and reducing barriers between health and social care' (Dixon and Mossialos 2002). So not all problems can be put down to the NHS as a system.

Public support for the NHS has remained high, with 80 per cent thinking that the NHS is critical to British society and must be maintained (Wanless 2002: 137). The beginning of the twenty-first century has seen a new commitment to the principles of the NHS from government departments. The NHS Plan in 2000 examined other forms of funding healthcare, and concluded that the systems used by other countries do not provide a route to better healthcare: 'The way that the NHS is financed continues to make sense. It meets the tests of efficiency and equity. The principles on which the NHS was constructed in 1948 remain fundamentally sound' (Department of Health 2000: 40). This new commitment is not just to universal principles, but also to a level of funding that will make a universal service work, 'universalizing the best' health care.

The Treasury plans unprecedented increases in public spending to bring the NHS up to modern European standards. The Department of Health plans increases the number and standards of hospital beds, the NHS workforce, equipment, and IT systems, and to produce national standards to replace the uneven quality or 'postcode lottery'. These are all improving buildings and reducing waiting times (King's Fund 2005). The positive uses of taxation, enabling state action, are to the fore in these plans to improve the quality of care.

Conclusion

If we look back to the ideals and ideas of those who began the NHS in 1948, there are obvious changes in all the elements identified at the opening of the chapter. The management of the health system is the most changed. Top-down planning was blamed for bureaucratic inertia

and insensitivity to local needs. Professionals were accused of self-interest. And markets have become much more prominent in the provision of health services. But perhaps more surprising is how much has survived through to the twenty-first century, through changes of government, economy, and society. Governments have turned to a more mixed economy of care involving markets and families as well as state provision, and charges for items such as prescriptions have increased. But the major part of NHS funding comes from taxation, as it has since 1948. The traditional commitments of the NHS to a universal service for all based on clinical need, not ability to pay, and a comprehensive range of services have been reasserted in the NHS Plan (Department of Health 2000), where they are declared as the plan's first two principles. There is a new commitment to defend the NHS in argument, and to support it with levels of funding to compare with other countries of Western Europe.

It can be argued that social and economic changes reinforce the need for an NHS based on principles of universal service rather than insurance by those in work or charges to patients at the time of use. Increases in the elderly population in proportion to the working population mean reducing the capacity of insurance systems based on employment to meet healthcare needs. They also bring an increasing population of vulnerable adults, with large healthcare needs and small incomes. An increasing population of disabled people growing up with significant health needs is another problem that is difficult to meet through any other system. Increasing social inequality and social exclusion are other reasons for the increasing relevance of a system that is not related to ability to pay.

After a period towards the end of the twentieth century when the core ideas of the NHS were under attack from critics who preferred a market-based system, these principles begin the twenty-first century strengthened. Governments and public opinion have acknowledged the value of a service that meets people's health needs mainly through taxation, on the basis of citizenship rather than payment or contribution. While the NHS has gained more generous public funding, it has also been subject to management by internal market and a more mixed economy of provision. Collectivist ideals also continue to support an individualist style of medical care. Medical authority is now more contested by patients, lawyers, and social movements, but the ideals of a public health movement remain on the margin. Perhaps the greatest challenge of the twenty-first century will be to address the problems of health and health inequalities discussed at the beginning of the chapter: all the new investment in the NHS has not reduced health inequalities, as infant mortality and life expectancy gaps have continued to increase (Department of Health 2005).

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USEFUL WEBSITES

Department of Health: www.doh.gov.uk

HM Treasury: www.hm-treasury.gov.uk

The King's Fund: www.kingsfund.org.uk

National Health Service: www.nhs.uk

National Statistics: www.statistics.gov.uk

Office for Health Economics: www.ohe.org.uk

Organization for Economic Cooperation and Development (OECD): www1.oecd.org/els/health/sof

World Health Organization (WHO): www3.who.int/whosis



GLOSSARY

biomedical model An understanding of health rooted in the biological and medical sciences. Its orientation is towards treating illness in individuals.

cost–benefit and cost effectiveness analysis Economic tools for assessing the merits of policies or practices. Both involve a broad assessment of the full costs of a decision to individuals, to the health service, and to society more broadly. Cost–benefit analysis also attempts to make a full assessment of the benefits, in order to compare treatments for different kinds of problem.

infant mortality rates These count the deaths of children under 1 year old and measure them over time, or in comparison with other countries. They are expressed per 1,000 live births, and are regarded as an indicator of comparative health.

internal market A structure for providing health (or other public services) in which the authorities responsible for making decisions about the availability of services, and for purchasing them, are separate from

the organizations which produce and deliver services to patients. They introduce competitive market forces into public services.

liberal, free-market-based approach An approach to social policy which is built on the assumption that individuals should be free to choose their own welfare, buying through markets, rather than having them provided through the state.

mixed economy of welfare A description of the diverse sources of welfare, in state, private, voluntary, and informal family sectors. During the latter part of the twentieth century governments saw it as their role to stimulate and support a wider range of sources of provision, beyond the state. This has largely continued under New Labour, though recent developments have re-emphasized the role of the state in funding and providing services, especially in health and education.

National Health Service (NHS) The system of health service provision established by the NHS Act in 1946. Its system of public funding, with no charges at the time of use, made it a model of the collectivist ideals of the postwar era, when the emphasis was on collective, state action to meet human needs and to regenerate society.

new social movements started as collective protests and aimed to work through public opinion and civil society. The women's movement and environmental (green) movements have influenced social policy widely, and both have significant health agendas.

north–south divide The evidence of different health experience in different regions in the UK is strong, with the poorer regions of the north having higher mortality rates than the richer south-east.

Primary Care Trusts (PCTs) PCTs in England and Local Health Groups in Wales are now the main purchasers of healthcare services. They receive money from central government, mainly according to their population size. They serve populations of between 50,000 and 250,000 people. PCTs provide primary care services, but purchase hospital and other services—which could include physiotherapy and alternative therapies—from other providers. In Scotland the system of purchasing and providing is more integrated.

rationing Decisions about allocating resources or setting priorities. These may be decisions about which services to provide as part of the NHS and which not to provide, as well as decisions about who should be treated and who not.

redistributive A system of taxation and benefits which reduces inequality by taking a higher proportion from higher-income groups and giving a higher proportion of benefits to poorer households.

social and environmental model A social model of health stresses the importance of people's place in society in making them healthy or sick: social class in particular is seen as a key determinant of health. Environmentalists share the concern with factors beyond the individual, but their attention is more to health hazards which may affect everyone: nuclear fallout, agricultural chemicals, air pollution.

social democratic regimes The social democratic belief that capitalism can be reformed by state intervention lies behind the welfare strategies of Scandinavian countries, especially Sweden. Here, social policies are based on government intervention to produce social cohesion, with higher taxation, income redistribution, labour market policies to bring people into work, and more equal outcomes than in most western European countries or the US.

standardized mortality rates Annual death rates per 100,000 in a population group. They are standardized to enable comparison between groups with different age structures.

third way The approach of the New Labour government which came to power in 1997. The Blair government looked for a way between two political traditions, based on the central state (old Labour) and the market (new Right), using a mixture of state and market, according to 'what works'.

universal service, universalizing the best The principle on which the NHS was founded was that of providing to the whole population, according to need rather than ability to pay. The stigma attached to

means-tested provision and the poorer quality of services for poorer people which characterized Poor Law systems were to be avoided by providing the highest-quality care for everyone, 'universalizing the best'. Insurance-based systems tend to leave some people out (e.g. those who are disabled, and/or have weak employment records). Such systems may have less than universal coverage, and they may have different levels or tiers of service for different groups of people.

Q ESSAY QUESTIONS

- 1 How can we best understand health inequalities in Britain?
- 2 What do you understand by a 'universal' health service and how universal was the service introduced in Britain in 1948?
- 3 What challenges have there been to the dominance of medicine in the NHS and how successful have they been?
- 4 Can the NHS provide comprehensive care?
- 5 What has been the impact of private finance on the NHS?
- 6 What is the 'internal market' in the NHS?
- 7 What alternatives are there to a NHS on universal principles? Are there alternatives in other countries which might work better?