

Development of the healthcare service



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Thanks to the dedication and hard work of the William Beveridge report of 1942 and Aneurin Bevan, minister of health, the National Health Service came into existence on the ‘appointed day’, (5th July 1948), was the first health system to offer free medical care to the entire population at the point of need. The service was paid for out of taxation, and was not based on the insurance principle, with entitlement following contributions. Before and during the war it was thought that the public health service in local government would provide the eventual basis for a national system.

However, hospitals were nationalised and, significantly, the role of local government was limited. The new service was totally free until 1951, when charges were imposed for prescriptions, dental care and spectacles.

(Christopher Harvie, 2000) The Beveridge report through time and countless governments and policies has seen the creation of one of the world’s biggest employment agencies, only ousted by the People’s Liberation Army, Wal-Mart, and Indian Railways. In 2012 the National Health Service occupied 1.7 million employees.

Long before the NHS was created in 1948, there were two types of hospitals, voluntary hospitals were independent charities established for the benefit of the ‘deserving poor’, who, according to Victorian values, were respectable working-class people who had fallen on hard times because of sickness.

People who were destitute had no alternative but to seek admission into a workhouse. Because many of these people had been reduced to poverty through either sickness or old age, the poor law authorities developed workhouses, opened hospital wards and even purpose-built infirmaries to

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treat them. (LiveStrong, 2011) The first poor law was introduced in 1349 and was changed and revised because of the Black Death when almost half of the population died. Hundreds of years later the second poor law made in 1601 were introduced stating that families should be responsible for each other's health. During the late nineteenth century the British government, under the Liberal party, acted according to the principle of laissez faire. Individuals were solely responsible for their own lives and welfare. A popular point of view at the time was that poverty was caused by idleness, drunkenness and other such moral weaknesses on the part of the working classes. At the dawn of the twentieth century there were no old age pensions, unemployment benefits or family allowances. If the main wage-earner died or could not work, a whole family could be plunged into terrible poverty. The state would not interfere. Two social surveys were published that not only shocked the British public but changed popular opinion on the causes of poverty. They helped pave the way for a whole range of government-led welfare reforms. Independently of each other, two wealthy businessmen, Charles Booth and Seebohm Rowntree, sponsored major investigations into the extent and causes of poverty in Britain. Booth and Rowntree's findings agreed on two key points, up to 30% of the population were living in or below poverty levels and the conditions were such that people could not pull themselves out of poverty by their own actions alone. Booth and Rowntree both identified the main causes of poverty as being illness, unemployment and age - both the very young and the old were at risk of poverty as it began to be recognised that the government had a role to play. To do this, political and social reforms were necessary.

Welfare state started to develop when surveys of poverty, by people such as Charles Booth and Rowntree showed inadequacy in the welfare provisions that could not deal with poverty with increasing industrialism and urbanisation.

After the First World War, the population of the UK was so malnourished and tired in spirit that millions were killed in the flu epidemic of 1919-1920. No government wanted to see a replay of this tragic event. In 1941, the government commissioned a report into the ways that Britain should be rebuilt after World War Two; Beveridge was an obvious choice to take charge. He published his report in 1942 and recommended that the government should find ways of fighting the five 'Giant Evils' of 'Want, Disease, Ignorance, Squalor and Idleness'. In 1945, Labour's new Prime Minister, Clement Attlee, announced he would introduce the welfare state outlined in the 1942 Beveridge Report. This included the establishment of a National Health Service in 1948 with free medical treatment for all. The new system was partly built on the national insurance scheme set up by Lloyd George in 1911. Many of the ideas behind the Welfare State came from William Beveridge. Before the First World War it took the determination of David Lloyd George to force through changes. After the Second World War, it was another Welsh politician, Aneurin Bevan, who overcame opposition to the Welfare State. People in work still had to make contributions each week, as did employers, but the benefits provided were now much greater.

The healthcare services in Britain are organised and funded in various ways by different trusts, foundations and institutes.

The National Institute of Clinical Excellence (N. I. C. E) sets guidelines for practitioners as to how various conditions should be treated and whether a particular treatment and medication should be funded. These guidelines are established by panels of medical experts who specialise in the area being reviewed. Every piece of NICE guidance and every quality standard are developed by an independent committee of experts including clinicians, patients, carers and health economists. (Politics, 2012)

The Department of Health (D. O. H) provides strategic leadership for public health, the N. H. S and social care. It is responsible for standards of care and sets out a system for adult care and helps control the cost on social care. The department of health also provides promotion and the protection of public health, listing environmental hazards on health, education, infectious diseases, safety of medicines and ethical issues. The D. O. H is also responsible for the allocation of money, to explain to the public how their money is being spent and what is being achieved.

The government is top of hierarchical structure of the N. H. S and the secretary of state for health is responsible for government objectives.

Strategic Health Authorities (S. H. A) is below the government and they manage N. H. S services over designated areas. Each SHA is responsible for enacting the directives and implementing fiscal policy as dictated by the Department of Health at a regional level. In turn each SHA area contains various NHS trusts which take responsibility for running or commissioning local NHS services. Parliament has devolved management locally to ten SHA's and these oversee operations in their area. This is hoped to produce

substantial financial savings. Primary Care Trusts commission primary, community and secondary care from providers. Until 31 May 2011 they also provided community services directly. Collectively PCT. is responsible for spending around 80% of the total NHS budget. PCTs have their own budgets and set their own priorities, within the overriding priorities and budgets set by the relevant Strategic Health Authority, and the Department of Health. They provide funding for general practitioners and medical prescriptions. (NHS, 2012)

The NHS trusts are responsible for specialized patient care and services which run most of the hospitals in the UK, the different trusts are Acute Trusts where short term care, e. g. maternity, accident and emergency, X-rays and surgery are provided and Care Trusts e. g. mental health and ambulance trusts. Ownership of Foundation trusts is by the local communities, employees and local residents. Patients have more power to shape their own health care based on their perceived needs to their satisfaction. Each trust has to meet foundation status before it can be granted.

The UK'S health service is split into two tiers, Primary and Secondary care. Although both tiers of health care have been available since the foundation of the NHS in 1948, it was not until the NHS act of 1977 that clarified the distinction. Primary health is defined as family health care e. g. opticians, family doctors and Secondary health is defined as community health, clinics, treatment in hospitals.

Changes and government reforms and legislations have changed since the form of N. H. S. many times under different governments; Including the Thatcher government of the 1980's where benefits were swept aside for a more internal market to increase efficiency to the N. H. S.

The NHS and Community Care Act in 1990 split the role of health authorities and local authorities by changing their internal structure, so that local authority departments assess the needs of the local population and then purchase the necessary services from ' providers'. To become ' providers' in the internal market, health organisations became NHS trusts, competing with each other. Community care ensures people in need of long-term care are now being able to live either in their own home, with adequate support, or in a residential home setting. (NHS, 2012)

NICE was first proposed by the new Labour government in its 1997 White Paper, " The New NHS". The purpose of the proposed body was to drive up clinical standards in the NHS, and make sure that improvements were consistent across the Service. Recently a new programme of work was to be established by NICE to help the NHS " identify and stop ineffective interventions". It was stated that this would potentially allow the NHS to reinvest millions of pounds on drugs and other treatments that improve patient care.(Politics, 2012) The principle of the white Paper July 2010 reform will be " no decisions about me without me". Under the new plans, patients will be able to choose which GP practice they register with, regardless of where they live, and choose between consultant-led teams. Groups of GPs will be given freedom and responsibility for commissioning care for their local communities. The government is proposing to scrap primary care trusts

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and give councils responsibility for public health and joint working between NHS and other services. The Health secretary's white paper reform also sets out plans for local GP consortiums to take on the PCT. role of commissioning hospital treatments. As expected, strategic health authorities will also be abolished. This will help the Department of Health's target of £20bn savings by 2013/14; abolishing PCTs would save £1bn, and helping to slash NHS management costs by 45%.

The Private Finance Initiative was introduced by the conservative party in 1992 as a way using private funding to pay for public hospitals and education. The Labour Party made a dramatic U-turn and continued using the system when came to power. Under the P. F. I the private sector consortia usually involves large construction companies being contracted to design and build hospitals. Payments are made by the N. H. S trusts over a lifetime; however in the 2007 financial crisis it highlighted how much it was costing the British taxpayer.

In the UK the health provisions available are voluntary, private and statutory. The NHS is a statutory organisation it is government funded and financed from taxation. It is free for all and allows everyone to have the same access to health care, because the organisation it is not a profitable business. However this comes at a price; as users will find longer waiting times, and high service demand, which could potentially lead to a poor service from too much high demand. Also with no completion it could become less motivated and efficient service. The private sector in health care has an extensive list of hospitals such as BUPA and the Nuffield; they provide fewer treatments than the NHS as most private treatment is for specialist referrals and most

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people retaining their NHS GP as their first point of contact. (Firth, 2010)The private sector does subcontracting work for the NHS so some patients may be treated in the private sector. The private sector provides patients with shorter waiting times and is able to invest in newer hospitals and extra staff. Disadvantages to private treatment are that it is not free for all and so not everyone has access to it which can lead to inequalities and it is a profit-making organisation which could see making money come before the well-being of the patient. Charitable and voluntary organisations are also available, these are non-profit making organisations. There are many of these in the UK and include Marie Curie, Macmillan Cancer support, Severn Hospice and Hope House. These are charitable run organisations and rely on fundraising and voluntary contributions. They are non-profitable and have a dedicated specialist staff. However they do rely on donations and volunteers to stay active, and with some charities more popular than others it can be a struggled for these organisations to find enough funds, as well as having to spend donated money on fundraising. The NHS works alongside the private and voluntary care institutions. In 1990 the national health and the community act in England became independent trusts, this encouraged competition and many more hospitals to be built with private funding and were then leased back to the NHS. (Firth, 2010)

Demography influences the provision of the health care services in the UK. Understanding of society's demography is an essential tool to determined current and future health needs. The health needs of the population differ considerably by age and sex, history of birth and death rates changes the age structure in a way that is easy to predict. The sex ratio between men

and women can affect healthcare needs. For most age groups the sex ratio is close to equal. However in general men have higher death rates than women. As a result at older ages sex ratios are much lower, as there are fewer men than women in elderly age. This leaves more elderly women alone, and to be able to care for themselves at elderly ages. (Health, 2012)

The number of over 65s in the UK is expected to rise by 53% between 2001 and 2031 to over 14m; with little change in the younger population (less people are having children). (BBC, 2012) It is predicted that by 2031 the number of cases of coronary heart disease would increase by 44% to 3.19m, with hospital admission rising by a third. Cases of heart failure were predicted to rise by 54% to 1.3 million in 2031, with admissions up 55%. And cases of irregular heartbeat, known as atrial fibrillation, were predicted to rise by 46% to 1.09 million, with hospital admissions increasing by 39%. (BBC, 2012)

The costs of other drugs, diagnostic tests and surgical procedures; more orthopaedic surgery such as Total hip and knee replacements are becoming more common and will continue to rise as with the age of the population. Other strains on the healthcare service resources would be less tax payers to fund the NHS, and the differences between population structure in rural and urban areas. Rural areas may have an older, less mobile population whereas cities may have a higher student and migrant population who are more ethnically diverse and younger and all with different health requirements.

These are just some elements of demography likely to place pressure on the health service.

People are living longer and have healthier lives, which although an amazing achievement from the NHS it can have consequences to all of society. The population is producing more pensioners and less working people to sustain pensions, higher healthcare costs and even in the future less carer's to provide care for the elderly population. (Health, 2012)

The NHS was launched in 1948, with the aim of providing healthcare funded by national taxation and free at the point of access for all UK residents- today, that is more than 60million people. The NHS is one of the world's biggest employers and deals with one million patients every 36 hours (Firth, 2010) (NHS, 2012), with a budget around forty two billion pounds a year. It is a sophisticated modern organisation with all the advantages of state of the art technology. It accommodates the needs of the diverse community it serves, and ensures a general awareness and understanding of equality and diversity to provide a healthcare service that is equitable to everyone. Although most people do not oppose the provision of free healthcare in the UK, some campaigners have drawn attention to the problems in the NHS, such as poor hygiene standards, postcode lotteries, long waiting lists and financial waste.

Bevan's baby is still regarded as one of the world's most successful organisations in the world today, yet arguments are still on-going today to find the best solution for the NHS to be organised managed, for the best results for everyone.

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