Correcting copy. (Note: pp. 1+3 re-typed)

FIRST DRAFT

Inequality and the Health Service

Many histories of the evolution of health services are based on the naive assumption of continuous progress. Sometimes progress is assumed to be steady and sometimes, after a dramatic discovery in medical science, the introduction of a new method of treating disease or the introduction of legislative and administrative reform, is assumed to be rapid. The establishment of the National Health Service in England and Wales, and of the parallel services in Scotland and Northern Ireland, tends to be regarded as a glorious achievement which will endure forever. But the truth is more complicated, the achievement less certain and the future less optimistic. If achievement means just the pieces of paper which are approved by Parliament it must logically be final. If it means a living reality serving certain principles of care and distribution of resources better and better as the years pass on, it is more contentious.

The Social Institutions of Health

Health services are social institutions and as such they can change relatively to their own past, relatively to other institutions, and, most important of all, relatively to the health needs of the community. This must include the possibility of retrogression as well as progression. Sociology is only beginning to trace the implications for medicine, nursing and public policy of a thoroughgoing social analysis of the provision of health services in these three distinct senses. That is partly because sociologists are only slowly becoming aware of the close relationship that exists between the form of the health services, definitions of the need for such services or even definitions of health, and social structure and values. That same awareness has also been slow to take root in medicine. Despite the distinguished history of epidemiology[1] the proportion of resources devoted to research and teaching in that subject remains miserably small. To take one small example, there were the whole-time equivalent of only seven specialists in social medicine among 8,500 consultants attached to hospitals in England in 1972.[2]

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Until very recently sociological work, particularly in the United States, has taken the 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. Now the need to study 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 relationship to national and international systems of social stratification is better recognised as providing the right framework for specialist study. This means, first, study of the structure of public and private health services through the various tiers of central government, regional and area health authorities and local government, hospitals, health centres and general practice; industrial, voluntary and private agencies and services; the structure and distribution of the professions, their training and recruitment; the social and other characteristics of the different occupational groups concerned with the health of the individual and of local communities; the allocation and control of resources and the experiences, attitudes and conditions of patients. But, second, this "internal" system cannot be separated from its national,cultural, economic and social setting. How far are health care values and practices shaped by the general structure of inequality in society? Or, to put this type of question the other way round, how far has the development of the medical and other professions within the structure of health services positively contributed to the conceptions of status and rewards generally held in society? Does the system of health services help to shape the structure and values of society in general, or is the direction of influence the other way? Can one, indeed, be disentangled from the other? Can equality in medicine, like equality before the law, be practised on a kind of island remote from the cruel inequalities of the rest of social life?

The development of health services takes place not only, of course, within a national but also, third, a world setting. Through social means knowledge about scientific discoveries, methods of curing, preventing and controlling illness and new types of health services is diffused. But we tend to dwell on the promotional and apparently constructive features of international relations between health systems instead of their exploitative and destructive features. Some uncomfortable facts about inequalities between nations are, it is true, revealed. Thus the statistical yearbooks of the United Nations and

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the World Health Organisation have called our attention to the fact that while there are between 120 and 200 doctors per 100,000 population in Britain, the United States and much of Europe there are only 32 in China, 22 in India, 19 in Pakistan, 4 in Indonesia and Tanzania, 2 in Malawi and Nepal and 1 in Ethiopia.(3) Too often such information is presented without any attempt to explain that some of the privileges of the rich countries are gained at the expense of the poor countries. A large proportion of Britain's hospital medical staff has been drawn from the Commonwealth. In the 12 months ending October 1969, 164 of 169 new general practitioners moving into under-doctored areas came from overseas.(4) Foreign doctors account for 20 per cent of the annual addition to the American profession and it has been calculated that the United States gains more in dollar value of medical aid from the rest of the world than it provides in aid to foreign countries, publicly and privately.(5) The third world is also disadvantaged in some respects by attempts to introduce inappropriate western concepts of medicine and treatment and by the profit-seeking operation of the drug companies. The international profit and loss account in relations between health service systems requires searching scrutiny, not just because inequalities in care in western systems may be reinforced and because western conceptions of health care may be culturally insular if not smug and there may be much to learn from health care systems overseas. (5a)

This analytic framework, although very sketchily drawn, has implications for any evaluation of change. I have spoken of conceptions of illness or health, the structure of the health care system and the pattern of health needs in society. Any one, or all, of these three may change significantly over time. If our definition of what constitutes illness and states of health is greatly extended and complicated our expectations of the health services, and the standards by which we judge them, change correspondingly. By this test the health services may fall further short of expectations. Even if our definition remains roughly constant we may find that the reduction in the prevalence of some diseases has to be weighed against the growth in prevalence of others. The reasons for disappointing as well as encouraging trends have to be sought in the structure and operation as much of the health care system as in society generally. I am alluding not simply to changes, for example, in the number, distribution and quality of health personnel, compared with the past, but also their responsiveness to present patterns of need.

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The development of health services therefore has to be measured in relation to changing conceptions of illness or health and to patterns of need. Conceptions are constantly being amended or revised. There are substantial cultural differences between developing and market or planned societies, and also among the latter. Revisions are made not just in response to the recognition and communication of social discovery and innovation, or to professional judgements of objective needs and of the status of different diseases and treatments, but also in response to the pressure of vested interests, and the level and type of public anxiety and demand. Pain, discomfort, debility and different forms of incapacity may come to play, in relation to prospective sudden death or physiological malfunctioning, a more prominent part in social and medical conceptions. Types of human behaviour may be shifted into the territory labelled "illness" and controversies about the demarcation of the boundaries settled. The boundary is continually being redrawn and disputed. This could be illustrated from the history of so-called "fringe" medicine, the history of the treatment of madness and the diverse history in different countries of the treatment of severe mental handicap. Fundamentally, all societies distinguish between those abnormal conditions and actions requiring 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. ~~We must observe that~~ In this debate we may observe, medicine is by no means necessarily on the side of humanitarian or radical values. While some types of criminals have been re-classified as sick and have as a consequence received rehabilitative rather than custodial or punitive forms of treatment some types of healthy people, who happen to have been critical of government or an embarrassment to the community, have been classified as sick and removed from view.

Just as the scope of the conception may change elements within it may be accorded different weight or priority. Views are reached about the seriousness of certain states of health. The construction and priorities of the health services follow suit. The relative scale and importance of different services tend to get distorted whether, for example, as a result of willingness on the part of consultants and general practitioners to accede to requests for certain forms of treatment and surgery (cosmetic surgery is a case in point) or as a result of

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the disproportionate esteem in which certain types of specialist roles are held within the medical profession (as in the unequal value accorded to acute as compared with chronic sickness, physical as compared with mental illness or handicap, surgery as compared with preventive health). Health personnel, patients and organisations come to be divided up more for purposes of status differentiation than mere convenience or efficiency. Once institutionalised, an unbalanced structure affects the behaviour of participants. It affects priorities, for example, by influencing the number and urgency of referrals and distorts professional as well as public judgments of medical need, and hence what is believed in society to be the nature of illness itself. In short, conceptions of illness or disability and therefore also of severity of condition are shaped socially. They are institutionalised in medical practice and the organisation, sub-divisions and administration of services.

That is why, under the aegis of the medical and social sciences, there has to be an unremitting search for independent, detached or objective standards of measurement or evaluation. As I have suggested, this can be done to a large extent by systematic application of the comparative method: conceptions of health standards of care and investment of resources can be compared cross-culturally, resources and quality of service can be compared regionally and locally, between short-stay and long-stay patients, between services in institutions and those in the community, between rich and poor, people of different age, the employed and the non-employed, and people suffering from different types of disease or disability. Like the scientist's use of the randomised control trial,[6] this approach represents one of the social scientist's methods of attempting to escape subjectivity and convention and so to comprehend the subtle operations of prejudice and privilege in our midst.

The National Health Service

Some of these ideas can be applied to the National Health Service. Its creation has deeper roots than is often supposed. The vast majority of hospital patients, for example, were treated free long before 1948. Paying patients had never accounted for more than a small fraction, perhaps about 5 per cent, of all hospital patients.[7] As elsewhere in Europe there was a long history of the sponsorship and control by consumers of pre-payment methods of meeting medical costs. In 1804, long before the British Medical Association was founded, there were about a million members of

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friendly societies in Britain and in 1900, seven million.[8] Between 1918 and 1939, beginning with the Dawson Report in 1920, a succession of studies and reports recommending a comprehensive public health service were issued by a wide range of different organisations, including the B.M.A. itself. The emergency medical scheme and the extension of national health insurance in the 1939 war ~~the~~ preceded the declaration of principle in the Beveridge Report and the Coalition Government's White Papers. A Tory Government would have been obliged in 1945 to sustain the momentum. But despite this propitious history and the formulation of a national consensus about the desirability of a service, political courage and staying power was still required to resolve the contest between different interest groups and create a more or less unified structure. Weaker or less astute men than Aneurin Bevan would have settled for a lot less than he did. Like other overseas historians Almont Lindsay concluded that "the Health Service cannot very well be excluded from any list of notable achievements of the 20th Century".[9] In his biography of Aneurin Bevan, Michael Foot pointed out that in July 1960 even the British Medical Journal paid tribute to the "imagination and flexibility" of "the most brilliant Minister of Health this country has ever had."[10] He quoted Lord Hill to suggest that certain major features of the final plans for the service - the fusion of voluntary and local authority hospitals into one nationally co-ordinated hospital scheme, and the abolition of the medical practices - owed much to Bevan.[11]

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Even now the immediate social effects are difficult to disentangle. In 1938 20 per cent of G.P.'s in their 40s earned under £700 per annum and the average G.P. only £938. The Spens Committee recommended a 13 per cent increase in this average, before adding any increase for inflation between 1938 and 1948.[12] There are therefore strong grounds for arguing that the profession as a whole, and particularly poorer doctors, gained in income as a result of the introduction of the service. Again, middle-class families could be said to have been freed for the first time from the crippling financial prospects of paying for care during a serious disabling illness. But working-class women and children also gained in the sense that they had not previously been covered by health insurance for G.P. consultations and prescriptions, though many obtained free or subsidised care through the voluntary hospitals. Certainly the Government's Surveys of Sickness show an

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Even now the immediate social effects are difficult to disentangle. In 1938 2½ per cent of G.P.'s in their 40s earned under £200 per annum and the average G.P. only £628. The Spens Committee recommended a 15 per cent increase in this average, before adding any increase for inflation between 1938 and 1948.[12] There are therefore strong grounds for arguing that the profession as a whole, and particularly poorer doctors, gained in income as a result of the introduction of the service. Again, middle-class families could be said to have been freed for the first time from the crippling financial prospects of paying for care during a serious disabling illness. But working-class women and children also gained in the sense that they had not previously been covered by health insurance for G.P. consultations and prescriptions, though many obtained free or subsidised care through the voluntary hospitals. Certainly the Government's surveys of sickness showed an

increase in the use of G.P. services by lower income-groups between and 1954 1952.[13] The question "who gained?" is still worth debating, in order to break down the myths and stereotypes which too easily circulate and to lay the basis for searching analysis of who gains today.

Suppose, then, we try to pursue the question of the achievements or effects of the introduction of the N.H.S.. After an initial period of panic about high and growing costs the Government and the profession were educated, especially by the Guillebaud Report and the measured evidence assembled by Brian Abel-Smith and Richard Titmuss, into more positive support of its operation and needs. The pronouncements of the two major medical journals afford significant illustration. From the start The Lancet was a powerful advocate. Ten years after the Act was passed the journal announced, "For our part we think the National Health Service one of the biggest improvements in the life of this country since the war ... It has done much to better the conditions of medical care, especially in hospital, and it has been an immense comfort to the public." But, "Any jubilation must be at best provisional." Morale was "not high"; the status of the doctor was "depreciating"; administration had to be made "more appropriate to its purpose, and more efficient."[14] Unsurprisingly, in view of its unremitting campaign against the introduction of the Service, the British Medical Journal was more critical. "The end of the first decade of a social revolution finds the profession in no mood for jubiliation ... whatever benefits it has received the public is beginning uneasily to wonder whether the price has not been too high in this free-for-all scramble for medical attention ... A plebiscite today [among the profession] would undoubtedly show a majority to be highly critical of the Service in favour of reform." The prophets of gloom and disaster were already qualifying their criticism heavily. Note the implicit acknowledgement of a "social revolution", "benefits" to the public and "reform" rather than dismantlement. The BMJ went on, "Most people would agree ... that from the point of view of the public the Health Service has been a success. Many barriers that existed before have been removed, especially for those of moderate means. There has been a more even distribution of consultants throughout the country and a general increase of hospital facilities. But many of the benefits laid at the door of the N.H.S. more properly could be credited to the advances of modern medicine."[15]

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Twenty years on The Lancet acknowledged the continuing criticisms of administrative structure and inadequate resources but concentrated on the issues of economising on resources by building upon collaborative experiments between different arms of the Service, group practices and health centres, the need to bridge the widening division between consultant and family doctor, and much better communication between doctor and patient. It maintained the view that "the first principle and chief strength of the N.H.S. was that good medical care is a right and not a privilege and, in application, is a powerful safeguard of standards of efficiency and courtesy."(16)

These views call our attention to the diverse nature of evaluation and the problem of monitoring changing expectations, performance and need.

Measures of Health

Estimates of the effect or value of the health service depend of course on the kind as well as availability of information used to measure such effect or value. There are measures of health as such, which depend on conceptions of health, and there are measures of utilisation and provision of services, each of which are needed to assist explanations of trends in health, and of social differences in mortality and morbidity.

Measures of the health of populations can take many different forms. Among the most familiar are mortality rates, prevalence or incidence morbidity rates, sickness-absence rates and restricted activity rates. Each is limited as an indicator of health and involves problems of measurement. If we concentrate too much attention on mortality we imply that health services can adopt the goals of death in life or medicated survival, and if on medically identifiable morbidity that some conditions of listlessness, depression, sleeplessness and anxiety can be discounted or ignored. If we subscribe to the goal of the World Health Organisation of positive physical, mental and social well-being and not just the absence of disease then we can see how wide and complex our measures need to be. Attempts are 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, if limited, lessons that can still be drawn by bringing continuing to apply the well-established studies, like Richard Titmuss' Poverty and Population, up to date.

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Let me give a few examples. By the test of trends in mortality rates critical questions have to be posed about the performance of Britain's health services. The test can be made in different ways. First, reduction in mortality rates has been slower in Britain than in some other advanced industrial societies. A Scottish study pointed out that despite a continuing reduction of infant mortality over the last 20 years England and Wales slipped from 5th to 8th place, and Scotland from 8th to 12th in the ranking of countries.(17a) Table 1 gives illustrations of the differential rates of improvement, including remarkable improvements in the Netherlands, Belgium, France and especially Japan.

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The same trends can be followed, though less reliably, at later ages. Even a cursory scrutiny of the United Nations Statistical Yearbook shows, for example for men, that while the expectation of life at birth has lengthened by two or three per cent in 20 years in England and Wales, it has lengthened more dramatically in other industrial nations, some of which have now surpassed, and others almost attained, our figure.

The explanation of the overall figures can be pursued by examining inequalities between the sexes, age-groups, classes, areas, types of disease and disability. Over a period of twenty years the ratio of female to male expectation of life in England and Wales has increased at all ages. While female expectation of life has lengthened at all ages male expectation has increased to only a modest extent among those in their 20s and 30s, has barely increased among men aged 45 and has decreased marginally among older men.

INSERT TABLE 2

The trends are different for people of different class, and in terms of probing constructively the operation of the health service, are perhaps the most important of all to examine. Between 1949-53 and 1959-63 inequality between social classes in mortality experience appears, from data published by the Registrar General to have widened. "Indeed, the social class gradient increases with successive censuses so that in 1959-63

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The trends are different for people of different class, and in terms of providing constructively the operation of the health service, are perhaps one most important of all to examine. Between 1949-53 and 1959-63 inequality between social classes in mortality experience appears, from data published by the Registrar General to have widened. Indeed, the social class gradient increased with successive censuses so that in 1959-63

the Standardised Mortality Ratio for social class I is only about half that of social class V."[18] The trouble is that the figures do not represent the real trends very accurately, because of changes introduced in 1960 in the classification of occupations, possible changes in the number and extent of discrepancies between the recording of occupations on death certificates and on census schedules and the fact that occupations in the Census of 1961 were based on a ten per cent sample.

Statisticians and social scientists have therefore been slow to utilise the data, dismayed perhaps by the Registrar General's statement that, "It is impossible to disentangle real differential changes in mortality in this context from apparent differences due to changes in classification."[19] But the Registrar General must bear responsibility for failing to disentangle these elements, for example, by working out the SMR's for each class in 1959-63 according to the 1950 Census of Occupations and not only for Social Class V, which he did as a kind of partial addendum. Specialist analysis and anxiety, and public comment, has been inhibited.

Yet the data are of immense significance. Further examination suggests that even if its exact extent remains debateable the trend of growing inequality is securely established. For example, the Registrar General points out that among the closed professions the data are "substantially free from the effect of classification changes, and errors due to mis-statement of occupation or change of occupation must be few" and between 1951 and 1961 the mortality rates for middle-aged lawyers, teachers and clergymen fell more sharply than those for all men. So "not all the improvement in social classes I and II is due to differences in classification."[20] Moreover, he finds that "the most disturbing feature of the present results when compared with earlier analyses is the apparent deterioration in social class V ... whilst the mortality of all men fell at all ages except 70-74, that for social class V ... men rose at all ages except 25-34. Even when the rates are adjusted to the 1950 classification, it is clear that class V men fared much worse than average." (my emphasis) An adjusted figure for class V as a whole is not given, but the adjusted figures for particular age groups (Table D6)

INSERT TABLE 3

suggest that if the old classification had been used the figure in Table 3 of 143 for social class would still be around 128, representing a clear deterioration between 1949-53 and 1959-63.

For ten separate causes, ~~of death~~ mortality rates for all age-groups of class V improved less, or deteriorated more, than the equivalent rates for all men. In 1959-63 more men class V died at every age than in 1949-53, from cancer of the lung, vascular lesions of the central nervous system, arteriosclerotic and degenerative heart disease, motor vehicle accidents and other accidents. Some diseases, like lung cancer and duodenal ulcer, which showed no trend with social class, or, like coronary disease an inverse trend forty years ago, are now producing much higher mortality in social classes IV and V than I and II.(21) In his latest report the Registrar General found that for 49 out of 85 separate causes of death applying to men, and for 54 out of 87 applying to women standardised mortality ratios for social classes Iv and V were both higher than for I and II, (Table E1). For only four causes of death in each instance was the class gradient reversed. It would appear from this evidence that undue attention has been given in recent years to the so-called diseases of affluence.

31

Inequality between the classes in mortality experience is roughly the same among married women, but rather less pronounced among single women, than among men (see Table 3). The disadvantages of membership of class V for women as well as men are marked. Inequalities tend to be most pronounced not among the oldest age-groups but, among men, between 25 and 44 and, among married women, between 15 and 44, and, among single women, between 15 and 34 (Table 4).

INSERT TABLE 4

These data need to be related to changes in the types and conditions of work, income, nutritional status, environmental conditions and styles of living. There remain, for example, big differences in death rates by area, with the urban industrial areas of the North and of Wales, on the one hand, and the country towns, seaside resorts and metropolitan suburbs of the South and South-East, on the other, continuing to represent the inequality of national industrial and social structure.

INSERT TABLE 5

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THE FUTURE

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TABLE 5

Taking all adults of both sexes between the ages of 15 and 64 the disadvantages during the five years 1959-63 can be summarised. If the mortality experience of social class I had applied to social class V only just over half of them would have died; 40,000 lives would have been spared.

This disturbing trend has to be judged in the context of a wide variety of other data. Although maternal mortality among married women has continued to fall the differences between the social classes has widened.(22) The recent trends in infant mortality are harder to establish. As Morris and others have shown the differential between the classes narrowed between 1930 and 1950 but this was during a period when the differential was greater than it was in the case of adult mortality.(23) By 1959-63 the differential seems to have come to correspond more closely with that for adults (see Table 6), but separate data for each social class and for different occupations for the three census periods have not been published.(24) This is a serious gap in medical and social knowledge, as Hart has eloquently argued.(25)

INSERT TABLE 6

In the early sixties the Department of Health became concerned about the slow decrease in the death rate for infants at ages between one month and one year and undertook a study in three areas to try to identify avoidable factors contributing to deaths. Two paediatric assessors estimated that there were avoidable factors in 28 per cent of cases, in about a third of which social factors, another third parental factors and a quarter of which general practitioner or hospital factors were believed to be responsible. The general practitioner factors included diagnostic delay or failure, slowness in reference to hospital, failure to realise severity of the situation and delay in visiting. The hospital service factors involved diagnostic failures or delay, hospital acquired infection and faulty management.(26) This was a pilot enquiry and it is likely that more rigorous research on a comparative basis would come better to grips with all the factors involved and ~~shed light on~~ demonstrate inadequacies not only of income, environment and education but health services too.

36

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DIGEST PART 6

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disadvantage of the partly skilled and unskilled occupational classes. For 1972 the General Household Survey found that in England and Wales nearly three times as many unskilled as professional men and more than three times as many females suffered, by their own account, from "limiting long-standing illness, disability or infirmity."[27] (Table 7) For 1971, according to the same source, nearly 2½ times as many unskilled as professional men reported absence from work due to illness or injury during a two week period and they lost an average of 4½ times as many days from work in the year.[28]

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INSERT TABLE 7

Inequalities in the Development of Services

I am painfully aware that these measures of health are incomplete and that a more comprehensive picture might be built up patiently from the rich literature which we possess, even if, in the end, the objective of developing in precise terms a balanced index of the health needs of the population remains unfulfilled. But the measurement of inequalities in need by class or by income is, I believe, central to that task and to the evaluation of the health service.

Explanations for inequalities in health have complicated aetiologies. The quality and distribution of different health services could improve relative to other social institutions as well as the past and yet, because of a relative growth in other forms of inequality of incomes or wealth, work conditions and physical arduousness, home, family and social conditions and life styles, the effects of such improvement on trends in mortality, mobbidity and states of health could be cancelled out. But trends in the organisation and utilisation of the health services must themselves be summarised and understood.

We must proceed from the general to the particular. Britain devotes a smaller proportion of its total resources to the health services than several other advanced industrial societies and this is growing less swiftly ~~(Table 8)~~. Earlier studies for the W.H.O. (29) and by the Canadian Royal Commission on Health Services[30] had shown that Britain's percentage of gross national product devoted to health had remained fairly static in the first years after the establishment of the National Health Service in 1948, while that of other countries had been

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INSERT TABLE 8

Although Britain spends relatively less than, say, the United States, this is partly because its health services are less expensive and partly because ~~its~~ rates of admission to hospital and rates of surgery are lower.(34) There is evidence too that, from a smaller cost-base, services are in some respects more equally distributed. Thus, utilisation of medical services by different status groups, by the acute and chronic sick or mentally ill and handicapped, and by adults below and above pensionable age, is more unequal in the United States than in Britain.(35) On the other hand, services in some European countries, like Czechoslovakia and Sweden, are less unequally distributed in some respects than in Britain, for example, between the acute sick and the chronic sick, mentally ill or handicapped in hospital.(36)

The hospitals have more than maintained their share (more than half) of total expenditure on health services. Against a slightly lower total number of inpatients (though with much higher admission and discharge rates) has to be set a doubling of both hospital medical and nursing staff between 1949 and 1971. But the number of general medical practitioners has not changed substantially. In 1959 there were 38 per cent more general practitioners than hospital medical staff in England and Wales. In 1971 there were 8 per cent less. This suggests the power or predominance of the hospital in the British system, the increasing location of clinical expertise outside local communities, and the evolution of a better-developed status hierarchy in medical practice, consultants obtaining enhanced power.

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In total the number of physicians in the United Kingdom has been growing less swiftly than in countries such as Sweden, France, Belgium and the United States and has substantially fewer doctors per 100,000 population than a wide range of countries. (Table 9) We can note in passing that there are countries like the Netherlands and Japan which have achieved marked reductions in infant mortality rates in recent years without marked addition to their medical manpower. Britain's heavy dependence on medical personnel from overseas makes comparison on the ~~other hand~~ with other countries, particularly the Third World, all the more poignant. In 1971 33.5 per cent were born in overseas countries other than Ireland; however, the figure is only 13 per cent for consultants, compared with 55 per cent for registrars and 61 per cent for senior house officers. Between 1969 and 1971 35 per cent of the net addition of 2038 to the total medical personnel of England and Wales were born overseas, including 76 per cent of the 500 medical practitioners.(37) The net addition in these two years of 714 from overseas represents more than the entire medical manpower of Guinea and Congo, ~~or Ethiopia~~ nearly the same as that of Kenya or the Sudan, and more than double that of Ethiopia.

INSERT TABLE 9

Is medical manpower better distributed as a consequence of the operation of the health service? Let me quote one authority. He said that although Britain's relatively low health expenditure "may be partly due to more economical delivery of our centrally financed services... it is still true that there is great unevenness in the distribution of the funds we have in proportion to population in Great Britain and within England. Some areas started with greater resources ~~of people and of things and a higher level of finance than others~~. The South East of England has substantial advantages over the North-East or the Midlands and Scotland has substantial advantages over England and Wales as a whole in manpower and money. At the end of 25 years these differences, particularly in the distribution of medical manpower, still exist." This was Sir George Godber, in his valedictory report last year as Chief Medical Officer on the State of the Public Health.(38) The sociologist might only comment that discussion of inequalities between regions and areas are too often sealed off from discussion of the underlying inequalities of class, income and housing and living conditions

created in our market economy and that these underlying inequalities are even more important to attend to if the claim that the National Health Service "has preserved more successfully than most of the other systems both freedom of access to medical and allied care at times of need and the availability of a personal medical attendant." is to be justified.(39) Neither social class nor income level features as a variable in analysis or even as a term so far as I can discern anywhere in the 182 pages of the C.M.O.'s report on the State of the Public Health for 1972, or for that matter in the reports of the previous three years and there is no discussion of the Decennial Supplements and other reports on the relationship between mortality and class.

In some respects long-term improvements in the distribution of medical manpower cannot be demonstrated. Since 1948 areas with too few doctors have been designated and mild inducements introduced for doctors to practise there. Up to 1958 the proportion of doctors working in areas with high average lists of patients fell, then fluctuated, and in the mid and late 1960s increased rapidly. A recent careful study concluded, "The National Health Service has not brought about any dramatic shift in the location of G.P.s ... 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 and keeping an adequate number of practitioners ... Certain areas of the country are medically deprived in the sense that the existing services are unable to cope with the demands placed upon them, while others have a relative abundance of medical resources in relationto their needs."(40) In planning health services deprived areas have to be identified more precisely, though in relation to the more fundamental problem of deprived strata.

According to some specialists evidence about consultation rates by social class broadly suggests an equitable distribution of services.(41) However, the evidence is limited either because in scope it does not allow precise analysis by individual class, age-group and type of area,(42) or because sufficient account cannot be taken of the place, type, length and content of consultation.(43) Data about large lists in industrial areas(44) and the tendency of middle-class patients to be on small lists or the lists of practitioners with further qualifications and easy access to diagnostic and special therapeutic facilities(45) do in themselves

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suggest unequal outcomes. For social classes IV and V the latest evidence suggests relatively low utilisation under the age of 5, relatively high utilisation in late middle age, and just under average utilisation over the age of 65. (Table 10) More important is the fact that utilisation is not standardised by need. For all age-groups utilisation by class does not correspond with measures of need, at least as expressed by those of mortality and limiting long-standing illness (as in Tables 4, 6 and 7).

INSERT TABLE 10

In pursuing measures of utilisation by social class or income level two distinctions are necessary. If the number of consultations in a year are aggregated for each of two categories which are to be compared, differences between the proportions in each category not consulting at all and those consulting frequently because of some long-standing disability may be obscured. Consultations for acute episodes and among the chronic sick need to be distinguished. Again, some effort has to be made to standardise for type of consultations. Some consultations may be more for "social control" or administrative purposes than to meet a specific health need, for example, medical certification for bad housing or sickness insurance.

I am arguing that measures of utilisation have to be related to measures of need. This principle has been applied imaginatively in Britain by some writers in recent years[46] but no opportunity seems to have been taken to apply it as systematically as in some other societies. For example, a Finnish study published in 1968 showed that the average number of consultations with a physician per 100 days was higher in the lowest than in the highest income group, but when consultations were standardised in respect of days of sickness, the trend was reversed. Moreover, the advantage of the relatively rich was shown for both the acute and chronic sick. "The lower the income, the higher the morbidity and the lower the utilisation of medical services in relation to morbidity." Incidentally, and this has important implications for the development in Britain of group practice, health centres, and district general hospitals of substantial size, the use of a physician's services was found to decrease with increasing distance to physician for all groups.[47]

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In building up a picture of utilisation of different health services it must not be supposed, because some services are heavily utilised by the poorer working classes, that this is necessarily contributory evidence of equitable provision of health services as a whole. Like other major institutional systems of society the health system is organised in a hierarchy of value and status. No one today would argue that the heavy utilisation of secondary modern schools by the working classes constitutes evidence of equality of educational provision. Despite the scarcity of data the point can be made for health institutions. In a national study of the elderly in institutions in the mid-1960s I found that more of those from non-manual than unskilled or partly skilled manual backgrounds were in geriatric hospitals than in psychiatric hospitals, even when some attempt was made to standardise among patients by degree of incapacity, confusion and lucidity, and were also in the better endowed hospitals within these sectors - defined by furnishings and shared spaces as well as staffing ratios. The same applied to the populations of private, voluntary and newly-built local authority residential homes, when compared with the populations of older local authority homes.(48) To some extent at least clinical and administrative decisions are influenced both by the status of institutions and the social class of patients. More too of the poorer working classes may stay longer in certain health and residential institutions for social reasons, either because there is no easy alternative mode of life for them in the community (they cannot find homes, have no capital and little income) and the institutions in which they live develop a functional need for their labour, for the lack of demand they make upon hard-pressed medical and nursing staff or their value for teaching.

That there is a hierarchy of status and quality of care can be illustrated from the hospital costings returns and new statistical studies of the distribution of services carried out by the DHSS. First, the structure of expenditure and staffing in different types of hospital is hard to defend. Table 11 shows that costs per patient in long-stay, chronic, mental illness and mental handicap hospitals ranges from only under a third to about two-fifths of that in acute hospitals. This is attributable not just to greater need for, and provision of, medical and nursing staff in the latter, as Table 12 demonstrates. Even the costs of domestic services, catering, laundry and general cleaning, for example, in the low status hospitals are substantially below half the comparable costs in the acute hospitals. And the pattern is even more

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~~astounding~~ astonishing when costs and staffing ratios for individual low-status hospitals are examined. The average number of medical staff in mental illness hospitals in 1971 was 1.8 per 100 patients but among hospitals with 200 beds or more varied from 0.75 to 8.7. The average number of nursing staff was 36.3 but varied from 22.5 to 70.6. In mental handicap hospitals the range ~~per~~ for 100 patients was between 0.05 and 2.55 for medical staff and between 15.4 and 59.2 for nursing staff.(49) Comprehensive official statistics can be used in this way to confirm the more elaborate findings of independent research surveys.(50)

INSERT TABLES 11 and 12

Second, the structure of inequality has not changed markedly over the years. Particularly depressing is the failure to raise expenditure per patient ~~relatively~~ relative to that in acute hospitals and for the acute sick in long-stay and mental illness hospitals and to raise it more than marginally in mental handicap hospitals, relative to that in hospitals despite a succession of investigations of bad conditions in the late 1960s and early 1970s, in different long-stay hospitals,(51) widespread publicity and concern, and the introduction of new Government policies aimed at promoting rapid improvement. 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 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

60

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

astonishing when costs and staffing ratios for individual low-status hospitals are examined. The average number of medical staff in mental illness hospitals in 1971 was 1.8 per 100 patients but among hospitals with 200 beds or more varied from 0.77 to 8.7. The average number of nursing staff was 36.2 but varied from 21.8 to 70.6. In mental handicap hospitals the range per 100 patients was between 0.06 and 2.55 medical staff and between 15.4 and 50.2 nursing staff.(49) Comprehensive official statistics can be used in this way to confirm the more elaborate findings of independent research surveys.(50)

INSERT TABLES 11 and 12

Second, the structure of inequality has not changed markedly over the years. Particularly depressing is the failure to raise expenditure per patient relatively in long-stay and mental illness hospitals, to raise it more than marginally in mental handicap hospitals despite a succession of investigations of bad conditions in the late 1960s and early 1970s, in different long-stay hospitals,(51) widespread publicity and concern, and the introduction of new government policies aimed at promoting rapid improvement. 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 likely than examination of any other sequence of events in recent years to yield insights into the general deficiencies of health services planning.

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

I have pursued the twin themes of inequality in health condition or needs and of provision of services. The evidence ... a searching re-appraisal of the whole development of our health system. There are problems of identifying performance, understanding the interconnections within the health system of different branches of service and defining its boundaries, and explaining why policies designed to lead to more equitable distribution of services have been frustrated. A deeper analysis of the persistence and even the widening of inequality may be required.

Of course, however widely the health system is conceived and drawn its potentiality is restricted. The system is not the only determinant of mortality or morbidity. States of health depend on peace or war, nutrition, living standards, education and the working environment. One illustration might be given. Whereas staffing ratios for health visitors, consultant obstetricians, paediatricians and general practitioners are all slightly higher in Scotland than in England and 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 found, for example, that the infant mortality rate was directly proportional to the degree of overcrowding.(52)

The interdependence of services within the system also deserves to be better understood. Measures of adequacy and efficiency must be developed not just for particular services, because that implies they are isolated from one another, and isolated in their effects. They 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. The relative scale, balance and working functions of each part of the system have to be identified for local communities as well as for the nation as a whole.

This functional interdependence has been recognised in the plans for the reorganisation in 1974 of the National Health Service. The trouble is that reorganisation takes a hierarchical form, 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 conflicts not only with democratic conceptions of health services, but with comprehensive conceptions of health needs, equitable and inexpensive deployment of resources and the long-term advance in standards of health education. 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 its proposed regional health councils were intended to have control only over the blood transfusion service and the organisation of post-graduate education and research, and only a third of the strong area health authorities were to be appointed by the

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Secretary of State. On grounds of managerial efficiency the present Government has introduced a multi-tier organisation almost totally controlled from above. The 15 regional health authorities in England have powers to plan the regions and allocate resources to and supervise area health authorities. 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 section comprise doctors, and the next, solicitors and accountants.(54) 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 half the members are in any case appointed by area health authorities. "The biggest single criticism of 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."(55)

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 are taken. Moreover, the change from Regional Hospital Boards to Regional Health authorities indicates the increased scope of their influence over planning decisions which also 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. In the history of all the professions there has been the problem of reconciling the acquisition or 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 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 have been developed with the intention of prescribing duties to the public and guaranteeing quality of service. Qualifications, training schools and conditions

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of entry to the profession have been introduced with the intention of ensuring conformity and high standards of practice. Humanistic and individualistic creeds have been established as a protective social force independent of the exercise of political power and impersonal bureaucracy. On the other hand there have been 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 conditions of remmeration and work, and resist change.

The development and significance of this contest has to be reviewed in different contexts. On the debit side might be listed the recent history of the medical profession's insistence, above all else, on high remmeration and privileged terms of service, including the expensive charade of merit awards;(56a) the failure to institute effective complaints procedures;(57) the failure to broaden medical education and to 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 industries), 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 signs of a critical spirit among new entrants to the medical profession,(60) the increase, though slow, in numbers of district nurses and home helps; the reduction in number of mental hospital patients and the beginning of alternative services, such as sheltered housing and workshops and day centres, for the mentally ill, mentally handicapped, elderly and disabled in the community. Although these trends are overshadowed by the reinforcement of consultant power and status in the hospitals, 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 health care, irrespective of class or income, remains to be firmly established. The treatment in particular of many of the aged, chronic sick and disabled, mentally ill and mentally handicapped, remains scandalously poor and can in the long

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run be dramatically improved only by a redefinition of 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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