Nhs: history of, and modern day

Introduction

Early approaches to health in the UK generally saw it as the responsibility of the individual to seek and pay for health services. However, we can see the emergence of government involvement as early as the late 1700s as Britain was emerging as an industrialised nation. This new age of wealth brought about medical advances but symptomatic of the laissez-faire (leave alone) attitudes of the time, nothing much was done about public health until the Cholera outbreak of 1831 which made government intervention essential. It took the deaths of over 100, 000 people in four cholera epidemics between 1831 and 1866 to get the British government to take action to improve public health in the cities.

Social reformers began to survey the living conditions of the poor and 1842 Edwin Chadwick published his Report on the Sanitary Conditions of the Labouring Population of Great Britain which concluded that the life expectancy of people living in the cities was about half of that living in the countryside. This was due to various forms of epidemic and endemic as a result of mainly overcrowding and the lack of drainage, ventilation and proper cleansing. Change was slow as the report offended many influential groups including water companies, corporations and public figures and the government disassociated itself from the report.

Initial public health acts failed, however, after the second outbreak of Cholera in 1848 the first Public Health Act was passed which allowed Councils to set up a local board of Health if 10% of the rate payers agreed.

Further public health acts were passed in 1872 and 1875, the latter completely changing public health as it forced councils to take action which included providing clean drinking water and proper sanitation. This was when we saw a concerted effort by the government to intervene in public health. Early hospitals were part voluntary, where the standards varied, and there were Local Authority Hospitals, which were developed from the workhouses. There were also Teaching hospitals, which were the best, but these charged fees. Most of the population paid for care they needed, although some were covered by national insurance. The services did not include dental care, ophthalmic services or hearing aids, specialised treatments and did not cover non insured family members.

In 1942 the British economist William Beveridge produced his Report on Social Insurance and Allied Service, later known as the Beveridge report.

It listed five basic problems in public health: idleness, ignorance, disease, squalor and want and proposed a scheme to look after people from ‘ the cradle to the grave’.

Later in 1948 we saw the beginning of full government responsibility in the form of the National Health Service Act when the people of Britain were provided with free diagnosis and treatment of illness, as well as dental and ophthalmic services.

Formation of the modern NHS

In 1980 the DHSS published the Black report which concluded that although overall health had improved since the introduction of the welfare state, there were widespread health inequalities. It also found that the main cause of

these inequalities was poverty and it stated that the death rate for men in social class V was twice that for men in social class I and that gap between the two was increasing. This report led to an assessment by the World Health Organization of health inequalities in 13 countries.

The situation did not improve and in 1992 the government published the Health of a Nation, which listed numerous targets to improve public health.

Approaches under the Conservative and New Labour governments saw an attempt to shift responsibility away from the state back towards the individual. Margaret Thatcher was unsure how to tackle the NHS in the 1980s, as it was so popular with the public, but eventually decided to follow her principles that she had followed on other policies, that of internal competition. The NHS was in real crisis at the time and it was felt by many that it had created aculture of dependency. The government wanted to transfer the emphasis from ‘ dependence’ to ‘ independence’, by ending the “ benefit culture”. The government believed that the NHS should be for the poorest and they actively encouraged the public to make their own provision with regards to their own health and insurance, either through company or private cover. These right wing ‘ think tank’ policies continue with the new Labour government in 1997 and this set about to fragment the NHS with autonomous foundation trusts.

Tony Blair did not want to dissolve Conservative reforms and was attracted to use incentives to kick start the modernisation of the HNS. He was determined to boost spending to the EU average and opposed to traditional socialist values, he believed that reform needed to be in partnership with the

private or voluntary sector. Waiting times were not falling and he wanted the patient to have a choice of which hospital or which doctor to treat them under patient controlled care. He states ‘ I need to know how to increase the role of the private sector in health’ (Seldon: p44). Against much hostility within the Labour Party on 19 November 2003, the bill was passed for the formation of self funding Foundation Hospitals. These hospitals are independent legal entities which can opt out of government guidelines. Critics argue that the top hospitals are attracting investment and more money, therefore creating a two tier system.

Structure of the NHS in England

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The NHS is divided into two separate sections. The first is primary care which is initially the first point of contact for most patients. The services are delivered by a large range of independent health care professionals such as GPs, dentists, pharmacist’s optometrists and podiatrists.

Secondary care can be either elective care or emergency care. Elective care is generally specialist medical care or surgery, typically following a referral from a primary health care professional such as a GP. There are also tertiary care services which offer specialist care, such as hospitals for sick children.

The Department of Health is responsible for running the NHS, public health and social care in England. This organisation provides organised direction, secures resources as well as setting national minimum service standards.

The NHS Executive is part of the Department of Health with offices in Leeds and London and eight regions across the country. It supports Ministers and provides leadership and a range of management functions to the NHS, while the regional offices make sure national policy is developed in their own areas.

In October 2002, 28 Strategic Health Authorities were created to manage the NHS at local level and act as a link back to the Department of Health. The role of the SHA is to support the local health service in improving performance, integrating national priorities into local health plans as well as resolving any conflicts between local NHS organisations. SHAs also monitor the performance of Primary Care Trusts and ensure that they meet their specific targets. The number of SHA was reduced in 2006 to 10 in order to provide a better service.

There are 147 Primary Care Trusts in England, each charged with planning, securing and improving primary and community health services in their local area. They work strongly with patients, the public, GP practices to deliver these healthcare services. PCTs are allocated 75% of the NHS budget to fund services and are accountable to their local SHA.

Primary Care Groups are there to improve the health of the population and they bring together GPs, community nurses, managers, social services, local communities, Health Authorities in partnership to improve services and the health of their community.

NHS Trusts employ the majority of the workforce in the health service. Most of their income is generated from Primary Care Trusts and are mainly self

governing, but accountable to SHA. They have to deliver results and if they don’t their agreements can be withdrawn. The main types of trust are as follows.

1. Acute Trusts

There are 168 acute trusts and they manage hospitals to make sure there is quality health care. They employ the vast majority of the NHS workforce.

2. Care Trusts

These Trusts are organisations that work in both health and social care. They are set up between local authorities to enable close integration and benefit the local community. They usually concentrate on specialist mental health and older people’s services

3. Mental Health Trusts

There are 60 Mental Health Trusts in England which provide specialist mental health services in hospitals and the local community.

4. Ambulance Trusts

There are 12 Ambulance Trusts in England providing patients with emergency access to health care.

5. Children’s Trusts

These are run by the local government and offer an integrated service for children.

6. Foundation Trusts

There are currently 122 Foundation Trusts which are non-profit making organisation owned by members of the local community. These Trusts remain within the NHS and its performance inspection system.

One significant change was in 2003 when The Commission for Patient and Public Involvement in Health (CPPIH) was set up. This is an independent body which collects information from the public so that they can be involved in health care. It represents public views on healthcare matters and provides advice and support to patients wanting to make a complaint about NHS Services.

Private Health Care

In an affluent society like Britain with an individualist culture, there has been increasing private health care in the UK since the 1980s when the conservative government introduced ‘ market orientation’ in which there was compulsory tendering for ancillary services such as catering and laundry. By 1985 private contractors undertook 40% of all ancillary services. Private health care has been actively encouraged by the government to ease the burden of the NHS and although there has been substantial expansion, it only accounted for 18% of the total spending on health care in 2005. Around three quarters of those using private health care pay for it by health insurance, usually by their employers. The amount of people with private insurance has increase from 2. 1 million in 1971 to 7 million by 2003. Some sorts of treatments like cosmetic surgery are only available through private medicine and there is also a tendency for people to make one off visits for minor operations to avoid long waiting times with the NHS. Patients generally get better treatment for private health care and competition between companies improves the all round service. One of the major downsides is that more affluent areas attract better hospitals and services and it the lower social groups that require more health care. People that do

not have the expertise about health sometimes may be persuaded under private health care to undergo operation they do not necessarily need.

The private sector is made up of different types of company, the largest ones being PLCs, companies like BUPA which carry out approximately 850, 000 operations each year. Another sector is smaller private limited companies and organisations such as Podiatrists and Physiotherapists.

Voluntary, alternative and complementary medicine

There has been a growing popularity of alternative therapies to challenge medical pre-eminence and is estimated that a fifth of the population has used some form of alternative medicine. These include professionally organised therapies such as acupuncture and chiropractic, complementary therapies such as aromatherapy and hypnotherapy and alternative disciplines such as kinesiology and radionics. Voluntary services are those which are considered not profit making and are registered charities i. e Age Concern and Mencap. They do not cover all localities and only a few are involved in the direct provision of health care.

Relationship between the different types of health care

Private health care often fails to care for those who need it the most, the poor and the elderly and private health care systems which are in competition with each other tend to be less efficient than the NHS. In 2002 the new labour government continued to use the private sector in conjunction with the NHS services to expand capacity, increase access and promote diversity in the provision and choice of health services (Department of Health, 2002). The NHS has pay beds which are rented out to the private sector, although these often cost more to service than the money they raise.

While most patients seek conventional medicine and receive treatment from the NHS, some alternative medicine has been recognised by the medical profession. These services have been incorporated into medical practices and treatments such as osteopathy and acupuncture are now available to NHS patients. Voluntary groups contribute to care in the community and can make improvements to people's lives, yet the ' mixed economy' of health care and the boundaries of responsibility are not always clear.

Conclusion

Originally the HNS was set up to be free at the point of entry and it has stayed largely unchanged for over 30 years. Since the 1980s ' internal market', changes have taken place and new labours reforms set up Foundation Hospitals and actively encouraged the private sector. In the future there will be undoubtedly further expansion of primary and preventative health care and more commercial involvement and expansion of the private sector.

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