Inequality and the Health Service

Many histories of the evolution of health services are based on the naive assumption of ~~blindly~~ continuous progress. Sometimes progress is assumed to be steady and sometimes hard on the ~~heels~~ heels of the ~~brilliant~~ discovery of a new method of treating disease or as the ~~initial~~ result of legislative and administrative reform, rapid. The establishment of the National Health Service in England and Wales, and of the parallel service in Scotland, tends to be regarded historically and contemporaneously as an achievement which will endure forever. But the truth is more complicated, the achievement less certain and the future less ophimistic. In the sense of bits of paper approved by Parliament the achievement must logically be final. In the sense of living reality intended to serve certain principles of care & distribution of resources the achievement is more contingent.

Health services are social institutions and as such they can change relative to their own past and to other institutions. The quality of recruitment to the various health professions can improve or decline, ~~the standard of~~ training become standardised or more variable and medical and nursing practice become more or less subject to the quality controls of professional and community. The needs of the population for health services can also change rapidly as a result of population growth, regional development, the incursion of new industries

This must include the possibility of retrogression as well as progression.

Social groups develop conceptions of illness and health which are controversially subject to revision in response to not only to scientific discovery and innovation but self-interested expression of what conditions require and deserve. Sympathetic consideration and intervention as distinct from those conditions and actions regarded as deviant and requiring social reprobation and correction. Such socially inspired conceptions & definitions are applied to categories of treaters and treated. Health personnel and treatments come to be given highly defined roles. They are divided into groups for purposes of status differentiation and not merely for convenience of

Triumvirate of scientific discovery, practitioners and public are engaged in constant communication to redefine the meaning of illness

Lancet June 9 73 pp 1293-4

" It is largely because of medicine's failure to pin down the causes and enable the prevention of modern epidemic chronic diseases in middle and old age that life-expectancy figures have lately been increasing little, if at all. There are, however, still many unexploited opportunities for imaginative epidemiological work on the causation and prevention of, for example, rheumatic disorders, neurosis, arterial disease, smoking, traffic accidents, congenital malformations, and other disabling conditions. In cancer, at least, (MRC Ann Repts 1971-72, Harts) steady, if slow progress is being made, much of it by epidemiological means. "

and the whole value system about inequalities of status & reward has been affected substantially by public concern about health, the

National
Morbidity
Survey

Cochrane A.L

Layman's uncritical belief in the medical profession due to "the doctors ability to reduce pain, the general placebo effect, the tendency of many diseases to disappear spontaneously or improve with time, and the higher education and social status of the doctor in the past which possibly assisted him in alleviating hysterical symptoms."

p.7 Between 1951 & 1968 requests for pathology tests increased three times, X-ray units of work nearly doubled.

p.13. Digest of Health Statistics trends 1959-1969.
p.14 Expectation of life trends. SMRs 1959-69 for different diseases
p.72 Allocation regionally of in-patient beds.

Tutor Unit [illegible]

Statistical tables.

1. Expectation of life trends
2. Mortality rates diff. diseases trends
3. Morbidity rates diff. disease trends
4. Social class SMRs trends. Discussion 1951-61.
5. Regional inequalities trends? a) g.ps areas b) hospital beds diff types
6. Inequalities in hospital costs
7. Inequalities in exp. diff types of diseases.

p. 13 Inf mortality

Tables

1. Exam Trends in mortality rates among diff societies
2. Expectation of life

Repositories of scientific knowledge

Expansion is not profound

dogmas of omniscience, omnipotence & infallibility

guarantee of quality of service for people ill-equipped to judge

personal service ethic

Code of ethics of profession

previously

duties to public

strong collectivist & altruistic considerations

specialisation of interest

increasingly fitted into new hierarchical orgs.

gp referral

humanistic & individualistic creeds of the professions provided a source of independent criticism of impersonal bureaucracy

TU role of prof. bodies to secure pay increases or special rem for extra duties "may lead to a dilution of the tradition of professional service. Self-interest may well be stressed at the expense of self-sacrifice." p11 Klein

monopolising technical know-how

political ideology plays a central role in diagnosis & treatment - the Chinese health care system. By 'deprofessionalising' patient management it makes the behaviour of medical workers susceptible to lay evaluation

socio-political awareness of patients needs

sensitise health workers to patients' social environment

m.1 hosps with 200+ beds 1971

Table 18 med staff 0.75 – 8.66

nurses 22.5 – 70.6

Table 27 m handicap

med staff 0.05 – 2.55

nurses 15.4 59.2

removing financial barriers less important than creation of framework within which quality of medical care cd. be improved faster than could be expected to occur in a private market.

dental services better with assistants - salaried rather than fee for service.
Opthalmic services to be under the "surveillance of medically qualified ophthalmologists."
Little to restrict the activities of drug industry

~~In the fact~~ In the early fifties the number of "underdoctored" areas was reduced. In the late 50s the number levelled off but began to increase in the 1960s.

"The broad patterns of staffing needs have not changed dramatically over the last twenty to thirty years. Areas which are currently facing the most serious shortages seem to have a fairly long history of manpower difficulties, whilst those which are today relatively well supplied with family doctors have generally had no difficulty in past years in attracting & keeping an adequate number of practitioners."

p. 42

Butler J R et al Family Doctors & Public Policy
London, 1973,

"The NHS is the expression of a particular theory of how medical care services ought to be organised. It is an attempt to make the public health services respond not only to medicine's increased ability to combat & control disease but to the changed pattern of disease in the community.

No. per 100,000 population

	Pop per physician			Pop per hosp bed		Average annual rate of growth per 100,000 population in the 1960s %
US	1969	149.5	669	1962 760	131.6	123	1.84
Austria	1970	185.2	540	1962 550	181.8	92	0.23
Belgium	1968	155.3	644	1962 720	138.9	125	1.88
Cz	1969	200	~~500~~	1962 540	185.2	97	1.10
DK	1969	145.1	689	1960 810	123.5	112	1.81
Fr	1970	133.9	747	1961 910	109.9 1969	113	2.22
Fed Rep	1969	168.4	594	1962 670	149.3	~~88~~ 87	1.73
Hungary	1969	191.9	521	1961 610	163.9	123	1.99
Italy	1970	180.8	553	1961 610	163.9 1967	99	1.10
Sweden	1969	130.2	768	1961 1000	100	67	3.35
Eng+W	1969	117.0	855	1960 960	104.2	106	1.30
Spain	1969	132.5	755	1962 820	122.0	218	1.19
Netherlands	1970	120.2	832	1961 890	112.4	192	0.75
Japan	1969	111.4	898	1962 900	111.1	79	0.04

UN Statistical Yearbook for 1971 and 1964

120 – 200

20 – 200

India	1967	4,610	22
Pakistan	1969	5,350	19
Ethiopia	1969	71,797	1
Nepal	1969	49,095	2
China	1969	3,170	32
Indonesia	1967	27,561	4
Laos	1970	16,536	6
Tanzania	1969	23,173	4
Malawi	1967	43,368	2

Table 5

62

Comparative incidence of social class mortalities in ~~selected~~ different age-groups

~~Standardised mortality ratios by social class~~ for men, married women and single women ~~of different age~~ (1959-63)

Men	Social class	15-19	20-24	15-24	25-34	35-44	45-54	55-64	65-74	~~70-74~~
	I	72	59	65	73	69	76	78	86	~~84~~
	II	106	85	95	72	73	77	84	94	
	III	97	90	94	89	97	100	102	116	
	IV	118	100	109	107	104	104	101	105	
	V	142	149	146	181	181	158	134	123	
Married women										
	I	(38)	(79)	(80)	83	75	78	76	74	
	II	(41)	64	64	76	79	82	85	93	
	III	97	97	98	99	102	102	102	111	
	IV	(88)	92	92	103	106	104	106	107	
	V	(159)	159	159	163	153	144	136	128	
Single women										
	I	97	79	(102)	(67)	82	86	83	103	
	II	103	70	94	56	65	82	99	144	
	III	78	72	76	74	73	86	104	144	
	IV	95	98	98	93	97	104	116	166	
	V	197	213	208	145	132	105	119	130	

~~pp. 315-319~~

Source: The Registrar General's Decennial Supplement, England & Wales, 1961, Occupational Mortality Tables, London, HMSO, 1971, Tables 3 and 4.

1. The figures for age-groups 15-19 and 20-24 in Tables 3A, 3B + 3C sometimes seem inconsistent with those ~~for the~~ as given for the age-group 15-24 in Table 4
2. The figures for ~~age~~ single women aged 65-74 seem unlikely (pp 315-319)

Table 6

Morbidity: Limiting long-standard illness, 1972

rates expressed as a percentage of those for all socio-economic groups

63 54

Socio-economic groups	Males				Females			
	All ages	15-44	45-64	65+	All ages	15-44	45-64	65+
Professional	64	89	63	-	55	71	65	-
Employers & managerial	79	94	62	84	69	94	60	75
Intermediate & junior non-manual	89	91	98	82	81	75	88	90
Skilled manual	95	96	101	101	96	122	102	100
Partly skilled	126	109	129	115	137	112	134	111
Unskilled	164	177	160	124	166	137	132	113
All So	100	100	100	100	100	100	100	100

Source: Social Trends No. 4., 1973, Table 69
Based on GHS, 1972.

Table 7

Consultation rates per person per year, for males only, 1971 ~~rates~~ expressed as a percentage of those per person for all socio-economic groups

Socio-economic group	Age					
	All	0-4	5-14	15-44	45-64	65+
Professional, employers & managers	100	113	105	100	91	100
Intermediate & junior non-manual	97	111	95	100	88	96
Skilled manual	103	107	95	104	100	107
Partly skilled and unskilled manual	109	65	105	117	132	96
All	100	100	100	100	100	100

Source: OPCS, Social Survey Division, The General Household Survey, London, HMSO, 1973, p. 319

Infant mortality

Bootle	33		
Oldham	30	Oxford	17
Preston	31	Ipswich	18
Merthyr Tydfil	33	Hampstead	18
Warrington	29	Exeter	18
Newport	29	Croydon	18
St Helens	28		
Salford	28		
Manchester	29		
Liverpool	28		
Bradford	29		
Burnley	28		
Dewsbury	29		

Male Deaths per 1000 population aged 45-64

Salford	20.1	Oxford	11.7
Bootle	18.4	Norwich	12.8
Burnley	18.3	Bath	12.5
Dewsbury	18.2	Bournemouth	12.9
Manchester	18.6	Croydon	12.6
Merthyr Tydfil	18.1	Exeter	12.8
		Gt Yarmouth	12.2
		Ipswich	11.1
		Southend	12.4

Females.

Burnley	10.4	Bootle	9.0	Oxford	6.2
Merthyr Tydfil	10.9	Blackburn	9.4	Reading	6.9
Salford	9.6			Ipswich	6.3
Stoke	9.3			Southend	6.6
Rochdale	9.2			Canterbury	6.5
Wakefield	9.1			Bath	6.9
Warrington	9.1			Bournemouth	6.7
Wigan	9.1			Croydon	6.4
Dewsbury	9.5			Eastbourne	6.8
Barry	9.9				

the very slight relative ~~improvement~~ increase lately in expenditure on mental handicap

Stuff to be typed.

the failure to raise ~~relative~~ expenditure for patient relatively in long-stay and mental illness hospitals and to raise it ~~expenditure only~~ more than marginally in mental handicap hospitals, despite a succession of ~~disturbing~~ investigations of bad conditions in the late 1960s and early 1970s in different long-stay hospitals (E1) (E2) and widespread publicity and concern, and the introduction of new Government policies aimed at promoting rapid improvement. ~~An~~ Examination of the whole episode – of the failure of the health system to respond to the new policies, or perhaps of the policies themselves to effect change – would be more ~~than anything else~~ than anything else likely to reveal ~~for what are the deficiences general deficiencies of health service planning~~ E

likely than examination of any other sequence of events in recent years to yield insights into the general deficiencies of health service planning.

The Problems of Professionalism, Managerial Control and Privileged Access to Knowledge

I have pursued the twin themes of inequality ~~of health need~~ in health conditions or needs of health and of provision of services. ~~The broader and~~ On both scores we ~~have~~ confront evidence which seems to demand a searching re-appraisal of the whole development of our health system. There ~~is~~ are problems of identifying performance, understanding the interconnections within the health system of different branches of service and ~~explaining why~~ defining the boundaries, and explaining why policies designed to lead to more equitable distribution of services ~~may have~~ have been frustrated. A deeper analysis of the persistence ~~of inequity~~ and even the widening of inequality may be required.

(*) However widely the health system is conceived and drawn its ~~restricted~~ potentiality ~~of the health system~~ is restricted has to be recognised. The system is not the only ~~or even the main~~ determinant of mortality or morbidity. ~~These depend on~~ States of health depend on peace or war, nutrition, ~~and~~ living standards, education and the working environment. One illustration might be given. ~~is that~~ Whereas staffing ratios for health visitors, consultant ~~obst~~ obstetricians, paediatricians and general practitioners are all slightly higher in Scotland than in England + Wales

The infant mortality rate remains relatively high. Scotland has a legacy of poor housing, particularly in the major cities, and a Scottish Health Service study showed that found, for example, that the infant mortality rate was directly proportional to the degree of overcrowding (52).

because that implies they are isolated from one another, and isolated in their effects. They must be designed to represent that interdependence.

The interdependence of services within the system also deserves to be better understood. ~~Measures of adequacy and efficiency must not be developed just for isolated parts of particular services if they were isolated from one another and must be designed to represent that interdependence.~~ General practice complements and is interconnected with hospital and specialist medicine on the one hand and with the public health and welfare or personal social services on the other. ~~This applies as much to~~ The relative scale, balance and working functions of each part of the system have to be identified for the local community as well as for the nation as a whole.

This functional interdependence has been recognised in the plans for the reorganisation of in 1974 of the National Health Service. The trouble is that the reorganisation takes a hierarchical form, ~~embodying the principles of~~ stressing the virtues of managerial control or efficiency, the superior status and power of the upper reaches of the medical profession and the exclusivity of knowledge. I believe it will come into conflict not only with democratic conception of health service, but with comprehensive conception of health needs, equitable and inexpensive deployment of resources and the long term advance in promotion of the highest standards of health education. ~~in health.~~ ~~What needs to be stressed~~ What is wanted is not a long and remote chain of command but access to, and involvement in, strong community health, welfare and housing services.

One might argue that the Labour Government's second green paper on reorganisation did not go far enough in devolving power and strengthening the community services. (53) But the proposed regional health councils were intended to have control only over the blood transfusion service and the organisation of postgraduate education and research, and the power to appoint to ~~health councils of the Secretary of State to appoint to~~

only a third of the ~~three~~ area health authorities were to be appointed by the Secretary of State. On grounds of managerial efficiency the present Government has introduced a ~~much stronger~~ multi-tier organisation almost totally controlled from above. The 14 regional health authorities in England have powers to plan the regions and allocate resources to and supervise area health authorities, ~~and the Secretary of State has~~ Few of those appointed to the 14 authorities are manual workers or consumers. Nearly a third are businessmen—bankers, company directors, business executives, property developers and brokers. The next largest ~~Another~~ section comprises doctors, ~~most of them~~ and the next, solicitors and accountants. (54) ~~The majority of~~ Half the members of the area health authorities are appointed by the professions, and half by the regional authorities. The new community health councils have few rights and are in any case appointed by area health authorities. (55)

"The biggest single criticism of ~~Sir~~ Sir Keith's plan is that there is likely to be even less informed public criticism of the needs of the health services than there is at present"

~~The critical decisions~~ really It is in such a managerial system that the consultants can exert greatest influence — on the DHSS through professional pressure-groups and all kinds of central departmental committees and working parties, and on the regional health authorities, where all the vital planning decisions about the hospital service will be taken. Moreover, the change from Regional Hospital Boards to Regional Health Authorities indicates the increased scope of ~~boards increases~~ their influence over ~~the~~ planning decisions which affect the general practitioner and other community health services

The accommodation of the health and other social service professions to the structure and operating assumptions of corporate management, whether of industry or state, represents the largest single threat to free access to health care and the aim of a healthy society. This ~~will~~ might be shown in a variety of contexts. In the history of all the professions there has been the problem of reconciling the acquisition and practise of "skills presupposing willingness to enter into social relations on a basis apparently incompatible with noble rank" with the ascription or temptation to secure attainment of high status as a guarantee of autonomy. (56) On the one hand there is the obligation to stress altruistic values, to serve the

community, consider the individual without regard to his social background or status, be available at all reasonable times and put the needs of clients, patients or consumers before self-interests. Professional codes of conduct ~~and ethics~~ are developed with the intention of prescribing duties to the public and guaranteeing quality of service. ~~Qualifica~~ Qualifications and training schools are introduced and conditions of entry to the profession with the intention of ensuring conformity and high standards of practice. ~~On the other hand~~ Humanistic and individualistic creeds are established as a ~~protection~~ protective social force independent of the exercise of ~~impersonal~~ political power and impersonal bureaucracy. On the other hand there are simultaneous tendencies to monopolise technical know-how, establish dogmas of omniscience, omnipotence or infallability, protect members against outside criticisms, use power to secure excessively privileged ~~standards of~~ conditions of remuneration and work, and resist change.

The development and significance of this context has to be reviewed in different contexts. On the debit side might be listed the recent history of the medical profession's ~~preoccupation with~~ insistence above all else, on high remuneration and privileged terms of service, including the expensive ~~reinforcement of~~ choice of merit awards (56a); the failure to institute effective complaints procedures (57); the failure to broaden medical education and ~~the entry to the profession~~ admit greater numbers of women and manual workers' children to medical training (58); the failure to introduce greater control over, and supervision of the pharmaceutical industry, as exemplified in the Sainsbury Report (59); and the failure to understand the implications of trends in patterns of disease and mortality for the wider control of industry (in the case of the tobacco and vehicle manufacturing industries), and ~~importance of~~ the value of health education and the importance of the social aspects of disease to the practice of medicine.

On the credit side might be listed the belated creation of a large number of health centres, the growth of group practice with ancillary workers and diagnostic facilities, ~~the slow~~ though slow increase in numbers of district nurses and home helps; the

The signs of a critical spirit among new entrants to the medical profession (60), the

~~experimental community mental service for the mentally ill and others; The recognition~~

reduction in number of mental hospital patients and the beginning of alternative community services, such as sheltered housing & workshops and day centres, for the mentally ill, mentally handicapped, elderly and disabled in the community. ~~Despite these reservations that would have to be made, for it is overshadowed~~ Although these trends are overshadowed by the reinforcement of consultant power and status in the hospitals, ~~this is a movement which has imaginative potentialities for the organisation of the health services of the future.~~ and in themselves are not above criticism, they provide the potentiality for the organisation of the health services of the future.

The right of the sick to free access to ~~needed~~ health care, irrespective of class or income, remains to be firmly established. The treatment in particular of many of the aged, ~~the~~ chronic sick and disabled, mentally ill and mentally handicapped, remains scandalously poor and can in the long run be dramatically improved only by a ~~reconstruction of~~ redefinition of ~~concepts~~ health and health needs, and by a reconstruction of professional values and organisation, the education and involvement of the patient, and the establishment of social equality.

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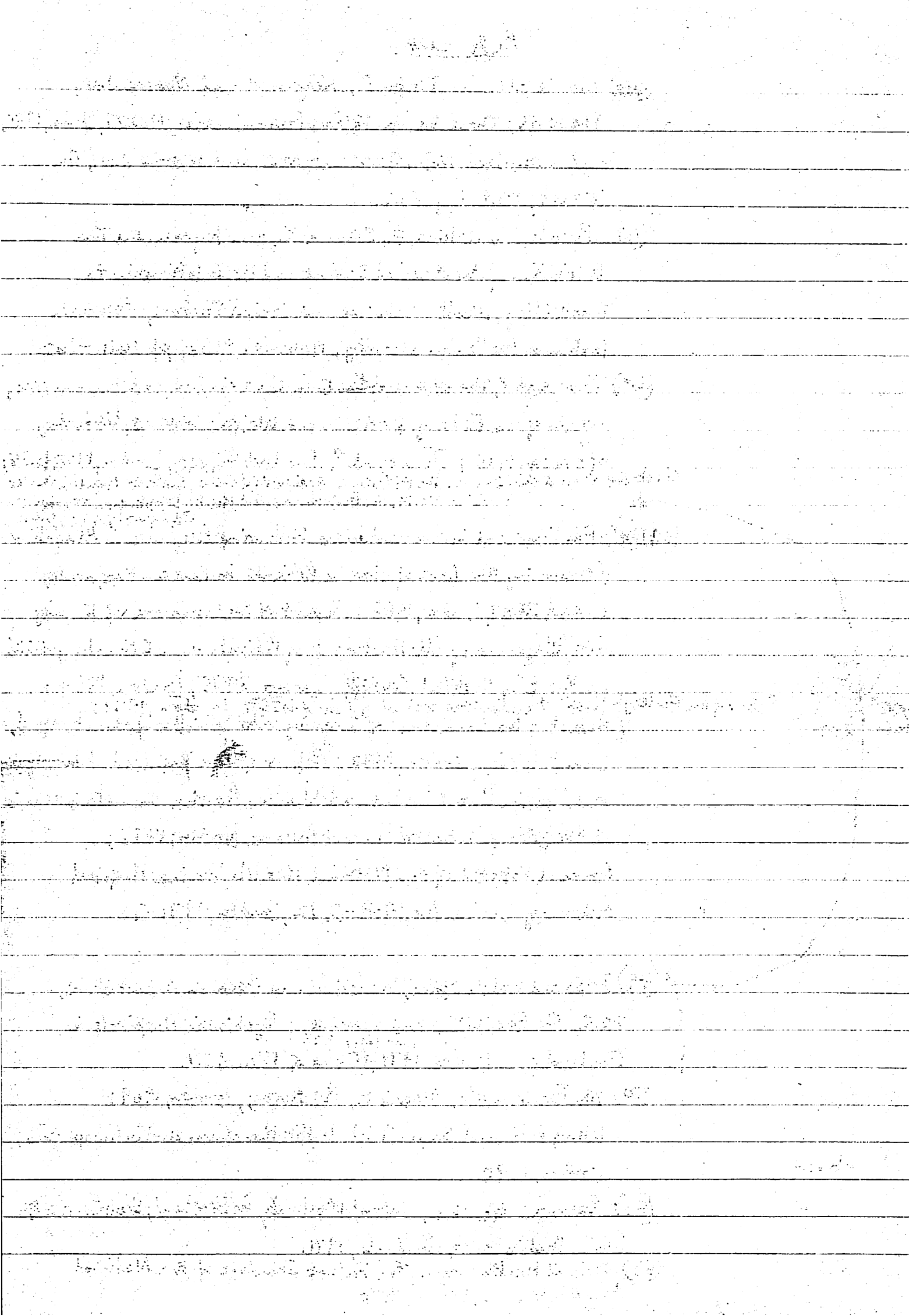

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The very slight relative improvement among long-stay hospital shown in other types of mental handicap hospitals and the fact that ~~improvement is not substantial~~ despite the development of new Government policies in the late 1960s and early 1970s a succession of disturbing investigations of conditions in different long-stay hospitals, widespread publicity and concern, and specific aimed at rapid improvement, the failure of the health system to respond to the new policies, or perhaps of the policies themselves to effect change, would be perhaps the most valuable episode in recent years to examine for the lessons that might be drawn for more effective planning of the health service

Honigsbaum discussion
Crossman - Costs of NHS

DHSS. Health & Personal Soc. Services Statistics for E & W (with summary tables GB) 1972

GB. T. 1.1 p11.	1949	1971
inf mortality per 1000 live births	33·7	17·8
mat. mortality per 1000 total births	1·00	0·17
Deaths per 000 population	11·7	11·6

E.

E & W		1959	
Hosp med staff	11,735	16,033	23,806
nursing staff	137,636	190,946	288,065
hosp ancillary staff	157,112	197,189	239,770
general m. practitioners	?	22,091	21,910

wre
10 Social medicine in hosp med. staff.

The no. of practices in E + W in which nos of patients are very high has nearly doubled, increasing from 3,305 "designated" with av. list size of 2,748 to 6,207 with av. list size of 8,781
Between 1963 & 71 the % number of ~~practices with 30~~ m. practitioners with 3000 or more patients increased from 18 to 20 per cent — the increase being greatest in the North & N W.

Registrar G's Decennial Supplement

John Bond

E.R. Branchy "Mental Illness & the Psychiatric Service" Social Trends No 4. 1973

E & W. 1954 152,000

1971 110,000 or 66% of 1954 rate ~~per 100,~~

But increase among over 75s. Biggest decline in middle aged groups.

~~Life~~ Lifetime chances of being admitted to a mental hospital was 1 in 9 for men & 1 in 6 for women

(Hill & B Stat. Res Report Ser. No 4 DHSS 1972)

—

Manpower 961,000 in 1972 full-time equivalent, of whom only 57,000 hosp medical staff & medical practitioners.

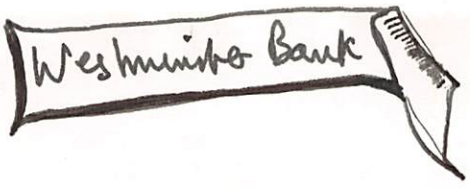
—

Infant mortality Of nine listed in ST. UK 3rd in 1950 after Netherlands in 1960 2nd & USA. In 1971 5th after

Bateman Thomson

Male

	Exp of life			
Est ~~Wk~~	68-70	68.6	67.3	1953
Austria	70	66.3	61.9	49-51
Belgium	59-63	67.7 ?	62.0	46-49
Bulgaria	65-67	68.8 ✓	45.9	25-28 ×
Cz	66	67.3	51.9	29-32
DK	68-9	70.7 ✓	✓ 67.8	46-50
Fin	61-5	65.4	58.6	46-50
Fr	69	67.6	63.6	50-51
German	66-8	67.5	64.6	49-51
Netherlands	70	70.7 ✓	✓ 70.6	50-52
Norway	61-5	71.0 ✓	✓ 69.2	46-50
Sweden	67	71.8 ✓	✓ 69.0	46-50
Switz	58-63	68.7 ✓	62.7	39-44



Phone Tony Lynes
Write Tony Rees
Joyce Pick
Kit Russell

Contract

Elizabeth Monck
Journal of Preventive & Social Medicine.

What may have served to

- ~~Expectations~~
I have spoken of conceptions of illness or health, the structure of the health care system
If our definition of what constitutes illness and states of health ~~grows substantially & becomes more~~ is greatly extended & complicated our expectations ~~and~~ of the health services & the standards by which we judge them, change correspondingly. Even if definitions remain the same the control & defeat of some diseases may have to be balanced by the growth ~~of~~ in prevalence of other types of diseases for which cures have not been ~~found~~ found or by the appearance of new kinds of health con

and the pattern of health needs in society.
Any one or all three of these may change significantly over time.

Why is this so? Partly it is because of an inefficient appreciation of the significance of health services in relation to social structure and values. Depending on how "health" is defined, expenditure on health in the United Kingdom amounts to between 6 per cent and 9 per cent of Gross National Product; and total personnel employed by the health services number about one million, or 4 per cent of the employed population. These are telling measures of scale of effort and, as studies in the early 1960s by the World Health Organisation and the Canadian Royal Commission on Health Services have shown (1, 2), they have been growing disproportionately in recent years in many different countries.

Sociological analysis has also tended, particularly in the United States, to take restricted forms of study of professional and patients' roles; of particular conceptions of illness, like mental illness; and of particular organisations like general hospitals for the acutely ill and mentally ill, rather than study of the entire system of health care and its internal structure as well as its external relationship to other systems, like the economy and the polity, and particularly its place in national and international systems of social stratification.

Work in social admin has concentrated on

TABLE 7

Comparative ratios for mortality (1959-63) and sickness absence (1961-62) for males by social class

Social class	All males 15-64 Standardised Mortality Ratio	Employed males 15-64 Sickness	
		Comparative Inception Figure	Comparative Duration Figure
I and II	80	64	50
III	100	100	93
IV	103	109	117
V	143	124	154

Source: Daw R H, Journal of the Institute of Actuaries, 97, 1971

MR SUAR

7 Abel-Smith ~~B. Bull N Y Acad Med 1964~~ The Hosp . . . .

p 00 ? Hart JT, Int J Hlth Serv. 1972, 2 = (1) 349

Vol no? ~~B~~ Abel-Smith B Bull NY Acad Med, 1964, ~~=~~ 525

p 000? 25 Daw RH J. Inst Actuaries, 1971, 97 p 17

Wrong ref? (50) Morris J.N. Proc. of the Royal Society of Medicine March 1973, Vol 66, No. 3. pp 225-232
Crawford MD Gardner MJ Morris JN Lancet 1968, i p000

p000? (75) Lancet 1970, i p (13 June) 1035 Green Paper.

Hosp costing returns £4·48 med. costs? How add to £78

Acknowledgements

I am grateful to the following for advice and comments,
Professor Brian Abel-Smith; Dr A.M. ~~Adelstein~~ Howard Goldstein Joyskeg, Dr Julian Tudor Hart,
Professor J. M. Tanner, Prof. J.N. Morris, Prof Margaret Stacey, Elizabeth Moncke
~~Dorothy Bond~~ Adrian Sinfield

Hy 1 14

Pain in health service May 9 1970
986

Yet their reaction may have been a blessing in disguise, because the Labour Party had not begun to recognise that the administrative practical implementation of our income guarantee would somehow be tantamount to the traditional administration of the means test

began to perceive the likelihood that in any form it would be implemented the income guarantee would resemble ~~traditional~~ means-tested welfare

Table 3

Standardised mortality ratios by social class

Social class	men (15-64) 1930-32	men (15-64) 1949-53	men (15-64) 1959-63	married women (15-64) 1959-63	single women (15-64) 1959-63
I Professional	90	86	76	77	83
II Managerial	94	92	81	83	88
III Skilled manual and non-manual	97	101	100	102	90
IV Partly skilled	102	104	103	105	108
V Unskilled	111	118	143	141	121

Note: 1. Information about occupations in the 1961 census, with which information from death certificates for 1959-63 was compared, was based on a 10 per cent sample.

2. Occupations in 1961 were re-classified on a new basis with the result that approximately 24 per cent would have been allocated to a different class if the 1950 basis of classification had been used. However, the vast majority (92%) of these were re-classified to the next ascending or descending class in rank order.

3. The SMRs for 1949-53 in column 2 have been adjusted by the Registrar General from the figures first published to correct certain errors.

Source: The Registrar General's Decennial Supplement, England and Wales, 1961, Occupational Mortality Tables, London, HMSO, 1971, Tables D4 and 4.

Table 4

Comparative incidence of infant mortality by social class

Social class	ratio of actual to expected deaths of infants 1930-32	1949-53	1959-63
I	53	63	73
II	73	73	
III	94	97	98
IV	108	114	119
V	125	138	

Source: Hart J L, The Lancet, 22 January, 1972

(52a) See, for example, Strauss A. et al, ~~"The Hospital and its Negotiated Order"~~ in Freidson E. (ed) The Hospital in Modern Society, New York, ~~The Free Press~~, 1963; Strauss A et al, Psychiatric Ideologies and Institutions, New York, 1964; Hunter T.D, ~~"~~ The Hospital, ~~its~~ April 1971.

(52b) ~~Draper P in The National Health Service: Three Views, Fabian Research Series 1970;~~ Draper P and Smart T., The Future of Our Health Care, Dept of Community Medicine, ~~Guys~~ Guy's ~~Medical~~ Hospital Medical School, London, 1972; Draper P, Community Medicine, 23 February 1973; and see the testy references to the critics in The National Health Service Reorganisation, London, Office of Health Economics, March 1974, pp 28-29.

(52c) Ministry of Health and Scottish Home and Health Department, Report of the Committee on Senior Nursing Staff Structure (The Salmon Report), London, ~~HMSO~~, 1966.

26a Ashley J.S.A., Howlett A and Morris J.N., The Lancet, II, 1971, 1308 11th December,

26b Daw R.H., Journal of the Institute of Actuaries, 97, 1971

26c Ibid pp 26-27

26d Ibid, p. 31

26e Ministry of Pensions and National Insurance, Report on an Enquiry into the Incidence of Incapacity for Work Part II: Incidence of Incapacity for Work in Different Areas and Occupations, London, 1965.

It was to bring wider conceptions of states of health into the picture that the World Health Organisation adopted the sweeping goal of positive physical, mental and social well-being rather than the absence of disease. This posed problems not only of measurement in research and the collection of appropriate statistical data but of the practical use of such measures in preventive and curative health policies. Attempts are indeed being made to construct more sophisticated health indicators. Thus, one "state of health" indicator combines the two dimensions of pain and restricted activity.(17) The problem here is that the pursuit of novel methods can lead to an arrogant disregard of the valuable lessons that can be drawn by contriving to apply the simpler methods used in pioneering studies, like Richard Titmuss's Poverty and Population.

NP To what extent are the patterns produced by analyses of mortality a misleading representation of patterns of illness? One source of information are sickness absence rates. While pointing out the unusual degree of care that has to be exercised in interpreting sickness absence statistics Some studies show, for example, high correlations between mortality and inception rates of sickness and between mortality and days of sickness. (26b) Various reservations have to be made about particular types of diseases and causes of mortality. Thus, diseases of the respiratory system cause a considerably larger proportion of sickness than of mortality but the average length of such spells of sickness is comparatively short. On the other hand, arteriosclerotic and degenerative heart diseases cause over a quarter of male deaths in the age range 15-64, but only a very small part of the total sickness is recorded against them but where such sickness does occur, it is of long duration" (26b) But in compiling overall mortality and sickness absence ratios both for specific occupations (ST) and for social classes, for purposes of comparison, such factors tend to balance out and there are high correlations between the two, especially between mortality and days of sickness absence (26d) Table 7 compares mortality with sickness absence ratios by social class. The sickness absence ratios were derived from claims for sickness benefit in Britain over the period 5 June 1961 to 2 June 1962, as analysed in a Government report (26e). Spells of notified sickness lasting less than four days were excluded, since very few such spells are reported. Some long term sickness was excluded because those who had been ill for a long time were less likely to be on an employer's payroll.

INSERT TABLE 7

A good start has been made in parallel work in hospitals. A number of research studies have demonstrated sharp differences among hospitals in the outcome of treatment for specific conditions, some types of hospital, for example, having much higher rates of case fatality. (26a) This type of work begins to call attention to inequalities in the distribution of resources, and quality of care, in the hospital service.

13A

of state of health is of
Another, indirect, measure is/ physique. ~~There is a long history of~~ Careful measures of differences in height and weight in a population can be valuable indicators of trends in health. In the mid 1960s data from the National Child Development Study for seven year-olds showed that there had been "little if any change in Social Class differences" since 1953. An average difference of 3·3 cm between children from Social Class I or II and those from Social Class V was found, compared with 2·8 cm between "upper middle class" and "lower working class" children in 1953. (28a)

The actual figures derived from the two studies show a slight widening of the gap – though this could be attributable to sampling and slight differences in method.

20a

The problem is far from being just that of establishing the consumer's right to comment on the operation of the structure. It is whether a hierarchical managerial model derived from industry is likely, in the end, to promote or retard effective "freedom of access to medical and allied care at times of need" for all members of the population. Certainly alternative models have received scant attention (52a) and undoubtedly the ~~it is likely that~~ but the criticisms now being expressed about recent reorganisation (52b), from the adoption of the Salman committee's recommendations on nursing in 1966 (52c) to the culminating Act of 1973 (52d), are likely to bring them to the forefront, (52e) or encourage others to be devised. ~~Even when~~

Although the structure is complex and embodies attempts, through multi-disciplinary district management and health care planning teams, to delegate certain powers to and thereby distribute some of these powers more equally among the different health-care professions working locally, its hierarchical form remains marked.

Infant Mortality

Scotland

by Social Class

	I & II	III	IV & V	
1951-2	21.1	35.5	45.1	214
1961-2	16.9	25.1	32.6	193
1971-2	13.5	18.4	24.8	184

Reg. Scotland.

A COLLEGE GLOSSARY

ACDA — Advisory Committee on Distinction Awards.

Advises the DHSS and the Secretaries of State of Scotland and Wales accordingly. Chairman Sir Hector MacLennan. Compostion of the Committee is given in the Annual Report of the Department of Health and Social Security and is not secret.

AEIME — Association Européenne de Médicine Interne d'Ensemble.

AEMIE

International association for doctors in internal medicine. Doctors can apply as a regular member, by filling in a special form which has to be signed by two proposers who are already regular members.

AFFILIATION — A Fellow or Member of a sister College of Physicians may apply to the Censors' Board for affiliation to the College. This gives the privileges of Collegiate Membership to those who would like to take advantage of the facilities of the College but who obtained their postgraduate qualifications elsewhere. Those admitted in affiliation are not entitled to nominate or vote in the election to the Standing Committee of Members, nor to use any initials after their name. The subscription is £7.00 per annum except that no subscription is asked from those who are working in this country for less than 12 months.

ASH — Action on Smoking and Health.

An independent organisation founded by the College to influence public opinion.

ASME — Association for the Study of Medical Education

The title is self-explanatory. All Fellows and Members are eligible for membership.
See British Journal of Medical Education (1966) 1,1.

NP The boundaries of medicine have been and are rigorously debated, and large sections of the population or a substantial proportion of, human behaviour may be shifted from one side of the boundary to the other, like the history of the treatment of madness, the present doubt that debate about whether the great majority of the severely mentally handicapped in hospital should even be in such an institution and the continuing doubt about the place of osteopathy and other branches of so-called fringe medicine. NP The relative scale and importance of different services priorities tend to get distorted, partly as a result of willingness on the part of consultants & general practitioners to accede to requests for certain forms of treatment & surgery (cosmetic surgery is a case in point) but also as a result of the disproportionate esteem in which certain types of specialist roles are held within the medical profession (acute versus chronic sickness Health personnel and patients are divided into groups for purposes of status differentiation and not merely convenience and scale. The availability and territorial distribution of services and even The unbalanced structure also affects priorities, for example, by influencing the number and urgency of referrals and distorts (and therefore the incidence of illness itself. professional as well as public judgments of medical need). In short, conceptions of illness or disability and therefore also of severity of condition are shaped socially. Such conceptions are institutionalised in medical practice and the organisation, and sub-divisions and administration of services. That is why, there has to under the aegis of the medical and social sciences, there has to be an unremitting search for independent, detached or objective standards of measurement and evaluation. Otherwise we may fail to comprehend the insidious operation of prejudice and unrecognised privilege in our midst. This is particularly important if the development of health services is seen as a struggle between contending social groups for access to medical resources, the struggle of an emerging medical profession to establish its autonomy and also its prestige and the efforts of successive governments to reconcile demands from influential elites and eventually the electorate for more equitable services with pressure to maintain administrative, professional and social hierarchies.

Fundamentally, all societies have to distinguish between those abnormal conditions and actions which require sympathetic indulgence and expert aid, and those conditions and actions regarded as deviant and requiring reprobation and correction. Inevitably medicine is drawn into the argument by virtue of its responsibility for definitions of illness or disability.

If some forms of "criminal" types of We must observe that there in the debate medicine is by no means necessarily on the side of humanitarian or radical values. While some criminals have been reclassified as sick some types of extremely healthy people, who happen to have been critical of government, have been reclassified as sick and moved out of positions of influence.

To a large extent many This can be done by systematic application of the comparative method: conceptions of health standards of care and investment of resources can be compared cross-culturally, the resources and quality of service can be compared regionally and locally, between short-stay & long-stay patients, between services in institutions and those in the community, between rich & poor, people of different age, The employed and the non-employed, and people suffering from different types of disease or disability.

CUT
last 7 lines?

30

Table 1

Infant mortality: rate per 1000 live births

ry	1950	1960	1970	1971
erlands	25·2	17·9	12·7	11·1
l	29·2	26·0	19·8	19·2
ted kingdom	31·4	22·5	18·4	17·9
ada	41·3	27·3	18·8	17·6 +
ce	52·0	27·4	15·1	14·4 +
gium	53·4	31·2	20·5	19·8
SR	—	35·0	24·4	22·6
~~gium~~	~~53·4~~	~~31·2~~	~~20·5~~	~~19·8~~
many (Fed Rep)	55·5	33·8	23·6	23·2
pan	60·1	30·7	13·1	12·4 +
aly	63·8	43·9	29·2	28·3

Source: UN Statistical Yearbook 1972

Austria	66·1	25·9	26·1
CZ	77·6	22·1	
Denmark	30·7	14·2	+
Finland	31·5	12·5	11·8 +
Hungary	85·7	35·9	34·9
Norway	28·2	13·8 (1969)	+
Poland	107·8	33·2	29·7
Spain	69·8	27·9	
Sweden	21·0	11·7 (69)	
Switzerland	31·2	15·1	+
Australia	24·5	17·9	17·4
NZ	27·6	16·7	

	1950	—	1970
E & W	5 12/13		8 12/13
Scotland	8 7/13		12 12/13

Towards an integr
child H.S.

Table 2

Expectation of Life, England and Wales

Age	Males: Years		Females: Years	
	1948-50	1968-70	1948-50	1968-70
~~Males~~ 0	66·3	68·6	71·0	74·9
5	64·2	65·3	68·4	71·3
25	45·3	46·0	49·4	51·7
45	27·0	27·1	30·9	32·6
~~65~~ 55	18·8	18·7	22·4	23·8
65	12·2	11·9	14·6	15·8

Source: DHSS, ~~Government~~ Health and Personal Social Services Statistics for England and Wales (with summary tables for Great Britain) 1972 London, HMSO, 1973, selected from Table 1.6

Separate page

Table 8

Weekly cost per patient of different types of hospital as per cent of cost per patient in acute non-teaching hospital (England & Wales)

Type of Hospital	1955-56 (1)	1958-9 (1)	1966-7	1970-71	1971-2 (2)
Teaching hospitals (London)	153	145	143	150	147
Teaching hospitals (outside)	121	120	127	136	130
Maternity	109	~~86~~ 103	104	101	102
Mainly acute	92	~~386~~	88	88	89
Chronic sick	45	43	42	41	40
Mental illness	30	29	31	33	33
Mental handicap	28	27	27	29	31

(1) Based on limited coverage of hospitals (2) England only

~~Source: DHSS, ibid, Table 2.10~~

Source: DHSS, Health and Personal Social Service Statistics for England ~~+ tables~~ (with summary for Great Britain), 1973, Table 2.9. ~~Total~~ Cost per in-patient week of acute non-teaching hospitals was £17·75 in 1955-56, £23·85 in 1958-59, £43·13 in 1966-67, £65.03 in 1970-71 and (for England only) £76.65 in 1971-72.

Why is this so?

Partly it is because of an insufficient appreciation of the significance of health services in relation to social structure and values.

Depending on how "health" is defined, expenditure on health in the United Kingdom amounts to between 6 per cent and 9 per cent of Gross National Product; and total personnel employed or 4 per cent of the employed population by the health services number about one million. ~~By these measures are in themselves indicative of scale and importance. The scale of effort in most countries is also~~ These are simple measures of the scale of effort. Moreover, as pioneering studies in the 1960s by the Canadian Royal Commission on Health Services and the World Health Organisation have shown, such measures of scale of efforts devoted to health, in recent years health expenditures and numbers of personnel have been rising proportionately in many different countries. (1,2)

~~So far as significance of health to the value system of society is concerned it would I believe it is possible to argue that public anxiety~~ concern about ill-health and readiness to alleviate it and in particular of the medical profession and But the growth of health services have also helped to establish bureaucratic organisations, have played no insignificant part, it might be argued, in establishing the general structure of inequalities of status and reward in society.

In capturing the scope, and interconnections and significance of the system of health services the disciplines of social medicine, medical sociology and sociology of social policy are ill-developed. To take one tiny example, in 1972 there were the equivalent of only whole-time consultant specialists in social medicine attached to among a total of 8,500 consultants attached to hospitals in England in 1972. (3)

general and public values about inequalities of status and remuneration can be argued to have been shaped in substantial measure by

Lab. Party (1)

Need for social plan.
Gains.
Cost benefit.

(4)

1 Clarification objectives ← socially perceived need

2 Derivation alternative objectives & ordering of objectives (targets) (through the application of the methods of comparative analysis to social structures, conditions and policies)

3. Development of theoretical scheme to guide the planning

4. Development of programme to reconcile problems of conflict between short-term & long term objectives, to produce & allocate resources, including manpower, to refashion the organisation & administration of social services & to guide the adjustment of social values.

5. Evaluation of policies & experiments by means of objective as well as different types of subjective criteria.

Social Policy Ad. Ctee of Labour Party

Examples: ~~Flat-off~~ Objectives — Higher pensions for existing pensioners £8 = £700m
float off means tests or raise SB.
Equality
~~Tax~~ Tying pensions to index of earnings
Retirement age for women
Contribution ceiling — ceiling on benefits
Funding - for appearances?
Contracting out.
→ Preference for very old — short-term 80s
— long-term disabled

Syllabus

Social policy — redistributive + non-discriminatory

citizenship

discretion · flexibility

rights at expansive time

advertising outlets & amenities

if it was doing its job properly no need for advisory bodies

1. Advising
2. Shelving
3. Reconciliation conflicting interests
4.

Sociology

Economics

The economy

economic
Social development

Welfare State

industrialisation
bureaucratisation
reached a formal level of centralisation

Services

Do you want heavy taxation to be victim of unknown flat-rate equality of tyranny

Concepts of aims of policy

Unpacking the values inherent
Conception

Survey of sickness shows shift in consultation rate for lowest income groups.

1930s BMA men 16–64 5·0 & 5·1

Demand not measured & may even have fallen

	Actual	Expected
Deaths Social class I	10,614	14,004
	4,454	5,795
	511	617
	15,579	20,416

Expected.	Actual
44 863	64, 233
15, 396	21, 638
1,277	1 551
61,536	87 422

40,000 lives would have been spared.

If Social class I mortality experience had applied to Social class 5 47,000 aged 15-64 would have died in 1959-63 In fact 87,000, or nearly twice as many, died in this period.

49 54

(85) (87)

+

-4 4

p 59 "There has been a considerable fall in the maternal mortality of all women since 1949-53, and as in the case of mortality from other causes, the differences between the social classes has widened."

123% = 55,218 ∴ 100 = 44,900

3rd Year — 17 Jan

Social Policy
Social services
Welfare State
Social planning.

} Page of definition
Elaborated by reading pp 1-7 Fuhrer SS.

Distinction between conventionally acknowledged & objective need correspond to distinction between Social Policy & Planning

Brief reference to policy system

Account of expenditure on public social services (from Problems of Social Growth) & Indicateurs de Securité Sociale.

① Expenditure on social services as % GNP & absolute
② " Ditto 1938-1969
③ ~~Expenditure~~ " Ditto ~~&~~ different countries

23rd Jan

Recapitulation

The Policy System:

Social Planning: The Comparative Approach

The Experience of Planning

Steps towards Planning

Recapitulation

1. Social Planning: Gans & others.
2. Social Plans: ~~Comparative Appl~~ The Future of the Social Series pp. 7-16
3. Social Planning: The Comparative Approach.
4. Official Statistics

Relative inequality can be demonstrated in an elaborate comparison of societies, communities, classes and age-groups.

Information: Among the traditions in Britain is, first, the polemical, comprehensive account of working & living conditions, as for example, in some of the writing of Engels, Masterman & Orwell. Masterman "Public penury, private opulence" ostentation" – at the heart of England's complaint. Public squalor, private affluence" Second, is the painstaking official commission of inquiry, ranging Chadwick's Report on the Sanitary Condition of the Labouring Population of GB in 1842 or for example, from the 1844 report of the Commission of Inquiry into the State of Large Towns to the 1965 report of the Milner Holland Committee on Housing in Greater London.

Third is the punctiliously specific research-study.

PCI ch. 1.

These are not ~~exact~~ systematic applications of the comparative method.

Comparisons different periods of history
of the life cycle

Examples Acute & mental hospitals
pensioners & wage-earners
married & single persons

Comparative analysis (3)

Area — countries, regions, local authorities areas, districts & wards.

Service — inter-service and intra-service comparisons

Social structure — age-groups, ethnic groups, types of family, social minorities, groups of different employment status, class, persons receiving & not receiving service.

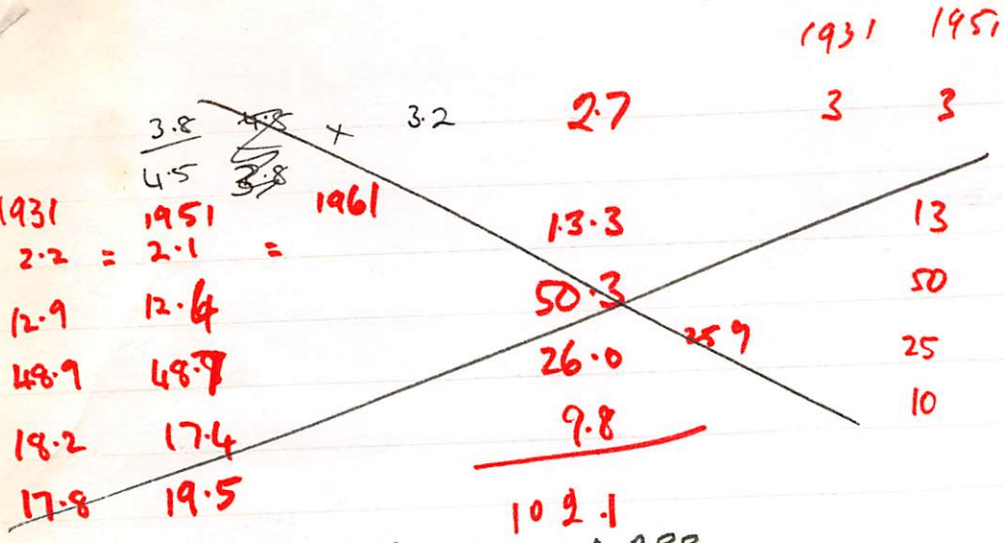
Admin sectors — public private & voluntary sectors
central & local authority
public, fiscal & occupational welfare sectors

Tables. ① mortality
② nutrition
③ % of Fams.

Royal Commission Reports

Official Statistics

Independent Research



SOCIAL CLASS

			1961	
1951 =	3·2	=	2·5	
	14·3		13·2	
	52·8		50·3	
	16·8		24·1	
	12·9		10·0	
1931 =	2·2	=	2·1	= 1·4 2
	12·9		12·4	11·3 11
	48·9		48·7	46·2 46
	18·2		17·4	24·7 25
	17·8		19·5	16·6 17

1971/2 average for England (non teaching) from HER

1961/8 range .. E&W .. Hospital Reference Book. DHSS. 1969.

	Treatment costs	Non treatment costs.
Acute 100+	49.19	29.39 13.53 – 32.98
long stay	19.61	15.25 5.36 – 25.61
Chronic	17.79	12.71 5.50 – 13.69
maternity	48.05	30.19 13.76 – 33.01
mental illness	13.27	12.18 4.16 – 16.89
" handicap.	11.28	12.11 4.90 – 12.58.

N.B. averages & range figs are by no means comparable (diff periods & areas) but just to give an idea of the range.

One could ~~not~~ make comparable, but not sure if HR Book is in library.

These two figures are shown in Figure 2, together with the expenditure series. From this it is clear that the three series move broadly in line until 1961, after that date the weight series falls substantially, whereas the number of cigarettes increases (after oscillating about a constant level for six years), and the expenditure series occupies an intermediate position. (The behaviour of the expenditure series clearly depends on the method of price deflation employed by the C.S.O.)

Table 2

	Disposable income per adult at 1958 prices	Price tobacco/ price other goods	Post 1962 time trend		
	Y_{58p}	p_T/π^*	T	$\bar{R}^2$	D.W.
(4) Expenditure	0.504	-0.254	-0.017	0.958	1.498
	(18.9)	(3.3)	(8.2)		
(5) Weight	0.464	-0.288	-0.022	0.953	1.401
	(17.8)	(3.8)	(11.1)		
(6) Number of cigarettes	0.515	-0.382	+ 0.0048	0.967	1.22
	(12.9)	(3.5)	(1.6)		

* In the case of equation (6) the price index relates to cigarettes only.

Table 2 shows the results obtained using the T.R.C. data while maintaining the same specification as Sumner. Comparing equations (4) and (5), we can see that the main difference in using the weight series is that the post 1962 trend is increased from 1.7% to 2.2%. This is a major change, and means that the quantity consumed in 1970 was 18% below its expected 'pre-publicity' level. The effect of publicity appears to have been noticeably larger in terms of lbs. of tobacco consumed than in terms of expenditure. If we turn to the number of cigarettes (equation (6)),

	0-14	15-39	40-59	60+	
	ill in bed last yr				
Upper non-man	35.0	37.5	25.6	33.1	
L non man	~~30.7~~ ~~29.9~~	33.0	30.8	~~32~~.8	
S Man	31.1 ~~26.3~~	29.9	34.9	37.7	
L. ~~non~~ man	26.6	29.2	29.8	35.6	
	1484	1919	1393	970	57 66

Royal Commission on Remuneration
Scarbrough Report

hosp med staff

In 1971 7,906 born overseas
24,353

but only 1209 Consultants
9490

Most senior house office + registrar grades

Oct 1970 10 Oct 1971 increase in England 275 no. of principals providing full general medical services
overseas 127

1972 401
214
overseas 187

1969 hosp med staff 35.4%
1971

Table 3.9 Health + personal Soc services for England

1972 33.5% born overseas
13.0 Consultants
55% registrar
61% Senior house officers

E & W 1969-71
Overseas additions 332 Total 1538
Med practitioners 382 500
714 2038

Costs (£s) per 'in patient week' for various services -

NHS non teaching hospitals during year ending 31st March, 1972.

England	Acute 100+	long stay	chronic	maternity	mental illness	mental handicap
		27	13	65	26	13
Medical	4.48	1.23	0.59	2.92	1.17	0.60
		66	66	152	45	40
Nursing	20.81	13.67	13.66	31.70	9.31	8.34
		58	60	143	27	27
Domestic	3.76	2.19	2.26	5.37	1.00	1.03
		55	48	100	45	43
Catering	7.39	4.08	3.55	7.40	3.36	3.15
		63	62	163	38	46
Laundry	1.45	0.92	0.90	2.37	0.55	0.66
		65	57	115	50	42
Powered	2.43	1.57	1.39	2.79	1.22	1.03
		60	50	92	60	54
Building etc	3.11	1.87	1.54	2.85	1.86	1.69
		68	55	182	35	32
Genl cleaning	0.74	0.50	0.41	1.35	0.26	0.24
		44	39	100	32	30
Net total costs.	78.58	34.86	30.50	78.24	25.45	23.39

Wales						
Medical	4.39	1.44	0.97	1.61	1.39	0.75
Nursing	21.53	15.89	16.20	48.66	9.32	9.97
Domestic	3.85	2.73	2.21	6.05	1.13	1.53
Catering	7.21	4.26	4.19	9.67	3.37	3.72
Laundry	1.51	0.99	1.15	3.21	0.50	0.99
Power +	2.73	2.28	2.05	4.77	1.23	1.37
Building +	3.50	2.53	1.65	3.42	1.75	1.92
Genl cleaning	1.05	0.85	0.76	2.65	0.18	0.32
Net total costs	80.78	41.31	36.39	101.52	26.68	28.34

Hospital Costing Returns, DHSS & Welsh Office, HMSO 1972.

The second reason for expecting the equation for cigarettes to be rather different is that it is widely believed that the Royal College report had a greater effect on cigarettes than on other forms of tobacco consumption. The results given in Table 2 indicate, however, quite the opposite as far as number of cigarettes is concerned - the trend is insignificant and positive. The specification of the publicity effect in the form T is clearly inappropriate; at the same time Figure 2 suggests that publicity did have some effect on the number of cigarettes consumed. Equations (9) - (11) in Table 3 show the effect of alternative specifications. The first of these returns to the shift variable D rejected by Sumner, and the results show that in the present case this is clearly superior to T: the coefficient is significant at the 5% level. The Durbin-Watson statistic is, however, still unsatisfactory and in view of this the alternative hypothesis is advanced that publicity has caused a sudden drop in consumption at certain dates with a gradual return to the previous level. The dates most clearly relevant are 1962 (the publication of the Royal College report) and 1965 when television advertising of cigarettes was banned and there was considerable public discussion.[1] Equation (10) is estimated on the basis that the effect in each of these years was the same; equation (11) allows for a different 'pulse' in these years. The results are clearly better than those given by Sumner's equation, and in particular the value of the Durbin-Watson statistic in equation (11) is much more satisfactory. The coefficients of the dummy variable indicate that the effect of publicity was rather larger in 1965 than in 1962 - 6% as opposed to 4% - and that the effect dies away at a rate of about 1% a year - see Figure 3. It should be noted that even at its maximum the effect is small.

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[1] The report of the American Surgeon-General in 1964 may also have had an influence on British consumption.

8 Exp. diff counties

	61-2	1969
UK	4·2%	4·8

9 Doctors per 100,000

10 Consultation rates

	All	0-4	45-64
	100	113	91
	109	65	132

11 Cost per patient

ch. sec	41	40
M ill	33	33
M had	29	31

12

	M ill	M had
Domestic	27	27
Catering	45	43
Laundry	38	46
Gen clerical	35	32.

Dual responsibility for the poor

Photocopy BMJ 5 July 1968 (or thereabouts)

Office of Population Censuses and Surveys - Studies on Medical and Population Subjects, No. 19; Regional and Social Factors in Infant Mortality, HMSO, 1966.

National Morbidity Survey

Survey of sickness