THE NATIONAL HEALTH SERVICE:

ITS SOURCES AND IMPACT

THE PARADOX OF THE BRITISH NATIONAL HEALTH SERVICE: AN ANALYSIS OF ITS SOURCES AND IMPACT

by

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ABSTRACT

Theories of the welfare state view it as a markedly different form of providing for the needs of the working class; as being introduced in response to demands of workers for reform; and as narrowing class inequalities. This analysis of the British National Health Service argues that such assumptions are misleading. Instead, it suggests that with respect to this particular health system, there was a continuity of structure with the previous health services; that it was largely a response to a recognized need for organizational rationality and a stable source of financial support; that those working within the health services were most actively involved in formulating plans for reform; and that while there is no marked class inequality in access to medical care, this has not resulted in a narrowing of class differences in health.

RESUME

Les théories de l'Etat pourvoyeur de bien-être (le Welfare State) considèrent le bien-être social comme une façon essentiellement différente de celles des régimes précédents de satisfaire les besoins de la classe ouvrière; elles soutiennent aussi qu'il fut mis oeuvre afin de repondre aux demandes de réformes venant des travailleurs; et, finalement, elles prétendent qu'il constitue un moyen de réduire les inégalités de classes. Cette analyse du Service britannique de santé nationale (British National Health Service) réfute ces prises de position. Elle prétend au contraire:

- que les structures de ce système d'assurance-santé perpétuent celles des services de santé qui l'ont procédé;
- que ce système provient d'abord d'une préoccupation de rationalisation administrative et de stabilisation de sa base financière;
- que ceux qui oeuvraient déjà dans les services de santé furent parmi ceux qui contribuèrent le plus à la réforme;
- et, bien qu'on ne remarque aucune inéquité de classe quant à l'accès aux soins médicaux, que la mise en place de ce système n'a pas entrainé une réduction de l'inégalité de classes.

PREFACE

Theories of the distribution of power in advanced industrial society have made a number of assumptions concerning the sources and impact of the welfare state. However, the validity of these assumptions has seldom been assessed through systematic study of specific welfare services and programmes. This is particularly true of one branch of the welfare state in Britain--the National Health Service. The service has been seen as the most socialist of welfare programmes (since care is available on the basis of need alone), and has generally been regarded with veneration. Yet no systematic attempt has been made to examine the origins and impact of the service in the light of its attention to class inequalities in health and access to medical care. This study focusses on these issues in order to assess the validity of assumptions which are made concerning the sources and impact of the welfare state.

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THE PROBLEM

The term welfare state has frequently been used to describe advanced industrial societies. But can we view the services and programmes typically seen as comprising the welfare state[1] as a radical departure from earlier provisions made for the poor and working class? Was the working class in a particularly disadvantaged position prior to the institution of these services and programmes? Can the introduction of welfare services be seen as a response to working class pressures for reform? Was the extension of welfare programmes and services addressed largely to the needs of the working class and thus to reducing class inequality? And has the welfare state operated in such a manner as to reduce class inequalities and achieve a measure of income redistribution? The research reported here attempts to answer these questions.

Inequality has largely been defined in economic terms: studies have explored variations in the distribution of wealth and income while placing relatively little emphasis on other than economic dimensions of inequality. In the light of this inattention to other dimensions of inequality, this study is addressed to inequalities in health and access to health care and to the function of the State in providing health care. More specifically, this is translated into a study of the British National Health Service--of the conditions under which it was introduced and its impact on class inequalities in health and

access to medical care. We will, therefore, seek to answer the questions posed above through an analysis of the sources and impact of the British National Health Service. The extent to which we can generalize to the British welfare state as a whole and to other countries is, however, a problem for additional research.

We have focussed on health services for a variety of other reasons, most important being the fact that health is a primary concern for most people. It affects our enjoyment of life, our ability to live a normal life, to work and maintain a measure of independence. And given the importance of good health and the greater morbidity and shorter life expectancy of the working class in all industrial societies, it is surprising that health services have received relatively little attention from sociologists until recently. We have chosen to study the British National Health Service as Britain was among the first countries to develop an extensive range of welfare state services, and its health system is regarded by many as being based on socialist principles, catering to all classes on the basis of need. For this reason alone, it presents an interesting and appropriate focus for exploring the issue of whether the welfare state successfully alters systems of class privilege.

Let us examine the basis for the questions which we have posed above and thus more clearly delineate the problems to which this study is addressed.

MARXIST AND PLURALIST IMAGES OF THE ROLE AND FUNCTIONS OF THE STATE

The concept of the welfare state--and perhaps more obviously that of the "New Deal"--emphasizes a point of transition in which the State is seen as assuming a new and qualitatively different role in providing for those in a permanently or temporarily disadvantaged position. This sense of transition, no doubt, stems partly from political expediency with political parties claiming significantly different programmes for providing for the needs of the underprivileged in just the same way as advertising seeks to convince us of the development of qualitatively different and better products. And it is probably reinforced by the quiet years of apparent progress and prosperity which were experienced by many Western nations during the 1950's and early 1960's. But irrespective of the source of the meanings we attribute to these terms, a recent change in the role and function of the State is generally recognized. So, for example, the welfare state in Britain is viewed as emerging during the 1940's, and as representing a point of radical departure from provisions made for the poor and the working class in prior decades.

Analyses of the new role and functions of the State are relatively scarce. Despite the fact that the welfare state is "one of the great structural uniformities of modern society,"[2] welfare services and the genesis and impact of social policy have seldom been the focus of attention for sociologists. As Wilensky comments:

> Students of the shape of modern society need a new sociology of knowledge to explain the inverse relation between the political importance of an institutional sphere and the systematic attention sociologists have given to it. The chief candidates for "least studied and most talked about" are the welfare state, the military, the mass media and mass entertainment, and the intellectuals and experts--perhaps the most distinctive marks of modern life.[3]

Some indication of the various interpretations of the new role and functions of the State and of their theoretical significance may, however, be found in the continuing debate on the distribution of power in advanced industrial society. Two major perspectives dominate this debate in relation to capitalist society--pluralist and marxist.[4] Essentially, the debate focuses on the power of the economic elite: within a marxist tradition, the economic elite is seen as wielding power beyond the economic domain, while pluralism argues that elites and various interests within other institutional areas successfully pursue interests which conflict with those of the economic elite.[5] In the latter, therefore, power is seen as being more widely diffused throughout the society.

Within these two broad perspectives, different images of the role and functions of the state are outlined. Pluralist analyses see organized interest groups as competing for power, and the government as acting in the capacity of referee to mediate between competing interests in order to ensure that no one group consistently dominates or secures control over decision making processes.[6] They view the economic elite as one of several powerful groups seeking the favour of government, and as being opposed to social reform and government intervention, with any such intervention being indicative of the State

acting to alter the system of class privilege and acting against property interests. Thus, the image of movements for the regulation of business and for social reform which is portrayed in such analyses is one of a victory of "the people" over "the interests."[7] The State is, therefore, seen as a redistributive force within society, and the emergence of the welfare state is taken as a primary example of its role in changing the structure of class privilege.

On the other hand, marxist analyses have identified the State with the protection of the interests of the ruling elite. However, some writers have recognized a modification of market and elite domination of the political system: for example, Birnbaum sees the State as essentially allied with property interests, but views it as occasionally detaching itself from such to mediate between the conflicting interests of property and a "public."[8] Miliband attributes this shift in the role of the State partly to the organization of the working class: challenges to the legitimacy of the existing order have, at points, changed that order.[9] Birnbaum recognizes elements within the political elite which have not been "crude servitors of industrial wealth" and whose interests have lain in maintaining social cohesion.[10] And, furthermore, studies have pointed to the existence within the economic elite of liberal elements which have not been opposed to government intervention and which have been instrumental in stabilizing capitalism and preserving class privilege through encouraging social reform. But Birnbaum sees welfare state functions as being secondary to government functions in guaranteeing property and

controlling the processes of production and distribution.[11] And Miliband argues that while the welfare state has diminished the inhumanities of total market systems, this is through redistribution effected within the working class rather than between classes.[12] Such analyses see the system of class privilege as having been stabilized and strengthened by welfare state measures rather than as having been significantly altered.

Assumptions Concerning the Sources and Impact of the Welfare State

At the risk of repetition, let us examine more fully the assumptions made by each of these theoretical perspectives with respect to the genesis and effect of the welfare state. It is important though to stress that we are discussing assumptions since many analyses of the distribution of power fail to provide their comments on the welfare state with a solid empirical foundation. And many statements about the impact of the welfare state have been lacking in clarity and precision. Bearing these comments in mind, we may note a series of linked assumptions concerning the sources and impact of the welfare state. In detailing these, it will be clear that while pluralist and marxist analyses diverge in their analysis of the distribution of power, several common assumptions are made with respect to the welfare state.

We have already argued that in the use of the term welfare state a point of transition is assumed--a point of radical departure from the previous role and functions of the State. Pluralist and

marxist analyses share this assumption, as also they do the view that welfare state measures were introduced in response to the pressures of workers. Strachey, in his analysis of the "new stage which capitalism has entered" sees power as no longer being located almost exclusively in the hands of a capitalist class, but as being diffused throughout the community. He sees the State as assuming a more important and powerful role, and as responding to and representing the varied interests within the community:

> . . .the House of Commons itself reflects and responds to the diverse, divergent, reciprocating social forces of the whole community. Every section of the British people has found a way of bringing to bear its influence on the making of the government decisions.[13]

For Strachey, the advent of the welfare state represents a triumph of representative democracy and an indication of the capacity of the State to act in the interests of wage earners. And he views the organization of workers into trade unions and the competitive bidding of the parties for workers' votes as important reasons for the development of the new stage of capitalism which is, in part, characterized by the welfare state. He comments: "We reach the paradoxical conclusion that it has been, precisely, the struggle of the democratic forces against capitalism which has saved the system."[14]

In the same vein, Miliband's development of a marxist analysis of the role of the State in capitalist society, suggests that the welfare state was introduced in response to pressures from workers. Writing of the National Health Service and the comprehensive system of social insurance established in Britain in the 1940's, he argues:

> These measures, which were the pillars of the "welfare State," represented of course a major, it could even be said a dramatic extension of the system of welfare which was part of the "ransom" the working classes had been able to extract from their rulers in the course of a hundred years.[15]

Furthermore, in making these assumptions as to the reasons for the introduction of welfare state measures, it is also implied that such changes were addressed to the needs of the working class, and that workers were in a particularly disadvantaged position prior to these changes. For example, Jay, writing in the pluralist tradition, implies a priority to reducing inequality when he comments that ". . .the assault on poverty and inequality through redistribution must remain the prime purpose for a very long way ahead."[16] (Italics mine.) And Frankel's marxist analysis of British society implies that the services comprising the welfare state were introduced in an effort to prevent the more marked class inequalities and deprivations of the working class in the pre-war years:

> During and after World War II. . ."Western" governments declared their intention to prevent a return to pre-war evils; and, in this spirit, the British Coalition Government asserted its determination to maintain full employment, to institute comprehensive social services, including secondary education for all, to break down old social barriers and to abolish want and poverty.[17]

We also see some similarity in interpretations of the impact of the welfare state--at least insofar as both marxist and pluralist analyses recognize an improvement in the position of the working class. Miliband, cautious in his assessment of the welfare state, recognizes that the working class largely pays for its own benefits (redistribution taking place within the working class rather than

between classes), but argues that the services have had a humanizing effect. The welfare state, he writes, "did not, for all its importance, constitute any threat to the existing system of power and privilege. What it did constitute was a certain humanization of the existing social order."[18]

Unfortunately, Miliband does not make clear exactly what importance he attaches to welfare state services. He is not explicit about what constitutes "humanization." And he gives no clear indication of what would constitute a change in the existing system of power and privilege: Is he talking about the distribution of wealth alone? Would he also include changes in the distribution of income? a reduction of inequalities in health or access to education or medical care? In view of such unanswered questions, it is difficult to determine exactly how the impact of the welfare state is interpreted.

Pluralist analyses also recognize benefits flowing from the welfare state: inequality remains, but has been reduced and the future will bring further improvements. Titmuss argues that such beliefs are widespread--beliefs that the age of the welfare state has arrived and that it affords very real protection to the working class against the vicissitudes of life, and in the process, achieves a redistribution of income.[19] Such arguments are advanced by Strachey, for example, who recognizes a reduction in class inequality which, though not marked, is evidence of the strengths of representative democracy and the new power in the hands of workers. And the future is viewed with similar optimism: "At this point in their development,

representative institutions are likely to be used by the wage earners to attempt to re-model the economic system in their interests."[20]

In these ways, we see similar assumptions being made within pluralist and marxist analyses of the distribution of power and the role of the State in industrial society. The major difference lies in their interpretation of the attitudes of the economic elite to the introduction of welfare services and programmes. Pluralism sees such social reforms as essentially opposed to the interests of business leaders and thus indicative of the diffusion of power. For example, Rose, writing of the U.S.A., sees economic elite pressure groups as having been defeated in the introduction of medicare for the elderly, federal aid to education, an anti-poverty programme, and a comprehensive civil rights act.[21] Such new services and legislation are of theoretical significance since they serve to demonstrate that the economic elite manifests power largely within the economic domain.

Marxist analyses postulate a very different attitude toward social reforms on the part of the economic elite. While viewing such reforms as being initiated by pressures from the working class and from middle class social reformers, studies have argued that the economic elite has not been fundamentally opposed to social reform and an extension of the functions of the State. Weinstein's study, for example, addresses itself to the "false consciousness of American liberalism," and argues that business leaders incorporated the ideals and programmes of social reformers and adapted them to their own ends. Writing of the U.S.A. between 1900 and 1918, he questions the

conventional wisdom as to the actions of business leaders.

> Businessmen were not always, or even normally, the first to advocate reforms or regulation in the common interest. . . . But. . .few reforms were enacted without the tacit approval, if not the guidance, of the large corporate interests. And, much more important, businessmen were able to harness to their own ends the desire of intellectuals and middle class reformers to bring together "thoughtful men of all classes" in "a vanguard for the building of the good community." These ends were the stabilization, rationalization, and continued expansion of the existing political economy, and subsumed under that, the circumscription of the Socialist movement with its ill-formed, but nevertheless dangerous idea for an alternative form of social organization.[22]

The economic elite is seen as not being necessarily opposed to social reforms and the extension of the welfare state. However, such reforms are not of central theoretical significance since they have little impact on the distribution and control of wealth.

To summarize, we have noted that analyses of the distribution of power and the role of the State in advanced industrial society make certain common assumptions concerning the sources and impact of the welfare state. These may be stated briefly as follows:

1. The welfare state represents a radical departure from the prior organization of services and programmes;
2. The working class was in a particularly disadvantaged position prior to the introduction of welfare state services;
3. The introduction of welfare services and programmes was a response to working class pressures for reform;
4. As such, welfare measures were addressed to the needs of the working class and to reducing class inequality;

5. The welfare state has reduced class inequalities and achieved a measure of income redistribution.

The research reported here is addressed to these assumptions.

THE LOGIC OF ANALYSIS

This study has grown from an effort to elaborate the assumptions detailed above. In seeking to understand the nature of the changes in the structure of the health system which occurred with the introduction of the National Health Service, it seemed that these assumptions neglected important issues, and in certain circumstances, had an inadequate empirical foundation. By means of an introduction to the issues discussed in later chapters and in order to convey the manner in which the assumptions made within marxist and pluralist theories became problematic, we will indicate the way in which our initial research led us to question these assumptions.

In examining the structure of the health system prior to 1948, it appeared that it was not markedly different from that of the National Health Service, and it became clear that precedents for the introduction of the National Health Service had been laid in the late nineteenth and early twentieth centuries. This suggested that the introduction of the new service might perhaps be more appropriately viewed as an organizational and administrative change, rather than as a radical shift in the structure of the health system.

Furthermore, in examining the development of the health services, it seemed that the introduction of the National Health Service

could be explained, at least in part, in terms of the internal dynamics of the health system. The increasing sophistication of medical science and technology helped to create a more central role for the hospitals within the health system and at the same time created organizational and financial problems which became increasingly severe during the 1930's and 1940's. Our initial analysis of such problems further suggested that the introduction of the National Health Service represented a response on the part of the government to a recognized need for a rationalization of the health system rather than being simply a response to pressures of workers for such changes. Indeed, public pressure for change does not appear to have been strong.

Moreover, our preliminary analysis of the development of the health services also indicated that a tradition of free or low cost medical care for the poor and the working class had existed since the mid-nineteenth century. Though the quality of this care was, at times, questionable and the working class patient faced many deterrents to obtaining medical treatment, these patients did have access at little or no cost to the best available hospital care. This, even in the early 1940's, was largely denied to middle class patients. It appeared that working class patients were not necessarily the most disadvantaged in access to care.

Thus, in seeking to understand the change in the structure of health services wrought by the National Health Service Act, we were increasingly led into an analysis of the development of the health system from the mid-nineteenth century since our initial readings

suggested that the National Health Service could not be viewed as a radical departure from the prior organization of services and that it could not be explained simply in terms of the unavailability of care for working class patients and pressures for reform from the working class.

But while it appeared that the development of the health system and the introduction of the National Health Service could be partly explained in terms of internal dynamics, was it, at the same time, a response to working class pressures for reform? While marxist and pluralist analyses view the introduction of welfare state services as a response on the part of governments to pressures for reform from the working class, our initial research indicated that such pressures were at a minimum. What seemed more important was the concern expressed by the medical profession and others working within the health system as to the need for reform. Also, these interest groups appeared to recognize that a reorganized health service would operate under government authority and that it would provide free care to the vast majority of the population. The government appeared to be responding to a need for change recognized within the health system. Furthermore, its response was in no sense an immediate one and was focussed on organizational and administrative issues rather than explicit issues of social justice and class inequality in access to medical care.

In these ways, we were led to question existing assumptions concerning the sources of the welfare state. With respect to the

British National Health Service at least, they appeared to be misleading. But what of the impact of the National Health Service? Here, we proceeded with an initial belief that the National Health Service did not provide equal access to health care for persons of different social class. Studies of medical care systems in Sweden and the United States indicate that working class patients make less use of health services than do middle class patients, even though their needs for care are apparently greater.[23] But similar patterns of use were not evident in studies of the use of general practitioner and hospital services which we consulted. In other words, marxist and pluralist assumptions concerning the role of the welfare state in reducing class inequalities appeared valid in the case of the National Health Service. However, in examining class differences in mortality and morbidity in order to provide a framework for the discussion of differences in the use of medical services by patients of different social class, it became evident that class inequalities in mortality rates were increasing in the decades following the introduction of the National Health Service. This suggested that the belief in progress underlying marxist and pluralist analyses of the welfare state is not wholly justified and that, at least in terms of health, class inequalities have not narrowed.

Thus, in seeking to elaborate the assumptions made within marxist and pluralist analyses, we became increasingly aware that these assumptions were open to question and that they neglected important issues. This study seeks to assess the validity of these

assumptions and questions them by developing alternative explanations of the sources and impact of the National Health Service. In so doing, we hope to convey the interplay of factors affecting the changing structure and operation of the health system. At each point in the development of our argument, we will seek to demonstrate how the issues discussed flow from our questioning of those assumptions made within marxist and pluralist theory.[24]

SOURCES OF DATA

Perhaps the most immediately apparent problem which we faced in seeking to understand the sources and impact of the National Health Service was the relative scarcity of data. The National Health Service has received little attention from sociologists, and its role in reducing class inequalities has been especially neglected. Even in critical analyses of British society, the Service has been conspicuously ignored. As Rossdale writes: "More than any other creation of the post-war Labour government, the National Health Service has been regarded with veneration and satisfaction by those on the Left."[25]

Where studies have focussed on the operation of the National Health Service, its effects in reducing class inequalities have been paid scant attention. Rossdale, in an article critical of definitions of health, of the doctor-patient relationship, and the existence of private practice, barely refers to class inequalities in access to health care and in quality of health.[26] Similarly, Bosanquet, in an

article which assesses Labour's achievements in reducing inequalities in health, fails to consider class inequalities in access to medical care under the service.[27]

In the analysis of the development of health services, this study has not made systematic use of original sources. For example, we have not systematically studied records of parliamentary debates, reports of Royal Commissions and of Trade Union conferences, professional journals, etc. In view of the breadth of the issues relevant to the problems which we have outlined, we have in most instances relied on secondary sources such as histories of the development of welfare services, analyses of the process of industrialization in Britain, accounts of the development of medicine, and the growth of the hospital system and studies of the process of negotiations preceding the introduction of the National Health Service. And in the analysis of class differences in mortality and morbidity, and the use made of various health services, we have largely relied upon official government publications and numerous small studies of morbidity, mortality, and the use of general practitioner, hospital and dental services.

Much of the data presented in the following chapter is not, therefore, "original." We are combining data in new forms insofar as we are addressing ourselves to a series of issues which have been neglected by sociologists. Indeed, relatively few of the sources consulted were authored by sociologists. But in using such secondary sources, we must bear in mind the fact that we are only sensitized to

issues which others have already defined as important.[28] This study must be viewed as exploratory in nature, as a historical case study which gives rise to a number of hypotheses, each of which might, most appropriately, be further pursued through the systematic use of original sources.

The chapters which follow proceed from the assumptions made in marxist and pluralist theory, and each seeks to indicate the manner in which data on the health services in Britain are inconsistent with these assumptions in several respects. In so doing, we shall be developing the following hypotheses:

1. The National Health Service was <u>not</u> a radical departure from the organization of health services prior to 1948.
2. Working class patients were not severely disadvantaged in obtaining medical care prior to 1948. Middle class patients were, in some respects, in a particularly disadvantageous position.
3. The National Health Service was in large part a response to the recognition of a need for organizational and administrative rationality and for a stable source of financial support for the hospitals. The National Health Service Act was addressed to these goals.
4. The recognition of problems within the health services and the concern for change came largely from the medical profession and hospital administrators.

5. The National Health Service may be no more effective in redistributing income than were the health services prior to 1948.

6. Though not specifically addressed to achieving such, there are no glaring inequalities in access to medical care within the National Health Service. This may be due, not so much to the system of socialized medicine per se, as to the central role of the general practitioner in the service.

7. While there are no marked inequalities in access to care, there is a growing class inequality in health levels as measured by mortality rates.

FOOTNOTES

[1]In writing of the welfare state, we are referring to a collective provision to protect individual rights to a minimum standard of living. This involves a complex of services and programmes such as social security, family allowances, unemployment insurance, old age pensions, etc. Wilensky defines the concept as follows: "The essence of the welfare state is government-protected minimum standards of income, nutrition, health, housing, and education, assured to every citizen as a political right, not as charity." H.L. Wilensky, The Welfare State and Equality (Berkeley: University of California Press, 1975), p. 1

[2]Ibid., p. 1 [3]Ibid., n. 1, p. xv.

[4]For a discussion of the issues upon which these two perspectives disagree, see: W. Kornhauser, "Power Elite or Veto Groups?" in R. Bendix and S.M. Lipset, Class, Status and Power (2d ed.; New York: The Free Press, 1966).

[5]For the development of a marxist perspective on power: N. Birnbaum, The Crisis of Industrial Society (London: Oxford University Press, 1969); R. Miliband, The State in Capitalist Society (London: Quartet, 1969); J. Weinstein, The Corporate Ideal in the Liberal State (Boston: Beacon Press, 1968); G.W. Domhoff, The Higher Circles (New York: Vintage Books, 1971).

For a pluralist perspective on national power, see: A. Rose, The Power Structure (New York: Oxford University Press, 1967); J. Porter, The Vertical Mosaic (Toronto: University of Toronto Press, 1965); J. Strachey, Contemporary Capitalism (London: Victor Gollancz, 1956); D. Jay, Socialism in the New Society (London: Longmans, 1962).

[6]R.P. Wolff, "Beyond Tolerance," in R.P. Wolff, Barrington Moore, Jr., H. Marcuse, A Critique of Pure Tolerance (Boston: Beacon Press, 1969).

[7]Weinstein, op. cit., p. xii.

[8]Birnbaum, op. cit., p. 57.

[9]Miliband, op. cit., p. 99.

[10]Birnbaum, op. cit., p. 48. [11]Ibid., p. 75.

[12]H. Frankel, Capitalist Society and Modern Sociology (London: Lawrence and Wishart, 1970), pp. 165 and 278; Birnbaum, op. cit., p. 78.

[13]Strachey, op. cit., p. 73. [14]Ibid., p. 154.

[15]Miliband, op. cit., p. 99.

[16]Jay, op. cit., p. 224.

[17]Frankel, op. cit., p. 69.

[18]Miliband, op. cit., p. 99.

[19]R.M. Titmuss, Essays on the Welfare State (London: Unwin University Books, 1963), pp. 34-39.

[20]Strachey, op. cit., p. 160.

[21]Rose, op. cit., p. 487.

[22]Weinstein, op. cit., p. ix.

[23]R. Andersen et al., Medical Care Use in Sweden and the U.S. Chicago, Center for Health Administration Studies, Research Series 27. (Chicago: University of Chicago Press, 1970).

[24]The values which underlie the definition of the problem should be made explicit. We believe that the nature and extent of inequality in advanced industrial society is neither desirable nor inevitable and that a greater degree of equality might be achieved. However, this study is not so concerned with defining what "should be," as with illuminating what "has been" with respect to one institutional area. It is built on the belief that only a fuller understanding of the dynamics of change will allow more conscious transformation of social structures.

[25]M. Rossdale, "Socialist Health Service?" New Left Review, No. 36, (1966), p. 3.

[26]M. Rossdale, "Health in a Sick Society," New Left Review, No. 34, (1965), pp. 82-90.

[27]N. Bosanquet, "Inequalities in Health," Labour and Inequality: Sixteen Fabian Essays, P. Townsend and N. Bosanquet, eds., (London: Fabian Society, 1972).

[28]See Appendix A for a fuller discussion of the limitations of the data and the arguments developed in this research.

PART ONE

PREFACE

In the four chapters which follow we are seeking to understand the introduction of the National Health Service in Britain. We have already indicated that the emergence of the welfare state in Britain during the 1940's has been interpreted by both marxist and pluralist theorists as a somewhat radical departure from the previous services which catered to the needs of the working class; as a response to working class demands for reform; and as being directed towards an amelioration of the situation of the working class and a reduction of class inequalities. As we have already explained, our initial efforts to elaborate these assumptions, with respect to the British National Health Service, cast doubt on their accuracy; and so in the next few chapters, we take each of these assumptions in turn, seeking to determine their validity and, where appropriate, either modifying them or developing alternative propositions.

We have already outlined the general questions to which we will address ourselves in this study. Perhaps it is useful to the reader if we indicate the more specific questions which guide us in the following chapters. We ask first whether the National Health Service can be regarded as a radical departure from the prior organization of health services. In particular, was provision made for the care of working class patients in the decades prior to the National Health Service, and did the State play an active role in the provision

of medical care? For socialized medicine is supposedly distinctive in that it ensures that care is available for the less privileged sections of a population and that it does so through the provision of free or low cost care by the State. If such provision was made prior to the introduction of the National Health Service, then we would conclude that it is inappropriate to view the new service as representing a radical change in these aspects of the organization and delivery of medical care.

Secondly, we ask whether working class patients were especially disadvantaged in access to medical care prior to the introduction of the National Health Service. For this is implied in the assumption that welfare services were introduced as a response to workers' demands for reform, and also in the argument that the introduction of new services and programmes were directed towards an amelioration of the situation of the working class. Obviously, it is insufficient to examine only those problems experienced by working class patients in obtaining care. We ask, therefore, what care was available for working class patients and whether middle class patients were generally in an advantageous position within the health services.

Anticipating the data which we present in the following pages, we may note that while working class patients did experience problems in securing health care, middle class patients also faced important barriers. It does not, therefore, seem appropriate to view the National Health Service simply as a measure designed to improve the access of working class patients to medical care. And this also

suggests that insofar as pressures for reform of the health services existed, these might not be limited to the working class alone. Indeed, these pressures do not seem to have been strong. And so we return to the question of how we can explain the introduction of the National Health Service. What problems led to a reform of the health services? Who was defining these problems? What pressures for change can be identified?

These then are the questions which we pose in the following pages. In seeking to assess the validity of the assumptions detailed above, we indicate their weakness and pose alternative ways of interpreting the emergence of the British National Health Service. Each chapter is centred around one of these alternative propositions: Chapter I argues that the National Health Service was not a radical departure from the prior organization of the health services; Chapter II argues that working class patients were not severely disadvantaged in obtaining medical care before 1948; in Chapter III, we develop the thesis that the new service was, in large part, a response to the recognition of a need for organizational and administrative rationality and for a stable source of financial support for the hospitals; and in Chapter IV, we indicate that the recognition of problems within the health services and the concern for change came largely from those working within the health system.

CHAPTER I

PRECEDENTS FOR THE NATIONAL HEALTH SERVICE

Introduction

Can the introduction of the National Health Service in 1948 be seen as a radical departure from the prior organization of health services? If 1948 marked a major transition in the organization and delivery of medical care, then we would expect to find that relatively little free or low cost care had previously been provided for working class patients.[1] For the introduction of a system of socialized medicine is seen as benefiting working class patients in particular as it provides care at no direct cost, and thus achieves a greater correspondence between needs for care and the use of medical services. Furthermore, we would expect to find that the State played a relatively minor role in the provision of health care prior to 1948, or at least that there was a shift in the principles underlying the provision of public medical care. However, if we examine the development of health services in the hundred years preceding the introduction of the National Health Service, we see that such expectations are not met. In this chapter, we will argue that:

1. A tradition of free and low cost public and charitable care for the working class existed for many decades prior to the introduction of the National Health Service.
2. Precedents for the National Health Service were

> laid during the late nineteenth and early twentieth centuries when the sphere of responsibility of the State in providing medical care was gradually increasing. Such observations suggest that the National Health Service did not represent a point of radical change in these respects, and that the principles upon which the new service was based were established several decades earlier.

We open this chapter with a description of sources of medical care in the mid-nineteenth century. We show that medical care was available to all classes and that the source from which care was obtained was closely related to a patient's class position. The latter parts of the chapter trace the growth of the role of the State in the provision of medical care.

SOURCES OF MEDICAL CARE IN THE MID-NINETEENTH CENTURY

Ambulatory Care

The source from which people obtained care was in large part determined by their class position.[2] For those who could afford it, and who thought it useful, private medical care was obtained at home or in a doctor's surgery. The rich were treated by the elite of the medical profession--fellows and licentiates of the Royal College of Physicians. Somewhat lower in status than these were the licentiates of the College of Surgeons; these were allowed to operate and to

treat internally, but not to administer medicines externally. Most of their operations were performed in patients' homes.[3]

For the less affluent, care was available from general practitioners. Though professional controls were instituted in 1858, there were no legally recognized qualifications for a general practitioner and their educational levels varied widely;[4] yet it was they who treated the vast majority of the population. For private patients, their fees varied in relation to the patient's income or yearly house rental: patients with an annual income over £500 were charged one guinea for a single visit while those with incomes under £100 were charged only two shillings and sixpence. For patients with an annual rental over £100, attendance at childbirth cost five guineas or more, whereas those paying a rent of £10- 25 were charged one guinea.[5] In this way, a process of income redistribution was operating.

Workers often provided for their care through membership in a variety of schemes in which treatment from general practitioners could be wholly or partially paid for with regular contributions. The growth of these clubs in the latter part of the nineteenth century is evidence of an increasing class of better paid wage earners. Medical clubs, provident dispensaries, and provident medical associations all provided care to members who paid contributions on a regular basis. These were organized by friendly societies, trade unions, groups of doctors, or employers who contracted doctors for their employees. Membership in the schemes was not expensive. Contributions

to medical clubs ranged from one penny to one and a half pence per person, while family clubs provided coverage for the whole family (excluding midwifery) for three pence per week. Friendly societies charged workers between two shillings and sixpence and three shillings a year.[6] By 1905, there were six million members of friendly societies with funds totalling £40 million.[7] But even with a considerable growth in such schemes, less than half of the working population were even moderately covered against the impact of illness.[8]

In fact, there existed several barriers to membership in these schemes. Many friendly societies did not cover women and children, and most schemes did not admit "bad lives," or those suffering from constitutional defects or chronic disease.[9] In many medical clubs, there was no obligation to continue the membership of those who developed chronic disease, and if the level of illness became too high, the doctor might discontinue the scheme.[10] Thus, those most in need of care were often excluded, and if unable to pay the fees charged a private patient, were forced to rely on charity and the Poor Law.

It was the Poor Law which provided non-institutional care for those at the base of the class hierarchy--for the destitute. Treatment was available from District Medical Officers appointed by the Board of Guardians within each Union.[11] Care was provided by the District Medical Officer, but the pivot of the whole organization was the Relieving Officer within the Union. He, with no medical

qualifications, was the executive authority and was responsible for issuing the medical orders without which no one could obtain care.

Many deterrents were built into this system. The Relieving Officer was not always easily accessible; in a rural Union, it might be a journey of six or eight miles to reach him. And those applying for medical orders were frequently treated as paupers rather than as patients. This is emphasized by the fact that the decision as to whether or not to grant an order was made by a non-medical officer on the basis of non-medical circumstances--destitution. Only the destitute were eligible for care and thus, "in some Unions the applicant for a Medical Order is required to attend personally before the Guardians at their meeting, and explain, at the cost of half a day's earnings, how he comes to need medical aid."[12]

But these deterrents to obtaining care under the Poor Law were, to some extent, mitigated by the treatment available at the outpatient departments of the voluntary hospitals. Here, there was unrestricted access to care. The whole ethos of the voluntary hospitals was quite different from that underlying the Poor Law. While the latter provided care only to the destitute in order to encourage self-help (in the form of medical insurance) among the poor, the former were the representatives of a tradition of charitable provision of care for those in need, with no means tests involved. For this reason, they catered to families above and below the level of destitution. But the care was hardly superior to that obtained under the Poor Law. Waiting rooms were crowded, treatment hurried, with no time for doctors

to consider the patient's problems in detail, unless the case was unusual and particularly interesting for teaching purposes. For the majority of patients, there was a long wait for a repeat of the same old bottle of medicine irrespective of its medical value.[13] The psychological effect of such may have been beneficial, but to conclude that there were any real preventive or curative effects would be a delusion.

Other sources also provided charitable care for workers and their families. Free dispensaries and medical missions abounded in the slum districts of large towns. These shared with the outpatient departments of the voluntary hospitals the drawbacks of superficial attention and poor care. They also possessed additional disadvantages: they were not under responsible and specialized supervision, and were not able to offer immediate institutional treatment to those in need of it.[14]

Hospital Care

Hospital care was provided mainly for the working class, most especially for the destitute. In the mid-nineteenth century, medical science was still in its infancy. Hospitals had little, if anything, to offer their patients. They could have had little effect on mortality rates except by isolating and eventually eradicating more virulent diseases.[15] Even Florence Nightingale's first requirement--that a hospital should at least do no harm to its patients--was only infrequently met.[16] Patients operated on at home were more

likely to recover and to recover sooner than if they had been hospitalized.[17] Those who could pay the fees were, therefore, generally operated on at home. But in fact, illness was seldom seen as requiring action--one could only wait, hope and pray for God's help--and it was normally endured at home.

It is understandable, therefore, that hospitals were essentially working class institutions.[18] Middle class patients could afford to pay for private treatment at home and for nursing and domestic help. Care was provided by the voluntary hospitals and under the Poor Law. Indoor medical relief under the Poor Law meant the workhouse, and though the care varied from Union to Union, it was generally poor. There was no separation of patients on the basis of symptoms: the acute sick, the pregnant, the insane, the tuberculous, and mentally defective were all housed together, often in one room. The workhouses were crowded; beds were shared (together with bed bugs); towels were shared; the food was poor and inadequate; sometimes inmates would act as nurses, and the doctors were hired by competition for the lowest price. Understandably, most people lived in fear of being sent to the workhouse.[19]

Summary

In the mid-nineteenth century, the source from which people obtained medical care was, in part, dependent on their class position. And while it is difficult to estimate the amount of medical attention received by working class families, we have seen that the working

class, including the destitute, were not denied care.[20] While middle class patients received private care in their homes, working class families could obtain medical attention from several other sources: free charitable care was available from voluntary hospitals; general practitioners charged low fees for their less affluent patients; the Poor Law provided both indoor and outdoor relief; and workers themselves provided for their own treatment through a variety of schemes organized by friendly societies, trade unions, doctors, and employers.

Thus, we see that a tradition of free and low cost care for the working class was established many decades prior to the introduction of the National Health Service. In the light of this observation, we might conclude that rather than providing care for a long neglected section of the population, the importance of the National Health Service may lie in the new basis on which it offered care--as a right of citizenship rather than as a privilege, from charity or from reluctant necessity. But even this argument is open to question since the following decades of the nineteenth century saw significant extensions in the public provision of medical care, and in the provision of treatment as a right of citizenship.

THE EXTENSION OF THE FUNCTION OF THE STATE IN PROVIDING MEDICAL CARE

Towards a Free Hospital Service

The reorganization of the Poor Law in 1834 had provided for a national approach by allowing for central direction of policy, and by

the early twentieth century, the national government had assumed a greater role in the provision of health care. The way was paved for change by the Metropolitan Poor Act of 1867 and the Poor Law Amendment Act of 1868. These Acts empowered London and the provincial unions to provide separate infirmaries for their destitute sick, and they were the first explicit acknowledgement that it was the duty of government to provide hospitals for the poor. As such, they represent an important step toward the creation of the National Health Service. Not all unions built separate infirmaries for their sick poor, but where these were established, they were generally far superior to the workhouse facilities in terms of design, staff, and equipment. Indeed, some people voiced their apprehension that the high quality of care and expensive treatment might act as an incentive for people to become paupers in order to qualify for treatment.[21]

Another important step toward a free hospital service was taken in 1891 when the Public Health (London) Act gave magistrates the power to order the confinement in hospitals of those people suffering from infectious diseases who appeared to have no other suitable place in which to receive treatment. The act also removed the power of the Poor Law authorities to charge those patients with infectious diseases. All London citizens were thus entitled to free treatment from the Metropolitan Asylums Board, and in the provinces, treatment for infectious diseases was provided by the sanitary authorities. The standards of service varied widely, but in most cases, in order to encourage use, there were no charges. Thus,

there developed in many parts of the country a chain of free public hospitals open to everyone. This also was an important precedent for the future development of Britain's health services.[22] The significance of these provisions for free hospital care is conveyed by Abel-Smith when he writes:

> For a century or more, medical care in hospitals had been regarded. . .as a responsibility for which the community should in some form provide. It was this heritage of shared opinion which was responsible for the widespread acceptance in Britain of what others chose to call "socialized medicine."[23]

But perhaps the most crucial step in the direction of a national health service was the National Health Insurance Act of 1911. Before discussing this, it is well to consider the reports of the Royal Commission on the Poor Laws since they indicate the direction in which the health services might have developed. Had the ideas of either the majority or minority reports of the Commission been heeded, the National Health Service might have assumed a very different form.

The Royal Commission on the Poor Laws

By the turn of the century, the inadequacy of the Poor Law in combatting pauperism had become obvious and its rising cost was a source of very real concern: in the 1850's and 1860's, the cost fluctuated between £5 million and £6 million; then in the 1890's, it rose to £10 million and was £14 million at the time the Royal Commission was established in 1905.[24] Such problems led to the appointment of the Commission and in 1909, its reports were issued. Both majority and minority reports were issued, but it is difficult to label the

latter as a radical departure from the views of the majority: neither was particularly critical of the Poor Law system.[25] For example, several witnesses claimed that paupers were not treated as well as paying patients, but rather than using this as a point of attack, the minority report argued that such criticisms did not do justice to the work and kindness of District Medical Officers.[26] Theirs was by no means an unqualified condemnation of the Poor Law.

The minority report called for a greater emphasis on education and preventive care in the treatment of the poor and recommended a merging of the Poor Law and Public Health Authorities since they often duplicated each other's work. They proposed the ultimate development of a national health service with charges according to means. A major concern of the Webbs, who were the main authors of the report, was the strengthening of the moral character of the poor and the inculcation of disciplined and regular ways of living. Their paternalism led them to encourage independence and self-reliance, and to oppose the easy dispensation of free care, though at the same time they recognized the necessity of removing deterrents to the use of services. Their opposition to a free State medical service with free choice of doctors was total: they saw this as being "not only politically impracticable, but also entirely retrograde in policy, and likely to be fraught with the greatest dangers to public health and to the moral character of the poor."[27]

The majority report expressed a general optimism as to the continual improvements in care provided under the Poor Law. They

believed that care should not be too readily available as this might encourage pauperism by destroying peoples' incentive to thrift, but they saw the more serious deterrents to use as decreasing. They also were totally opposed to any universal free service since this would destroy the existing voluntary organizations and remove the independence of the medical profession. In their eyes, private insurance schemes should be encouraged with the Poor Law providing for only those who could not provide for themselves.[28] They had no wish to "make medical assistance so attractive that it may become a species of honourable and gratuitous self-indulgence instead of a somewhat unpleasant necessity resorted to because restoration to health is otherwise impossible."[29]

The minority report aroused more interest than the majority, and at first, it was thought that the government might introduce a comprehensive medical service on the lines proposed in the former. But the agitation of the public for this reform was not sufficiently intense at this time and the divisions within the Commission provided the government with an excuse for alternative action.[30] If the views expressed in either of the reports had been translated into legislation, then a universal free health service might never have developed in Britain.[31] Their common emphasis on charges related to a patient's ability to pay, and the encouragement of private health insurance schemes might have diverted the development of public services wherein care was available to all citizens at no direct cost. But evidently, Lloyd George was not aware of the proposals in the

reports of the Commission until his own plans for national health insurance were well advanced.[32] He had been very impressed by the German system of social insurance and patterned his own plans on this as well as on the health insurance schemes of the trade unions and friendly societies. His proposals became legislation in 1911.

The National Health Insurance Scheme

The National Health Insurance Act of 1911 laid the basis for the development of a free health service.[33] Coming into effect in 1913, the scheme provided primary medical care from general practitioners and sickness benefit to all manual workers and others who were paid £250 a year or less.[34] These were the basic benefits to which all were entitled. Insurance was covered by contributions of fourpence a week from employees, threepence from employers, and twopence from the Treasury--Lloyd George's "ninepence for fourpence."

Additional benefits could be claimed through the workers' Approved Society. While local insurance committees were responsible for providing medical services, the National Health Insurance scheme was administered by Approved Societies which were responsible for providing workers with cash benefits and distributing other benefits which included dental treatment, hospital and convalescent care, medical and surgical appliances, and opthalmic treatment.[35] These additional benefits were financed from the surplus held by each Approved Society after other expenses had been met.

Though much criticism might be levelled at the National Health Insurance scheme, it was the first major attempt on the part of the

State to provide free general medical care for workers above the level of destitution.[36] It was intended as only the first step in a more thorough reform of the health services and the possibility of extending benefits to workers' families was frequently raised in later years. But it was not until the introduction of the National Health Service that the State achieved a further reorganization of the medical services.

Summary

The latter part of the nineteenth century was marked by an increase in the functions of the State. During this period, we see establishment of public hospitals for the destitute and the provision of free hospital care to all people, irrespective of means, who suffered from certain diseases. Thus, a network of free hospitals was established under public aegis. And in providing free general practitioner care for workers through the National Health Insurance scheme the State rejected the principle of charging for primary care on the basis of a patient's ability to pay. In these ways, precedents were laid for the introduction of a universal free health service.

CONCLUSION

To what extent may we see the National Health Service as representing a radical departure from the prior organization and delivery of health care? The foregoing discussion suggests that while it was by no means an automatic development of the health system in the early twentieth century, neither was it a marked departure from this.

The development of the health services, culminating in the National Health Service, was, to use Lindsey's phrase, "evolutionary rather than revolutionary."[37] It did not mark the introduction of free health care for working class patients--this was already available many decades before--and neither were they especially disadvantaged in access to care.[38] And the principles upon which the new service was based were established many years before. The roots of the National Health Service extended back over a century. The growing acceptance of the State's function in providing medical care increased in the years following the introduction of the National Health Insurance scheme and subsequent debates focussed on the issue of how the State might further intervene rather than on whether it should do so. It is in the light of these observations that we argue that the National Health Service was not a radical departure from the prior organization of health services. Rather, the new service extended and developed practices which had been built up over many generations.

FOOTNOTES

[1]For a discussion of the use of the concept of social class in this study, see Appendix B.

[2]Our discussion of the sources of medical care in the mid-nineteenth century is largely based on: M. Bruce, The Coming of the Welfare State (London: B.T. Batsford, 1966); B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964); B. Webb and S. Webb, The State and the Doctor (London: Longmans, Green and Company, 1910); R.G. Hodgkinson, The Origins of the National Health Service (London: The Wellcome Historical Medical Library, 1967).

[3]A. Forder (ed.), Penelope Hall's Social Services of England and Wales (London: Routledge and Kegan Paul, 1971), Chapter VI.

[4]In the same year, 1858, the State published the Medical Register from which the public could distinguish the qualified from the unqualified medical practitioners.

[5]These fees are quoted by S.W.F. Holloway, "Medical Education in England, 1830-1858: A Sociological Analysis," History, Vol. 49, (October, 1964), p. 316.

[6]Membership charges are quoted by A. Cox, Among the Doctors (London: Christopher Johnson, 1950), and by Great Britain, Royal Commission on the Poor Laws and Relief of Distress, Vol. I, Report (London: H.M. Stationery Office, 1909), p. 333.

[7]Ibid., p. 333; and M. Bruce, op. cit., p. 96.

[8]M. Bruce, op. cit., pp. 95-96.

[9]S. Webb and B. Webb (eds.), The Break-up of the Poor Law: Being Part One of the Minority Report of the Poor Law Commission (London: Longmans, Green and Company, 1909), p. 255.

[10]Ibid., p. 255; and B. Webb and S. Webb, The State and the Doctor, op. cit., pp. 138-139.

[11]The Union was the local unit of administration for the Poor Law. The 15,000 parishes of England and Wales were combined into 600 unions.

[12]B. Webb and S. Webb, The State and the Doctor, op. cit., p. 48.

[13]S. Leff, The Health of the People (London: Victor Gollancz, 1950), p. 101.

[14]S. Webb and B. Webb, The Break-up of the Poor Law, op. cit., pp. 250-252.

[15]B. Abel-Smith, op. cit., p. x.

[16]Ibid., p. 1.

[17]R.G. Hodgkinson, op. cit., p. 593.

[18]B. Abel-Smith, op. cit.

[19]S. Leff, op. cit., p. 97.

[20]The quality of care and additional problems in obtaining it are further discussed in Chapters II and III.

[21]B. Abel-Smith, op. cit., p. 85; B. Webb and S. Webb, The State and the Doctor, op. cit., Chapter 3.

[22]B. Abel-Smith, op. cit., p. 129.

[23]Ibid., p. 500.

[24]M. Bruce, op. cit., p. 87.

[25]Perhaps justifiably. Hodgkinson argues that any unqualified condemnation of the Poor Law would be unjust since "in great sections of the country the Poor Law provided medical aid far superior to what the poor could procure for themselves." R.G. Hodgkinson, op. cit., p. 695.

[26]S. Webb and B. Webb, The Break-up of the Poor Law, op. cit., p. 219.

[27]B. Webb and S. Webb, The State and the Doctor, op. cit., p. 150.

[28]Great Britain, Royal Commission on the Poor Laws and Relief of Distress, op. cit., p. 375.

[29]Ibid., p. 379.

[30]S. Leff, op. cit., pp. 109-110.

[31]B. Abel-Smith, op. cit., p. 231.

[32]M. Bruce, op. cit., p. 183.

[33]For a thorough discussion of the National Health Insurance scheme see: H. Levy, National Health Insurance (Cambridge: Cambridge University Press, 1944).

[34]This limit was increased to 420 per annum from January, 1942.

[35]It was pressure from the friendly societies whose position was threatened by the introduction of the National Health Insurance scheme that led to the creation of Approved Societies and their being assigned partial responsibility for the administration of the scheme. Any group could register as an Approved Society as long as it was non-profit making and democratically organized. Friendly societies, trade unions and life assurance companies eagerly took on themselves such a role, where necessary creating non-profit sections. For them, it was an introduction to potential members and clients who might be persuaded to take advantage of other profit making services they had to offer.

[36]The weaknesses of the National Health Insurance scheme are discussed in Chapter III.

[37]A. Lindsey, Socialized Medicine in England and Wales (Chapel Hill, N.C.: University of North Carolina Press, 1962), p. 23.

[38]Class differences in access to medical care are discussed in the following chapter.

CHAPTER II

ACCESS TO MEDICAL CARE: A PROBLEM FOR ALL PATIENTS

Introduction

Were working class patients in a particularly disadvantaged position in their access to medical care prior to the introduction of the National Health Service? Working on the assumption that this was indeed so, we would expect to find that there were few opportunities for working class patients to receive medical care; that though it was available, they did not fully use these services, or else that the quality of care received by them was in some ways inferior to that received by middle class patients. In other words, we would expect to find that working class patients were denied the advantages of middle class patients in terms of availability and quality of medical care.

In the previous chapter, we have indicated that, even one hundred years before the introduction of the National Health Service, free or low cost hospital and ambulatory care was provided for the working class. This chapter looks at the changing conditions under which care was available during the years leading up to the introduction of the National Health Service. We will argue that:

1. Class differences in access to health care became an important dimension of class inequality only when medicine achieved the status of a scientific discipline, when health became a focus of attention for people, and

when demand for care increased. These changes were occurring in the late nineteenth century.

2. From the latter decades of the nineteenth century, problems in securing health care were not experienced by the working class alone, middle class patients were increasingly disadvantaged--most particularly in their general exclusion from the best hospital care within the mainstream of the hospital system.

But before we examine the changing conditions under which care was obtained, let us first consider the access to medical care of working class and middle class patients during the mid-nineteenth century.

ACCESS TO MEDICAL CARE IN THE MID-NINETEENTH CENTURY

Even though the source from which people obtained medical care was dependent on their class position, did working class and middle class patients, nevertheless, have equal access to care? Or, were working class patients in a relatively disadvantaged position? To answer these questions, we need information on both the rates of use of medical services and the quality of care received by patients of different class background in the mid-nineteenth century. Unfortunately, it is impossible to say to what extent people actually made use of the services available to them: there is no data on class patterns of use of different medical services during this period. It

may be that wide class inequalities existed, with the wealthier sections of the population consulting a doctor frequently and the poorest only occasionally. But there is no data to suggest that this, or any other pattern of use of services prevailed, though obviously, the crowded waiting rooms of the hospitals indicate that large numbers of the working class did seek medical treatment.

It is doubtful whether there were any marked differences in the quality of care received by different social classes. Medicine had relatively little to offer people even in the late nineteenth century. The 1880's marked a turning point in the understanding and treatment of disease, but it was many years before these discoveries were fully incorporated into the day-to-day care and treatment offered by doctors and hospitals. And so, in the mid-nineteenth century, the quality of the actual medical treatment obtained from different sources was unlikely to vary widely. Even though the rich received care from the elite of the medical profession, the treatment was not likely to be very sophisticated. Fellows and licentiates of the Royal College of Surgeons were not always highly qualified practitioners:

> As late as 1834, membership of the College could be obtained for a down payment of fifty guineas after three examinations lasting some twenty minutes each. A man could pass the examination "who is a good classical scholar but knows nothing of chemistry, nothing of medical jurisprudence, nothing of surgery, little or nothing of anatomy, nothing of the diseases of women in childbed, and nothing of the manner of delivering them."[1]

The fee paying patients may have had more time with their doctors and the psychological benefit of talking to a sympathetic listener,

but otherwise, the treatment they received was unlikely to be much superior to the popular bottle of medicine dispensed by medical officers, free dispensaries, and voluntary hospitals alike. At the turn of the century, the Webbs, in criticizing the practice of dispensing vast quantities of medicine for the poor, were not arguing for a higher standard of treatment. Rather, they were calling for a greater emphasis to be placed on the education of the poor, and the inculcation of good habits of living: discipline and a regular life were to be extolled, the popular belief in the value of a bottle of medicine to be destroyed.[2]

Thus, it may be that few differences existed in the quality of treatment provided for middle class and working class patients even though they received care in different settings. Medical science was still in its infancy, and compared to the 1970's, treatment uniformly lacked sophistication. This point is important. We are concerned with class inequalities in access to medical care, but insofar as medicine had relatively little to offer patients in the mid-nineteenth century, and insofar as people endured illness with a sense of fatalism,[3] inequality in access to care may not have been an important dimension of class inequality at this time. It became a more important dimension when medical care became a valued service--when people's attitudes towards health grew less passive, and when treatment increased in sophistication.[4] In other words, people's health may have depended little on whether they consulted a doctor, and they may have felt no sense of deprivation if they could not or did not consult a doctor.

We can, however, distinguish changing attitudes towards health and illness during the latter part of the nineteenth century. And these were paralleled and reinforced by major developments in medical science and rapid innovation in the field of medical technology. These developments were of consequence for both middle class and working class patients, and as a result of them, inequality of access to medical care became a more important dimension of class inequality. For this reason, it is useful to outline these changes before discussing access to care during the decades leading up to the introduction of the National Health Service.

CHANGING ATTITUDES TOWARDS HEALTH AND ADVANCES IN MEDICAL SCIENCE

The rise of the industrial and commercial bourgeoisie and their growing prosperity produced a prosperous and expanding clientele for the medical profession. But the increasing demand for medical care on the part of the middle and upper class did not simply depend on the fact that they had more money to spend. It also stemmed from shifting attitudes toward health. As man's ability to control nature increased, so also people saw their own bodies as being more subject to control. The fatalism with which illness had been borne started to decline: less frequently was disease viewed as a punishment for sin or just an unavoidable aspect of life. The belief in progress, so obviously confirmed by increasing productivity, produced gradual changes in the attitudes toward health among the Victorian middle class.[5]

Coupled with the idea of progress was the notion of individualism and the emphasis on success and self-help also served to generate new attitudes toward health and an increase in the demand for medical care: the more we think is expected of us in fulfilling our various roles, the more concerned we are likely to be with the quality of our health. Illness can prevent such fulfillment. Samuel Smiles, the "apostle of self-help," writing in the mid-nineteenth century, was emphatic about the close connection between good health and the attainment of worldly success.[6] "Practical success in life," he noted, "depends more upon physical health than is generally imagined."[7] He showed how successful men had also been very healthy, and argued that the "success of even professional men depends in no slight degree upon their physical health."[8] In such ways, people were taught the importance of good health in increasing their chances of success.

As new attitudes toward health and medical care were developing among the middle class, changes were also taking place in medicine. Towards the end of the nineteenth century, rapid advances in the diagnosis and treatment of disease were occurring. Medicine had for centuries been slowly freeing itself from the religious dogmatism of medieval times, but it was not until the last decades of the nineteenth century that major discoveries were made and the growing body of knowledge was assimilated into the actual practice of medicine.[9] It was around this point in time that medicine truly lost its ties with religious scholasticism and assumed the status of a scientific discipline. Table I indicates the increasing number of "major

TABLE 1.--Selected major innovations in medical science

Date	Innovator	Event
1628	William Harvey	Description of circulation of the blood
1670	Peter Chamberlen	Invention of obstetrical forceps
1673	Anton Leeuwenhoek	Invention of microscope
1694	William Cowper	Description of muscular system
1738	William Smellie	Modification of obstetrical forceps
1761	Giovanni Morgagni	Description of pneumonia, cancer, gallstones, meningitis
1769	Percival Pott	Description of fractures
1776	Matthew Dobson	Description of sugar diabetes
1797	Edward Jenner	Discovery of smallpox vaccine
1809	Ephraim McDowell	First ovariotomy performed
1816	René Laennec	Invention of the stethoscope
1842	Crawford Long	First surgery with ether anesthetic (U.S.)
1846	Robert Liston	First surgery with ether anesthetic (Brit.)
1846	William Morton	Perfection of ether as an anesthetic
1849	Claude Bernard	Discovery of glycogen
1851	Herman Helmholtz	Invention of ophthalmoscope
1855	Manuel Garcia	Invention of laryngoscope
1858	Rudolf Virchow	Description of cellular pathology
1859	Albrecht von Graefe	Established modern ophthalmology
1866	Gregor Mendel	Discovery of genetic transmission, mutation
1866	Joseph Lister	First use of antiseptic methods in surgery
1869	Gustav Simon	First excision of the kidney
1872	Jean Charcot	Description of nervous system
1872	Eduard Pfluger	Description of metabolism
1876	Robert Koch	Discovery of anthrax bacillus
1877	Robert Koch	First microphotographs
1882	Robert Koch	Discovery of tubercle bacillus
1883	Robert Koch	Discovery of cholera bacillus
1890	Robert Koch	Discovery of tuberculin
1892	William Welch	Discovery of staphylococcus
1895	Wilhelm Roentgen	Discovery of x-ray
1895	Ronald Ross	Discovery of the cause of malaria
1900	Walter Reed	Discovery of the cause of yellow fever
1901	Emil von Behring	Discovery of diphtheria and tetanus antitoxins
1908	William Osler	Revolutionized system of medical education
1910	Paul Ehrlich	Discovery of cure for syphilis
1922	Frederick Banting	Discovery of insulin
1923	Willem Einthoven	Invention of electrocardiograph
1928	Alexander Fleming	Discovery of penicillin
1948	Paul Mueller	Discovery of effects of DDT
1949	Antonio Moriz	First prefrontal lobotomy
1954	Jonas Salk	Discovery of polio vaccine

Source: R.M. Coe, Sociology of Medicine (New York: McGraw Hill, 1970), p. 178.

innovations" in medical science which took place from the 1850's onward.

As the benefits of these advances diffused to the treatment delivered to patients, they helped to further stimulate the demand for medical care. They also fostered the growth of specialization, and, together with the developing medical technology, vastly increased the costs of providing care.[10] As a consequence of these changes, the hospitals provided more and more sophisticated care and assumed an increasingly important role within the total health system. And since middle class and working class patients received care from different sources, the significance of these changes was different for each class. Let us first consider the effect which they had on working class patients.

CHANGING CONDITIONS OF OBTAINING CARE: WORKING CLASS PATIENTS

An Increased Demand for Hospital Care

In the late nineteenth century, we see changes taking place in the social class of patients admitted to hospitals. Poor Law hospitals were accepting patients above the level of destitution. With the establishment of separate infirmaries, the stigma attached to accepting hospital care under the Poor Law slowly disappeared and people started to make a distinction between the workhouse and the infirmary.[11] As a result of the higher quality of care and the improvements in conditions which resulted from Florence Nightingale's reforms,

patients above the level of destitution were seeking hospital treatment more frequently, and by the 1890's, the Poor Law infirmaries were admitting some patients of the non-pauper class. As the Webbs indicate, the Poor Law was treating, under the common designation of pauper, a range of people

> varying from those miserables whom nothing but the imminent approach of starvation drives into the hated general mixed workhouse, up to the domestic servants of the wealthy, the highest grades of skilled artisans and even the lower middle class who now claim as a right the attractive ministrations of the rate-maintained Poor Law hospitals characteristic of some of the great towns.[12]

In those cases where patients were not paupers, attempts were made (not always successfully) to regain at least part of the costs of care.

The Metropolitan Poor Act of 1867 assigned the responsibility for providing London with hospitals for indigent fever and smallpox cases to the Metropolitan Asylums Board. Though care was supposed to be provided for the pauper class alone, the demand for care was not so limited. In the smallpox epidemic of 1871-1872, over one-third of the patients in these hospitals were not paupers at the time of admission. In 1871, 82 per cent of the patients in the Hampstead Hospital were in gainful employment, the majority as skilled artisans. And a similar situation prevailed in the epidemic of 1876-1877: about 90 per cent of patients in the Metropolitan Asylums Board hospitals had never received poor relief before.[13]

The Poor Law hospitals provided the bulk of care--in many areas the workhouse or infirmary was the only source of care. In larger towns, there was usually a choice between a Poor Law infirmary and

a voluntary hospital, but the former generally provided the majority of beds. In 1906 in London, for example, there were 16,300 infirmary beds and 10,224 in voluntary hospitals. In Liverpool, the number of beds was 2,000 and 1,172 respectively, and in Birmingham, 2,200 and 838.[14] The voluntary hospitals were more likely to deal with acute, unique, and medically interesting cases while chronic cases were cared for under the Poor Law. The former provided care for many people of the same status as those who were treated under the Poor Law,[15] but they also were admitting more patients of higher social class and they most frequently served patients above the level of destitution. A census of inpatients at the London Hospital on November 28, 1906, revealed that 60 per cent of the hospital population were neither paupers nor on the verge of pauperism.[16]

The Introduction of Charges for Hospital Treatment

In the light of rising costs of care and the growing number of patients above the level of destitution, hospitals started to introduce charges for treatment. Toward the turn of the century, there was a growing concern expressed at the amount of free care available to patients when a portion of these could afford to pay at least something toward the cost of their treatment, and by 1890, many London hospitals were taking steps to reduce the number of outpatients who were being treated free of charge. Efforts were less strenuous in the provinces, but here also, there were attempts to limit cases and exclude those who could afford to pay for care.[17] The voluntary

hospitals were caught in a dilemma. They needed to minimize demands on their resources, but they also needed large numbers of outpatients as this would help in their appeals for funds, and would also provide a large pool from which to select interesting cases. They could have extended the system of charges which some hospitals operated, but this would have invited protests from general practitioners. Yet the easy dispensation of free care also invited protest: the doctors feared the competition which the hospitals could provide--it was in their interests that the hospitals provide free care, but only to those unable to pay a doctor. So in the 1890's, hospital almoners were employed in checking whether patients could afford to pay toward the cost of their treatment. It is noted in the Royal Commission of 1909 that the almoner of Westminster Hospital in London estimated that in 1903, 1904, and 1905, approximately 15.6 per cent, 13.6 per cent and 17.2 per cent of patients might have arranged for their own treatment through a provident dispensary, friendly society or such like.[18]

It was the Poor Law infirmaries (or, as they later became, the local authority hospitals)[19] which were the most likely to "screen" patients and submit them to some form of means test. Unlike the voluntary hospitals, they were not in need of interesting cases for teaching purposes, and they had separate services under the Poor Law for those who could not afford the fees of a doctor. But by the end of 1920, most London hospitals had adopted a system of payment by the patients or were considering doing so. Their strained finances, and

the move to patients paying at least part of the costs of care was reflected in the change in the role of almoners. Whereas they had previously checked patients whom they thought might be able to pay for care, now they were checking those who claimed they could not.[20] Whereas the voluntary hospitals had been largely charitable institutions serving the sick poor, they were now becoming primarily business concerns.

The increase in paying patients is reflected in the proportion of the current income of London teaching hospitals which such payments represented. In 1920, payments by patients accounted for 10 per cent of their current income, and in 1921, 25 per cent.[21] In the 1930's, there was a continuing increase in the numbers of patients paying the full costs of care and in funds from pre-insurance schemes. By the eve of the Second World War, approximately 50 per cent of the costs of the voluntary hospitals was paid for by patients.[22]

The Growth of Contributory Schemes

This decline in the availability of free charitable and public care prompted a growth in the contributory schemes organized by friendly societies, trade unions, etc. There was a marked growth in such schemes after 1870 when deterrents to obtaining relief under the Poor Law were increased, and the voluntary hospitals were starting to restrict the number of patients treated free of charge.[23] And as the hospitals' needs for funds grew, their efforts to charge people for at least a part of the cost of their treatment were strengthened.

During the 1920's and 1930's, in response to the growing financial problems of the hospitals, there was again a rapid growth in the contributory schemes designed to provide hospital care for workers above the level of destitution.

The largest contributory scheme was the Hospital Savings Association which in 1924 had sixty-two thousand contributors and which had grown to six hundred and fifty thousand only five years later.[25] In this, members made a weekly contribution of threepence and were guaranteed general hospital care for no further payment. Most schemes had income limits, but the efforts of the British Medical Association to establish such (since the schemes would otherwise be a threat to private practice) were not always successful. A British Medical Association enquiry in 1930 showed that of the contributory plans in operation in 352 hospitals, 237 operated an income limit.[26]

The members of these schemes were, in the main, drawn from those sections of the working class with regular jobs, wages above the minimum, and families of modest size.[27] Thus, they catered largely to working class families; middle class patients generally received few such concessions in obtaining medical care. Apart from spreading the costs of obtaining medical care, membership in these schemes was also an avoidance of the means tests otherwise encountered when treatment was sought. The Political and Economic Planning report on the British health services in the 1930's indicated that

> the working classes are prepared to pay considerable premiums for medical insurance without any forms of means test. Insurance payments are popular, but means tests, however mild, have become odious. Hence the extraordinary popularity of hospitals contributory schemes, with nearly five and a quarter million subscribers of between twopence and fourpence a week.[28]

The most important changes during the 1920's and 1930's were taking place in the hospitals since they were assuming a leading role in the delivery of medical care. Yet contributory schemes were not limited to the provision of hospital care. While workers obtained general practitioner care through the National Health Insurance scheme after 1911, many dependents of insured workers and others not eligible for National Health Insurance care continued to provide for their general medical needs through membership in friendly societies, family clubs, and provident medical associations. These latter were endorsed by the British Medical Association, and seen by the medical profession as an effective solution to the problems of lay control experienced by doctors working in some form of contract practice. They were formed by doctors working within the same area who would share patients' contributions in proportion to the number of patients for which each was responsible. They were intended for lower income groups, people earning less than £250 per annum, and their membership grew steadily. In the late 1930's, Herbert notes that there were over six hundred and fifty thousand persons in sixty different societies with the London service being extended to middle class families with incomes up to £550 per annum, and fees ranging from £4 to £5 per annum for a family of four.[29] For many, most particularly low income families, the main

motive for joining such schemes was to avoid the need to rely on charity or public assistance. As the Royal Commission on the operation of the National Health Insurance scheme indicated:

> There is a certain amount of evidence that many insured persons are reluctant to go to outpatients' departments, as a charity, while they would not hesitate to avail themselves of the same specialist services if included in medical benefit, as they would then feel that they had a full, legal, and moral right to receive the services when needed.[30]

Summary

Thus, we see that though free care was less easy to obtain, working class patients continued to have access to relatively low cost medical care during the early decades of the twentieth century. Hospitals opened their doors to a wider spectrum of the working class, and though limitations were increasingly placed on the availability of free care, these were in part counterbalanced by the growth in contributory schemes providing hospital and general medical care. These contributory schemes drew their membership largely from the working class.

CHANGING CONDITIONS OF OBTAINING CARE: MIDDLE CLASS PATIENTS

Changes were also taking place in the patterns of obtaining medical care among the middle class. As we noted in the previous chapter, the middle class showed little inclination to enter hospitals during the mid-nineteenth century, and by paying inflated consultation fees, they subsidized the care of those patients using the voluntary

hospitals (for which consultants worked for no cost). Towards the turn of the century though, the greatly improved quality of hospital care prompted a greater willingness of patients to be hospitalized. And there was a growing recognition of the new demand for care from the middle class: in the pages of the medical journals, there was a continued discussion of the need to provide hospital care for those who could afford to pay for it.[31] This, coupled with the fact that the voluntary hospitals were facing financial problems, meant that there was a considerable incentive to start admitting paying patients. And so in 1881, St. Thomas' Hospital started to treat paying patients and in 1884, Guy's Hospital followed its lead. By 1890, five of the eleven London teaching hospitals were admitting paying patients and their payments accounted for 5 per cent of the income of the London hospitals.[32] Such patients were, however, relatively small in number--in part because the medical profession was opposed to the admission of paying patients to voluntary hospitals.

The demands for hospital care continued to increase, particularly after the First World War. Fewer middle class families could afford domestic help to care for the sick at home, and this, together with the recognition of the positive worth of hospital care and the increasing reluctance of surgeons to perform operations at home or in poorly equipped nursing homes helped to increase the trend towards hospitalization among middle class patients. In some areas where there was no other hospital care available, the Poor Law infirmaries began to admit paying patients.[33]

The Growth of a Private Hospital System

Though both voluntary and public hospitals admitted increasing numbers of private patients, their reluctance to do so remained. Even though fee paying patients might have helped to solve the immediate financial problems of the hospitals, they were reluctant to admit such patients on an extensive scale for fear that this might jeopardize their efforts to preserve their image as charitable institutions. They were fearful of anything which might deter charitable contributions. And the medical profession continued to oppose the treatment of fee paying patients in local and voluntary hospitals. General practitioners would have favoured this only if they could secure access to these hospitals, but the hospitals were reluctant to take this step since, they argued, it would lower the standards of care. Therefore, the British Medical Association policy supported separate institutions with patients remaining under the general medical supervision of their own general practitioner and having a free choice of consultant.[34]

And so, in order to meet the growing demand for hospital care from the wealthier sections of the population, separate nursing homes and home hospitals sprang up near the major hospitals. By 1891, there were approximately 9,500 beds in England and Wales in nursing and convalescent homes; by 1911, this figure had risen to about 13,000 and by 1921, to 40,000.[35] The provision of private beds was higher in nursing homes than in the voluntary and public hospitals combined. Toward the end of the 1920's, it was estimated that there

were 3,000 - 4,000 nursing home beds in the London area compared to about 1,000 private beds in voluntary hospitals.[36]

But conditions in these private nursing homes frequently left much to be desired and they seldom approached the quality of care in the main hospital system: half had no operating theatre; less than one-quarter had an elevator, and they seldom had X-ray apparatus, laboratories or resident doctors.[37] Predictably, arguments were made that the poor were the most privileged in terms of access to the best care. An article in The Hospital entitled "The Advantages of Poverty" claimed that the poor, as a result of their easy access to hospital care, could most easily secure the opinions of the best consultants. In contrast, the wealthier sections of the population received only inferior care:

> Any arrangements that can possibly be made in a private house are at the best merely makeshift, while it is doubtful. . .if there is a single nursing home in existence in which conditions are not passed which, in a hospital, surgeons would absolutely condemn. The rich man with all his wealth does not, and practically cannot, obtain the scientific advantage which the poor man can and does obtain for nothing.[38]

Periodically, the issue was raised as to how treatment should be provided for middle class patients. Should nursing homes be expanded and improved? Or should the middle class be admitted to voluntary and local hospitals? With the exception of the patients in question, the latter solution was generally opposed, and the annexation of middle class patients in a separate hospital system presented a dilemma which continued until the introduction of the National Health Service.

Summary

During the early decades of the twentieth century, then, there was a network of relatively small private hospitals developing alongside the voluntary and local authority hospitals. This developed in response to the demands of middle class patients for hospital care, and as a result of the hospitals' and the medical profession's unwillingness to treat fee paying patients in voluntary and local hospitals. As a consequence, middle class patients were generally unable to receive the best hospital care.

CONCLUSION

We opened this chapter with the question of whether or not working class patients were particularly underprivileged in access to medical care prior to the introduction of the National Health Service. We have argued that this question is most meaningful when we consider the latter years of the nineteenth century and the early decades of the twentieth. For it is only as medicine became more sophisticated and medical care more effective and more highly valued that class differences in access to health care became a potentially important dimension of class inequalities.

The data which we have reviewed do not indicate that working class patients were especially underprivileged in access to care. Though the costs of obtaining care had become higher for working class patients above the level of destitution, these were mitigated, in part, by the growth of contributory schemes, and such patients

were more readily admitted to voluntary and public hospitals. Undoubtedly, working class patients experienced real problems in obtaining care--the quality of general practitioner care was probably less than that available to private patients, and they often received care through charity rather than as a right of citizenship. We are not denying this.[39] But our main concern is to draw attention to the fact that middle class patients were also disadvantaged in access to care. They received no financial concessions in obtaining care since contributory schemes were generally closed to them, and in paying high consultation fees, they subsidized the care of working class patients. More important, they were generally excluded from the best hospital care. Only the National Health Service, with its safeguards for general practitioners and consultants, brought middle class patients into the mainstream of the hospital system. In this respect at least, working class patients had preferential access to medical care.

It is for these reasons that we argue that working class patients were not the most disadvantaged in access to health care: most patients, irrespective of class position, experienced problems in securing high quality medical treatment. It does not seem fruitful, therefore, to view the introduction of the National Health Service simply as an attempt to improve the availability of care for working class patients and to reduce class inequalities in access to care.

FOOTNOTES

[1] B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964), p. 2.

[2] S. Webb and B. Webb, The State and The Doctor (London: Longmans, Green and Company, 1910), Chapter IV.

[3] S.W.F. Holloway, "Medical Education in England, 1830-1858: A Sociological Analysis," History, Vol. 49 (October, 1964), p. 319.

[4] We are working with the assumption that as medicine achieved the status of a scientific discipline, it became a more valuable service and that access to health care became an important determinant of people's mortality and morbidity experience. Equality of access to medical care is thus an important element in achieving a reduction of inequalities in health. Though common, these assumptions are, however, open to question, and we will consider their validity in our concluding chapter. For a challenging discussion of the impact of medicine see: I. Illich, Medical Nemesis (Toronto: McClelland and Stewart, 1975).

[5] For an analysis of changing attitudes towards health see: S.W.F. Holloway, op. cit.

[6] A general discussion of Smiles' work and its influence on the formation of an entrepreneurial ideology can be found in: R. Bendix, Work and Authority in Industry (New York: Harper and Row, 1963), pp. 109-116.

[7] S.W.F. Holloway, op. cit., p. 320.

[8] Ibid., p. 320.

[9] R.M. Coe, Sociology of Medicine (New York: McGraw Hill, 1970), Chapter 6.

[10] The increased costs of care and their impact are further discussed in the following chapter.

[11] S. Leff, The Health of the People (London: Victor Gollancz, Ltd., 1950), p. 99; B. Abel-Smith, op. cit., pp. 130-131.

[12] B. Webb and S. Webb, op. cit., p. 123.

[13]B. Abel-Smith, op. cit., pp. 122-125.

[14]Great Britain, Royal Commission on the Poor Laws and Relief of Distress, Vol. I, Report (London: H.M. Stationery Office, 1909), p. 328.

[15]Before the establishment of separate Poor Law infirmaries, when indoor medical relief was administered as part of the ordinary workhouse system, paupers were often sent to voluntary hospitals for surgical operations or special treatment. The interest of the Poor Law in such institutions was emphasized by the Guardians being allowed to subscribe to them. These ties were weakened when separate infirmaries which could provide the necessary care were built.

[16]Great Britain, Royal Commission on the Poor Laws and Relief of Distress, op. cit., p. 329.

[17]B. Abel-Smith, op. cit., p. 117.

[18]Great Britain, Royal Commission on the Poor Laws and Relief of Distress, op. cit., p. 330.

[19]The Local Government Act of 1929 allowed local authorities to appropriate Poor Law institutions. But even in 1937, the majority of sick beds were still operated under the Poor Law. B. Abel-Smith, op. cit., p. 371. See also: S.M. Herbert, Britain's Health (Harmondsworth: Penguin Books, 1939), pp. 122-123.

[20]B. Abel-Smith, op. cit., p. 296.

[21]Ibid., p. 309.

[22]A. Lindsey, Socialized Medicine in England and Wales (Chapel Hill, N.C.: University of North Carolina Press, 1962), p. 15.

[23]B. Abel-Smith, op. cit., p. 117.

[24]Ibid., p. 327.

[25]Ibid.

[26]Ibid., p. 332.

[27]Ibid., p. 386.

[28]Quoted by S.M. Herbert, op. cit., p. 102.

[29]Ibid., p. 74.

[30]Quoted by H. Levy, National Health Insurance (Cambridge: Cambridge University Press, 1944), p. 164.

[31]B. Abel-Smith, op. cit., pp. 138-141, 187-189.

[32]Ibid., p. 149. [33]Ibid., p. 305.

[34]Ibid., pp. 187, 189, 195-196, 344. [35]Ibid., p. 339.

[36]Ibid., p. 343. [37]Ibid., p. 343. [38]Ibid., p. 192.

[39]Predominantly working class areas frequently suffered from a shortage of general practitioners, and the National Health Insurance scheme contained many anomalies which meant that those most in need of care were sometimes the least likely to receive it. Such problems in obtaining care are discussed in Chapters III and IV below.

CHAPTER III

FINANCIAL AND ORGANIZATIONAL PROBLEMS WITHIN THE HEALTH SERVICES

Introduction

Was the introduction of the National Health Service a response to working class pressures for reform? We have already seen that working class patients were not especially disadvantaged in access to medical care, and this might lead us to suppose that insofar as pressures for reform existed, they were not limited to one class alone. But if we assume that the demand for reform was confined to the working class, we would expect to find, if not actual demonstrations of workers, at least pressures being exerted through trade unions. Or else, we might predict that the Labour party, as a representative of the working class, was active in defining problems within the health services and formulating plans for reform. Yet such pressures do not appear to have emanated either directly or indirectly from the working class. In none of the sources consulted in this research was there evidence of such pressures, and the Labour party committed itself to reform of the health services at a relatively late stage, well after other groups had recognized the need for change.[1] The extent to which there was a general public demand for reform is not altogether clear. But one study in an industrial town reports that 93 per cent of the families indicated that they were receiving adequate medical treatment prior to the National Health Service.[2] And even though

the proposals for a national health service financed through taxation and insurance contributions was generally welcomed, there is little evidence that public pressures for reform were strong.[3]

But if we cannot explain the genesis of the National Health Service in terms of class inequalities in access to care and consequent pressures for change, then how can we explain the introduction of the new service? What problems existed within the health services which created the need for change? Who was defining these problems and seeking to resolve them? This chapter focusses on the first of these questions, and argues that financial and organizational problems within the health services became increasingly severe during the 1930's and 1940's and provided the basis for a recognition of a need for reform.[4]

Changing attitudes towards health, increasing demands for health care, and the growing sophistication of medicine had two consequences which will concern us.

Firstly, they led to the establishment of stronger ties between the voluntary hospitals and the State. The increasing cost of providing medical care which resulted from advances in medicine created financial problems for the hospitals--particularly the voluntary hospitals which, unsupported by public funds, had no reliable and steady source of income. The early decades of the twentieth century saw a growing dependency of the voluntary hospitals on public financing. By the 1940's, it was generally recognized that the voluntary hospitals must rely on the State for continuing financial support. In these

strengthening ties, we see precedents for the National Health Service being created.

Secondly, the increasing costs of providing care and the growth of specialization demanded a greater co-ordination of the various units providing care. The rationality of medicine demanded a similar rationality in the units delivering care. But efforts to ensure such were largely unsuccessful: wasteful duplication, maldistribution, and poor co-ordination of services continued. The demands of wartime revealed the fragmented and chaotic state of the health system, and its reorganization under a single authority was recognized as being essential.

THE EMERGING CRISIS IN THE HOSPITAL SYSTEM

The early growth of specialization is shown in the special clinics opened by hospitals: Guy's Hospital introduced a clinic for skin diseases in 1851 and for aural diseases in 1862; in 1867, St. Bartholomew's Hospital started an ophthalmology department and by 1880, it had clinics for diseases of throat and skin, for orthopaedics, obstetrics and gynaecology; and the London Hospital opened an obstetrics department in 1852, an ear, nose and throat department in 1866, and were specializing in orthopaedics also by 1875.[5] By the 1940's, hospitals which had at one time employed a few consultants together with a small nursing and administrative staff now employed a wide range of specialists. Apart from more specialized consultants, there were laboratory technicians, dietitians, occupational therapists, radiographers, and many others who were now part of the changing

hospital system.[6] And apart from the increases and the diversity in the new personnel employed, the rapid developments in medical knowledge increased the costs of the actual diagnosis and treatment of patients. Not only did discoveries follow each other in rapid succession, broader and broader applications were also being developed for these. In 1918, one major provincial hospital conducted less than six hundred X-ray examinations, but by the late 1940's, it was performing nearly twenty thousand. In the same hospital, the number of pathological examinations in 1947 was thirty-three times the number in 1927. And the same period saw a fifty-fold increase in blood counts.[7] Such increases in the use of diagnostic techniques played a large part in the escalation of operating costs of hospitals. Unlike business concerns, the expansion of the hospitals could lead simply to a growth in spending capacity and not necessarily to a greater earning capacity. Whereas the voluntary hospitals of England and Wales spent £500,000 in 1900, in 1947 they were spending 640 times that amount.[8]

The increasing costs of medical care altered the ties which linked the hospitals with the State. Particularly during wartime, the hospitals were forced to rely more heavily on payments from the national government. This was especially true of the voluntary hospitals. These funds together with other grants designed to prevent the collapse of the voluntary hospital system unintentionally created a dependence on public funds. And so, the links between the State and the health services were not only increasing in the manner

indicated in Chapter I, more subtle ties were also developing in the twentieth century in response to the almost continual state of financial crisis in which the hospitals found themselves. It is the combination of these two developments in the relationship between the State and the health system which laid the basis for the government's assumption of almost total responsibility for health care in 1948.

Let us examine a little more closely the voluntary hospitals' growing dependency on the State. At the close of the nineteenth century, the hospitals were already experiencing financial problems. The rising expenses of the Poor Law which prompted much concern have already been mentioned.[9] The voluntary hospitals also had insufficient funds. In 1887, the total deficit of teaching hospitals was over £32,000, and three years later this had risen to about £100,000.[10]

These problems became more severe in the early decades of the twentieth century. One source of increasing costs was the rising pay for nursing staff. The pay of personnel in military hospitals was relatively high and with the advent of World War I, personnel in civilian hospitals received pay increases to bring wages to a similar level. The Local Government Board revised the scale of pay for nursing staff in institutions used in the war effort, so that they received about 3 per cent more than nurses in Poor Law institutions. Soon after, the voluntary hospitals and Poor Law institutions followed suit in order to maintain competitive wages. In the Sheffield Royal Infirmary, for example, the annual wages of probationer nurses rose from £5 in 1914 to £30 in 1918, while those for sisters rose from £30 to £40 - £50 per annum in the same period.[11]

The voluntary hospitals which were important for the War were paid £880,000 by the War Office between 1914 and 1919. This was to cover the costs of care for the sick and wounded. It was claimed that this amount lagged costs by £530,000, but charity contributions increased and for some hospitals compensated for the deficit. Between 1915 and 1919, charitable organizations held a surplus in excess of £7 million.[12] However, post-war inflation hit hard and the hospitals continued to struggle with financial problems. Though rebuked for such a suggestion, Lord Knutsford, Chairman of the London Hospital, suggested, in 1920, that State aid was imperative to ensure the continuation of the hospitals and that such aid should cover one-third of the hospital costs. While the idea was dismissed since it would threaten the independence of the voluntary hospital system, the recognition of the State as a stable and continuing source of finance was already in people's minds.[13]

At the time at which Lord Knutsford spoke, there was a sense of crisis within the hospital system. The Manchester Royal Infirmary reported that it needed £9,000 extra each year to restore the finances of the hospital; the London Fever Hospital was said to be closing; and the National Hospital was discharging all its patients.[14] Grants from the King Edward Hospital Fund and the National Relief Fund helped the hospitals meet their deficits and a crisis was averted without State intervention. Yet this was but a temporary solution.

In 1921, the Cave Committee was appointed to investigate the financial situation of the voluntary hospitals.[15] It was clear

that the hospitals could not rely solely on charity contributions and that either government support or an extension of the recently introduced system of patients' payments would be necessary. The Committee noted that the majority of voluntary hospitals were operating under a deficit, their problems being due to rising costs rather than falling income, but since it was considered unlikely that increased contributions would erase the deficits, they recommended that the hospitals receive temporary support from the government for a period of two years. The idea of temporary support was a measure designed to avert the immediate crisis without compromising the independence of the hospitals. But though the Committee recommended a sum of £1 million, the government gave only half this amount.

Thus, the accounts of the hospitals were restored to a state of momentary health: in 1920, 452 provincial hospitals had a deficit of approximately £280,000, while in 1923, 624 provincial hospitals were operating with a surplus of around £270,000; one hundred and thirteen metropolitan hospitals worked with a deficit of £320,000 in 1921, but by 1923, one hundred and sixteen had a surplus of £230,000.[16] Yet financial problems were to emerge again. The hospital system had grown in response to donations and legacies rather than demonstrated need for services. Some areas had too many hospitals, others too few. Some were relatively affluent; others operated with a continuing deficit. And whereas money might be available for building a hospital, there were often severe problems in meeting operating costs: the charitable base of the hospitals had led to haphazard growth and

while donations had financed expansion programmes and the building of new hospitals, they had not provided a stable source of support for the operation and maintenance of these.[17]

The growth of contributory schemes and the admission of private patients had added an important source of income, but these could not be relied upon to prevent future crises. It was World War II which most clearly demonstrated the need for reform.[18] The pressures of wartime highlighted the need for a unified health system and during this period the hospitals became dependent on the national government for maintenance expenditures. Many were damaged in air raids, and government grants saved them while public money generally financed new equipment. The voluntary hospitals ended the war with added reserves of over £10 million. But they were not in a strong position: many plans for maintenance and repairs had been postponed during wartime, and prices were increasing again while interest rates were low. If the standards of wartime service were to be maintained, the hospitals needed an additional source of income. The precedents for government support had already been created, and it was the government alone which could provide the necessary income on a continuing basis.

In these ways, unwittingly, the dependence of the voluntary hospitals on the national government was created. No strong private interests had become involved in the health services, and thus, only the State could be turned to for the continuing financial support which the hospitals so obviously needed. Over several decades, the

government had provided a source of temporary income in order to avert crises and the precedents were thus created for State intervention in the voluntary hospital system. By the 1940's, it was clear that these ties must become more formal with the State providing more than intermittent support. The need for the State to provide a continuing source of revenue was recognized; it was the precise form of this relationship which was open to debate. It is for these reasons that we argue that the introduction of the National Health Service was, in large part, a response to the financial problems of the hospitals. Analyses of the National Health Service which emphasize its role in meeting the needs of the working class for health care have neglected these factors.

THE NEED FOR RATIONALIZATION

While the health care crisis recognized in the 1940's stemmed in part from the perceived need for a stable and continuing source of financial support for the hospitals, it was also prompted by the obviously chaotic structure of the health services. As the previous chapters have indicated, medical care was available from a variety of sources in the mid-nineteenth century and these continued to provide care throughout the early decades of the twentieth century. However, there was little co-ordination of these units. A welter of hospitals, small local contributory and prepayment schemes, and scattered general practitioners were combined in an inefficient system with minimal co-ordination between the different units, duplication of services,

varying standards of care, and poorly distributed services. Eckstein identifies four major problems within the health services: shortages of facilities and of trained manpower; unsatisfactory clinical conditions; uneconomic use of services; and poor geographic and functional distribution of services.[19] By way of example of this latter, we may note that middle class areas were likely to have a surfeit of general practitioners while working class areas needed to attract more doctors: in the late 1930's, there were 50 per cent less doctors per capita in South Wales as in London, and only 25 per cent as many per capita in the industrial Midlands as in the coastal resort of Bournemouth.[20]

We might also consider some of the deficiencies of the National Health Insurance scheme.[21] For while it was an important step towards a more comprehensive system of socialized medicine, it contained several anomalies. Approved Societies were not compelled to accept members and they generally refused membership to the chronic sick. But since additional benefits were only available through the Approved Societies, these patients received cash benefits alone. They were unable to obtain dental treatment, hospital and convalescent care, medical and surgical appliances and opthalmic treatment. Those most in need were least able to benefit from the scheme. And even those workers who were accepted members of Approved Societies faced problems in securing additional benefits. These benefits were financed from the surplus held by each Approved Society after other expenses had been met, and thus, where demand for general practitioner care and

sickness benefit was high, the surplus was small and few extra benefits could be financed. Where morbidity was high, where need was greatest, additional care was least available.

A further anomaly existed in that it was financially more advantageous for a worker to be drawing unemployment benefit than to be receiving sickness benefit. Writing in the late 1930's, Herbert notes that an unemployed man with a wife and one child received thirty shillings per week in unemployment benefit if he was fit, whereas if he was unemployed due to sickness, he received fifteen shillings in National Health Insurance benefit. He remarks that: "Doctors are often placed in the embarrassing position of being asked to sign off patients who should still be receiving medical attention solely in order that they may draw unemployment benefit."[22]

There is some evidence that the care received by patients under the National Health Insurance scheme was inferior to that available to fee paying patients.[23] The care and attention for such patients was claimed to be perfunctory--doctors were more interested in their more lucrative private patients. Since this was, financially, the most important section of their practice, many doctors would employ an assistant to treat their panel patients while they devoted their own time to their private patients. If, on the other hand, a practice was made up solely of National Health Insurance patients, the doctor's list was likely to be much larger than in a mixed practice. And though, in theory, panel patients were entitled to all necessary drugs free of charge, there were pressures on doctors to choose the

cheapest: above average costs of prescribing were likely to be questioned and the doctor might even have to bear part of the excess cost himself. Doctors were, therefore, likely to err on the side of safety and restrict pharmaceutical benefits. This was not likely to be the case with private patients.

In these ways, the National Health Insurance scheme failed to meet many of the medical needs of workers. Those most in need of treatment and care generally had access to a limited number of benefits. While unemployment benefit was paid at a higher rate than sickness benefit, there was a strong deterrent to seeking medical care. And when it was obtained, it was apparently inferior to that received by private patients. And the scheme was by no means self-supporting, even with respect to primary medical care. Whereas the incentive for doctors had previously been to restrict the numbers of people treated at outpatient departments, so as to ensure themselves paying patients, now there was an incentive for doctors to reduce their workload, at least with respect to National Health Insurance patients. They were paid on a per capita basis for these, and it was to their advantage to refer the more troublesome cases to hospital outpatient departments.[24] Thus, the outpatient departments lost many of their more trivial cases, but retained the more troublesome and time-consuming ones. In effect, they acquired a new role in complementing the work of the general practitioner by providing a specialist or consultative service.[25]

Here, we see some of the organizational problems existing within the health services prior to 1948. During the early decades of the

twentieth century, efforts had been made to rationalize the health services, but divisions in responsibility and competition between different sections of the medical profession had rendered these efforts ineffectual.[26] Whether co-ordinated action would have been achieved without the experience of World War II is impossible to say. It certainly intensified the sense of crisis and united the country. The pressure placed on services and the experience of doctors and consultants in unfamiliar environments forced the medical profession, hospital administrators, and government personnel to recognize as never before the inefficiency of the health services and the need for a unified national health system. It was almost automatically recognized that this would be achieved under a state system.

CONCLUSION

In the absence of evidence of strong working class pressures for reform of the health services, we have focussed our attention on financial, organizational, and administrative problems and argued that these provided the basis for a recognition of a need for reform. Furthermore, the State's responses to the financial problems of the voluntary hospitals unwittingly created a dependence on public funds and established further precedents for an increasing role in the provision of medical care.

This crisis which was emerging in Britain in the 1930's and 1940's bears some marked similarities to that recognized in the U.S.A. in recent years. The American health services have experienced a

decline in the number of charitable facilities for care and the whole system has been labeled as chaotic, fragmented, and extremely expensive.[27] However, the response of Britain was very different from that evolving in the U.S.A., where the government will not, in all probability, assume full responsibility for the rationalization of the system and the provision of care, and likely will work through existing hospital and commercial insurance schemes. Why? One important explanation of these varying responses is the development in Britain in the nineteenth century of a strong tradition of public care for the poor and the gradual emergence of public care for people of all classes with certain diseases: precedents were established for both general practitioner and hospital care financed through local and national government schemes. Private insurance schemes never assumed the size and important role of those in the U.S.A. Though catering to a significant proportion of the population, their membership was largely working class, and they remained small, scattered, independent schemes, lacking the power to successfully oppose government intervention. As Abel-Smith comments:

> . . . the prepayment agencies operating in Britain were unbusinesslike, ineffectively co-ordinated and run by persons without power or influence. They were swept into the background without antagonizing any important section of opinion. If the large profit-making insurance interests had ever entered the hospital field, the replacement of "voluntary" prepayment with a scheme based on taxation and compulsory "contributions" would have been less easily accomplished.[28]

For these reasons, we argue that the response of Britain to the crisis of the 1940's was in large measure determined by the

developments in the organization and delivery of medical care over the previous hundred years. Its response was, in many respects, ordained by the changes of the past century and the gradual extension of its role in providing care. It was responding to a desperate need for financial support and administrative and organizational rationality. And rather than marking a point of radical change directed towards reducing class inequalities, the government's action appears to have been prompted more by the recognition of a need to support and maintain the existing structures, to rescue the health services from chaos. These issues we return to in the following chapter.

FOOTNOTES

[1]These issues are further discussed in the following chapter. Runciman argues that during the interwar years "the most obvious comparative reference group for the prosperous manual worker was still other workers less fortunate than himself." (p.77) These other workers experienced severe hardships, but militant discontent was never widespread and the majority of the victims of the Depression appear to have thought of themselves as "victims of misfortune rather than injustice." The relative absence of social and political protest may be intelligible in terms of the relatively low level of deprivation felt by workers because of limited reference groups. W.G. Runciman, Relative Deprivation and Social Justice (London: Routledge and Kegan Paul, 1966), pp. 57-77.

[2]D. Reid Ross, "National Health Service in Factorytown: A Survey of the Demand for Medical Care in an Industrial Community," Medical World, Vol. 78, No. 2, (February, 1953), pp. 125-138.

[3]H. Eckstein, The English Health Service (Cambridge, Mass.: Harvard University Press, 1958), p. 102.

[4]The following chapter will be addressed to the question of who was defining these problems.

[5]B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964), p. 159. This discussion of the growing crisis within the hospital system is based largely on this excellent study.

[6]A. Lindsey, Socialized Medicine in England and Wales (Chapel Hill, N.C.: University of North Carolina Press, 1962), p. 24.

[7]Ibid., p. 24.

[8]F. Roberts, The Cost of Health (London: Turnstile Press, 1952) pp. 57-58, 63-65.

[9]See Chapter I.

[10]B. Abel-Smith, op. cit., p. 163.

[11]Ibid., p. 269.

[12]Ibid., p. 282.

[13]The hospitals administered under the Poor Law and later by local authorities were experiencing financial problems, but since these were already dependent on public funds, we will focus on the problems faced by the voluntary hospitals and their increasing dependency on the State.

[14]B. Abel-Smith, op. cit., p. 297.

[15]For a discussion of the Cave Committee findings, see: Ibid., pp. 307-309.

[16]Ibid., p. 326.

[17]While they led to a haphazard growth of the hospital system, such charitable donations were more discriminating than the dozen half bottles of champagne and dozen bunches of grapes distributed in one street by a carriage borne lady! Quoted from the Royal Commission on the Poor Laws by S. Leff, The Health of the People (London: Victor Gollancz, 1950), p. 65.

[18]B. Abel-Smith, op. cit., pp. 438-440.

[19]H. Eckstein, op. cit., Chapter 3.

[20]A. Lindsey, op. cit., p. 7.

[21]For a description of the National Health Insurance scheme and its deficiencies, see: H. Levy, National Health Insurance (Cambridge: Cambridge University Press, 1944).

[22]S.M. Herbert, Britain's Health (Harmondsworth: Penguin Books, 1939), p. 98. See also, H. Levy, op. cit., p. 66.

[23]However, the Royal Commission investigating the operation of National Health Insurance in 1926 concluded that patients treated under the scheme did not receive inferior care. See, H. Levy, op. cit.; A. Lindsey, op. cit., p. 7.

[24]H. Levy, op. cit., p. 128.

[25]B. Abel-Smith, op. cit., p. 247.

[26]Ibid. The competing interests within the medical profession are well documented herein.

[27]B. Ehrenreich and J. Ehrenreich, The American Health Empire (New York: Vintage Books, 1971).

[28]B. Abel-Smith, op. cit., p. 332.

CHAPTER IV

THE POLITICS OF THE NATIONAL HEALTH SERVICE

Introduction

We have argued that working class patients were not especially disadvantaged in access to health care and that there is no evidence of strong working class pressures for reform of the health services. Thus, we doubt the assumption that the National Health Service was a response to problems of working class patients in obtaining medical care. Rather, we have identified financial, organizational, and administrative problems which grew increasingly severe in the 1930's and 1940's and led to the recognition of a need for reform. But the question still remains: Who was creating an awareness of these problems and urging change? If pressures were not being exerted by workers, was the government or the political parties taking the initiative and acting in the interests of patients? Or did pressures for change emanate from other groups? In this chapter we argue that:

1. The recognition of problems within the health system and initial efforts to resolve these came from those working in the health services.
2. The Labour Party, as a representative of workers, and the State were relatively slow in responding to these problems and in formulating plans for reform.
3. Negotiations concerning the new service focussed on organizational and administrative issues. Issues of

social justice and equality of access to care were not a central concern.

This latter point, while not denying the concern of planners with creating a more just system of health care, reinforces our argument that the National Health Service was, in large part, a response to a perceived need to rationalize the organization and delivery of health care. Analyses of the welfare state which view it as a response to class inequalities and which see it as resulting either from working class pressures or from the State acting in the interests of workers, fail to recognize--with respect to the National Health Service at least--that its introduction can be explained largely in terms of the internal dynamics of the health system.

PROPOSALS FOR REFORM

Proposals for reform which were issued during the 1920's and 1930's indicate that those working within the health services were actively defining and seeking to resolve the problems of finance and disorganization well before the government addressed itself to these issues. During these years, a need for a unified health service was increasingly recognized, and almost without exception, the reports which contained blueprints for future reforms recognized the central role which the national government would play in a future health service.

The first such major report--the Dawson Report--was issued in 1920 and represented the views of the Consultative Council on Medical

and Allied Services which was organized under the Ministry of Health after the First World War.[1] It envisaged a regional organization of health services with health centres providing primary care, and where necessary, referring patients for treatment in general hospitals. These services would be unified under a single medical authority, and they saw this rationalization and unification of services as essential if the fruits of medical knowledge were to be distributed to the public, and if medicine were to be practiced with efficiency and economy.

The proposals of the British Medical Association, presented in 1930, were more cautious. Rather than long range programmes, they envisaged an extension of benefits under National Health Insurance and the co-ordination and reorganization of the hospitals.[2] They balked at the idea of a free service with public medical care available to all patients. These proposals were followed in 1933 by the reform programme of the Socialist Medical Association which argued for free services, salaried medical personnel, health centres, and regional organization of hospitals.[3] In 1937, the Voluntary Hospitals Commission (established by the British Hospitals Association) issued a report which included recommendations very similar to those of the Socialist Medical Association, though they sought to preserve the identity of the voluntary hospitals.[4] And the last in this series of reports was issued in 1942 by the Medical Planning Commission which had been organized by the British Medical Association and the Royal Colleges.[5] This argued for the organization of the hospitals on a regional basis, the establishment of health centres, and the central planning of

medical services by public authority. Indeed, on these three issues there seems to have been quite wide agreement in the various proposals for change.

The preparation of these programmes for reform indicates that the medical profession was very much aware of the problems existing within the health services and was actively involved in formulating policies for reorganization. The content of these reports also indicates a general consensus that the State would play a considerable role in the reorganization of the health services. While the British Medical Association hesitated at the idea of a totally free public medical service, the profession did generally recognize that the costs of health care were rising so rapidly that only about 10 per cent of the population was in a position to pay for care on a fee for service basis.[6] In the light of these observations, the opposition of the British Medical Association to the plans for the National Health Service which were eventually formulated by the government appears anomalous. But this opposition was by no means total. It was generally confined to specific issues (such as the sale of practices and the salaried status of doctors), and it was in large part concentrated within the elite of the Association--doctors with little experience of salaried service and of working in organizational contexts.[7] In general, the principle of a public medical service was accepted. Referring to 1942, Eckstein writes:

> The whole profession seemed to be in a reformist heat. It is said that late that year it was impossible to stage a debate on the desirability of a comprehensive State medical

service in one of the London teaching hospitals because no one could be found to oppose such a service.[8]

But though there was a general recognition that a new service would be organized under the auspices of the State, the political parties and successive governments were slow to assume this responsibility.

THE STATE ASSUMES RESPONSIBILITY FOR REFORM

The involvement of those working within the health services in the formulation of policies for reorganization preceded the involvement of the political parties. The Socialist Medical Association's programme for reform was accepted in broad terms by the Labour party in 1934, but it was not until 1942 that the party became fully committed to the details of the programme.[9] The party, as a representative of the working class, was relatively slow in formulating a policy on health services. As Eckstein comments, the Labour party "joined the team, at best, in the middle of the game."[10] Fraser notes that in 1941 the government was still talking in terms of a reorganization of the hospital system alone.[11] And the suggestion of a correspondent with the British Medical Journal in 1942 that pressure should be exerted on the parties to prepare legislation, further highlights the relatively late entrance of the parties into the debates on reorganization.[12]

It was the war which helped to both highlight and intensify the problems within the health system and which spurred the government to action.[13] The Emergency Medical Service, created in 1939 as

part of the wartime measures, heightened the awareness of the medical profession of the need for reform. Specialists left the familiar environment of the well-provided metropolitan and teaching hospitals to work in local hospitals which were, in contrast, often small and poorly equipped. Such experiences in unfamiliar environments helped to increase people's awareness of the inadequacy of the existing services and precipitated the decision to create a unified national health service.

The demands of wartime strained the resources of the poorly co-ordinated health system and ultimately deepened the financial problems of the hospitals. But the war also generated a sense of community and urgency. It was in this atmosphere of unity and crisis that much of the legislation on which the present welfare state is based was enacted. By 1940, under a coalition government, there was a rising conviction of the urgent need to study the problems of post-war industrial readjustment and social reconstruction, and in 1941, Sir William Beveridge was invited to head a committee charged with surveying existing schemes of social insurance and allied services and with making recommendations for the future. The Beveridge Report, issued in 1942, recommended, amongst other things, a comprehensive national health service organized under government authority.[13] The report received a warm reception; two weeks after it was issued, approximately 95 per cent of the public had heard of it.[14] Though it was most frequently associated with pension benefits, its proposals for a national health service were enthusiastically welcomed. Of those surveyed by

the British Institute of Public Opinion, 88 per cent favoured the idea of a comprehensive health system. It was one of the most popular of the many recommendations made by the report.

In this climate of public opinion, the government accepted, in February, 1943, the responsibility for planning a national health service. And in the following month, Ernest Brown, Minister of Health, completed his proposal for the new system. The years between Brown's plan and the National Health Service Act of 1946 involved a series of negotiations between the government and different interest groups which sought to protect their position within the new service. One of the main studies of this process of negotiation suggests that the medical profession succeeded in gaining the greatest concessions while property interests fared worst.[15] We will pursue these arguments advanced by Willcocks in a little more detail. For apart from indicating the composition and political strength of the groups involved in the negotiations, his analysis also points to the relative inattention to issues of social justice on the part of the government and interest groups. The pattern of negotiations indicates that the National Health Service was in part shaped by the demands of the medical profession, and largely addressed to the creation of a more rational and efficient organizational structure. The reduction of class based inequalities in health and access to medical care do not appear to have been the dominant concern in these negotiations.

THE PROCESS OF NEGOTIATIONS

Willcocks distinguishes three main interest groups involved

in the negotiations. Firstly, he identifies those with skills employed by the health services. This was by no means a united group for it included general practitioners represented by different associations; specialists and consultants; and medical officers of health employed by the local authorities. Secondly, the common interests of administrative bodies are identified, the most important of these being the local authorities. Property interests formed the third grouping, with the British Hospitals Association acting as spokesman for the voluntary hospitals. Though negotiations often proceeded in secrecy, and only one of the plans prior to the National Health Service Act was published, Willcocks seeks to reconstruct the gradual reformulation of the government's plans for a health service. His analysis points to the power and strong bargaining position of the medical profession, particularly specialists and general practitioners, and the relatively weak position from which the voluntary hospitals negotiated.

The contents of the Brown plan of March, 1943 were never made public. However, it apparently envisaged

> a unified health service, all the services being the responsibility of one administrative unit, based on a system of regional local government units or possibly joint authorities. The voluntary hospitals would be "utilized" although what is meant by this is not clear. . . . General practitioners were apparently to be full time salaried servants within this administrative system.[16]

The plan was vehemently rejected. The proposed local government authority and the employment of general practitioners on a salaried basis were most strongly opposed. After the hostile reaction it engendered,

the idea of a fully unified health service was abandoned and eventually replaced by a tripartite structure which in part reflected the interests of dominant groups within the health services.[17]

In the three years which intervened between the first plan and the National Health Service Act, the medical profession succeeded in having many of its demands met.[18] The consultants and specialists were in a particularly strong bargaining position: they were the possessors of valuable skills which could not be easily replaced. Their status and power had increased as medicine had become more sophisticated and specialization had developed. If the National Health Service was to operate successfully, it was essential for the government to secure the co-operation of those whose skills were in short supply. Thus, the negotiations proceeded with good will, and the elite of the medical profession achieved the regional hospitals which they had wanted, the hospitals were freed from the proposed local government control, and the medical teaching hospitals received preferential treatment. They also negotiated their conditions of service and pay. They were allowed to continue their private practice with access to National Health Service hospital beds and achieved a high level of control over both appointments and promotion and also the allocation of merit awards. In these respects, the medical elite secured important concessions from the government.

The bargaining position of the general practitioners was undermined by the specialists' acceptance of Bevan's plan for the National Health Service. For example, it was difficult for them to argue in

favour of retaining the right to sell the good will of a practice when the specialists had accepted part time or full time salaried positions under the National Health Service--an apparently less commercial contractual agreement. But despite the government's use of the elite's acceptance of its plans in negotiations with the general practitioners, the latter were successful in gaining concessions which included the withdrawal of proposals to employ them in full time salaried service with local government control.

The branch of the profession which was least able to exercise control over its position within the National Health Service was that of the public health practitioners. They lacked status and prestige within the profession (the major beneficiaries of their work were the urban working class, the group least able to confer status) and they were already in local government service. They had no independent power base from which to negotiate.

The major loss in the process of negotiation was experienced by the voluntary hospitals. None of the plans preceding that of Bevan had envisaged the nationalization of the voluntary hospitals, yet in retrospect, it is not surprising that this was finally proposed. As we indicated in the previous chapter, the hospitals were in a financially weak position and had been intermittently dependent on government grants for several decades. They were in a weak position to oppose government plans: just as the public health practitioners, they had no independent bargaining position.

In view of such gains and losses, Willcocks concludes that

consultants and specialists were most successful in securing changes in the government plans while the property interests represented by the voluntary hospitals achieved no real gains. But there is more that we can draw from this study. In addition to the light which it sheds on the roles and power of the various interest groups, Willcocks' analysis is important for what it omits. Throughout his discussion of the negotiation process, there is virtually no mention of class variations in health and access to medical care, and there is little emphasis on the needs of the potential consumers of the new service.[19] Each of the groups involved sought to protect its own interests--to secure as much autonomy as possible and to maximize the satisfaction likely to be gained from conditions of work and income. In the process of negotiation, one set of interests was unrepresented--those of the users or potential users of the health services.[20] There were no organized groups which represented these interests alone. Each of the pressure groups claimed to represent the public, yet their interpretations of the public interest neatly coincided with their own self-interest.

The sadly incomplete information on the negotiations suggests, therefore, that the participants in this process were largely concerned with introducing an organizational and administrative coherence. Inevitably perhaps, negotiations focussed on specific issues of organization, and we have no indication of the extent to which ideological commitments to greater equality and social justice with respect to health and health care were a guiding concern. Further research could

usefully pursue the role of ideology through the analysis of biographies, parliamentary debates, party publications, etc.; such an analysis has been beyond the scope of this study. But in the light of our present knowledge, at least, it appears that the National Health Service was directed less towards improving the access of working class patients to care than towards achieving a rationalization of the health services. Even the universal provision of free care--perhaps the most egalitarian aspect of the new service--was not justified simply in terms of an egalitarian ideology: there was general agreement that because of the high costs of care, at least 90 per cent of the population would have to receive free treatment and the idea of a means test had already been rejected in 1911.

CONCLUSION

Let us draw together the main arguments developed in this and previous chapters. Our concern has been largely with explaining the reasons for the introduction of the National Health Service. Questioning explanations which focus on the service as a response to demands for reform and greater social justice on the part of the working class, we have focussed our attention on problems within the health services and the recognition of a need for change by those responsible for providing health care. Financial problems, particularly those experienced by the voluntary hospitals, became increasingly severe during the 1920's and 1930's. At the same time, the lack of co-ordination of the various units providing care and the wasteful

duplication of services became increasingly obvious. It was those working within the health services who first addressed themselves to these problems and to the task of formulating plans for reorganization. The government was relatively late in taking initiatives to resolve these problems. Their intensification, together with the sense of urgency created by the war, finally prompted government action, and the first plan for a reorganized health system was completed in 1943. The emphasis in this and successive plans was on the rationalization of the health services rather than on the reduction of class inequalities in health and access to care. And though well received by the public, these plans do not appear to have been a response to direct public pressures for change. While the first major step towards socialized medicine--the National Health Insurance scheme--might be seen as being partly a response to demands for reform from an increasingly organized working class,[21] after this point, changes in the health service can be understood mainly in terms of the internal dynamics of the health system.

While we know relatively little about the actual use made of services and the quality of care received by patients of different social class, we have shown that care was available at little or no cost to working class patients prior to 1948. It may be that primary care was superior for fee paying patients, but in respect of hospital care, working class patients appear to have received somewhat better treatment. Class inequalities in access to care were not of the nature and magnitude sometimes assumed: middle class, as well as working

class patients, faced problems in securing high quality medical care. The problems of providing health care in the early decades of the twentieth century were not so much those of delivering care to the working class as of generally rationalizing the delivery of care. Even the removal of most of the direct costs of care can be explained by the fact that only a small fraction of the population could afford to pay for private care personally.

The National Health Service was built upon the existing institutional framework. The role assumed by the government in formulating plans for a unified national health service and the responsibility it took upon itself for providing health care, we have explained in terms of the long tradition of publicly provided care and its growing importance in the early decades of the twentieth century. Throughout the late nineteenth and early twentieth centuries, we see a growing general acceptance of a stronger government role. And private insurance schemes--a potential source of opposition to the expanding government role--never assumed an important role in the health sector: membership was largely working class and they remained small, scattered, independent schemes, lacking the power to successfully oppose government intervention. In the 1940's, almost without exception, it was recognized that a national health service must be organized under the aegis of the government. Debate centred around the form of the service rather than the appropriateness of a State medical care system--though certain principles had already been established by the provision of hospital care to all patients suffering certain illnesses, and

by the rejection of a means test in the National Health Insurance scheme.

In addition to laying the foundation for the government's assumption of responsibility for providing medical care, the development of the health services during the century preceding the National Health Service had generated a variety of groups, each with specific interests and each acting to safeguard these in the formulation of plans for a new service. The continuity of structure and the form which the National Health Service assumed owes much to the bargaining power of these groups--most especially the consultants and specialists. While initiating plans for the new service, in the reformulation of these, the government's power was limited by its recognition of a need to secure the compliance of the medical profession in order to ensure the success of the service. Other groups which were more dependent on the government and whose functional importance in the service was seen as being less, were in a weaker position to dictate their terms of participation. The increasing sophistication of medicine had not only generated a need for reform. It also bestowed power on the elite of the medical profession.

We have examined the sources and nature of the problems within the health system and the planning process prior to the introduction of the National Health Service. Our analysis suggests the inadequacy of studies which view the introduction of welfare state services in the 1940's as marking a point of radical departure from the past; which see the working class as particularly disadvantaged in access

to services; which view them as a response to pressures from the working class; and which portray them as being introduced in order to reduce class inequalities. Such assumptions certainly ignore the complex history of the British health services. Drawing the major points from the discussions in the foregoing chapters, we have argued, firstly, that the National Health Service was not a radical departure from the organization of health services prior to 1948, but that it was built on the existing institutional framework and its roots may be traced back over a century. Secondly, it appears that working class patients were not severely disadvantaged in obtaining medical care prior to 1948: middle class patients were, in some respects, in a particularly disadvantageous position. Thirdly, we have argued that the service was in large part a response to the recognition of a need for organizational and administrative rationality and for a stable source of financial support for the hospitals: the National Health Service Act was primarily directed towards these goals. And fourthly, we have indicated that the recognition of problems within the health services and a concern with change came largely from the medical profession and hospital administrators.

But if not directed primarily to reducing class inequalities in quality of health and access to care, did the National Health Service nevertheless operate in such a way as to narrow these inequalities? The following chapters address this issue.

FOOTNOTES

[1]The Dawson Report on the Future Provision of Medical and Allied Services (London: King Edward's Hospital Fund for London, 1950)

[2]A General Medical Service for the Nation (London: British Medical Association, 1930).

[3]A Socialized Medical Service (London: Socialist Medical Association, 1933).

[4]Report of the Voluntary Hospitals Commission (London: British Hospitals Association, 1937).

[5]"Draft Interim Report of the Medical Planning Commission," British Medical Journal, Vol. I, (1942), pp. 743-753. A final report was never issued.

[6]A. Lindsey, Socialized Medicine in England and Wales (Chapel Hill, N.C.: University of North Carolina Press, 1962), p. 29.

[7]For a discussion of the nature and extent of the British Medical Association's opposition see: H. Eckstein, The English Health Service (Cambridge, Mass.: Harvard University Press, 1958), pp. 143-155.

[8]Ibid., p. 122. [9]Ibid., p. 109. [10]Ibid., p. 108.

[11]D. Fraser, The Evolution of the British Welfare State (New York: Harper and Row, 1973), p. 204.

[12]"The Planning Commission's Report," British Medical Journal, Vol. 2, (1942), p. 112.

[13]"Whether or not payment towards the cost of the health service is included in the social insurance contribution, the service itself should

(i) be organized not by the Ministry concerned with social insurance, but by Departments responsible for the health of the people and for positive and preventive as well as curative measures;

(ii) be provided where needed without contribution conditions in any individual case."

Great Britain, Report on Social Insurance and Allied Services by Sir William Beveridge (Cmd 6404) (London: H.M. Stationery Office), pp. 158-159. The Report did not address itself to specific issues of

organization, administration and financing, though it did recognize that if contributions for general practitioner care were included in the compulsory social insurance scheme (which had no income limits), then it would provide free care to the whole population and not just 90 per cent as envisaged by the Medical Planning Commission.

[14]Data on the public response to the Beveridge report are quoted from: The Beveridge Report and the Public (London: British Institute of Public Opinion, undated).

[15]A.J. Willcocks, The Creation of the National Health Service (London: Routledge and Kegan Paul, 1967). See also, A.J. Willcocks, "'A Process of Erosion?': Pressure Groups and the National Health Service Act of 1946," Sociological Review, Monograph No. 5, (July, 1962), pp. 9-19. The following discussion of the negotiations prior to the introduction of the National Health Service is based on these sources.

[16]A.J. Willcocks, The Creation of the National Health Service, op. cit., pp. 24-25.

[17]For an analysis of the effect of differing professional interests on the structure of the National Health Service see: D.G. Gill, "The British National Health Service: Professional Determinants of Administrative Structure," International Journal of Health Services, Vol. F, No. 4 (1971), pp. 342-353.

[18]In these years, two other plans were formulated before Bevan's plan was presented to Parliament.

[19]Willcocks confirms that there was indeed little discussion of class inequalities or issues of social justice. (personal communication.)

[20]A.J. Willcocks, The Creation of the National Health Service, op. cit., p. 33.

[21]The extension of the functions of the State during the nineteenth and early twentieth centuries has been explained as a response, in part, to demands for reform from the working class. But, just as in the years preceding the introduction of the National Health Service, the importance of working class pressures for reform is not clear. For the increasing functions of the State can also be explained in terms of the paternalism of some sections of the middle and upper class, their own fear of infectious diseases and an interest in maintaining a reasonably healthy and productive labour force. See: M. Bruce, The Coming of the Welfare State (London: B.T. Batsford, 1966); R. Bendix,

Work and Authority In Industry (New York: Harper and Row, 1963); N. Birnbaum, The Crisis of Industrial Society (London: Oxford University Press, 1969.).

PART TWO

PREFACE

In this study, we have identified a series of assumptions concerning the sources and impact of the welfare state. These are not confined to any single theoretical perspective and they are reflected in popular conceptions of the welfare state. We have addressed ourselves to all but one of these assumptions--that concerning the role of welfare services and programmes in reducing class inequalities.

If we assume that the National Health Service has narrowed class inequalities, we might predict that it channelled benefits mainly to the working class and that it achieved a measure of income redistribution greater than that occurring prior to 1948. Certainly, such themes may be identified in discussions of the role and functions of the welfare state. For example, Frankel, in a marxist analysis of British society, recognizes that the working class largely pays for its own benefits, but argues that it has, nevertheless, benefited from the introduction of welfare programmes. He writes that

> it is absolutely true that the growth of public welfare has brought very real gains to all working people by way of educational opportunity, a national health service, unemployment and sickness benefits and retirement pensions.[1]

And Strachey directs our attention to the issue of income redistribution when he argues that with the emergence of the welfare state "a modest, but distinct redistribution of the national income was actually effected."[2] Titmuss writes of public images of "something akin to a stereotype or image of an all pervasive welfare state for the working classes."[3] And this image is reflected in one edition of The Montreal

Star which reports that

> post-war Britain has had remarkable achievements in assuring minimum standards for all her citizens. The welfare system and the National Health Service have greatly reduced the worst cruelties of income inequality. . . .[4]

But in addition to channelling benefits to working class families and achieving a greater measure of income redistribution, we would (working on the assumption that the National Health Service reduces class inequalities) also predict a reduction of inequalities in access to care and a narrowing of class differences in quality of health. For though writers such as Strachey, Frankel and Miliband[5] are not always explicit as to the benefits or humanizing effects of the welfare state, these may be assumed to be the most specific ones to flow from socialized medicine.

In order to assess the role of the National Health Service in reducing class inequalities, the following chapters will be addressed to these issues. We ask: Can the National Health Service be viewed as channelling benefits largely to the working class? Did the introduction of a system of socialized medicine achieve a greater amount of income redistribution? Did it also reduce class differences in access to care and, while not necessarily achieving equality of access, eliminate marked inequalities? And has there been a reduction of class differences in levels of health? Lest such questions appear naive to a reader sceptical of the benefits flowing from welfare services and programmes, it is well to note once again that the National Health Service has generally been seen as the most socialist of all welfare

programmes and that it has generally been regarded with veneration even by those on the political left.[6] These questions do not appear to have been raised by many writers and none have sought to answer them by means of systematic research.

But before focussing our attention on these issues, let us outline the structure of the National Health Service since this will serve as a background for our discussion in the following chapters.

THE STRUCTURE OF THE NATIONAL HEALTH SERVICE: 1948-1974

The National Health Service was introduced in 1948 and remained relatively unchanged until a major reorganization in April, 1974.[7] The tripartite structure of the service reflected three basic divisions in the health system prior to 1948: the hospitals, the public health authorities and independent medical practitioners. It was comprised of three parallel networks of authorities, each of which was subordinate to the Department of Health and Social Security. The Department had over-all administrative and financial responsibility for the service, but little opportunity for direct executive action.

Public health services were administered by the local health authorities which had a long established role in this field. They were responsible for maternity and child welfare, ambulance services, home nursing, health education, home helps (for assistance with domestic duties) and special services for the elderly, the handicapped and mentally ill. The old National Health Insurance Committees were reorganized as Executive Councils and these then formed the second branch

of the National Health Service. The planning and delivery of general medical care was in the hands of independent general practitioners, dentists, opticians and pharmacists, but the Executive Councils assumed an administrative responsibility for the services which they provided. The main duties of the Councils were payment of these medical personnel, dealing with complaints, and advising consumers and personnel on various details of the system. The hospital system comprised the third arm of the service and provided both inpatient and outpatient specialist care. These hospital and specialist services were administered by fourteen Regional Hospital Boards and locally by Hospital Management Committees. Each Regional Hospital Board was associated with a medical school, though the teaching hospitals were affiliated with universities and administered by boards of governors.

First contact care was provided by general practitioners and each person was free to register with a doctor of his own choice. Private care, outside the National Health Service, was available and could be provided by a general practitioner who was in contract with the National Health Service, but approximately 97 per cent of the population have been registered as National Health Service patients. Doctors generally worked from their own premises, frequently in small groups, and employed their own staff. The health centres which were originally envisaged as the basic units in the health service were never developed though there is again a growing emphasis on them.

Access to specialist services has generally been through a general practitioner. Inpatient and outpatient care by specialists

has ordinarily been obtained at a hospital and the specialists have usually been the same for both types of care. If specialist treatment or advice has been considered necessary, a general practitioner has referred his patient to a clinic at a local hospital outpatient department. Direct access to specialists has existed in the case of accidents, emergencies and venereal disease. Admission as an inpatient has been either through the outpatient department, directly through a general practitioner, or through the casualty unit as an emergency case.

While general practitioners have been paid a capitation fee with additional payments for particular services, specialists have been paid a salary by the hospital. Those specialists working in hospitals could also treat private patients in which case they have foregone a small fraction of their hospital salary. The hospitals have provided private beds, but such patients have amounted to less than 10 per cent of all referrals.

The services offered by each of the three branches of the National Health Service were at first available to all at no direct cost. But in 1951, prompted by growing apprehension over the alleged abuses and apparently escalating costs of the service, the Labour government amended the National Health Service Act so as to allow charges on spectacles and dentures.[8] Those unable to meet the costs were eligible to receive help from the National Assistance Fund. The following year, a one shilling charge was imposed on prescriptions, a one pound charge for a course of dental treatment and certain

surgical appliances became subject to charge. In January, 1968, the fee for a course of dental treatment was increased by 50 per cent, and a charge of two shillings and sixpence was levied on all prescriptions. From the first, provision was made for hardship cases and National Assistance recipients to receive reimbursement of charges. At no time have charges been introduced for hospital treatment (both inpatient and outpatient) or general practitioner care.

The service did, therefore, provide general practitioner and hospital care to all at no direct cost, while other services were available at low cost. The myriad sources of care prior to 1948 were combined in one system and differences in the sources from which different social classes received care were formally removed.

FOOTNOTES

[1]H. Frankel, Capitalist Society and Modern Sociology (London: Lawrence and Wishart, 1970), p. 278.

[2]J. Strachey, Contemporary Capitalism (London: Victor Gollancz, 1956), p. 261.

[3]R.M. Titmuss, Essays on the Welfare State (London: Unwin University Books, 1963), p. 37.

[4]A Lewis, "The True-Blue Middle Class," The Montreal Star, July 9, 1974, p. A-7.

[5] R. Miliband, The State in Capitalist Society (London: Quartet, 1969).

[6]M. Rossdale, "Socialist Health Service?" New Left Review, No. 36 (March-April, 1966), p. 3.

[7]The structure of the National Health Service is not discussed in detail. For a fuller description of the service, the reader may refer to: R. Stevens, Medical Practice in Modern England (London: Yale University Press, 1966); A. Lindsey, Socialized Medicine in England and Wales (London: Oxford University Press, 1962).

[8]The apprehension was not warranted: in pounds of constant value, the increase in spending for the service was relatively small. See, B. Abel-Smith and R.M. Titmuss, The Cost of the National Health Service in England and Wales (Cambridge: Cambridge University Press, 1956).

CHAPTER V

THE NATIONAL HEALTH SERVICE: ITS REDISTRIBUTIVE EFFECT

Introduction

In this and the following chapters, we address ourselves to the assumption that the welfare state reduces class inequalities. Contained within this assumption is the implication that the introduction of welfare services and programmes brought considerable benefits to the working class while being of relatively little value to middle class families. Certainly, this is consistent with the belief that such programmes were addressed to the needs of the working class--a point we have already questioned. Furthermore, the emphasis on the role of the welfare state in redistributing income is often coupled with a belief that the amount of redistribution is greater than any achieved prior to the introduction of welfare services.

This chapter addresses itself to these issues and argues that:

1. While working class patients undoubtedly benefited from the introduction of the National Health Service, middle class patients also received considerable benefits.
2. The National Health Service may be no more effective in redistributing income than were the health services prior to 1948.

BENEFITS EXPERIENCED BY MIDDLE CLASS FAMILIES

The changes wrought within the health system by the introduction

of the National Health Service in 1948 were essentially of an administrative nature and they had relatively little immediate impact on the actual delivery of medical care. The majority of people were likely to receive care from the same doctor, dentist, and hospital, though they would have to consult their general practitioner in order to be referred to a hospital. For the poor, used to consulting the outpatient department of a hospital for care, there was, therefore, a change in the pattern of obtaining care. And for wealthier patients, used to paying for private care, there was now the opportunity to receive treatment in former local authority and voluntary hospitals. But for the majority of patients, there was probably no change in the pattern of obtaining care. Perhaps the major difference for most people was in the method of paying for treatment. Here, the financial benefits were certainly as significant for the middle class as for the working class patient, and these, together with the removal of the barrier to admission to the local authority and voluntary hospitals, convey the importance of the National Health Service for middle class families.

Just prior to the introduction of the National Health Service, many patients provided for their treatment through contributory or provident schemes.[1] The bulk of the working class belonged to contributory schemes which required only partial prepayment for care and which served those who were unable to pay the full costs of treatment. Those families in the middle and upper classes who did not pay private fees whenever care was necessary, provided for their needs through

provident insurance schemes which aimed to cover the full costs of care. The aged, unemployed and those who did not or could not make regular payments into such schemes had the right to free hospital care after a means test. And the local authorities, through public assistance committees, made arrangements for the medical attention of the destitute.[2]

The National Health Service removed most of the direct costs of obtaining care and thus undoubtedly benefited most patients. Free care became a right of all citizens and so, in as much as there was a stigma attached to receiving free care, this was removed. Even partial payments for treatment would have been a burden for many families close to destitution, and, therefore, the removal of the direct costs of treatment would have been welcomed by lower income families. But the benefits flowing from the National Health Service were not confined to working class families alone. Let us consider the position of middle class families.

Those sections of the population most "neglected," most likely to be feeling the pinch of the increasing costs of care, were families in middle income brackets. They were not eligible for charity care; in general, the income limits operating in contributory schemes excluded them. They were private fee paying patients of general practitioners, and in the hospitals, they either paid the full cost of care whenever hospitalized or else guarded against such unanticipatable high bills by membership in a provident insurance scheme. Generally, they bore the brunt of neglect. They received no financial concessions in

meeting their medical requirements and they indirectly subsidized the poor. The National Health Service brought them the first such concessions. Writing of the development of the health services in Britain, Means notes: "Those in the middle income brackets became the neglected persons. It was not until the National Health Service came in 1948 that something was done for the middle classes."[3]

The benefits which accrued to middle class families are illustrated by a business executive who recounts the freedom from worry over expenses of childbirth and any major illness in the family which came with the National Health Service.[4] Similarly, a middle class father of four children writes,

> I can see that to middle class families, it is not just a benefit, but a necessity; the cost of living has risen so greatly since 1939 that private medical care would be another increasingly expensive burden.[5]

And in introducing the National Health Service, the Minister of Health spoke of its special value to families in the middle and professional classes who had so often been "hit cruelly hard by heavy surgical and medical fees which have a habit of coming at the wrong moment."[6]

But the National Health Service did not only provide middle class patients with important financial benefits; it also secured their access to the mainstream of the hospital system. As we have already indicated, prior to the introduction of the National Health Service, middle class families were generally unable to obtain care in the local authority and voluntary hospital system. Instead, they were confined to smaller and less well equipped private hospitals and nursing homes. With the introduction of the new service, they

were able to gain admittance to the often superior care available in the major hospitals. And at the same time, they secured the privilege of paying for private care in these hospitals, thus receiving benefits not available to National Health Service patients.[7]

It appears, therefore, that the National Health Service brought important benefits to the middle class: some relief from the financial burden of paying for health care and considerably improved access to hospital care. Discussions of the welfare state which see it as channelling benefits largely to the working class--thereby reducing class inequalities--fail to recognize that insofar as the National Health Service is concerned, its introduction channelled significant benefits to the middle class. It was not a change which catered to the problems of working class families alone.

Let us now consider in more detail the financial significance of the National Health Service. We have argued that the new service brought important financial concessions for the middle class. But what of its role in redistributing income?

INCOME REDISTRIBUTION WITHIN THE NATIONAL HEALTH SERVICE

It is generally recognized that the National Health Service has operated as a mechanism for redistributing income with subsidized medical goods and services representing an increment to the income of poorer families. The amount of redistribution is, however, likely to be relatively small. And it is not clear whether the service is more effective in reducing income inequalities than those redistributive mechanisms operating within the health services prior to 1948.

The service is financed largely from general taxation revenue. In 1966, this accounted for 72 per cent of National Health Service revenue. Flat rate contributions are deducted from wages and salaries, and these amount to 12 per cent of revenue. The balance is made up of 12 per cent from rates and grants from local authorities and 4 per cent from direct payments by consumers for goods and services.[8]

These costs have not fallen equally on all families. Even though poor families have been able to claim exemption from charges, it appears that their total contributions to the National Health Service represent a higher proportion of their income than is the case for middle and higher income families. Taxation, both direct and indirect together, has been progressive except at the lower end of the income range where it has been regressive.[9] A study by Merrett and Monk of taxation in Britain in 1962-3 shows that those with an income of less than £559 per annum were paying a higher proportion of their income in taxes than those earning between £559 and £1,752 per annum. For example, people in this latter range were paying at a virtually uniform average rate of 28 per cent while people with incomes between £180 and £382 per annum were paying at an average rate of 34 per cent.[10]

Flat rate deductions are regressive since they consume a higher proportion of the income of low income families. Thus, the charges which have been in effect for most years since the introduction of the National Health Service will have consumed a higher proportion of the income of low income families. Efforts have been made to

counteract this regressive element by exempting certain groups, particularly low income families and individuals, from charges. However, there is evidence that those who have been eligible for such exemptions have not claimed them. About 50 per cent of those eligible for free care do not receive it.[11]

The combined effect of taxation and charges for drugs and services has, therefore, been regressive: the costs of the service have consumed a larger proportion of the budget of low income families than of high income families. Studies of the role of benefits in kind, and direct benefits generally, in redistributing income have shown that they do have a small redistributive effect.[12] But because of the regressive costs of the National Health Service, and because it is a service catering to all income groups, its role in this respect is likely to be a minor one.

INCOME REDISTRIBUTION BEFORE AND AFTER THE NATIONAL HEALTH SERVICE

What impact did the National Health Service have in terms of redistribution? Since a measure of income redistribution occurred prior to 1948, with wealthier patients subsidizing the care of the poor, did the new service increase this? This is not clear. The fact that the costs have been regressive at the lower end of the income scale suggests that, on a financial basis at least, the poor may have lost some benefits. Their contribution to the costs of their medical care may have increased, but it is impossible to state this with any

certainty. Measures of the redistributive role of welfare state services and programmes are somewhat inadequate since they do not provide us with information for the National Health Service alone--the combined effect of cash benefits and benefits in kind is presented. Furthermore, we need additional data on the direct and indirect costs of obtaining medical care before 1948. The poor were eligible for free care before 1948. Was this care completely free or were there indirect costs? To what extent did the taxes they paid subsidize the care which they received? What proportion of their incomes were spent on medical goods and services which either complemented or substituted those which they could obtain at no cost? We need data for different income groups on the costs of obtaining medical care before 1948. Certainly, a mechanism of redistribution was operating through private philanthropy and the high private fees paid by wealthier patients which subsidized the care of the poor. Indeed, The Times referred to the pre-1948 health services as a system of "'Robin Hood' medicine which despoiled the rich in order to be charitable to the poor."[13] What is not clear is whether the National Health Service had the effect of consuming a greater proportion of the income of the poor.

Attempts to assess the impact of the National Health Service must take into account the pre-1948 organization of health care. Unfortunately, the data which are available do not permit us to answer many questions. However, given the relatively small amount of redistribution which is likely to be occurring under the National Health

Service, there is some reason to suppose that it has been no greater than that prior to 1948. It may be that the mechanism rather than the extent of redistribution changed with the introduction of the National Health Service.

CONCLUSION

Our discussion of benefits accruing to middle class families upon the introduction of the National Health Service suggests that the service cannot be seen as ameliorating the position of the working class alone. We have argued that the new service brought real benefits to working class patients in that the direct costs of care were largely removed and treatment became a right of citizenship rather than an object of charity. But our emphasis has been on an often neglected point--that middle class patients reaped considerable benefits from the introduction of the new service. We have already indicated in Chapter II the manner in which middle class families experienced problems in securing health care--financial problems in meeting the mounting costs of treatment and problems of access to local authority and voluntary hospitals. This chapter has shown that the National Health Service solved these problems overnight.

The role of the National Health Service in redistributing income appears to be relatively small. We have questioned whether the Service achieved a greater degree of redistribution than the health services prior to 1948. Given that the amount of redistribution is likely to be small, and that prior to 1948 a redistributive mechanism existed

(through charity and the subsidization of the care of the poor through wealthier families paying high private fees), we have argued that it may be the form rather than the degree of redistribution which has changed. Clearly, more research into the redistributive role of the National Health Service is needed.

On the basis of these arguments, it would appear that the role of the National Health Service in reducing class inequalities has been overemphasized. Further pursuing this issue of the impact of the National Health Service on class inequality, we will move on to a consideration of inequalities in access to general practitioner, hospital, and dental care. But in order to provide the framework for a discussion of class differences in the use of these services, we will first focus our attention on class variations in needs for health care.

FOOTNOTES

[1]B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964), p. 401-402.

[2]These services were, however, little better than those provided under the Poor Law fifty years earlier. S. Leff, The Health of the People (London: Victor Gollancz Ltd., 1950), p. 122.

[3]H. Eckstein, The English Health Service (Cambridge, Mass.: Harvard University Press, 1958), p. xvii.

[4]"The National Health Service Act in Great Britain," The Practitioner, Vol. 163, 1949.

[5]Ibid., p. 96.

[6]Quoted by A. Lindsey, Socialized Medicine in England and Wales (Chapel Hill, N.C.: University of North Carolina Press, 1962), p. 72.

[7]The significance of private health care is discussed in Chapter VIII.

[8]J. Fry, Medicine in Three Societies: A Comparison of Medical Care in the U.S.S.R., U.S.A., and U.K. (New York: American Elsevier Publishing Company, 1970), p. 50.

[9]Taxation here includes both local rates and National Health Service contributions.

[10]A.J. Merrett and D.A.G. Monk, "The Structure of U.K. Taxation, 1962-63," Bulletin of the Oxford University Institute of Economics and Statistics, Vol. 28, No. 3 (August, 1966), pp. 145-162. The average income of manual workers in 1962-63 was 825.

[11]A. Oppenheim, "Dental Charges: A Survey of the Means Test at Work," Cambridge Poverty, No. 3 (January, 1972), pp. 5-7. Also M. Walker, "Housing: The Meanest Test of All," The Guardian, December 28, 1972, p. 11.

[12]For analyses of the redistributive role of welfare services and programmes, see: Merrett and Monk, op. cit.; J.L. Nicholson, "Redistribution of Income in the United Kingdom in 1959, 1957 and 1953," in C. Clark and G. Stuvel (eds.), Income and Wealth, Series X (London: Bowes and Bowes, 1964); Great Britain, Central Statistical

Office, "The Incidence of Taxes and Social Service Benefits in 1963 and 1964," Economic Trends, No. 154 (August, 1966), pp. i-ix.

[13] The Times (London), July 5, 1948, p. 5.

CHAPTER VI

CLASS DIFFERENCES IN MORTALITY AND MORBIDITY

Introduction

In previous chapters, we have argued that the introduction of the National Health Service may be viewed as a response by the state to the recognition of the need for reform emanating from within the health services. As such, the new service was directed toward a rationalization of the health care system. The creation of a service in which patients had equal access to care and in which care was available on the basis of need alone does not appear to have been a priority. Yet even though this was not a major goal, we can ask whether the National Health Service has, nevertheless, operated in such a manner as to provide equality of access to care and to achieve a narrowing of class inequalities in health. For this is what we would predict on the basis of assumptions as to the relative success of the welfare state in reducing class inequality.

The following chapters examine access to general practitioner, hospital, and dental care in terms of rates of use of these services by patients of different social class and in terms of variations in the quality of care received. If equality of access prevails, we would expect to find no differences in the quality of care received by patients of different social class. But we would not necessarily expect to identify similar rates of use of services: equal rates of use do not signify equality of access if the needs for health care

are greater among working class than among middle class patients. Since data on different patterns of use of medical services are meaningless if we have no indication of whether needs for health care vary along social class lines or whether they are constant, this chapter focuses on class differences in mortality and morbidity in order to ascertain variations in needs for medical care.

The data on mortality and morbidity which we review below indicate greater needs for health care among working class families: mortality rates are consistently higher for classes IV and V, and lower class persons appear to experience illnesses of greater severity. They also suggest that class differences in mortality have increased since the introduction of the National Health Service. Thus, in addition to providing a framework for the discussion of access to health care, they also give us an indication of the impact of the National Health Service on class inequalities in health. We will not, however, pursue this issue at present since it is more useful to consider the impact of the National Health Service on health in the light of data on access to care under the National Health Service.

PROBLEMS IN THE MEASUREMENT OF CLASS DIFFERENCES IN HEALTH

Mortality Rates: Reliability and Validity

Due in part to a pre-occupation with mortality data and, until recently, a relative neglect of morbidity patterns, existing measures of the health levels of populations are generally inadequate. As

White argues:

> Health statistics have been used over many years for administrative purposes, but no country, as yet, has a comprehensive health statistics system. Most emphasis has been placed on vital statistics, and particularly on death statistics. Modest emphasis has been placed on measurements of disease through sickness surveys and epidemiological studies of specific diseases.[1]

Health levels have traditionally been measured through the calculation of life expectancies, crude and age adjusted death rates, and infant mortality rates. The reliability and validity of these measures is open to question. Inaccuracies occur in reporting and diagnosing the cause of death: the quality of diagnosis has been shown to vary for urban and rural areas and for different age groups; and there is evidence that socially unacceptable diseases are inaccurately recorded for higher status groups. However, given such limits to precision, the reliability of these ~~data~~ is generally viewed as acceptable.[2]

What is more open to question is the validity of using such measures as an indication of the health levels, and by implication, the needs for health care of a given population.[3] The assumption is often made that changes in mortality rates reflect changes in other aspects of a population's health. But the need for an index based on the health characteristics of the living as well as on mortality has become apparent. The death rate tells us little about the living. For example, mortality rates for the U.S.A. have stabilized after declining in the first half of this century, whereas morbidity rates have been increasing.[4] People with chronic illnesses who once would

have died at a relatively early age are now having their lives prolonged by new drugs and treatments. Thus, the incidence of chronic disease increases, yet an index of health based on mortality alone shows us nothing of such changes in the health of the living.

Since improved medical knowledge and treatment have changed patterns of health, a greater emphasis is being placed on morbidity data in the measurement of health levels. The reliability and validity of these data is, however, more open to question than is the case with mortality data.

Morbidity Data: Reliability and Validity

The most simple approach to the measurement of morbidity focuses on demands for medical care and use of services. This is clearly inadequate. As Feldstein argues, ". . .need is generated by the incidence of illness while demand is generated by the interrelationship of illness with other factors."[5] Such data do not allow for those instances in which a need for care is not translated into a demand for care--for reasons such as the costliness of care, fear of the diagnosis, or failure to realize the appropriateness of receiving medical help.

In an effort to obtain data which will more nearly reveal needs for health care, various survey techniques have been used by some researchers. These may involve medical examinations or else focus on the subjects' own reporting of symptoms and resulting disability. A greater emphasis on disability has stressed the personal and social consequences of disease, and measures dimensions of illness which are

important to the individual, but may not be indicated by clinical diagnoses.

But though survey techniques based on clinical diagnoses and disability do more clearly indicate health levels, they cannot be regarded as providing a full measure of health needs. Clinical examinations reveal more morbidity than is reported in interviews, but these are time consuming and costly, and only a limited number of examination procedures can be accommodated in any survey based on clinical diagnosis. In addition to morbidity being under-reported in surveys, the reliability of survey reported illness seems to be affected by such things as the length of time between interviews, by the episodic nature or social undesirability of the conditions experienced, by interviewer variability, and by differences in questions and instruments of data collection. Furthermore, those studies which concentrate on disability are faced with the problem that disability can be affected by the same factors which help determine whether an individual will seek medical care. An inability to fulfill the requirements of one's roles, on either a long or short term basis, reflects decisions which

> take into account such factors as need for income, availability of sick leave, pensions and other supports during illness, and the amount of physical effort involved in the individual's occupation and other activities.[6]

However, there is only infrequent evidence of class differences in the reliability and validity of morbidity data.[7] Such differences as are reported derive from the sources of data used: community health surveys and examinations tend to favour more observed conditions

among the middle class, while reliance on the records of public facilities seems to increase the observed morbidity of the poor. Insofar as such biases affect the morbidity data reviewed below, they are likely to err on the side of the middle class since none make use of such public records of morbidity.

Summary

There are no generally reliable and valid measures of health needs at present, but since it is important that we have some indication of social class variations in health, we have to rely on the best available data. Data on both mortality and morbidity are discussed below. Our concern here is with differences in health levels and needs for medical care, between persons from different social classes. Given this emphasis on differences rather than absolute levels, mortality rates are an important source of data. And a fuller picture is obtained when these are supplemented with morbidity data. The morbidity data discussed are mainly from surveys focusing on disability and reports by subjects on symptoms experienced. The limitations of these various measures must, however, be borne in mind.

CLASS DIFFERENCES IN MORTALITY

Infant Mortality

Infant mortality rates, in particular post neo-natal mortality rates, are perhaps the most sensitive indicators of class differences in health levels and needs for care. A variety of studies have shown continuing class differentials with respect to infant mortality.

Looking at data since 1911, it can be seen that rates have declined for all classes, but the differences have remained almost constant up until the mid-1960's.

Data on neo-natal deaths (deaths which occur in the first month of life) and post neo-natal deaths (those occurring between four weeks and one year of age) are presented in Table 2. Rates per one thousand legitimate live births are presented for England and Wales in relation to father's social class for selected years between 1911 and 1949.[8] The decrease in rates from 1911 to 1949 is also expressed as a percentage of the 1911 rates. This latter calculation facilitates a comparison of the changes in mortality rates for each of the social classes.

With respect to neo-natal death rates, there is a clear reduction in these for each social class: taking the two extremes of the class hierarchy, we see that the rate for class I fell from 26.8 in 1911 to 13.5 in 1949-50 while that for class V dropped from 42.5 to 21.9 during the same period. The percentage decrease varied little between classes though the improvement was greatest in class II (54.0 per cent decrease), and least in class V (48.5 per cent decrease). The class differentials observable in 1911 did, therefore, continue almost unchanged through the years to 1949-50: in 1911, the rate for class V was 62.2 per cent higher than that for class I while in 1949-1950 it was 58.6 per cent higher. More recent data for 1964 indicate a continuation of these patterns of neo-natal mortality with a slightly greater degree of improvement occurring in classes I and II.[9]

TABLE 2.-- Neo-natal and post neo-natal mortality rates per 1,000 legitimate live births, by father's social class, England and Wales, for selected years 1911-1950

Father's Social Class	Neo-natal Deaths					Per cent * Decrease From 1911 To 1949-1950
	1911	1921	1930-32	1939	1949-50	
I. Professional	26.8	23.4	21.7	18.9	13.5	49.6
II. Intermediate	34.8	28.3	27.3	23.4	16.0	54.0
III. Skilled workers	39.6	33.7	29.4	25.4	17.8	52.5
IV. Partly skilled workers		36.7	31.9	27.7	19.9	
V. Unskilled workers	42.5	36.9	32.5	30.1	21.9	48.5
All classes	39.1	33.9	30.2	26.4	18.2	53.5

Father's Social Class	Post Neo-natal Deaths					Per cent * Decrease From 1911 To 1949-1950
	1911	1921	1930-32	1939	1949-50	
I. Professional	28.3	15.0	11.0	7.9	4.9	82.7
II. Intermediate	63.2	27.1	17.8	11.0	5.9	89.1
III. Skilled workers	85.8	43.2	28.2	19.0	10.5	85.7
IV. Partly skilled workers		52.7	34.9	23.7	14.1	
V. Unskilled workers	110.0	60.2	44.6	30.0	17.9	83.7
All classes	85.8	45.3	31.4	21.0	11.1	87.1

* Calculated from rates in table.

Source: J.N. Morris and J.A. Heady, "Social and Biological Factors in Infant Mortality: V. Mortality in Relation to Father's Occupation, 1911-1950," in Lancet, (March 12, 1955), p.554.

A much more marked reduction in rates is evident with respect to post neo-natal mortality. The rate for class I fell from 28.3 in 1911 to 4.9 in 1949-50 and that for class V from 110.0 to 17.9 during the same period. There was relatively little difference in the percentage decrease in rates for each of the social classes--with the exception of that for class II which was somewhat higher than that for other classes. As in the case of neo-natal mortality rates, class differences remained very similar between 1911 and 1949-50, but the magnitude of these differences is considerably greater in the case of post neo-natal rates. In 1911 the rate for class V was 288.7 per cent higher than that for class I, while in 1949-50 it was 265.3 per cent higher. Data for 1964 indicates a further reduction in rates, but no marked narrowing of class differences.[10]

The same pattern as we perceive for neo-natal and post neo-natal mortality--a reduction in rates, but no reduction of class differences--is also evident when we look at data on stillbirths. Table 3 indicates still birth rates for 1939 and 1949 and the percentage decrease in rates which occurred during this period. In both years, there is a clear inverse relationship between rates and social class. The percentage decrease in rates over the ten year period was highest in class I (39 per cent) and lowest in class V (30 per cent) with intermediate classes showing little variation. Data for 1964 indicate a further reduction in these rates with the most marked changes occurring in classes I and II, and the least in classes IV and V.[11] Not only have class differences persisted in spite of

TABLE 3.--Still birth rates (per 1,000 single legitimate births) standardized for mother's age and parity and percentage decrease from 1939 to 1949; England and Wales 1939 and 1949

	Father's Social Class				
	I	II	III	IV	V
1939	23.4	29.3	33.2	36.3	37.2
1949	14.3	18.9	21.5	23.2	26.0
Per cent Decrease	39	35	35	36	30

Source: J.N. Morris and J.A. Heady, "Social and Biological Factors in Infant Mortality: V. Mortality in Relation to Father's Occupation, 1911-1950," in Lancet, (March 12, 1955), p.558.

TABLE 4.--Standardized mortality ratios for males by social class: England and Wales, 1930-32, 1949-53, and 1959-63

	Social Class					
	I	II	III	IV	V	Excess V/I * Per Cent
1930-32	90	94	97	102	111	23.3
1949-53 (published)	98	86	101	94	118	20.4
1949-53 (adjusted)	86	92	101	104	118	37.2
1959-63	76	81	100	103	143	88.2

* Calculated from table.

Source: Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1961. Occupational Mortality Tables. (London: H.M. Stationery Office, 1971), Table D4, p. 22.

generally lowered rates, these differences have become somewhat more marked in the 1950's and 1960's.

Adult Mortality

Adult mortality data also show a growing disparity in the mortality experience of different social classes. The most recent mortality data published by the General Register Office are summarized in Table 4 in which standardized mortality ratios for males by social class are presented for three periods: 1930-1932, 1949-1953, and 1959-1963. Since the occupations comprising each of the social classes were modified for the last census period, the 1949-1953 rates are presented for both the old and new classifications. It is clear from this table that the benefits of the relative prosperity of the late 1950's and the early 1960's were not enjoyed by lower class persons: the differences in ratios between classes I and V were markedly greater in 1959-1963 than in 1949-1953. The earlier period, between 1930-1932 and 1949-1953, brought a slight reduction in differences in ratios for classes I and V, but these gains were probably lost by 1959-1963 when the ratio for class V was 88.2 per cent greater than that for class I.

Mean annual death rates per one hundred thousand men by age and social class for 1930-1932 and 1959-1963 indicate an improvement in younger age groups for all social classes, though the reduction in rates is less marked for class V. This improvement continues in varying degree for older males in classes I, II, and IV. For class III, there is, however, an absolute increase over 1930-1932 rates for men

over sixty-five and in class V for men over fifty-five.[12] These data should be interpreted with caution since they do not incorporate adjustments for classification changes between the two periods. However, 1959-1963 rates adjusted to the 1950 classification were 102 per cent, 103 per cent and 107 per cent higher than 1949-1953 rates for class V men aged fifty-five to sixty-four, sixty-five to sixty-nine, and seventy to seventy-four years respectively.[13] It is clear, therefore, that while rates for men in each class at all ages have improved, the difference between classes I and V has widened considerably and there has been an absolute increase in rates for certain age groups in class V. By way of an example of the relative absence of change, the Registrar General's Supplement comments:

> It is interesting to note that in 1860-1861 the death rate among miners of ages 45-54 was 115 per cent of that of all men at those ages whilst in 1959-1963 the ratio was 112 per cent.[14]

This persistence of class differences in mortality rates may be further illustrated by mortality rates analysed by cause of death. Four diseases have traditionally been associated with poverty: respiratory tuberculosis, rheumatic heart disease, bronchitis, and cancer of the stomach. Table 5 presents standardized mortality ratios for deaths from these and all causes for 1930-1932 and 1950, and also indicates the percentage difference in ratios between classes I and V for each period and each cause of death. Adult males in class V compared with those in class I had a far greater chance of dying of one of the four diseases. This pattern is evident in both 1930-1932 and 1950. Furthermore, comparing the differences between classes I and V

TABLE 5.--Standardized mortality ratios for death from four causes and all causes for adult males aged 20-64 years by social class, England and Wales 1930-32 and 1950

Cause of Death and Year	Social Class I	II	III	IV	V	Excess V/I Per Cent
Respiratory t.b.:						
1930-32	61	70	100	104	125	205
1950	64	62	103	95	149	233
Rheumatic heart disease:						
1930-32	65	92	97	111	112	173
1950	61	87	103	102	114	187
Bronchitis:						
1930-32	31	57	91	124	156	503
1950	33	53	97	103	172	521
Cancer of the stomach:						
1930-32	59	84	98	108	124	210
1950	57	67	100	114	132	232
All causes:						
1930-32	90	94	97	102	111	123
1950	97	86	102	94	118	122

Source: J.N. Morris and J.A. Heady, "Social and Biological Factors in Infant Mortality: V. Mortality in Relation to Father's Occupation, 1911-1950," in Lancet, (March 12, 1955), p. 557.

for the two time periods, we see that they were somewhat greater in 1950 than in 1930-1932 for each of the causes of death.

Death rates from some other causes are, however, higher in social classes I and II. For example, higher social classes are more prone to death from poliomyelitis, leukemia, cancer of the breast and the prostrate, and cirrhosis of the liver.[15] But patterns of mortality do appear to be changing: positive mortality gradients (where rates are high in low social classes) now extend to diabetes, vascular lesions of the nervous system, and coronary disease;[16] and whereas there was no social class trend in deaths from lung cancer and duodenal ulcer in the mid 1930's, there was twenty years later a clear trend of increasing mortality with declining social class.[17]

These data indicate growing disparities in the mortality experience of the classes. Class differentials have increased slightly for those diseases traditionally linked with poverty. At the same time, lower classes are becoming increasingly susceptible to death from causes normally associated with class I. And for some diseases where once there were no class differences in mortality, rates are becoming proportionately higher for lower classes.

Finally, we may note the changing class differences in standardized maternal mortality ratios. Data for 1949-1953 and 1962-1963 indicate positive mortality gradients and increasing class differences: in 1949-1953 the ratio for class V was 94.1 per cent greater than that for class I, and in 1962-1965 the difference had increased to 223.6 per cent.[18]

Summary

Both infant and adult mortality data indicate positive mortality gradients: infant mortality rates show persistent class differences while adult mortality rates suggest a growing disparity in the mortality experience of different social classes. With few exceptions, mortality rates have decreased through the 1930's to the early 1960's, yet the decline in rates for adults in class I have beem more marked than those in class V. Since our main aim in this chapter is to provide a framework for the discussion of class differences in the use of health services, we will simply note these variations in class mortality rates. They have been interpreted in terms of the biological inferiority of the working class;[19] the environment in which the working class lives and works;[20] the low level of education of the working class;[21] and social processes which tend to select individuals with special traits (in this case, good or bad health) for upward or downward mobility, so that particular social classes may have a predominance of persons with good or bad health.[22] However, we will not at this point explore such explanations of positive mortality gradients. In our present effort to understand variations in needs for health care between different social classes, it is sufficient to note the existence of positive mortality gradients. But, as indicated earlier, it is necessary to examine morbidity data also in order to paint a more realistic picture of health needs. We turn now to a review of such data.

CLASS DIFFERENCES IN MORBIDITY

Since a certain amount of illness will never be seen by doctors, reliance on morbidity data based on treatments received from doctors and hospitals will lead to an underestimation of morbidity. We must, therefore, in seeking to determine class differences in needs for health care concentrate on survey data. An estimate of the discrepancies in data collected by these two methods suggests that in England and Wales there are

> over two million with hypertensive heart disease, nearly half a million women with urinary infections, three hundred thousand rheumatoid arthritics, an equal number of glycosurics, six hundred thousand bronchitics, and perhaps one and a half million people with conspicuous psychiatric disturbances. And none in receipt of medical treatment.[23]

We will, therefore, limit ourselves to presenting survey data on morbidity since these will include illnesses never presented to doctors. There is, however, relatively little such data and almost nothing since 1952 which analyses results in terms of social class. This absence of class morbidity data may be a further indication of the relative complacency as to the extent to which the National Health Service meets the health needs of different social classes.

Childhood Morbidity

Concerning ourselves with children first, there are two main surveys providing information on morbidity: one, a national study of children born during the first week of March, 1946,[24] the other, a survey of children born to mothers resident in the city of Newcastle-

upon-Tyne in May and June, 1947.[25] Both reports indicate a rise in the incidence of infective illness from classes I to V in the first two years of life. This is for all respiratory infections and is most evident where infective illnesses were multiple or recurrent. The incidence of tuberculosis was not related to social class.

The national study by Douglas and Blomfield shows that colds and lower respiratory tract infections were more common among children of lower social class. These differences were more marked for the latter infections, particularly during the first nine months of life when they are most dangerous. There were no marked class variations in the incidence of the usual infectious diseases of childhood, though children of manual workers were more likely to get measles and whooping cough in early infancy when the chances of death are greater. Such differences do explain, in part, the higher rates of infant mortality for the lower classes. The follow-up studies in this continuing research concentrate on factors affecting educational achievement, and there is very little emphasis on health. But, as measured by absences from school, there appeared to be no class differences in the health of the children.

Adult Morbidity: The Survey of Sickness

With respect to adults, one major source of morbidity data exists: the government Survey of Sickness which started in 1943 and continued until 1952. At first, this covered a representative sample of the population aged 16 to 64 years. From December, 1944, it was

extended to include persons 65 years of age and over. The data published from this survey are not analysed in relation to social class. However, the data are presented with reference to the respondents' income level and occupation. These two variables we will use as indices of social class.

Data from the earlier years of the survey indicate an inverse relationship between income level and illness. During the period from February to April, 1945, 82.41 per cent of the lowest income group reported illness, while 77.37 per cent of the highest income did so.[26] But when these data are analysed by occupational group, there are no clear and consistent differences in the proportion of subjects who had been ill.[27]

In subsequent years, more sophisticated measures of morbidity were employed in the Survey of Sickness. A person was considered ill if he felt ill, but different dimensions of illness were conveyed through three different measures: the sickness rate was defined as percentage of people reporting some illness or injury in a month; the prevalence rate was defined as the number of illnesses or injuries per 100 persons in a month (this can exceed 100); and the incapacity rate indicates the number of days off work or confined to the house in a month per 100 persons interviewed.

Data for January, 1946 indicate no clear pattern in the morbidity experience of different occupational groups--the two highest status groups do not have sickness, prevalence or incapacity rates which are consistently lower than the blue-collar groups. The highest

sickness rates are experienced by the mining and quarrying group, and the retired and unoccupied; the particularly high rate for the former is reflected in the high incapacity rate for this group. But it is the retired and unoccupied who have the highest prevalence rate--suggesting that sickness is a more pervasive feature of life for these people with greater experience of recurring illness.[28]

Data for the remaining years of the survey are more suggestive of a relationship between social class and morbidity. However, differences which exist between high and low income groups become less marked when the data are analysed by occupational status. If income is used as an index of social class, then the differences between the highest and lowest social classes are greater than when occupation is used as an index. This may be because sickness tends to push people into lower income groups temporarily: low income is in part a result of illness. Long term, chronic, or recurrent illness may result in downward occupational mobility. But while ill health is less likely to affect occupational status than income level, the effects of downward occupational mobility may be more permanent.

For example, during 1947, 1949, and 1951, persons in lower income groups had higher sickness prevalence and incapacity rates than those in higher income groups.[29] But during the same years, there were no marked differences in sickness and prevalence rates for different occupational groups.[30] One persistent difference remains in an occupational analysis: incapacity rates are generally lower for non-manual workers than for those in manual occupations and in the

retired and unoccupied category. From July, 1947 to June, 1949, for example, incapacity rates were nearly 40 per cent higher for manual workers than for those in non-manual occupations.[31] For lower status occupational groups and for the retired and unoccupied, illness appears to be of greater severity and longer duration than for those of higher occupational status. This will, in part, be a reflection of the downward mobility experienced by those with chronic illness, and it can also be explained in terms of occupational health hazards and social class influences. The relative importance of each of these factors in explaining differences in incapacity rates is not clear. However, the very existence of a difference in rates is suggestive of a greater need for health care among persons of lower occupational status.

To summarize, no consistent variations in morbidity are evident in these data from the Survey of Sickness. Differences which are apparent when the data are analysed by income are less marked in an occupational analysis. However, the information relating to the later years of the survey does give some indication of a greater amount of ill health among lower status persons, and suggests that when lower class persons are ill, their symptoms are likely to be more severe than those of persons in higher social classes (reflected in the greater disparities in incapacity rates). Jewkes notes that absences from work are higher where sick benefits and/or wages are paid during periods of disability, and that they tend to increase with the generosity of sickness payments.[32] But this observation cannot be used to explain the higher incapacity rates of lower class workers. It is

these workers who are most likely to experience severe financial problems as a result of disability.[33]

Adult Morbidity: Other Studies

In addition to the Survey of Sickness, there are a few studies which provide less extensive data on the morbidity of different social classes. A random sample of the population of Lambeth found no significant class relationship in the prevalence of disability among men. But for women, there was a significant increase in the number of disabled in lower social classes.[34]

A P.E.P. survey in mid-1957 in Northampton and the Greater London area asked a random sample of mothers whether they thought their health was good. The percentages who believed their health was not too good increased with decreasing occupational status: 11 per cent of the managerial and professional category felt their health was not too good; 14 per cent of the supervisory, technical and clerical personnel; 17 per cent of the skilled worker, and 27 per cent of the unskilled worker categories.[35]

The College of General Practitioners' study of the incidence of chronic bronchitis among men and women aged 45-64 years has also shown class differences.[36] The study revealed a greater incidence of bronchitis among lower class persons, the difference being only partly explained by differences in smoking habits. Even when more rigid criteria of classifying bronchitics were used, the social class gradient was still obvious. On the basis of their results, the authors

suggest that the social class gradient in mortality from bronchitis is unlikely to be due to differences in the diagnostic skills or habits of the doctors certifying death. But it should not be assumed that there is a simple causal relationship between low social class and the incidence of bronchitis. A study by Meadows has shown that bronchitic hospital patients are more likely to be downwardly mobile than persons without bronchitis.[37] Such mobility may account for some of the excess morbidity and mortality in lower social classes.

Data published by Morris suggest a relationship between incapacity for work and poor social conditions.[38] Morris has matched the sickness index for insured males (which refers to the number of days of incapacity for work) against an index of local social conditions for selected county boroughs in England. This latter index draws on data on overcrowding, unemployment, and the proportion of people in the lower social classes: the higher the figure, the worse the social conditions. Unfortunately, we are given little information on the compilation of this index and no indication of the basis on which the county boroughs were selected.

Summary

It is frequently assumed that morbidity is inversely related to social class. The data reviewed above do not indicate such a clear relationship, and the paucity of morbidity data, particularly for the 1950's and 1960's, prohibits the development of well reasoned arguments for such a relationship. However, the data published by

the General Register Office suggests that persons in higher status occupations (classes I and II) are slightly less likely to be sick, and when they are sick, are likely to be incapacitated for a shorter period of time than people in lower status occupations (classes IV and V). Other studies also suggest that morbidity may be inversely related to social class. However, these studies are few in number. Insufficient attention has been directed toward class variations in morbidity patterns. We have little understanding of class differences in the incidence of different illnesses and no indication of variations in class morbidity experience over time. Furthermore, though there is evidence suggestive of more severe and prolonged morbidity among lower class persons, we have limited understanding of the reasons for this--of the extent to which it can be explained in terms of general social class influences, of the downward mobility of the chronic sick, or in terms of occupational health hazards.

But since our concern is with establishing class variations in needs for health care, this inability to fully explain variations in health levels is not crucial. It is sufficient at present to note that the available data indicate somewhat more severe illness among lower class persons, and by inference, somewhat greater needs for health care.

CONCLUSION

This chapter has explored class variations in needs for health care. While recognizing the problems of reliability and validity

which are associated with mortality and morbidity data, the above review suggests greater needs for health care among lower class persons. Class mortality rates have generally declined since the earlier decades of the century, but there has been no improvement in rates for class V relative to those for class I. Indeed, the most recent occupational mortality data indicate a growing disparity in the rates for these classes, and suggest that socialized medicine has failed to reduce class inequalities in health.

A reduction in mortality rates may be accompanied by an increase in the incidence of chronic illness. Since mortality rates for class I are lowest and have shown most marked improvements, it might, therefore, be supposed that the incidence of chronic illness is greater in class I. But the data reviewed above do not bear out this supposition. Rather, it appears that people of lower income and in lower status occupations are those most likely to experience illnesses of longer duration.

The proportion of symptoms resulting in disability which are such as to require medical care is not clear, but some are undoubtedly not in need of professional diagnosis and treatment. The reporting of illness and incapacity cannot necessarily be equated with a need for medical care. However, in the absence of more sophisticated measures of needs for health care, we must rely on the clues provided by existing morbidity and mortality data. The following chapter is concerned with access to general practitioner care, and the data on rates of consultation will be discussed in the light of an apparently greater need for medical care on the part of working class patients.

FOOTNOTES

[1]K.L. White, "International Comparisons of Health Services Systems," The Milbank Memorial Fund Quarterly, Vol. 46, No. 2, (April, 1968), p. 119.

[2]For a discussion of reliability and validity of mortality and morbidity data see, Paul W. Haberman, "The Reliability and Validity of the Data," Poverty and Health, J. Kosa et al., (Cambridge, Mass.: Harvard University Press, 1969).

[3]For a discussion of methodological problems in developing indices of health, see: U.S. Department of Health, Education, and Welfare, Public Health Service. National Centre for Health Statistics. "Conceptual Problems in Developing an Index of Health," Vital and Health Statistics Series 2, No. 17. (Washington, D.C.: Government Printing Office, 1966), p. 14.

[4]H.M. Somers and A.R. Somers, Doctors, Patients and Health Insurance (Washington, D.C.: The Brookings Institution, 1961).

[5]P.J. Feldstein, "Research on the Demand for Health Services," The Milbank Memorial Fund Quarterly, Vol. 44, No. 3, (July, 1966), Part 2, p. 141.

[6]United States, National Centre for Health Statistics, op. cit.

[7]Haberman, op. cit., p. 383

[8]For a discussion of the Registrar General's definition of the social classes, see Appendix B.

[9]Great Britain, General Register Office, Regional and Social Factors in Infant Mortality, by C.C. Spicer and L. Lipworth. Studies in Medical and Population Subjects, No. 19. (London: H.M. Stationery Office, 1966), p. 15. There was a 38 per cent decrease in neo-natal mortality rates for classes I and II, and a 30 per cent decrease for classes IV and V between 1949 and 1964.

[10]Ibid. For classes I and II, there was a 52 per cent decrease in post neo-natal mortality rates and for classes IV and V, a 56 per cent decrease between 1949 and 1964.

[11]Ibid. Between 1949 and 1964, there was a 41 per cent decrease in stillbirths in classes I and II, and a 23 per cent decrease in classes IV and V.

[12]Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1961. Occupational Mortality Tables (1971) (London: H.M. Stationery Office, 1971), Diagram 2, p. 28.

[13]Ibid., Table D6, p. 24. [14]Ibid., p. 1

[15]M.W. Susser and W. Watson, Sociology in Medicine (London: Oxford University Press, 1971).

[16]Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1961, op. cit.

[17]"Health and Social Class," Lancet i (February 7, 1959), pp. 303-305.

[18]For 1949-53 data, see: Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1951. Occupational Mortality, Part II, Vol. 2, Tables. (London: H. M. Stationery Office, 1957), Table 8A, p. 346.
For 1962-65 data, see: Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1961, op. cit., Table 6A, p. 503.

[19]R.M. Titmuss, Birth, Poverty, and Wealth (London: Hamish Hamilton Medical Books, 1943).

[20]M.W. Susser and W. Watson, op. cit.

[21]"Health and Social Class," Lancet i, op. cit.

[22]R. Illsley, "Social Class Selection and Class Differences in Relation to Stillbirths and Infant Deaths," British Medical Journal, Vol. II, No. 2, (1955), pp. 1520-1524.

[23]G. Forsyth, Doctors and State Medicine: A Study of the British Health Service (London: Pitman Medical Publishing Company, Limited, 1966).

[24]J.W.B. Douglas and J.M. Blomfield, Children Under Five (London: George Allen and Unwin Limited, 1958).

[25]J. Spence et al., A Thousand Families in Newcastle-upon-Tyne (London: Oxford University Press, 1954). And F.J.W. Miller et al., Growing Up in Newcastle-upon-Tyne (London: Oxford University Press, 1960).

[26]Great Britain, Government Social Survey, Survey of Sickness: October, 1943 to December, 1945, by P. Slater (London: H. M. Stationery Office, 1946), Table 7, p. 22.

[27]Ibid., Table 6, p. 21. [28]Ibid., Appendix C, p. 72.

[29]Great Britain, General Register Office, The Survey of Sickness, 1943-52, by W.P.D. Logan and E.M. Brooke. Studies in Medical and Population Subjects, No. 12. (London: H.M. Stationery Office, 1957), p. 57.

[30]Ibid., Table 7, pp. 50-51.

[31]W.P.D. Logan, "Illness, Incapacity and Medical Attention Among Adults, 1947-49," Lancet i (April 22, 1950), p. 775.

[32]J. Jewkes and S. Jewkes, Value for Money in Medicine (Oxford: Basil Blackwell, 1963).

[33]A. Cartwright, Human Relations and Hospital Care (London: Routledge and Kegan Paul, 1964). It may be that people in higher status occupations are more motivated to return earlier to their work (which is often more congenial) and that they are, therefore, "incapacitated" for shorter lengths of time. But the financial problems of workers in lower status occupations may counteract this effect.

[34]A.E. Bennet, J. Garrad, and T. Halil, "Chronic Disease and Disability in the Community: A Prevalence Survey," British Medical Journal, Vol. 3, No. 2 (1970). Disability was defined as the inability to perform unaided certain defined activities essential to daily life; for example, walking, getting in and out of bed, dressing, shopping, and holding an unmodified job in open industry appropriate to the individual's age, sex, and skill.

[35]Political and Economic Planning, Family Needs and the Social Services (London: Allen and Unwin, 1961).

[36]College of General Practitioners, "Chronic Bronchitis in Great Britain," British Medical Journal, Vol. 2, No. 2 (1961).

[37]S.H. Meadows, "Social Class Migration and Chronic Bronchitis," British Journal of Preventive and Social Medicine, Vol. 15, No. 4, (1961).

[38]J.N. Morris, "Priorities in the Health Service," in The N.H.S.: Three Views by P. Draper, M. Kogan, and J.N. Morris, (London: Fabian Society, Fabian Research Series, No. 287, 1970), Table 11, p. 6.

CHAPTER VII

PHYSICIAN CARE

Introduction

The assumption that welfare services and programmes operate in a manner such as to reduce class inequalities leads us to predict that the introduction of socialized medicine achieves a narrowing of class inequalities in access to health care. For though both marxist and pluralist theories have recognized the persistence of class inequalities, these are seen as being somewhat less severe than they were in the decades prior to the emergence of the welfare state. In this and the following chapters, we seek to assess the impact of the National Health Service on class variations in access to care and the nature of inequalities under this system of socialized medicine. Unfortunately, there is relatively little information on the use of health services prior to 1948, and for this reason, our major emphasis is on the nature of class inequalities within the National Health Service.

We will examine variations in access to physician hospital, and dental services--three major sources of care within the National Health Service. Our definition of access to care includes rates of use of medical services by different social classes and also variations in the quality of care received. It is possible, for example, that rates of use of services reflect the differing mortality and morbidity experience of the classes, but that differences in the

quality of care are such as to place middle class patients in an advantageous position.

This present chapter is concerned with access to general practitioner care. The general practitioner is the cornerstone of the National Health Service: he provides first contact care and where necessary refers patients to specialists or admits them to hospital. Consultations with specialists can only be obtained by referral from a general practitioner. Over 95 per cent of the population is registered with a general practitioner under the National Health Service. Assuming that socialized medicine achieves a closer correspondence between needs for care and consultations with doctors, we would predict a change in this direction after the introduction of the National Health Service. And if socialized medicine creates equality of access to care, we would expect, bearing in mind the apparently greater health needs of lower class families, higher rates of consultation with a general practitioner on the part of classes IV and V. Furthermore, we would expect no variations in the quality of care received.

The first part of this chapter reviews data on rates of consultation with general practitioners; the latter part considers variations in the quality of care received by patients of different social class. We will argue that:

1. Though there is some suggestion that middle class patients made more frequent use of general practitioner services before 1948, we cannot rely too heavily on these data since others indicate that low income groups made greatest use of general

practitioner services. Thus the impact of the National Health Service is unclear.

2. Increases in consultation rates among lower income groups after 1948 may be inexplicable in terms of the introduction of the National Health Service.
3. While the majority of the working class appear to make more frequent use of general practitioner services than do middle class patients, this relatively equal access may not be intelligible simply in terms of the introduction of a system of socialized medicine. It may also be explained by reference to the critical role of the general practitioner within the service.
4. Middle class patients may receive care of better quality than that obtained by working class patients.

Thus, we question the degree of importance which may be attached to socialized medicine as a means of achieving equal access to care. But let us first review the data which exist on the use of physicians' services by patients of different social class.

USE OF GENERAL PRACTITIONER SERVICES

Children

Studies of the care received by children from general practitioners indicate that the advent of the National Health Service brought about a change for some social classes in the sources from which they received primary medical care. It appears that children from working

class families had more ready access to general practitioner care after 1948. Prior to the introduction of the National Health Service, they had made frequent use of hospital outpatient departments, child welfare centres, and health visitors, but after 1948, they were channelled directly to general practitioners for first contact care. But the working class is not homogeneous in this respect. This change in the source from which care was obtained does not seem to have occurred among some sections of the working class: children of unskilled and agricultural workers are less likely to consult a general practitioner than children from any other social class. It is not clear whether care from other sources substitutes for this low use of general practitioner services.

In addition to the studies by Spence,[1] Miller,[2] and Douglas and Blomfield,[3] data are available from General Register Office statistics from general practice.[4] Spence's study of children born in Newcastle-upon-Tyne in mid-1947 shows the different sources from which children obtained care prior to the introduction of the National Health Service. Children from higher status families were more likely to consult a general practitioner--those whose fathers were in business or professional occupations were attended by a doctor for 63 per cent of their illnesses while the comparable figure for the children of men in semi-skilled and labouring work was 50 per cent.[5] Lower status families were more likely to turn to hospital outpatient departments in the event of illness--the children of men in semi-skilled and labouring jobs were over three times as likely as those of men in

business and professional occupations to receive outpatient care at a hospital.[6] These data are not unexpected. Since compulsory health insurance did not provide medical benefits for dependents, the cost of a doctor's services would undoubtedly act as a deterrent for some lower class patients. Instead, it was in the outpatient departments, the "mammoth shops, run by underpaid doctors for the mass treatment of symptoms with free bottles of medicine," that the poorer sections of the population had traditionally received their medical care.

A later study of these children, covering the period up until 1952, analyses health and utilization data mainly in terms of age rather than class.[7] However, the authors do indicate that the negative relationship between social class and use of outpatient services disappeared after the first year of life. This is undoubtedly a result of the National Health Service--from 1948, outpatient care was available only through referral from a general practitioner or on an emergency basis.

The study by Douglas of a national sample of children born in March, 1946 also indicates class variations in the use of doctors' services. Of children with lower respiratory tract infections, more than twice as many from families of manual workers as from those of professionals were likely to receive no professional medical care. But the proportions in each class are relatively small: 3 per cent of children from the professional and salaried group and 7.9 per cent of those whose fathers were semi- and unskilled workers received no treatment.[8]

We noted, when discussing morbidity, that there were no class differences in the incidence of infectious diseases of childhood. However, the proportion of children receiving treatment for such diseases was greater among the higher social groups: 98.2 per cent of children with fathers in the professional and salaried group were seen by a doctor when they had measles, compared with 87.5 per cent of those whose fathers were manual workers. Clearly, children with fathers in higher status occupations were most likely to receive professional medical care though the differences between the groups are not great. One interesting observation which Douglas makes is that fewer of the deaths of children from families which make relatively little use of medical services occurred in hospital. This, together with the higher death rates, would suggest that these parents sought medical advice at a later stage in the child's illness than did the other parents. But whether this was because they failed to recognize serious illness, because they preferred to rely on lay advice, or because doctor's services were too expensive and they were reluctant to accept charity, is not clear.

The data on Newcastle and those from the Douglas studies straddle the period during which the National Health Service was introduced, and it is difficult to tell whether the increased availability of medical care at no cost led to any change in the use of doctors' services. It is not clear whether the class differences noted by Douglas continued after 1948 or whether the data average out considerable differences in rates of use before 1948 and minimal ones after

that date. But if we compare the above data with those from a study of general practice published by the General Register Office, then it appears that some benefits have accrued to the children of lower class parents.

The information which is presented in Table 6 was collected in a study of seventy-six practices (covering nearly 120 general practitioners) between May, 1955 and April, 1956. The patient consulting rate indicates the number of patients per one thousand who had one or more consultations with a general practitioner during the study period. It does, therefore, tell us something about the proportion of patients in each class who received treatment, but nothing about the frequency with which doctors were consulted by these patients. No consistent relationship is evident between use of general practitioner services and social class. The rate for children of skilled workers is highest, and while the differences between the other classes are small, the lowest of these is that for class I. If, instead of looking at the rates for each class, we look at the breakdown in rates for classes III, IV, and V, some wide variations can be seen. This is most marked in class IV: the rate is very low for the children of agricultural workers, but higher than any other class or socio-economic group (except the clerical) for other semi-skilled workers. The rate for children of unskilled workers, other than building and dock labourers, is also rather low.

On the basis of these data for children, it appears that the families of clerical workers and, more obviously, skilled and semi-

TABLE 6.--Patient consulting rates for children under 15 years by social class of father with occupational breakdowns for classes III, IV, and V, May, 1955-April, 1956

Class	Father's Occupational Group	Patient Consulting Rates*	
I	Professional, managerial	671	
II	Intermediate	680	
III	Skilled:		
	(a) Mineworkers		707
	(b) Transport workers		712
	(c) Clerical workers		727
	(d) Others		722
	(e)		
IV	Partly skilled:	679	
	(a) Agricultural workers		591
	(b) Others		723
V	Unskilled:		
	(a) Building & dock Labourers		695
	(b) Others		654
All Classes		699	

*The number of patients per 1,000 who had one or more consultations with a general practitioner.

Source: Great Britain, General Register Office. Morbidity Statistics from General Practice, by W.P.D. Logan and A.A. Cushion. Studies in Medical and Population Subjects, II, No. 14, Occupations, (London: H.M. Stationery Office, 1960), p. 151.

skilled workers in non-agricultural work may have consulted with general practitioners more frequently after the introduction of the National Health Service. Before 1948, these groups made quite frequent use of hospital outpatient departments, child welfare centres, and health visitors. The extension of free doctors' services to all appears to have altered patterns of consumption of medical care by enabling parents in these groups to consult general practitioners more readily about their children's illnesses. But these changes have had no obvious impact on patterns and rates of use of services by the families of agricultural workers and many unskilled workers. The absence of more recent data on class patterns of use of child welfare centres and the health visitor service prohibits us from forming any detailed picture of the care received by children in these groups. We cannot say whether care obtained from such sources substitutes for their low rates of use of general practitioner services. If not, these differences would indicate that the benefits of free medical care have not reached these families.

Adults: The Survey of Sickness

Data on the use of physician services by adults is more plentiful and indicates a similar pattern of use: there is some evidence of a greater use of services by the middle class prior to 1948, while data for later years indicate higher rates of consultation on the part of most working class patients. Given their apparently greater needs for health care, this would suggest that the majority of working class persons are not disadvantaged in terms of use of general practitioner

services. However, there are varying rates of use within the working class with unskilled workers consulting general practitioners less frequently than their morbidity and mortality experience would lead us to expect. And elderly working class patients are less likely to consult doctors than are their middle class counterparts. We will first discuss data from the Survey of Sickness, and then present more recent research on general practice.

Unfortunately, the Survey of Sickness does not present data on consultations with general practitioners alone. Rather, medical consultation rates--the number of visits per one hundred persons in a month to, or by a medical practitioner--include medically qualified opthalmic and other specialists though it does exclude dentists and care provided by specialists to hospital inpatients. Care received in outpatient departments is, therefore, included. Data for January, 1946 suggest some bias towards the middle class: for the professional and managerial group, sickness, prevalence, and incapacity rates are lower than average while the medical consultation rate is higher than average--their sickness experience is very close to that of agricultural workers, but their consultation rate is considerably higher.[9] Similarly, sickness and prevalence rates for clerical workers are only slightly higher than average and the incapacity rate lower; yet they have the second highest consultation rate. On the other hand, the mining and quarrying group, with particularly high sickness, prevalence, and incapacity rates, is less likely to consult a medical practitioner than either of the white collar groups.

But this pattern does not continue in later years. Medical consultation rates analyzed in relation to income for men and women for the three years 1947, 1949, and 1951, indicate a closer correspondence with morbidity rates and the disappearance of this apparent class bias.[10] These consultation rates are presented in Table 7. The rates for those earning less than £3 per week are considerably higher than those for other groups, and the differences between the other groups in 1947 and 1949 are not particularly marked. By 1951, there is a fairly consistent decline in consultation rates with increasing income. Though there is no marked change in morbidity rates (those for 1947 and 1951 are nearly identical), the consultation rates for the lower income group are somewhat higher in 1949 and 1951. This may be a result of the increased availability of free care, but it is strange that the increases are slightly less for women since it is they, and not men, who had free general practitioner care extended to them. It is also important to note that women appear to have somewhat greater needs for health care as measured by sickness and prevalence rates, but that in the lower income group their consultation rates are less than those for men for each of the three years.

In general, these Survey of Sickness data provide no evidence of a wide discrepancy between needs for and use of medical services. However, the introduction of the National Health Service does appear, at first sight at least, to have improved the access to care of lower class men: rates of consultation after 1948 more nearly reflect the

TABLE 7.--Mean monthly medical consultation rates per 100 persons interviewed by sex and income group of chief wage earner, 1947, 1949, and of head of household, 1951, England and Wales

Income Group of Chief Wage Earner In 1951, Income Group of Head of Household	Medical Consultation Rate	
	Male	Female
1947		
Under £3	68	55
£3 -- £5.10	38	38
£5.10 -- £10	34	42
Over £10	39	49
Not known	29	44
Total	39	42
1949		
Under £3	89	63
£3 -- £5 or £5.10	45	49
£5 or £5.10 -- £10	34	44
Over £10	36	47
Not known	33	48
Total	41	49
1951		
Under £3	77	62
£3 -- £5	59	56
£5 -- £7.10	41	47
£7.10 -- £10	36	44
Over £10	34	39
Not known	45	46
Total	47	51

Source: Great Britain, General Register Office, The Survey of Sickness, 1943-52, by W.P.D. Logan and E.M. Brooke. Studies in Medical and Population Subjects, No. 12. (London: H.M. Stationery Office, 1957), p. 57.

differing morbidity experience of men of different social class. Why women have not benefited in the same or greater measure is not clear. We will return to these issues later.

Adults: Other Studies

Similar patterns of use are evident in figures published by the Government Social Survey.[11] An inquiry into general practice was carried out from February to May, 1952 in conjunction with the Survey of Sickness. Table 8 shows the data obtained for February and March relating to medical consultation rates and the proportion of consultations which resulted in a prescription. Clearly, persons in lower income groups are more likely to consult a doctor (the rate decreases fairly steadily with rising income level), and their consultations are also more likely to result in a prescription.

However, the General Register Office survey of seventy-six general practices suggests variations within the working class. There are no pronounced differences in patient consulting rates for each social class (the lowest is for class I and the highest for class III), but we are given some indication of variations within these classes when the data are analyzed by socio-economic groups. As can be seen in Table 9, consultation rates are relatively high for skilled and semi-skilled workers, but given their poor morbidity and mortality experience, the rate for unskilled workers is remarkably low. We would have expected these to be among the heaviest users of doctors' services. At first glance, the most startling rates are the very low ones for

TABLE 8.--Weekly medical consultation rate per 100 persons and proportion of consultations resulting in a prescription by weekly income of head of household, February and March, 1952, England and Wales

Weekly Income of Head of Household	Weekly Medical Consultation Rate Per 100 Persons*	Per Cent Consultations Resulting in a Prescription
Under £3	16.0	82
£3 < £5	11.3	79
£5 < £7.10	9.1	74
£7.10 < £10	9.2	72
Over £10	8.9	71

*Including outpatient consultations.

Source: Great Britain, Government Social Survey, General Practice Under the National Health Service, by P.G. Gray and A. Cartwright. Reports, New Series, 197. (London: H.M. Stationery Office, 1961), p. 14.

TABLE 9.--Patient consulting ratios by socio-economic group for males aged 15 - 64 years, May, 1955 - April, 1956

Socio-economic Group	Patient Consulting Ratio*
Higher administrative, professional and managerial	93
Other administrative, professional and managerial	102
Shopkeepers	95
Clerical workers	99
Shop assistants	99
Personal service workers	96
Foremen	114
Skilled workers	104
Semi-skilled workers	113
Unskilled workers	99
Farmers	81
Agricultural workers	80
All socio-economic groups	100

*The number of patients per 1,000 who had one or more consultations during the twelve months.

Source: Great Britain, General Register Office, Morbidity Statistics from General Practice, by W.P.D. Logan and A.A. Cushion. Studies in Medical and Population Subjects, II, No. 14, Occupations, (London: H.M. Stationery Office, 1960), p. 13.

farmers and agricultural workers--20 per cent below the average. These echo the differences which this same study found in consulting rates for children. But these will, in large part, be a reflection of the lower mortality and morbidity rates in rural areas. These data suggest that we cannot view the working class as being homogeneous.

The most recent large scale survey on the use of doctors' services is that by Cartwright.[12] This involved a random sample of nearly 1,400 persons living in twelve parliamentary constituencies in England and Wales. These people were interviewed in the summer of 1964 and asked about their doctors and medical care. The doctors were also asked for their opinions and information on the way in which they ran their practices. For the moment, we will limit ourselves to presenting data on consultation rates. Unfortunately, these data do not distinguish between different sections of the working class. They do, however, indicate variations within each class by age.

Cartwright notes that at first there appeared to be an inverse relationship between social class and consultation rates. But when these data were analyzed by age, many of the differences disappeared.[13] Among those under 45 years of age, the working class patients had higher consultation rates than the middle class, and there was little difference between working and middle class patients aged 45-74 years. But among the patients aged 75 years and over, the middle class were more likely to consult their doctor than the working class. When urban areas were compared, consultation rates were higher in working class than in middle class areas.[14]

The respondents in this study were also asked whether they would consult a doctor about various conditions if they experienced them.[15] Out of six conditions, working class patients would consult for an average of 2.7 and middle class for an average of 2.4. The working class respondents were more likely to consult for problems that might not be thought of as strictly medical: 50 per cent said they would consult their doctor if they had experienced difficulty in sleeping for a week (38 per cent for the middle class), and 58 per cent said they would do so if they had been depressed for three weeks (47 per cent in the middle class). Obviously, the respondents were faced with a hypothetical situation and may well act differently in reality. However, these responses do suggest that working class patients do not experience a great social distance between themselves and their doctors.

A few other studies, concerned with particular areas in England, provide us with additional information on the use made of general practitioner services. Kessel and Shepherd's study of a general practice in Beckenham (a middle class dormitory suburb of London) examined the attendance patterns of the 1,503 people who were continuously registered with the practice during the first ten years of the National Health Service.[16] They classified these patients as either attenders or non-attenders: attenders had consulted a doctor in 1957 or 1958; non-attenders had last consulted a doctor in 1956 or earlier. They found no class differences between these categories, and the non-attenders appeared to be healthy. A study by Stein of a London general

practice found that the percentage of attenders and the mean number of consultations was higher in classes IV and V, but the differences between the classes were not significant.[17]

Kedward studied all consultations during a three month period (1959-60) in a rural general practice in Nottinghamshire.[18] The practice had a virtual monopoly of the care of the 1,500 population. A higher proportion of blue collar households consulted a doctor during the survey period--mining families being most likely to do so. If we look at the average number of consultations per patients at risk, we see only small differences between social classes except that the number for class I and for mining families are above the average for the practice. But consultations did not take the same form for all patients, and Kedward notes some marked differences in the types of consultations made by persons from different social class backgrounds: classes I-IV (equivalent to the Registrar General's classes I and II) were much more likely to consult by telephone, and were also more likely to be visited or to make a request through a chemist.

Finally, there is the study by Ashford and Pearson of the general practice lists of thirty-five general practitioners in Exeter.[19] About three-quarters of the population of the city was included in the study which covered the period November, 1966 to October, 1967 and which involved only National Health Service patients. The results show a general tendency for the number of patient contacts to increase slightly with decreasing social class and decreasing educational level. Unfortunately, the authors present their data only in the form of

charts and do not give actual values: the charts indicate less clear "general tendencies" than the text suggests.

The Initial Impact of the National Health Service

At first sight, these data on class rates of use of general practitioner services suggest that working class patients may have benefited from the introduction of a system of socialized medicine. The children of clerical, skilled, and semi-skilled non-agricultural workers may have consulted with general practitioners more often after 1948. And whereas data for January, 1946 show that middle class patients were somewhat more likely to consult doctors than were other patients, by 1951, rates of consultation vary inversely with social class. We must, however, interpret these data with caution.

Firstly, it is not clear that middle class patients did have easier access to general practitioner care before 1948. We have information for adults for only two periods preceding the introduction of the National Health Service--for January, 1946 and for 1947--and those for the latter period do not show higher rates of consultation among middle class patients. It is sometimes misleading to compare data referring to short periods of time since rates of consultation can vary from month to month.[20]

Secondly, it is not certain that the increases in consultation rates after 1948 among lower income groups were a result of the introduction of the National Health Service. The increases for women are not as large as those for men, and yet it was women who stood to gain

the greatest benefits from the introduction of the new service--men already received free general practitioner care under the National Health Insurance scheme. If it was the National Health Service which produced the increase in rates of consultation among lower income groups, we would, therefore, have expected a more marked increase in consultation rates among lower income women.

Clearly, more data are necessary in order to determine whether the National Health Service did achieve greater equality in the use of general practitioner services. And, we must question whether changes in consultation rates after 1948 are explicable in terms of the National Health Service.

Equal Use: Socialized Medicine or General Practitioner?

The data on the use of general practitioner services under the National Health Service give no evidence of marked class inequalities. There is scattered evidence that parts of the working class underutilize the service: old people and some sections of class V are among those least likely to receive general practitioner care, yet their needs for such are greatest. However, rates of consultation have generally tended to be highest where the need for care is greatest--among manual workers and their families. How can we explain this relatively equal access to care?

The assumption that welfare services and programmes reduce class inequality leads us to predict an improvement in the position of the working class, and thereby a narrowing of class inequalities. There is good foundation for such an assumption with respect to the

National Health Service. Socialized medicine provides care to all at little or no direct cost and thus, with financial barriers to care removed, we might expect that rates of use of services would more closely mirror needs. But we have already argued that the contribution of socialized medicine to the increase in consultation rates among lower income groups is unclear. And we cannot make any clear statement as to its role in reducing inequalities in the use of general practitioner services. We may further question whether the relative equality of access to primary care under the National Health Service is a direct result of the introduction of a system of socialized medicine. For if we were to examine similar data for Sweden, which also has an extensive system of socialized medicine, we would see that rates of use of physician services are lower for the working class than for the middle class.[21] What then is peculiar to the British experience which would account for the high degree of use which working class patients make of general practitioner services?

The general practitioner occupies a central position within the National Health Service. He provides first contact care, and it is only through him that patients can be referred to specialists or admitted to hospital. In many other advanced societies, such as Sweden, the general practitioner occupies a less central role: first contact care is more frequently obtained from specialists or in the outpatient departments of hospitals.[22] Access to care is, therefore, much simpler in Britain. No choice has to be made; no lay analysis of symptoms is necessary in order to decide which specialist should

be consulted. Titmuss has argued the need for a family doctor for an individual "to help him humanely to find his way among the complex maze of scientific medicine."[23] It is possible that this different system of organizing the delivery of medical care facilitates the use of health services in Britain. One reason which has been advanced for the low rates of use of medical services by lower class persons is their lack of knowledge about symptoms of ill health and how to obtain care. Here, the knowledge required is at a minimum; no choice has to be made other than whether or not to consult a general practitioner.

And the general practitioner may be important in other respects also. Many studies have documented the social distance which exists between doctors and their lower class patients. There is some evidence that this is not particularly marked in Britain. The British Medical Association appears to have been very successful in projecting the image of a friendly and approachable family doctor. Doctors' waiting rooms may often be rather cold and bleak and uncomfortable, frequently located in a house or in a row of ramshackled shops. But they are not as forbidding as a sparkling new, sterile health centre, manned by efficient secretaries and nurses, might be to many lower class persons.

We have already noted the willingness of the working class patients in Cartwright's study to consult doctors about problems which are not strictly medical. This same study of general practice paints a picture of ". . .satisfied and appreciative patients. Many

seem to feel a definite sense of identification with their doctor."[24] The most frequent comments which patients made was that their doctor was "approachable," "homely," "friendly," "considerate," "sympathetic." Two-thirds of the patients thought that if they met their doctor on the street, he or she would know them by name. Selecting a general practitioner seems to cause no problem, and most people do not use sophisticated criteria of choice. The vast majority register with the nearest doctor, or if no move to a new area is involved, will inherit the one who takes over the practice of their old doctor. Four-fifths of the patients took less than fifteen minutes to get to their doctor's surgery and over half normally walked all the way. Furthermore, unlike Sweden, there is a strong tradition of domiciliary care in Britain; about 20 per cent of consultations take place in the home, compared to about 5 per cent in Sweden. This latter is also likely to facilitate the use of physicians' services in that one can see one's doctor on "home territory."

All this suggests relatively little social distance between working class patients and their doctors (at least, the patients give no evidence of this) and fairly easy accessibility of doctors. As Cartwright concludes:

> Most people in this country have a general practitioner they have known for some time, who is accessible, comes to their homes when needed, cares for other members of the family, and gives them what might be described as a semi-personal service. Few people are directly critical of their doctor, most have confidence in his decisions and care, and many have a friendly and satisfying relationship with him.[25]

These traditional characteristics of the general practitioner, his accessibility, his homely and approachable image, his role as a guide

through the "maze of scientific medicine," may in part help to explain the high rates of use of physician services by working class patients.

Summary

While there is some evidence that middle class patients were more likely to consult with general practitioners before the introduction of the National Health Service, after 1948 rates of consultation have tended to be highest among the working class where needs for care appear to be greatest. However, the greater use of general practitioner services by middle class patients is open to doubt and the apparent increase in consultation rates among lower income groups after 1948 is not clearly attributable to the introduction of a system of socialized medicine. We have also argued that the relative equality of use of the general practitioner service may not be so much a result of socialized medicine as of the critical role of the general practitioner within the National Health Service. In securing their near monopoly in providing primary care under the National Health Service, general practitioners may not have served their own interests alone--they may also have facilitated the access to care of working class patients.

But we have defined access to care under the National Health Service in terms of both use of services and quality of care. It is important to complement these data on consultation rates with information on the quality of care received by patients. Can we perceive a similar equality in the nature of the care received by patients of

different social class? We turn now to a discussion of such data.

VARIATIONS IN QUALITY OF CARE

We cannot conclude that the health needs of a large part of the working class are being met if, even though they are more likely to consult a doctor than middle class patients, the quality of the care they receive is inferior. Criticisms of the National Health Service have largely centred around the issue of quality, overall quality rather than differences in the care received by various sectors of the population. But the few studies which have focussed on class variations in the care obtained by patients suggest that working class patients may be receiving care of inferior quality.

The Doctor and his Practice

In a study of a representative sample of people who had been hospitalized sometime during the six months before the survey period (October, 1960-March, 1961), Cartwright obtained data on the care received from general practitioners. This study suggests that middle class patients may be receiving a rather better service from their general practitioners.[26] Doctors practicing in middle class areas had smaller lists; a higher proportion had further qualifications; more had graduated from Oxford, Cambridge, or London; twice as many had a hospital appointment or hospital beds; and a higher proportion had direct access to X-ray equipment and physiotherapy. Furthermore, 14 per cent of middle class patients were visited by their general practitioner in hospital while only 4 per cent of working class

patients received such a visit. Moreover, there was evidence that doctors were more likely to send their middle class patients directly to hospital.

In her later study of general practice, Cartwright sought confirmation of these differences.[27] She found no significant differences between middle class and working class patients in the size of their doctor's list, though those in professional occupations were rather more likely to be on small lists of under two thousand. Patients in the professions were also most likely to have doctors who had qualified since 1945, and middle class patients were more likely to have doctors with hospital appointments. But there were no differences in the proportion of doctors who had access to hospital beds or other facilities; in the number of procedures carried out by doctors in their own practices; in the membership of doctors in the College of General Practitioners; in their views on preventive care; and in their enjoyment of general practice. On the basis of these results, Cartwright modifies her original hypothesis and suggests that only patients in the professions seem to get better care.

Whereas Cartwright uses several different indices to assess variations in quality of care, Taylor's comments on the standard of work of general practitioners are much more impressionistic.[28] In a study which was largely an effort to brighten the dismal picture of general practice painted by Collings, Taylor interviewed and observed at work ninety-four general practitioners who were recognized by their colleagues as good doctors.[29] The explicit purpose of the

study was to describe the best in the general practitioner service. It was in the working class industrial areas that he found the poorer practices. Doctors in these areas tended to have the largest lists of patients while those in middle class urban-residential areas generally had smaller lists. Most doctors were providing their patients with a high standard of care, but the working class areas did contain a substantial minority "who fail to give their patients the service they have a right to expect."[30]

The doctors working in these areas did so for a variety of reasons. For some, there was no other choice. They lacked the ability to work in better areas. For others, there was a financial incentive, their aim being to make as much money as possible in a short period and then leave the area. These, Taylor argues, were giving their patients no more than a good garage mechanic offers to his customers. And there were also those who worked in such areas from a sense of vocation, but many of these would bow under the strain of a heavy work load and become mediocre doctors. It was among the doctors in these areas that low morale was most common.

> It is here that the potentially good general practitioner will most often complain of frustration; the less conscientious general practitioner will undergo a lowering of standards, without himself realizing what has happened; lack of contact with colleagues is most marked; and the need to raise the standards of general practice is most obvious.[31]

Given the aim of Taylor--to show the best in the general practitioner service--we may perhaps place more reliance on his negative observations than if his aim had been quite the opposite.

The Nature of the Doctor-Patient Relationship

The quality of care which a patient obtains does not depend only on the doctor he consults. The patient will, or can, play a role in determining the care he receives and the nature of the doctor-patient relationship appears to vary according to whether patients are working class or middle class. Rates of consultation may be an inadequate measure of the extent to which patients receive care commensurate with their needs since middle class patients may be able to obtain more from any single consultation. They are more likely to play an active part in the relationship while working class patients are more passive. Titmuss argues that the working class patient is more easily disciplined and managed. He expresses the hope that a generally higher standard of education is ". . .likely to herald the gradual disappearance of an uncomplaining, subservient, class-saturated acceptance of low standards of professional service."[32] Collings noted that middle class patients tended to be resented by general practitioners because of their demands for more time and attention, and a readiness to question diagnoses, to seek reasons for statements and instructions, and even to challenge the doctor. Their "less fortunate neighbours" were more respectful of their doctors' expert knowledge and skills.[33] Similarly, Cartwright indicates that the higher a patient's social class position the more likely he is to ask for information about his illness and its treatment, and thus to manipulate his relationship with his doctor.[34] And Taylor observes that

> the doctors in the industrial areas tend to have specially friendly and uncritical relations with their patients, each taking the other side as it finds it. Indeed, those doctors with mixed urban-residential and industrial practices almost always prefer their working class patients, because they are less exacting and more appreciative.[35]

It is interesting that the response of doctors to their patients appears to have changed with the introduction of the National Health Service. Previously, panel patients seem to have received less time and attention while fee paying patients, in whom the doctors had a direct financial interest, were more welcome and received more careful attention. But once this interest was removed, the least demanding patients were those most welcome.

But does the more active participation of middle class patients in the doctor-patient relationship lead to a better quality of care? If we accept that the doctor is the sole repository of knowledge about health and illness, then perhaps not. But this is a narrow view. We have to be our own doctors to some extent.[36] Some understanding of his illness and its treatment may lead to fuller co-operation on the part of the patient in following a course of treatment. It may also help in the recognition of adverse symptoms and of a need for further consultations.

Most people can, to a certain extent, assess the competence of their doctors and the care they provide. In many instances, they will know what is good for them and what is not. And at times, it will be obvious that the doctor does not. The patient fighting a long depression who is told to "pull yourself together," the woman with three young children who is simply told to "take it easy," are

not necessarily being offered very constructive advice: their neighbours might have been more helpful. If such patients are able to indicate that the advice is inadequate, then they may gain some benefit from the consultation. If not, they leave the surgery no wiser and no closer to recovery.

Doctors are not infallible. Mistaken diagnoses and treatments may only infrequently endanger the life of a patient, but they will delay recovery.[37] The active participation of the patient, his willingness to express his doubts, to challenge, to ask for more information may be one guard against this. For these reasons we would argue that the more active role of middle class patients in the doctor-patient relationship may well lead to better care. Exchanges of information between doctor and patient, explanations on the part of the doctor, questioning on the part of the patient, increase the patient's knowledge of his body and illness and enable him to make more intelligent use of his doctor. In this way, by educating his patient and encouraging him to assume more responsibility for his health, the doctor would be playing a larger role in preventive care.

Summary

The scattered studies which have been addressed to variations in the quality of care received by patients of different social class indicate that middle class patients may be receiving care of superior quality. But further research into these issues is necessary. Less reliance on impressionistic data and the construction of indices

of quality would enable us to build a clearer picture of the nature and importance of variations in the quality of care offered to patients by general practitioners.

CONCLUSION

The foregoing review of data on the use and quality of general practitioner services raises two distinct issues. Firstly, we may pursue one step further the issue of whether the needs for health care of different social classes are being met. The relatively low rates of consultation on the part of class V and elderly working class patients indicate that they are not receiving the care which their mortality and morbidity experience would lead us to expect. But what of other sections of the working class? Here, it is more difficult to assess the extent to which needs for care are met.

If mortality rates are taken as an index of needs for treatment, then these needs obviously increase from class I to class V and we would expect consultation rates to increase in a similar manner. But consultation rates for class IV are not markedly higher than for classes I and II, and this might mean that needs for care of middle class patients are most nearly met. Yet doctors report that such patients are those most likely to consult for trivial complaints,[38] in which case their proportional overutilization would not indicate that they are more likely to receive <u>needed</u> care. If on the other hand, we take morbidity rates as an index of health needs, class differences are not marked and consultation rates, therefore, indicate a greater correspondence between needs for care and use of general

practitioner services. Unfortunately, we do not have the data which would enable us to measure the extent to which different classes receive care appropriate to their level of health. Indices of health and class differences in needs for medical care must be developed and we must seek a fuller understanding of the significance of data on rates of consultation--of what is involved in the doctor-patient relationship and of the quality of care received. At present, we can merely note that though there are some possible exceptions, there do not appear to be class based inequalities in access to general practitioner care.

Secondly, we wish to emphasize the importance of the general practitioner within the National Health Service. Insofar as the welfare state is seen as narrowing class inequalities, socialized medicine per se is regarded as the major mechanism by which equality of access to health care is achieved. We do not deny the probable importance of the removal of direct costs or of the availability of free health care as a right rather than as a result of philanthropy; additional data are necessary in order to assess the impact of these on consultation rates. However, we have sought to draw attention to the fact that the structuring of the National Health Service around the general practitioner may have played a crucial part in maintaining relatively equal access to health care.

This is an important point to be considered in the planning of health services in Britain and other countries. Criticisms have been voiced of the relatively low level of training and expertise of the

general practitioner and arguements have been advanced which support a greater degree of specialization in primary medical care. Such visions of the future have been coupled with an increasing emphasis on health centres which group together a variety of specialists and ancillary personnel. It is true that the isolation of many general practitioners can have deleterious effects on the quality of care provided, but the potential dangers of a new and intimidating organizational structure should also be borne in mind. The specialist may effectively replace the general practitioner as long as the patient continues to be guided through the "complex maze of scientific medicine." But increasing numbers of secretaries and nurses who act as gatekeepers to the medical care system may also act as a deterrent to many patients who should seek treatment. The absence of social distance, the community based doctor, the sense of familiarity must be maintained if we are not, while improving the quality of care, to generate new problems which deter patients from seeking such.

FOOTNOTES

[1]J. Spence et al., A Thousand Families in Newcastle-Upon-Tyne (London: Oxford University Press, 1954).

[2]F.W.J. Miller et al., Growing up in Newcastle-Upon-Tyne (London: Oxford University Press, 1960).

[3]J.W.B. Douglas and J.M. Blomfield, Children Under Five (London: Allen and Unwin, 1958).

[4]Great Britain, General Register Office. Morbidity Statistics from General Practice, by W.P.D. Logan and A.A. Cushion. Studies in Medical and Population Subjects, II, No. 14, Occupation, (London: H.M. Stationery Office, 1960).

[5]Spence et al., op. cit., p.154. [6]Ibid., p. 156.

[7]Miller et al., op. cit., p. 65.

[8]Douglas and Blomfield, op. cit., p. 71.

[9]Great Britain, Government Social Survey. Survey of Sickness: October, 1943-December, 1945, by P. Slater. (London: H.M. Stationery Office, 1946), Appendix C, p. 72. For definitions of sickness, prevalence and incapacity rates, see Chapter VI, p. 120.

[10]Great Britain, General Register Office. The Survey of Sickness, 1943-52, by W.P.D. Logan and E.M. Brooke. Studies in Medical and Population Subjects, No. 12, (London: H.M. Stationery Office, 1957), p. 57.

[11]Great Britain, Government Social Survey. General Practice Under the National Health Service, by P.G. Gray and A. Cartwright. Reports, New Series, 197, (London: H.M. Stationery Office, 1961).

[12]A. Cartwright, Patients and Their Doctors: A Study of General Practice, (London: Routledge and Kegan Paul, 1967).

[14]Ibid., p. 44. Estimated annual rates of 4.8 and 3.1 respectively. A recent study by Cartwright of the care received by people during their last year of life has shown some class differences. The proportion of persons receiving domiciliary care from consultants ranged from 29 per cent in class I to 6 per cent in class V. (Personal communication.)

[15]Ibid., p. 209.

[16]N. Kessel and M. Shepherd, "The Health and Attitudes of People Who Seldom Consult a Doctor," Medical Care, Vol. 3, No. 1, (January-March, 1965), pp. 6-10.

[17]L. Stein, "Morbidity in a London General Practice: Social and Demographic Data," British Journal of Preventive and Social Medicine, Vol. 14, No. 1 (January, 1960), pp. 9-15.

[18]H.B. Kedward, "Social Class Habits of Consulting," British Journal of Preventive and Social Medicine, Vol. 16, No. 3, (July, 1962), pp. 147-152.

[19]J.R. Ashford and M.G. Pearson, "Who Uses the Health Services and Why?" Journal of the Royal Statistical Society, Series A, Vol. 133, Part 3, (General), (1970), pp. 295-345.

[20]For a discussion of the dangers of such comparisons, see W.P.D. Logan, "Illness, Incapacity, and Medical Attention Among Adults, 1947-1949," Lancet, i, (April, 1950), pp. 773-776.

[21]R. Andersen et al., Medical Care Use in Sweden and the U.S. Chicago, Center for Health Administration Studies, Research Series 27, (Chicago: University of Chicago Press, 1970).

[22]O.L. Peterson et al., "What is Value for Money in Medical Care? Experiences in England and Wales, Sweden and the U.S.A.," Lancet, i (1967), pp. 771-776. R. Andersen et al., op. cit., p. 9.

[23]R.M. Titmuss, "Role of the Family Doctor Today in the Context of Britain's Social Services," Lancet, i (1965), p. 1.

[24]Cartwright, op. cit., p. 9. [25]Ibid., p. 26.

[26]A. Cartwright, Human Relations and Hospital Care (London: Routledge and Kegan Paul, 1964), p. 191.

[27]Cartwright, Patients and Their Doctors, op. cit., pp. 205-207.

[28]S.J.L. Taylor, Good General Practice (London: Oxford University Press, 1954).

[29]J.S. Collings, "General Practice in England Today," Lancet, 1 (1950), pp. 555-585.

[30]Taylor, op. cit., p. 38. [31]Ibid., p. 41

[32]Titmuss, op. cit., p. 3.

[33]Collings, op. cit.

[34]Cartwright, Human Relations and Hospital Care, op. cit., p. 81.

[35]Taylor, op. cit., p. 40.

[36]For the development of challenging ideas on this theme, see: I. Illich, Medical Nemesis (Toronto, McClelland and Stewart, 1975).

[37]Ibid.

[38]Cartwright, Patients and Their Doctors, op. cit., pp. 51-52.

CHAPTER III

HOSPITAL CARE: PUBLIC AND PRIVATE

Introduction

Following the same logic of analysis as in the previous chapter, our focus here will be on class variations in the use and quality of hospital care within the National Health Service. But we extend our analysis in this instance to examine the significance of private hospital care for the development of the National Health Service and the perpetuation of class inequalities in health care.

The National Health Service Act of 1946 guaranteed the continued existence of private health care: patients were free to consult a doctor and pay for the services they received; doctors who contracted to work within the National Health Service were also free to treat private patients; and the Minister of Health was empowered to provide special accommodation for patients who wished to pay for the whole cost of the care and services which they received in hospitals. Only a small proportion of the population has availed itself of these private services, but they are, nevertheless, of significance for this study of the National Health Service.

Private health care is important, not for its extensiveness, but for its symbolic significance and for the threat which it may pose for the quality of care available under the National Health Service. While the introduction of a system of socialized medicine has been assumed to reduce class inequalities and provide care on

the basis of need alone, the continued provision of private health care is an institutional affirmation of inequality. The existence of a private health sector symbolizes the existence of two levels of care and recognizes the right of patients who have the money to pay for certain privileges. Furthermore, the continuing growth of the private health sector may rob the National Health Service of its most demanding and critical patients--patients who might otherwise prompt improvements within the National Health Service. And an increasing use of National Health Service facilities for the treatment of private patients may place National Health Service patients in a disadvantaged position as the former are given priority in the use of diagnostic and surgical facilities. For these reasons, this chapter will discuss both public and private hospital care.[1] We will argue that:

1. The major studies which present data on hospital admissions suggest that rates of hospitalization of middle class and working class patients mirror their needs for care.
2. Private health care represents an institutionalization of class inequalities in access to hospital care. In the future, it may develop in a direction such as to reduce the quality of treatment available under the National Health Service and to increase class differences in access to care.

USE OF NATIONAL HEALTH SERVICE HOSPITALS

Data on class variations in the use of hospital services by

National Health Service patients are contradictory: some studies suggest a proportional over-representation of working class patients while others indicate an under-representation. The most comprehensive of such studies indicates that working class patients, who appear to have the greatest needs for medical care, are more frequently hospitalized than middle class patients. However, smaller scale studies which suggest quite the opposite pattern highlight the need for further research and the exploration of possible regional variations in class patterns of use of services.

Evidence of a Proportional Over-representation of Working Class Patients

The 1957 Political and Economic Planning study suggests that hospitals serve a larger proportion of working class than middle class persons. Eighty-nine per cent of unskilled operatives' families had at some time received treatment in an outpatient department and 84 per cent of the families of managerial and professional workers had done so. Hospital inpatient care had been given to 89 per cent of the former and 75 per cent of the latter.[2]

From MacKay's data for England and Wales for 1949, it is difficult to assess the representation of different social classes within the hospital population since there is a large proportion for which class is not stated.[3] However, if we assume that those patients for whom social class is not reported are proportionally distributed between the classes, there is evidence of a proportional over-representation of men and women in classes IV and V. Nevertheless,

the validity of this assumption is open to doubt. Abel-Smith and Titmuss have also presented data for this period and as Table 10 indicates, the class distribution of males within each of the three types of hospital is very close to that in England and Wales, and for the London teaching hospitals, to that in greater London in 1951.[4] The writers argue that because of the higher death rates and possibly greater sickness of classes IV and V, one would expect them to make greater demands on the hospital service. They conclude that there is inequality of access to hospital care as working class patients are less likely to be hospitalized than their needs for medical care would lead us to expect.

The most comprehensive and most recent study of hospital admissions is the Hospital Inpatient Enquiry (H.I.P.E.) for 1960 and 1961.[5] This is one of the few such inquiries which provides data on the social class of patients. Table 11 shows admissions, mean duration of stay, and percentage of beds used for each social class and for occupational groupings within classes III, IV, and V. Comparing the representation of the classes within the hospitals (for all ages and for those under sixty-five years of age) with the class distribution of males in England and Wales in 1961, we see that class IV and, particularly, class V are proportionately over-represented. Class V has both high admission rates and longer than average periods of hospitalization, and while classes IV and V represent 21 per cent and 9 per cent of the population, they occupy 26.5 per cent and 14.2 per cent respectively of hospital beds. This bias towards the lower

TABLE 10.--Proportionate distribution by social class of discharges in 1949 from three groups of hospitals participating in the General Register Office's study of hospital morbidity in England and Wales. Males aged 25-64 years. All diagnostic conditions excluding injuries.

Social Class	London Teaching Hospitals	Provincial Teaching Hospitals	Regional Board Hospitals	England & Wales 1951	Greater London 1951
	Per cent	Per cent	Per cent	Per cent	Per cent
I and II	21	16	15	20	21
III	56	55	58	51	55
IV and V	23	29	27	29	24

Source: B. Abel-Smith and R.M. Titmuss, The Cost of the National Health Service in England and Wales (Cambridge: Cambridge University Press, 1956), Table 88, p. 149.

TABLE 11.--Admissions, mean duration of stay, and percentage of beds used by social class. England and Wales, 1960 - 1961

Social Class	Admissions in sample Under 65	Admissions in sample All Ages	Mean duration of stay (days)	Per cent beds used	England & Wales (males) 1961
	Per cent	Per cent			
I Professional	2.3	2.4	17.3	1.9	4
II Intermediate	10.8	11.6	19.2	10.2	15
III Skilled workers	51.4	50.0		47.3	51
a) Mine workers (all types)	1.4	1.3	23.5	1.4	
b) Transport workers	5.8	5.5	19.9	5.0	
c) Clerical workers	7.4	7.4	20.1	6.7	
d) Armed forces	.9	.9	27.7	1.2	
e) Others	35.9	34.9	20.8	33.0	
IV Semi-skilled workers	22.9	23.2		26.5	21
a) Agricultural	2.2	2.4	39.3	4.4	
b) Others	20.7	20.8	23.3	22.1	
V Unskilled workers	12.6	12.8		14.2	9
a) Building & dock labourers	1.8	1.8	25.0	2.1	
b) Others	10.8	11.0	24.2	12.1	
Total	67,727	82,629	22.0	51,268	

Source: Great Britain, Ministry of Health and General Register Office. Report of Hospital Inpatient Enquiry for the Two Years 1960 and 1961. Part III, Commentary. (London: H.M. Stationery Office, 1967), Table VI.8, p. 365. The social class distribution in England and Wales in 1961 is taken from D.C. Marsh, The Changing Social Structure of England and Wales 1871-1961 (revised edition, London: Routledge and Kegan Paul, 1965), p. 198.

classes is also evident in a study by Ashford and Pearson.[6] Their survey of the people on the lists of thirty-five general practices in Exeter shows a marked tendency for the hospital admission rate to increase with decreasing social class. The difference between class I and class V is almost 50 per cent of the average of all classes.

The studies which contradict these findings are not national studies, but it is not clear whether we should place less reliance on them because of this. However, they must lead us to question the reliability of studies which indicate a proportional over-representation of working class patients within the hospital service, and they do show the need for further research in this area.

Studies Indicating a Proportional Under-representation of Working Class Patients

Barr's study of hospital admissions in April and May, 1956 sought to determine whether admission rates were linked with the quality of social environment.[7] The data refer to the area served by the group of four hospitals in the county borough of Reading. Four indices were used to assess the social environment--the social class distribution, persons per household, density per room, and the proportion of persons with the exclusive use of piped water, a water closet, stove, sink, and bath. Standardized hospital admission ratios for each sex and speciality were correlated with each of these social indices. There was some evidence that admission rates increased as environment improved with most of the significant correlations occurring in

traumatic and orthopaedic surgery and gynaecology specialities. Barr points out that the degree of correlation in many instances was not great, but that nevertheless the results were reasonably consistent.

Similar results have also been obtained in a study by Airth and Newell in the Hartlepools and Tees-side in 1957-1958.[8] The authors expected to find higher admission rates in areas with poor living conditions (because poor health forces people into, or keeps them in, such areas, and these living conditions can give rise to ill-health). They took the number of persons per room in the study areas as an index of living conditions. This index had a strong negative association with the proportion of persons in classes I and II in the areas. The results are presented in Table 12. Class A areas (with fewer than 0.61 persons per room) produced nearly 2 per cent more hospital cases per 1,000 population than Class E areas (with over 0.92 persons per room). The difference between the areas becomes more marked when specialities with widely variable durations of stay are excluded. For all specialities, Class E areas required 30 per cent more bed-days per head than Class A areas in the fifteen months of the survey. Excluding long stay specialities, the excess is 10 per cent. A case admitted from a Class E district stayed, on average, one-third as long again as one from Class A districts. For restricted specialities, the difference was 15 per cent. This suggests that middle class persons are slightly more likely to be admitted to hospital, but that they have a shorter period of hospitalization than working class persons.

TABLE 12.--The demand for hospital beds, Hartlepools and Tees-side, 1957 - 1958

	Class A area*	Class E area**
All specialities		
Cases per 1,000 population	118.6	116.6
Bed-days required in 15 month period per head of population	1.534	1.994
Average duration of stay per patient	12.93 days	17.10 days
Restricted specialities***		
Cases per 1,000 population	107.5	102.6
Bed-days required in 15 month period per head of population	1.119	1.233
Average duration of stay per patient	10.41 days	12.02 days

*Class A areas consist of eight wards and civil parishes with a total population of 34,647 and with densities of occupation in 1951 of 0.55-0.60 persons per room.

**Class E areas consist of twenty-seven wards and civil parishes with a total population of 189,527 and densities of occupation in 1951 of 0.92-1.13 persons per room.

***Specialities excluded: tuberculosis and diseases of the chest, geriatrics, traumatic and orthopaedic surgery.

Source: A.D. Airth and D.J. Newell, The Demand for Hospital Beds. (Newcastle-upon-Tyne: University of Durham, King's College, 1962), Table 12, p. 51.

Two studies by Alderson also indicate an under-representation of working class patients in hospitals. One, a study of patients who died from cancer in April, 1969 and who were resident in Manchester C.B., shows that semi and unskilled manual workers are more likely to be nursed at home. However, the numbers are small and the differences not significant.[9] The other is a study of a representative sample of adults who died in Bristol between October, 1962 and September, 1963. Of the 2,243 deaths, 590 (26 per cent) had not been referred to hospital for either investigation or treatment. If deaths from neoplasms (where the vast majority attended hospital), sudden deaths, and those from coronary disease (where death is unexpected) are excluded, there is a total of 1,446 deaths, 29 per cent of which had not been referred to hospital. The percentages rose from 24 per cent in classes I and II to 36 per cent in class V.[10]

We may also note a reluctance on the part of some working class women to have their babies delivered in hospital. A study by Butler and Bonham of perinatal mortality indicates that married women in classes IV and V are most likely to plan to have their children at home (even though more complications are likely to arise at birth.)[11] These data for mothers giving birth between March 3 and 9, 1958 in England and Wales are shown in Table 13. Women in classes I and II, and unmarried women are most likely to arrange to have their children in hospital or a general practitioner unit. These differences are not so pronounced for actual deliveries since a higher proportion of women have their children in hospital than plan to do so. Consequently,

TABLE 13.--Place of booking, place of delivery, and grade of prenatal care by social class of father, for mothers giving birth March 3-9, 1958, England and Wales

	Social Class					No Husband	All
	I	II	III	IV	V		
Place of Booking	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
Hospital	44.4	40.0	40.6	38.3	39.8	52.0	40.9
Home	29.5	35.0	41.8	46.8	44.4	12.9	40.2
G.P. Unit	16.5	16.2	13.2	11.2	10.7	16.3	13.2
Other	9.6	8.8	4.4	3.7	5.1	18.8	5.7
Place of Delivery							
Hospital	50.4	47.6	48.7	46.9	47.8	63.9	49.0
Home	27.0	31.4	37.2	41.9	41.0	14.7	36.1
G.P. Unit	15.9	15.0	12.2	10.7	10.7	17.1	12.4
Residual Births	6.7	6.0	1.9	0.5	0.4	4.3	2.4
Prenatal Care							
Hospital only	25.0	19.7	20.4	16.0	19.9	27.9	20.2
Partly hospital	28.9	28.6	28.7	29.5	28.2	28.5	28.8
Other	46.1	51.7	50.9	54.5	51.9	43.6	51.0

Source: From N.R. Butler and D.G. Bonham, Perinatal Mortality (London: E. and S. Livingstone, Limited, 1963), pp. 52, 53, and 69.

though there are still marked class variations in the proportion of births taking place at home or in a general practitioner unit, there are only small differences in the proportions of hospital births: mothers in class I are slightly more likely than mothers from other social classes to give birth in hospital. Also mothers in class I are more likely than mothers in other social classes to receive all their prenatal care from a hospital.

Finally, there is some evidence of other types of class differences in Titmuss' study of blood donors.[12] In addition to tabulating social class of blood donors, he presents figures on the social class of recipients of blood transfusions. The number of recipients of blood increases with social class. The differences are most marked among men: the percentage excess of classes I and II over IV and V is 120 per cent for men and 35 per cent for women. He concludes that these data signify real class differences--the higher social classes receive more blood transfusions and surgical operations or other medical treatments calling for blood. He comments:

> This is an unexpected finding. The whole weight of evidence on the social class incidence of mortality and morbidity, of industrial accidents and to a large extent road accidents, and of the risks of child-bearing among mothers with large families from poor homes would have indicated contrary results. In short, we would have expected--particularly under a free National Health Service--to find that, taking account of these factors, blood transfusions would be relatively more numerous among S.C. IV-V.[13]

No explanation of the differences observed are offered by the author. It is important to note that these data are based on a survey of blood donors--we know nothing of the experience of people who have <u>not</u> given

blood. It is, therefore, unwise to generalize these observations, even though there appear to be no marked class variations in the persons donating blood.

Summary

Data on class variations in the use of hospital services by National Health Service patients are inconsistent. While several national surveys indicate no class bias, some more limited studies suggest that working class patients receive less hospital care than their mortality and morbidity experience would lead us to expect. The representativeness of the former studies leads us to place more reliance on these data and to conclude that there are no marked class inequalities in access to hospital care. However, it is obvious that further research is essential in order to understand the discrepant results in these studies. One fruitful avenue of research might be the study of possible regional variations in class patterns of use of hospital services and the effect of differing organizational patterns and admission policies which may affect the rates of hospitalization of working class and middle class patients.

The extent to which there is equality in the use of hospital services in unclear for other reasons also. We have worked on the understanding that such equality exists when working class patients are proportionally over-represented in hospitals. This is based on the fact that needs for medical care appear to be greater among working class than among middle class patients. But this pattern of use is identifiable in countries where obvious inequalities exist in

access to care. In the United States, for example, working class patients are disadvantaged in access to primary care and they have higher rates of hospitalization and longer periods of stay than do middle class patients--in part perhaps because they receive care at a later stage in an illness.[14] The point we are making is that higher admission rates for working class patients may be taken to represent either equality of access or quite the opposite. Clearly, in order to assess the nature and extent of class inequalities in access to care, we need more sophisticated data on the use of hospital services, including some indication of the stage in an illness when patients are hospitalized and the nature of the care received prior to hospitalization. We cannot view data on hospitalization without reference to primary care, and we need information, analyzed by social class, on the sources from which care is received at various stages in an illness. It may be that those in need of hospital care usually receive it, but that the crucial class differences are in the stage at which treatment is received and also in the quality of care received.

In the absence of such data, we can but argue that in the light of the relatively equal access to general practitioner care, the studies which we have reviewed indicate no marked inequalities in the use of hospital services. But this conclusion may need to be qualified since the sections of the working class which make less use of the general practitioner service than their needs for care would lead us to expect are those with high admission rates and long periods of hospitalization.[15] In fact, this observation reinforces our argument

that we cannot view data on hospitalization without reference to the use made of other sources of care throughout the course of illness.

QUALITY OF CARE RECEIVED BY NATIONAL HEALTH SERVICE PATIENTS

Admission to Teaching Hospitals

In the previous chapter, we defined access to medical care as the use people make of services and the quality of care which is provided for patients. The data on class patterns of use of hospitals are, as we have seen, contradictory. This is also true with respect to quality of care. One important index of quality is whether or not patients are admitted to teaching hospitals: care in a non-teaching hospital may often be inferior to that in a teaching hospital,[16] since the latter have 37 per cent more consultants, six times as many senior registrars, 56 per cent more registrars, 171 per cent more house officers, and 60 per cent more full-time nurses.[17] Forsyth writes,

> There is no doubt that patients of comparable age, sex, and social class stand a much higher chance of dying in a non-teaching hospital from conditions such as appendicitis with peritonitis, hyperplasia of the prostrate, ischaemic heart disease, skull fracture and other head injuries, and a number of other common causes of hospital admission. . .the gap between the two types of hospital is by no means narrowing over the years.[18]

The difference in case-fatality ratios may, in part, be a result of selection of cases by social class. But it is not clear whether there are differences in the proportions of different social classes within the two types of hospital. Cartwright found no class

differences in whether patients were admitted to a teaching or non-teaching hospital.[19] However, Ashley at al. found that within the same catchment area, a teaching hospital may attract or select the more advantaged.[20] Their study of local admissions from a district in which both types of hospitals were situated shows that 46 per cent of the patients in the regional board hospital belonged to classes IV and V, while only 33 per cent of those in the teaching hospital did so. A similar difference was not found in the other three hospitals included in the study. Clearly, as with several other issues we have touched on, further research is needed in this area. As the authors indicate:

> Why this should be so after twenty years of the National Health Service is one of the seemingly innumerable questions that can be asked about the loose--even random--matching of needs and resources in the medical and social services. For a start, nobody seemed to have the facts.[21]

Other Indices

As far as other indices of quality are concerned, there appear to be no class differences. Cartwright's study of hospital patients indicates that there were no class differences in delays in admission to hospital; in the proportions visited at home by a consultant; in facilities such as curtains, screens, telephones, visiting times, and the hours at which patients were woken in the morning; in the proportions of surgical patients who had seen the surgeon and anaesthetist; and in the size of the ward.[22] In fact, only one major difference between classes emerged in her study of hospital care and she summarizes

this as follows:

> The most striking class differences is in the amount of financial hardship experienced by patients who normally worked. In this respect we are indeed two nations, one receiving full wages or salary from their employers, the other reduced to the penury of national insurance sickness benefit.[23]

Summary

While there is little evidence of marked differences in the quality of care received by working class and middle class patients, the study by Ashley et al. does prompt us to question the circumstances under which class inequalities exist, and further studies could serve to highlight the nature and extensiveness of these. We can but indicate the need for additional research into variations in the quality of care obtained by patients of different social class.

PRIVATE HOSPITAL CARE

Private Medical Care Schemes

With the introduction of the National Health Service in 1948, contributory and provident societies were faced with a threat to their continued existence. While contributory schemes were associated with the working class, provident societies catered to the middle class. The former turned to providing mainly sickness benefits to their members--such as cash benefits during a period of hospitalization, and contributions toward glasses, dentures, and surgical appliances--while the provident associations, on the other hand, focussed their efforts on insuring their members against the costs of private hospital care.[24]

Thus, their class role was duplicated after 1948.

There is little detailed information on the types of patients who choose private medical care. However, one survey in 1966 shows that the British United Provident Association (the largest of such associations) was disproportionately composed of older, highly paid, married men approaching the end of their working careers who were members of group or company schemes. Only 2 per cent of the membership were manual workers, while 37 per cent were employed in professional and managerial occupations.[25]

The British United Provident Association was formed in 1947 and soon amalgamated with several existing provident associations. This scheme now has a virtual monopoly of the "market" and received 80 per cent of the total subscription income from all provident schemes. In 1955, all provident schemes had a total of 258,000 subscribers. By 1969, after an annual increase during the 1960's of 7 1/2 - 8 per cent, the total number of subscribers amounted to 883,000.[26]

Group schemes account for a high proportion of this membership increase. Between 1965 and 1969, individual subscriptions increased by 18 per cent while group subscriptions increased by 44 per cent. By 1969, about 64 per cent of subscriptions were on a group basis.[27] The British United Provident Association policy is directed toward attracting members on a group basis. It allows a 20 per cent rebate for groups where a company sponsors the scheme, but does not contribute to the cost; a 25 per cent reduction where the company contributes

50 per cent or more of the cost; and a 33 1/3 per cent reduction where the whole cost of membership in a scheme is paid for by the company. The companies themselves can claim their payments into such schemes as a tax deductible business expense--which reduces their costs by a further 40 per cent.[28] However, it is not clear to what extent the increase in group memberships is comprised of company sponsored schemes which provide private care as a fringe benefit for management personnel. But it is interesting to note that

> the advantage of this appeal over that to individuals is that it avoids the controversial issue of individual preference and preferred treatment in a democratic welfare society. By placing the onus on the firm's need, private insurance becomes the handmaiden of efficiency and higher productivity and enhances social rather than individual goals.[29]

The growth of these provident schemes is a measure of the vitality of private practice and it can act as a stimulus to further growth. Their growth convinces people of the inherent advantages of private care, and conversely, of the limitations of care within the National Health Service. At present, the private health sector cannot exist without access to the facilities of the National Health Service: approximately 60-70 per cent of British United Provident Association patients are treated in National Health Service hospitals, the remainder in private hospitals and nursing homes.[30] But there may be in these private hospitals the beginnings of an independent, parallel private service.

British United Provident Association has a virtual monopoly of the privately controlled hospitals and private facilities outside the National Health Service. It is building small hospitals with

about thirty beds and full X-ray, theatre and diagnostic facilities at the rate of two to three per annum. At present, these facilities are provided through a charitable trust into which British United Provident Association channels profits from its investments and deeds of covenant.[31] But the future may bring significant changes in the rate of growth of such facilities and the nature of their funding. A British United Provident Association spokesman comments:

> Increasingly as the demand for these places grows, I am looking in economic terms at whether it would be advisable to go to the market and raise capital and pay interest on it, and try running in parallel, particularly in the London area, with hospitals which were entirely there on a non-profit, but certainly commercial basis, where we would have full control.[32]

It is anticipated that such developments would induce new membership.

The Significance of Private Health Care for the National Health Service

As indicated above, the private sector is small, but its continued growth may in the future pose a threat to the care available within the National Health Service. The eagerness of firms, such as British United Provident Association, to expand their operations is but one element fostering the growth of the private health sector. We must also examine the ways in which the very existence of private health care can lower the quality of care under the National Health Service and thus create additional demand for private care.

Why do people seek private hospital care? The main reasons appear to be the opportunities to choose the time of hospitalization; to receive care more quickly than National Health Service patients (in non-urgent cases); to choose one's consultant and be sure that he

will perform any operations; to have more attention paid to medical tests (which have the consultant's name on them); and a feeling they would generally receive better service and attention.[33] Arguments have been advanced that National Health Service patients are deprived of the care which they should be receiving as a result of the demands made by private patients on hospital facilities and on consultants. These arguments gained such prominence that in 1970-1971, the House of Commons' Employment and Social Services Sub-committee conducted hearings on the use of National Health Service facilities by private patients. The minutes of evidence of this committee provide numerous examples of the ways in which the treatment of National Health Service patients suffers because priority is frequently given to private patients. The report of the Expenditure Committee summarizes a part of this evidence as follows:

> Though the number of beds approved for private use are required to be made available to National Health Service patients if not in use, it was alleged that it was "not uncommon for beds to be wasted because they are being kept empty for private admissions." Also, it was added that because of long waiting lists for some types of surgical treatment, private patients obtained preferential admissions to National Health Service hospitals for surgical treatment, which meant National Health Service patients had to wait longer. It was stated that National Health Service patients who should be nursed in single rooms, for medical reasons, may be kept in large wards or moved into large wards so that private patients may obtain the privacy paid for.
>
> Other statements concerned the preferential use of operating theatres and diagnostic facilities. It was said that when private patients were included in the National Health Service operating sessions, they were usually placed early in the list so that operations on National Health Service patients "with an equal or superior priority" might be delayed or even cancelled. Regarding diagnoses such as special radiological investigations, it was asserted that though patients would be

> booked for specific times long in advance, if a private patient were brought in at short notice, it "usually led to the cancellation of one or more National Health Service appointments."[34]

Evidence was also presented of National Health Service beds being used by private patients;[35] of a lowering of staff morale due to consultants' neglect of their National Health Service work and excessive delegation of responsibility of such patients to juniors;[36] and of specific abuses such as the theft or borrowing of medical equipment and expensive instruments for private work.[37] But the many such examples of the lowering of the quality of National Health Service care due to the demands of private practice were given only token recognition by the Expenditure Committee. Albeit by a narrow majority, their conclusions were:

> that private practice operates to the overall benefit of the National Health Service. We recognize that, from time to time, abuses may occur as they may in any large organization. We do not condone this situation, but we do not believe abuses to be widespread or of any magnitude.[38]

Such a conclusion is not surprising perhaps if we consider the interests of consultants in retaining private practice unchanged. Certainly, their evidence before the Expenditure Committee was supportive of existing arrangements for private practice. If they wish, instead of working full time for the National Health Service, consultants may be employed on a part time basis. A maximum part time consultant accepts the obligations of a full time post, but is paid only 9/11th of the full time salary. In exchange, he has the right to engage in private practice. This combination of private and National Health Service work can be lucrative: in 1955-56, the average income

of part time male consultants in Britain was £3,603 while that of full time consultants was £3,002, and the average income of those in the highest income decile of part time workers was £5,393 while their full time counterparts received an average of £3,782.[39] Any restrictions on consultants' rights to enter private practice would, therefore, lower their income considerably and cause many to leave the country. The Report of the Expenditure Committee did recognize, therefore, the role played by private practice in keeping top consultants in Britain. But it failed to recognize the implications of a continued growth of private practice for the National Health Service.

As we have already noted, the private sector of health care accounts for only a small proportion of the population. Small numbers of patients are involved and the extent to which they deprive National Health Service patients of the care which they should receive is as yet small, but there are reasons for expecting a continuing growth in private practice and hence a further deterioration in National Health Service. However, the significance of the continued existence of the private sector has to be found in other than present numbers and the extent to which National Health Service patients are now deprived of care which they would otherwise receive.

We can focus, instead, on two related issues in illustrating the significance of private practice for the National Health Service. Firstly, there is the symbolic significance of private practice: the existence of a private health sector recognizes the right of patients who have the money, to pay for certain privileges which are by no

means simply non-medical privileges. Thus, recognition is given to the distribution of medical care on a basis other than need, and to the availability of two levels of care. Mencher comments:

> Since the rationale for private practice, when free medical care is available to all, must largely imply some service, the question of private practice cannot be comfortably divorced from the provision of two standards of care.[40]

In a symbolic sense at least, it can be argued that the National Health Service produced little change; just as before 1948, the wealthy can pay for private care while the poor receive public care. It is true that the majority of people receive public care, but a privilege has been retained--one which appears to be increasingly attractive to middle class patients. Continued growth of the private sector could produce two parallel health services: one catering largely to the middle class, the other, to the working class.

And herein lies the further significance of private practice for the National Health Service. The existence and continued growth of the private sector is important in that it can have in the future an increasing impact on the quality of care received within the public sector. In order for a demand for private care to exist, the National Health Service has to provide inferior care, and its existence can make public care even more inferior. By attracting mainly middle class patients, it robs the National Health Service of its more vocal and critical patients--patients whose continued use of the National Health Service might otherwise help to generate improvements within the public service. A circular process may be set in motion: the continued growth of provident schemes serves to convince people that

they do have something to offer, and as they grow in membership, their negative impact on the quality of National Health Service care may increase. Thus, yet more patients may be attracted to private practice, and as the private sector continues to prosper, the public service continues to deteriorate.

Summary

In conclusion, we argue that private patients compete for resources with National Health Service patients and that the claims of the former are frequently given priority. At present, because of the relatively small number of private patients, this has relatively little impact on the quality of care available under the National Health Service. However, the very existence of a private health sector gives formal recognition to the availability of two levels of care. And continued growth of provident schemes--which is particularly likely if they become an accepted fringe benefit--could lead to the development of two parallel health sectors. This would in many respects represent a return to the pre-1948 situation.

CONCLUSION

Our review of data on the use and quality of National Health Service hospitals indicates relatively equal access to health care, but studies which suggest the existence of class based inequalities do indicate the need for further research. We have argued that data on hospital admissions are relatively meaningless unless viewed in a broader context. Since similar patterns of hospitalization may exist

in medical care systems which contain marked inequalities in access to services and in those where equality of access prevails, hospitalization data must be interpreted in the light of the accessibility of primary care. And so because we observed no marked class inequalities in access to general practitioner care, we have argued that there appears to be relatively equal access to hospital care within the National Health Service. However, the question of whether unskilled and agricultural workers are disadvantaged in access to both general practitioner and hospital care has to be resolved by further research.

In our discussion of the private health sector, we have argued that the very existence of private care is a formal recognition of the availability of two levels of care and of the right of patients with high incomes to pay for care of superior quality. The private sector is, admittedly, small and it presents relatively little threat to the quality of care provided within the National Health Service. But while it is difficult to engage in social forecasting, the potential paths of development of the public and private health sectors should be considered in future planning of the health services. If group based private schemes become more widely accepted by companies interested in extending the fringe benefits of management, if the full page British United Provident Association advertisements which, over the past few years, have appeared more frequently in the better newspapers are successful in attracting new members, then the present annual growth rate of close to 8 per cent may increase. And should this be so, the possibility of a deterioration in the quality of care

within the National Health Service also increases. The potential development of two parallel health sectors should not be too easily dismissed.

We have already argued that whereas middle class patients were disadvantaged in access to hospital care prior to the introduction of the National Health Service, under the new service, the doors of the major hospitals were opened to them. We now see that they have fully availed themselves of National Health Service hospital care, and that they have, at the same time, retained the right to pay for private care and the privileges which it brings. And private hospital patients are no longer confined to smaller hospitals providing inferior care. In effect, therefore, middle class patients benefited from the introduction of socialized medicine,and at the same time, saw an extension of the benefits attached to receiving private care.

FOOTNOTES

[1]Data for the private health sector are available only for hospital services. About 2-3 per cent of patients receive private care from a general practitioner, but we have no data on the social class of these patients, the use they make of general practitioner services, or the quality of care which they receive. D.S. Lees, "Private General Practice and the National Health Service," Sociological Review, Monograph No. 5, Sociology and Medicine, (July, 1962), pp. 33-47. A. Cartwright, Patients and Their Doctors: A Study of General Practice (London: Routledge and Kegan Paul, 1967).

[2]Political and Economic Planning, Family Needs and the Social Services (London: George Allen and Unwin, 1961), pp. 55-57.

[3]Great Britain, General Register Office, Hospital Morbidity Statistics, by D. MacKay. Studies in Medical and Population Subjects, No. 4 (London: H.M. Stationery Office, 1951).

[4]Data on adult males were used as they are more complete than those on women and children. B. Abel-Smith and R.M. Titmuss, The Cost of the National Health Service in England and Wales (Cambridge: Cambridge University Press, 1956), Appendix H.

[5]Great Britain, Ministry of Health and General Register Office, Report of Hospital Inpatient Enquiry for the Two Years 1960 and 1961 Part III, Commentary (London: H.M. Stationery Office, 1967).

[6]J.R. Ashford and N.G. Pearson, "Who Uses the Health Services and Why?" Journal of the Royal Statistical Society, Series A (General) Vol. 133, Part 3, (1970), pp. 295-345.

[7]R. Barr, "Hospital Admissions and Social Environment," The Medical Officer, Vol. 100, No. 23 (1958), pp. 351-354.

[8]A.D. Airth and D.V. Newell, The Demand for Hospital Beds (Newcastle-upon-Tyne: University of Durham, King's College, 1962).

[9]M.R. Alderson, "Terminal Care in Malignant Disease," British Journal of Preventive and Social Medicine, Vol. 24, No. 2 (May, 1970), pp. 120-123.

[10]M.R. Alderson, "Referral to Hospital Among a Representative Sample of Adults Who Died," Proceedings of the Royal Society of Medicine, Vol. 59, No. 2, (1966), pp. 719-721.

[11]N.R. Butler and D.G. Bonham, Perinatal Mortality (London: E. and S. Livingstone, 1963). Airth and Newell's study in Hartlepools and Middlesborough also found that women from poorer areas and council estates were least likely to have their children in hospital. Airth and Newell, op. cit.

[12]R.M. Titmuss, The Gift Relationship (London: George Allen and Unwin, 1970).

[13]Ibid., p. 136.

[14]R. Andersen et al., Medical Care Use in Sweden and the U.S, Chicago, Center for Health Administration Studies, Research Series 27 (Chicago: University of Chicago Press, 1970).

[15]See data for agricultural and unskilled workers in Table 11 above.

[16]This does not imply that care in a non-teaching hospital is inadequate.

[17]G. Forsyth, Doctors and State Medicine: A Study of the British Health Service (London: Pitman Medical Publishing Company, Limited, 1966).

[18]Ibid., p. 97.

[19]A. Cartwright, Human Relations and Hospital Care (London: Routledge and Kegan Paul, 1964). Also the analysis by Abel-Smith and Titmuss of hospital discharges in 1949 indicates no middle class bias in teaching hospitals. (See Table 9 above.) Abel-Smith and Titmuss, op. cit.

[20]J.S.A. Ashley, A. Howlett, and J.N. Morris, "Case Fatality of Hyperplasia of the Prostrate in Two Teaching and Three Regional Board Hospitals," Lancet, ii (December, 1971), pp. 1308-1311.

[21]Ibid., p. 1311.

[22]Cartwright, Human Relations and Hospital Care, op. cit.

[23]Ibid., p. 202. Of middle class heads of families who normally worked, 77 per cent received full wages, 12 per cent received no money from their employer, and 9 per cent felt they had encountered severe or moderate financial strain. The comparable figures for working class heads of families were: 20 per cent, 12 per cent, and 52 per cent respectively.

[24]B. Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964), p. 401-2.

[25]M. Lee, Opting out of the National Health Service (London: Political and Economic Planning, June, 1971), p. 16.

[26]Ibid., p. 13

[27]Ibid., p. 15.

[28]Great Britain, House of Commons, Expenditure Committee, National Health Service Facilities for Private Patients (London: H.M. Stationery Office, 1972), Fourth Report, p. 35. See also, S. Mencher, Private Practice in Britain (London: G. Bell and Sons, 1967).

[29]Mencher, op. cit., p. 30.

[30]Great Britain, House of Commons, op. cit., p. 36.

[31]Ibid., p.44

[32]Ibid., p. 47.

[33]Mencher, op. cit., Chapter 3.

[34]Great Britain, House of Commons, op. cit., p. xvi.

[35]Ibid., p. xxi.

[36]Ibid., p. xvii.

[37]Ibid., p. xviii.

[38]Ibid., p. xxii.

[39]Mencher, op. cit., p. 19

[40]Ibid., p. 73.

CHAPTER IX

DENTAL CARE: AN EXCEPTION TO THE GENERAL PATTERN

Introduction

As in the previous two chapters, the initial question from which we proceed is that of whether class inequalities in use of dental services exist. In other words, to what extent are the needs for dental care of patients of different social class being met within the National Health Service? We will argue that:

1. Unlike general practitioner and hospital services, working class patients do not make as full use of the dental service as their needs for treatment would lead us to expect. All patients make less frequent use of dentists than is warranted by their needs for care, yet this gap is considerably more obvious for working class patients.
2. This inequality in the use of dental services may be explained by the absence of a tradition of public or charitable dental care for the working class, by the comparatively high costs of care, and by the rather negative public image which the dentist possesses. Variations in access to health care cannot, therefore, be explained simply in terms of the presence or absence of a system of socialized medicine.

The first sections of this chapter review the data on needs for dental care, and the use made of the dental service by patients of different social class. The latter sections are devoted to a discussion

of the probable reasons for the much more obvious class bias than exists in the case of the other two major sources of care within the National Health Service.

NEEDS FOR DENTAL CARE

The same pattern which emerges in relation to general morbidity is evident with respect to dental health: persons of lower social class experience poorer dental health and have a greater need for care. A thorough study of the need and demand for dental treatment has been sponsored by the Nuffield Provincial Hospitals Trust.[1] The research covered a random sample of the population aged twenty-one years and over in two towns in England--Salisbury and Darlington. The sample in Salisbury was examined between April and September, 1963, and that in Darlington between September, 1963 and March, 1964. Table 14 shows the proportion of teeth present which were found to be decayed by the social class of the individuals examined. The results are presented separately for the two towns. It can be seen that the proportion of decayed teeth (and thus the need for care) is higher in the manual groups than in the non-manual: the proportion of people with no decayed teeth ranges from 40 per cent in classes I and II, to 15 per cent in classes IV and V in Salisbury, and from 37 per cent to 13 per cent respectively in Darlington. These types of results have also been found in later studies. The first dental survey on a national scale was conducted by the Government Social Survey in 1968. This covered a random sample of adults aged sixteen years and over

TABLE 14.--Social class and proportion of teeth present found to be decayed, Salisbury and Darlington, 1963-64

Social Class	Teeth Present Found to be Decayed				
	None	Less than 1/3	1/3-2/3	Over 2/3	Total N = 100%
Salisbury					
I and II	40	53	8	-	40
III non-manual	32	64	4	-	47
III manual	22	66	9	3	76
IV and V	15	75	10	-	20
All groups	28	63	8	1	183
Darlington					
I and II	37	52	7	4	27
III non-manual	38	55	8	-	40
III manual	14	78	7	1	91
IV and V	13	73	15	-	40
All groups	22	69	8	1	199

Source: J.S. Bulman et al., Demand and Need for Dental Care (London: Oxford University Press, 1968), p. 17.

in England and Wales and showed an increasing level of tooth loss as social class declined.[2]

These studies indicate that needs for dental care are greater among working class patients, and yet data on use of dental services show that it is middle class patients who make the most frequent demands for care.

USE OF THE DENTAL SERVICE

The Survey of Sickness provides mean annual dental consultation rates for the period 1943-1952.[3] These rates, for males aged sixteen years and over, show a clear increase with increasing income level: they range from thirty-seven for those earning less than £3 per week to eighty-eight for those earning over £10 per week.

The more thorough study of needs and demands for dental care which was sponsored for the Nuffield Provincial Hospitals Trust indicates a similar variation. In all social classes, the need for care exceeds the actual demand, but the discrepancy between need and demand increases with lower social class. Table 15 indicates the proportion of teeth which had been restored by the social class of the persons examined in both Salisbury and Darlington. In Salisbury, 85 per cent of the subjects from classes IV and V had less than one-third of their teeth restored, and in Darlington, 88 per cent. The comparable figures for classes I and II were 28 per cent and 44 per cent. It is also interesting to note the differences between the manual and non-manual sections of class III. In Table 14, it can be

TABLE 15.--Proportion teeth found to have been restored by social class, Salisbury and Darlington, 1963-64

Social Class	Teeth Restored				
	None	Less than 1/3	1/3-2/3	Over 2/3	Total N = 100%
Salisbury					
I and II	10	18	58	15	40
III non-manual	9	49	43	-	47
III manual	23	41	33	1	76
IV and V	25	60	10	5	20
All groups	17	40	38	5	183
Darlington					
I and II	11	33	48	7	27
III non-manual	5	48	48	-	40
III manual	44	38	18	-	91
IV and V	60	28	13	-	40
All groups	35	38	27	1	199

Source: J.S. Bulman et al., Demand and Need for Dental Care (London: Oxford University Press, 1968), p. 19.

seen that non-manual workers in class III are less likely to have decayed teeth than manual workers in the same class. And Table 15 indicates that the former are more likely to seek dental care: in Salisbury, 9 per cent and in Darlington, 5 per cent of non-manual workers had no teeth restored while the equivalent figures for manual workers in the same class were 23 per cent and 44 per cent.

This study by Bulman et al also presents data on the period of time which had elapsed since the last visit to the dentist, and on the patterns of dental visits within the five years preceding the survey. Working class patients were least likely to obtain regular dental care. Over one-third of those from classes IV and V, and close to 15 per cent of those from classes I and II, had not visited a dentist in the ten years before the study. And, as Table 16 indicates, none of those in class V had received regular dental care in the past five years while one-third of those from classes I and II had done so. Furthermore, the proportion of people who did not consult a dentist at all during the preceding five years rises steadily from classes I and II to class V: in Salisbury, for example, the percentages range from nineteen for classes I and II to sixty-four for class V, and in Darlington, from 22 per cent to 50 per cent.

Further confirmation of this relationship between social class and use of dental services is found in a study by Cook and Walker.[4] Their analysis of payments made to dentists shows that in executive council districts with a high proportion of the population in professional and managerial occupations, the volume of dental treatment

TABLE 16.--Pattern of dental visits during past five years by social class, Salisbury and Darlington, 1963-64

Social Class	Pattern of Visits					
	Regularly	Occasionally	Rarely (Pain)	Rarely (Dentures)	No Visits	Total N = 100%
Salisbury						
I and II	33	23	10	15	19	88
III non-manual	28	20	18	3	30	93
III manual	14	17	15	11	43	203
IV	6	8	23	11	53	53
V	-	9	18	9	64	22
Darlington						
I and II	35	29	8	6	22	49
III non-manual	21	9	24	14	32	91
III manual	6	8	29	13	45	248
IV	1	10	23	15	51	79
V	-	4	30	15	50	46

Source: J.S. Bulman et al., Demand and Need for Dental Care (London; Oxford University Press, 1968), p. 39

was higher than in those executive council districts with a high proportion of unskilled and semi-skilled manual workers. They also compare expenditures on dental care in 1952 and 1962. After adjustments for price changes, the 1962 figure for England and Wales shows an increase of 51 per cent over the 1952 figure, and there was a tendency for the greatest increase to be in those districts in which most money was already being spent on dental treatment--predominantly middle class districts.

Clearly, although needs for dental care appear to be greater on the part of working class persons, it is middle class patients who make the most frequent demands for care. Why do these clear class differences exist with respect to dental care when they do not for the other medical services which we have discussed? There seem to be several possible explanations, and we move first to consider the pattern of development of dental services in Britain.

HISTORICAL DEVELOPMENT OF DENTAL SERVICES

The Absence of a Tradition of Care

While there has been a long tradition of providing both hospital and general practitioner care for the poor,[5] no such tradition developed with respect to dental care. It has always been a service provided largely for, and mainly valued by the middle class. While higher income families were able to develop habits of fairly regular dental inspections and treatment (thus protecting their teeth and preventing extractions), lower income families tended to have to wait

until pain forced them to visit a dentist, when extraction was usually the only possible treatment.[6] As Herbert comments in 1939:

> The wealthier classes have acquired the habit of visiting a dentist regularly and looking to him to protect their teeth rather than to extract them when decay has finished its work. But the working classes generally have not come to realize the importance of dental health, and in any case many of them cannot afford regular dental treatment. Accordingly, they tend to wait until pain drives them to the dentist. By that time extraction is often the only remedy.[7]

The minimal provision of public or charitably supported dental care, no doubt, stems partly from the nature of dental problems. While infectious diseases were a potential threat to the wealthy, decayed teeth were a problem to their bearer alone. Self-interest did not, therefore, lead the wealthy to provide for the care of those less fortunate than themselves. But we should also recognize that dental treatment had a relatively low value placed upon it by all sections of society--even motivated by altruism, the wealthy were not likely to see this as an important benefit to be made available to workers.

The low value placed on dental care is in part dependent on the nature of dental problems which allow for a greater amount of discretionary behaviour--it is much easier to ignore cavities (unless they become the source of real pain) than it is to ignore many general medical problems. It is also undoubtedly related to the status of the profession and the later development of dentistry and dental treatments. Dentistry "only slowly achieved the dignity of a profession": professionalization took place at a relatively late date, considerably

after the classic age of British philanthropy. Whereas the General Medical Council (supervising the medical training and qualifications of doctors) was established in 1856, the similar body for dentistry was only established in 1921.

Prior to the introduction of the National Health Service, and apart from private care, dental treatment was available at maternity and child welfare clinics, ante-natal clinics, and through the School Medical Service. Treatment was also provided at dental hospitals, the outpatient departments of general hospitals and at municipal clinics. And if patients were covered by none of these services and were unable to pay privately for care, Public Assistance Committees and some charitable organizations would provide help for needy cases. But these services were in no way as extensive as those for general medical and hospital care.

Dental Care Under the National Health Insurance Scheme

Dental care was provided as an additional benefit under the National Health Insurance scheme, but less than 10 per cent of the insured population eligible for dental benefit actually applied for treatment in any given year. In fact, procedures for applying were by no means straightforward, and there were no clear guarantees that the National Health Insurance scheme would pay for the treatment received. Should the dentist do a thorough job and the cost be high, an Approved Society might deny payment--even if the treatment had been formally approved by the Dental Benefit Council. This alone

was likely to lead to different treatments for insured and private patients.

The Approved Society rarely paid the whole cost of care--unless it was under 10 shillings, and the procedure for claiming such benefit was not simple. After applying for benefit, the insured person might be required to submit to an examination by a Regional Dental Officer. Then, if the claim were accepted, there would often be a delay before receiving treatment since the Committee of Management of an Approved Society had to fix the proportion of the cost to be paid by the Society--which in no case should be less than half the cost of treatment. And, since such additional benefits were dependent on the Approved Society having surplus funds, where morbidity was high or needs for care great, such additional benefits were least likely to be available. As Levy notes,

> These administrative conditions and circumstances do not tend to stimulate dental treatment on the part of a class which is in general inclined to take dental conservation lightly and tries to avoid medical action in what in many cases is at first regarded more as an inconvenience than a sickness.[8]

Summary

The development of dental services was of a rather different nature than that of general practitioner and hospital services. From its beginnings, dentistry was essentially a service catering to middle class fee paying patients. The professionalization of dentistry took place at a relatively late date in Britain, and public or charitable dental care was never provided for workers and their families

in the same measure as general medical and hospital care. Quite simply, working class patients were in no position to develop the habits of obtaining dental care and the dentist never became a familiar figure in working class areas. In no position to develop a long tradition of valuing and obtaining regular care, working class patients were, therefore, unlikely to place a high priority on dental treatment as soon as the National Health Service made it more readily available.

But in seeking to explain present class inequalities within the dental service, we must go beyond a historical explanation and examine the organization of these services and the factors which continue to operate as a deterrent to working class patients seeking care. To these, we now turn.

CONTEMPORARY BARRIERS TO OBTAINING CARE

There is, in all classes, a discrepancy between needs for dental care and actual treatment, but the discrepancy is much greater for working class patients. Several features of the dental services within the National Health Service may help to explain these low rates of consultation on the part of working class patients. Firstly, the costs of dental care may prevent some patients from seeking treatment. The cost of dental care is comparatively high since patients pay a substantial part of the total cost at the start of a course of treatment.[9] And whereas the "hidden" costs of obtaining general practitioner care are only likely to present a problem for persons close to the

poverty line or below it, the costs of using dental services are likely to act as a deterrent to a wider section of the population. The study by Bulman et al. notes that manual workers were most likely to express dissatisfaction about the high cost of dental care: the dissatisfied were those most likely to visit a dentist only when they were in pain.[10] This, no doubt, help to explain the higher proportion of manual workers who have no natural teeth, and yet have no dentures.[11]

But costs alone are not a full explanation. The availability of dental care is also important. A study by Cook and Walker of the geographical distribution of dentists within the United Kingdom suggests that care may be less available for working class patients since dentists are more likely to set up their practices in middle class areas. Speaking of the geographical distribution of dentists, they note that

> In England and Wales there is clear evidence of an association with the social class structure of the population; the higher the proportion of persons in socio-economic group I (managerial and professional). . .the higher the proportion of dentists, and the higher the proportion of persons in socio-economic group III (unskilled or semi-skilled manual workers). . .the lower the proportion of dentists.[12]

That this may be an important factor in explaining lower rates of use on the part of working class patients is suggested by the fact that where more facilities are provided, the demand for treatment does rise to make use of them.[13]

Another possible explanation may lie in the public image and acceptance of the dentist: we can note distinct differences in the

popular images of dentists and doctors. In Chapter VII, we spoke of the homely and approachable image of the family doctor. The image of the dentist is quite different. It is almost as though the general practitioner exists to help you, while the dentist is there to hurt you. How many mothers tell their child, before a visit to the dentist, that "it won't hurt"? And how many have to make a similar promise before a doctor's visit? The Political and Economic Planning study of the health services notes that the major reason for not getting dental treatment when it is needed is that people are scared and apprehensive.[14] This fear which people have of dentists is brought out in Bulman's comments on the response to an offer of a free dental examination (an examination--not treatment!):

> No one who was examined objected to the examination procedure and many who came expecting to experience some discomfort were agreeably surprised. Several "examination refusals" were converted to acceptances after seeing a friend or relative emerge unscathed from the ordeal.[15]

And when these subjects were asked what they looked for when choosing a dentist, the most frequent answer was a "dentist who puts you at ease," and the next most frequent, "a dentist who doesn't hurt."

This negative image may explain the discrepancy between needs and demands for treatment in all social classes. But it may be more important for working class patients where knowledge about dental health and care may be lower,[16] where no long tradition of seeking regular dental care has developed, where dentists are not easily accessible, and where costs are already acting as a deterrent. Each of the factors which help explain the low rates of consultation on

the part of working class patients may thus tend to reinforce each other. And though the National Health Service did, in theory, provide more ready access to dental care, these aspects of the organization and delivery of care may have inhibited many patients from using the new services offered to them.

CONCLUSION

There is an obvious difference between the patterns of use of dental services and of general practitioner and hospital services. In the latter cases, relatively few instances of class inequalities are evident, but with respect to dental care, we see quite obvious inequalities. While all patients fail to obtain the care which dental examinations indicate as being necessary, working class patients are considerably less likely to receive the care which they need. We have argued that the low rates of consultation on the part of working class patients may be understood in terms of the historical development of the dental service and the present organization of this service. The absence of a tradition of public and charitable care prevented the identification of the dentist as an integral part of the working class community and hindered the development of values and attitudes conducive to patients seeking care on a fairly regular basis. And though the introduction of the National Health Service made care more readily available, the relatively high costs of obtaining this, the tendency of dentists to locate their surgeries in middle class areas and the continuing negative image of dentists may

have further hampered the development of habits of fairly regular dental inspection and treatment among working class families. A greater correspondence between needs for care and use of the dental services might be achieved with a reduction in the costs of care, a relocation of many dentists in working class areas and an educational programme on dental health and treatment. But further research is essential if we are to determine which of these factors are most important in explaining the frequency with which patients seek care.

Insofar as the welfare state is viewed as reducing class inequalities, it is socialized medicine which is seen as narrowing inequalities in access to care. We have, in our discussion of general practitioner services, argued that the introduction of a system of socialized medicine is only one of several factors which may operate to produce equality of access to medical care. This discussion of the dental service reinforces these arguments. It again draws our attention to the importance of the tradition of care existing before the introduction of socialized medicine, and to the extent to which practitioners--whether general practitioners or dentists--possess a favourable public image. While the general practitioner is and has for many decades been an accepted element within the working class community, this has not been true of the dentist.

Though dental care is provided within the National Health Service, the costs involved in obtaining it are greater than is the case for general practitioner care. For this reason, it is not as good an example of socialized medicine as we might wish, and we must

limit the inferences we might make from a comparison of the dental and general practitioner services. However, it appears that variations in access to medical care cannot be explained simply in terms of the presence or absence of a system of socialized medicine.

FOOTNOTES

[1]J.S. Bulman et al., Demand and Need for Dental Care: A Socio-Dental Study (London: Oxford University Press, 1968).

[2]Great Britain, Government Social Survey, Adult Dental Health in England and Wales in 1968, by P.G. Gray et al. (London: H.M. Stationery Office, 1970).

[3]Great Britain, General Register Office, The Survey of Sickness, 1943-52, by W.P.D. Logan and E.M. Brooke. Studies in Medical and Population Subjects, No. 12 (London: H.M. Stationery Office, 1957).

[4]P.J. Cook and R.O. Walker, "The Geographical Distribution of Dental Care in the United Kingdom: Part 2, Changes Between 1952 and 1962," British Dental Journal, Vol. 122, No. 11 (1967), pp. 494-499.

[5]The reader may refer back to Chapter I above, for a discussion of the development of this tradition.

[6]A. Forder (ed.), Penelope Hall's Social Services of England and Wales (London: Routledge and Kegan Paul, 1971), Chapter 6.

[7]S.M. Herbert, Britain's Health (Harmondsworth: Penguin Books, 1939), p. 148. The author's comments are based on a Political and Economic Planning report on the British health services which was completed in 1937.

[8]H. Levy, National Health Insurance (Cambridge: Cambridge University Press, 1944), p. 155.

[9]R.M. Titmuss, Essays on the Welfare State (London: Unwin University Books, 1963).

[10]Bulman et al., op. cit., p. 53.

[11]Gray et al., op. cit., p. 101.

[12]P.J. Cook and R.O. Walker, "The Geographical Distribution of Dental Care in the United Kingdom: Part 1, Sources of Information; Methods of Presentation; Distribution of Dentists," British Dental Journal, Vol. 122, No. 10 (1967), pp. 445-446.

[13]P.J. Cook and R.O. Walker, "The Geographical Distribution of Dental Care in the United Kingdom: Part 2," op. cit., p. 498.

[14]Political and Economic Planning, Family Needs and the Social Services (London: Allen and Unwin, 1961), p. 121.

[15]Bulman et al., op. cit., p. 11

[16]Ibid.

CONCLUSION

While there is a continuing debate between marxist and pluralist theories as to the nature of the distribution of power in advanced industrial societies, we have identified certain common assumptions concerning the introduction of welfare services and programmes, and the extent to which they have contributed to the reduction of class inequalities. Both marxist and pluralist theories have assumed that:

1. The welfare state represents a radical departure from the prior organization of services and programmes;
2. The working class was in a particularly disadvantaged position prior to the introduction of welfare state services;
3. The introduction of welfare services and programmes was a response to working class pressures for reform;
4. As such, welfare measures were addressed to the needs of the working class and to reducing class inequality;
5. The welfare state has reduced class inequalities and achieved a measure of income redistribution.

These assumptions also embody a class theory of social change and convey a sense of continuing progress. Though the two theoretical perspectives differ on the issue of how widely power is distributed throughout society, they both appear to assume that a measure of progress results from those redistributive processes which channel benefits, traditionally received by the middle class, to working class families.

This study has examined the sources and impact of the National Health Service in Britain and, in questioning the assumptions made in marxist and pluralist theories, has developed alternative interpretations of the emergence and operation of this one branch of the welfare state. The research was conceived as an exploratory study. Obviously our arguments concerning the National Health Service cannot be generalized to other welfare services and programmes in Britain, nor to public health care systems in other countries. These are issues for further research. Similarly, the arguments developed in this study must be viewed in the form of hypotheses which might be tested in more focussed studies drawing upon original sources. The breadth of the issues upon which we have touched have precluded such systematic analysis of original sources.

SEVEN ALTERNATIVE PROPOSITIONS

Drawing together the threads of the arguments developed in the preceding chapters, we propose that:

1. The National Health Service was not a radical departure from the organization of health services prior to 1948.
2. Working class patients were not severely disadvantaged in obtaining medical care prior to 1948. Middle class patients were, in some respects, in a particularly disadvantageous position.
3. The National Health Service was in large part a response to the recognition of a need for organizational and administrative

rationality and for a stable source of financial support for the hospitals. The National Health Service Act was addressed to these goals.

4. The recognition of problems within the health services and the concern for change came largely from the medical profession and hospital administrators.
5. The National Health Service may be no more effective in redistributing income than were the health services prior to 1948.
6. Though not specifically addressed to achieving such, there are no glaring inequalities in access to medical care within the National Health Service. This may be due not so much to the system of socialized medicine per se, as to the central role of the general practitioner in the service.
7. While there are no marked inequalities in access to care, there is a growing class inequality in health levels as measured by mortality rates.

Let us address ourselves to each of these issues in turn, indicating the way in which we were directed by questions arising from those assumptions made within marxist and pluralist theories and briefly reviewing the data which we have discussed in the preceding chapters.

1. The National Health Service was not a radical departure from the organization of health services prior to 1948.

Both marxist and pluralist theories assume that the emergence of the welfare state represents a marked departure from the earlier

provisions made for the poor and the working class. While the exact nature of this change is not made explicit, we might take it to imply one of several things in relation to health services. The image of a marked change may be founded on the assumption that no tradition of publicly provided care existed before 1948; or that care was generally not available to the working class prior to the introduction of the National Health Service; or that the principle on which care was provided was different from that under the National Health Service. But our analysis of the development of health services in Britain from the mid-nineteenth century onwards suggests that none of these assumptions are valid. As we have shown in Chapter I, the roots of the National Health Service can be traced back to the mid-nineteenth century and beyond: during this time, a strong tradition of public and charitable care was established in Britain and care was available for the destitute and the working class at little or no cost. And in the latter part of the nineteenth century and the early decades of the twentieth century, the State gradually extended its sphere of responsibility in providing health care. These facts do not lead to the beguilingly simple thesis that the National Health Service was a natural extension of this early tradition. But it should be recognized that the principles upon which the National Health Service was founded were established many decades prior to the introduction of the service: the basis for the new service was laid by the National Health Insurance scheme (1911), and by the extension of free hospital services to all persons suffering from certain diseases. Through

such measures the principle of free care with no means test was early established.

This sense of continuity may also be understood in terms of the interest groups generated by the structure of health service prior to 1948. As our discussion in Chapter IV indicated, not all these groups were successful in protecting their interests in the negotiations prior to the introduction of the National Health Service, but the relative success of consultants and general practitioners does help to explain the continuity of structure within the health services.

It is on the basis of such data that we argue that the National Health Service cannot be regarded as a radical departure from the prior organization of health services, and that it was in large part built upon the existing institutional framework.

2. Working class patients were not severely disadvantaged in obtaining medical care prior to 1948. Middle class patients were, in some respects, in a particularly disadvantageous position.

Marxist and pluralist theories convey the impression that welfare state services and programmes were introduced in an effort to reduce class inequalities. With respect to health care, such an assumption leads us to predict that before the introduction of the National Health Service, the poor and the working class were either denied the care available to middle class patients, or that the care which they received was of distinctly lesser quality than that obtained by middle class patients. However, it appears that no such simple statements can be made concerning class inequalities in access to care and use

of services prior to 1948.

Free public and charitable care was available for the working class even in the mid-nineteenth century and treatment was provided at small cost through various types of contributory schemes. From 1911, workers received free general practitioner care while their dependents continued to receive treatment from the same sources as previously. The rising costs of care led to limitations being placed on the amount of free care available, and those above the level of destitution began to be charged for a part of the cost of treatment, yet these increasing costs were partly balanced by the rapid growth in membership of contributory schemes. There is little data to indicate the use made of health services by patients of different class background, but that which is available for the two years before the introduction of the National Health Service indicate just slightly lower rates of consultation with doctors on the part of working class patients.

Differences in the quality of care received by working class and middle class patients were probably minimal in the mid-nineteenth century. But as medical care increased in sophistication, it is possible that in terms of general practitioner care, middle class patients received better treatment. However, this was not so in respect of hospital care. Local and voluntary hospitals in the early 1940's were admitting mainly working class patients while middle class patients were confined to the smaller and less well equipped private hospital system. In this respect--and in the fact that they received no

financial concessions in obtaining care--middle class patients were in a disadvantaged position.

It is not that the problems in obtaining health care were non-existent for working class families--even small costs may have severely strained the purses of workers' families, and in addition to financial deterrent to seeking care, the moral stigma of accepting charity may have inhibited some from obtaining care. Rather, we argue that it is inappropriate to recognize problems as existing for the working class alone: middle class patients received no financial concessions in obtaining care and were generally unable to obtain care in the mainstream of the hospital system.

3. The National Health Service was in large part a response to the recognition of a need for organizational and administrative rationality and for a stable source of financial support for the hospitals. The National Health Service Act was addressed to these goals.

Insofar as marxist and pluralist theories argue that welfare services and programmes were addressed to class inequalities, they are not only insensitive to the problems faced by middle class patients in obtaining medical care, they also ignore the internal problems within the health services prior to 1948. We have argued that the practical problems of providing medical care in large part explain the genesis of the National Health Service: it was predominantly a response to the increasing costs of care and to the chaotic organization of the health services. The development of medical science created increasingly sophisticated drugs, and more efficient and complex diagnostic and surgical procedures secured a more central role

for the hospitals within the health system. At the same time the costs of providing care increased considerably and during the 1920's and 1930's, the hospitals were starved of funds and the voluntary hospitals became increasingly dependent on government money. These financial problems must be viewed against the background of the chaotic organization of the health services: care was available from myriad sources, there was much duplication of services and equipment, and little co-ordination of administratively separate units.

The demands of wartime highlighted and intensified these problems. There was a very real need for a stable source of finance for the hospitals, and also for a rationalization and integration of the health services; it was to these issues that the plans and negotiations prior to the National Health Service were addressed. Unfortunately, these negotiations were largely conducted in secrecy, but it appears that neither equality of access nor improved access to care for working class patients were the primary focus in the evolution of plans for the new service. Given the fact that working class patients were not severely disadvantaged in access to care, and that organizational issues are inevitably paramount in any such process of planning, this seeming inattention to issues of social justice is perhaps not surprising. But further research might usefully explore the manner in which the State's proposals for the new service were guided by an egalitarian ideology committed to reducing severe class inequalities.

4. The recognition of problems within the health services and the concern for change came largely from the medical profession and hospital administrators.

Both marxist and pluralist theories view the introduction of welfare services and programmes as being a response on the part of the state to pressures for reform from the working class. Such an argument leads us to predict pressures from workers through unions or the Labour party for changes in the organization and delivery of health care. But such direct pressures for reform of the health services do not appear to have been strong.

The problems in providing health care had been recognized for several decades. But the initial recognition came not from the working class, nor the Labour party (as a representative of workers), nor so much from the State, as from members of the medical profession and hospital administrators: the problems were largely defined by, and blueprints for a new service formulated by those working within the health services. The proposals for a reorganized health system--the reports of the Socialist Medical Association, the British Medical Association, the Dawson Report, the Medical Planning Commission--stemmed mainly from the various branches of the medical profession. Public pressures appear to have been at a minimum and in negotiations prior to the introduction of the National Health Service, representatives of the public were excluded. The political left, as a representative of the working class, was not in the forefront of pressures for reform--the Labour party only really accepted the proposals of the Socialist Medical Association in 1942 when there was already a

general acceptance of an urgent need for reform within the health services. And even in 1941, the government was thinking simply in terms of a reorganization of the hospital system.

It is on the basis of such data that we have argued that those working within the health service were in the forefront of the movement for reform. While the first major step towards socialized medicine--the National Health Insurance scheme--may be viewed in part as a response to pressures from increasingly organized workers, changes within the health services after 1911 appear to be intelligible mainly in terms of the internal dynamics of the health system.

5. The National Health Service may be no more effective in redistributing income than were the health services prior to 1948.

Underlying the assumptions made in both marxist and pluralist theories as to the impact of welfare services and programmes, there is an implicit belief in continuing progress. The welfare state is seen as reducing the most severe class inequalities. With respect to the National Health Service, this sense of continuing reduction of inequality appears, at first sight, to be well founded. Not only are there no glaring inequalities in access to general medical care--a point we will turn to in a moment--the health service, financed largely through general taxation, also achieves a small measure of income redistribution. However, its exact contribution to the redistribution of income is not clear and if we also consider the fact that mechanisms of income redistribution were operating before the introduction of the National Health Service, we must question whether the new service has

a greater redistributive effect than the mechanisms operating before its introduction. Through public medical care, philanthropy, and middle class patients paying high private medical fees, thus subsidizing the free or low cost care of poorer patients, a measure of income redistribution was occurring prior to 1948. Unfortunately, in the absence of data on taxation, on the costs of care, and the use made of medical services before 1948, we are unable to assess the amount of redistribution which occurred. And in the absence of more precise data on the redistributive effect of the National Health Service, we can neither assess its present impact nor compare its effectiveness with that of the health services prior to 1948. But, in the light of the regressive costs of service, we have argued that its redistributive role is likely to be quite small and that it is possible that the mechanism rather than the amount of redistribution has changed. Further research might usefully explore this issue.

6. Though not specifically addressed to achieving such, there are no glaring inequalities in access to medical care within the National Health Service. This may be due not so much to the system of socialized medicine per se, as to the central role of the general practitioner in the service.

With respect to general practitioner and hospital care, there appear to be no marked inequalities in the use of services by different classes. There is some evidence of class variations in the quality of care received, and some suggestion that parts of class V make less use of services than their mortality and morbidity experience would lead us to expect. However, the overall impression is one of relatively equal access to care.

It is a paradox that though the National Health Service was not specifically addressed to achieving equality of access, there appears to be less class inequality under the National Health Service than under other public medical care systems. We have argued that this relative equality of access is intelligible not simply in terms of the availability of free care, but also in terms of the long history of care which had been available to the working class which has rendered the doctor an accepted member of the community and, most particularly, in terms of the organization of the National Health Service around the general practitioner. The general practitioner is responsible for guiding patients through the complexities of the medical system and there appears to be relatively little social distance between the doctor and the working class patient. Such arguments are lent support in the observation that class inequalities are marked in the use of dental services where there is no long tradition of care and the dentist is often seen in negative terms.

7. While there are no marked inequalities in access to care, there is a growing class inequality in health levels as measured by mortality rates.

We have discussed differences in levels of health between working class and middle class patients in Chapter VI in order to establish a framework for interpreting data on the use of services. But these data also give us an indication of the consequences for people's health of use of medical services. Paradoxically, we see that though there is relatively equal use of medical services under the National Health Service, there has been a widening of class differences in levels

of health as indicated by mortality rates.

Two types of influence are reflected in these mortality data. Firstly, what might be called social class influences which include "wealth, intelligence, personal habits, diet, home environment, and general occupational factors such as physical exercise and mental stress,"[1] and secondly, the occupational hazards which are specific to a job. These effects are difficult to disentangle, but one useful comparison is that between men and women. Wives, to some extent, act as a control for their husbands in respect of social class factors, so that a marked difference in rates between men and married women suggest that variations in male mortality rates might be largely due to differences in occupational risks.

If we compare standardized mortality ratios for males and married women between the ages of 15 and 64 for selected causes of death, we see that of seventy-nine causes of death applying to both men and women, a common negative class gradient is evident for thirty-seven. In these instances, the rates for social class V are higher than those for social class I for both men and married women. This would suggest some common social class influence. For a further twenty-two causes of death, there was no uniform class gradient for either sex, and for twenty, there was a class gradient (usually negative) for only one of the sexes.[2] These latter may be a reflection of occupational risks and sex role differences.

These data suggest that class variations in mortality are not simply a result of the greater hazards involved in lower class occupations. Similar variations in rates for men and women indicate that

more general social class factors are important in explaining differences. But it is not clear why improvements in rates for class V have not been of the magnitude of those for other classes. It is obvious, however, that the National Health Service has failed to reduce class inequalities in levels of health (as measured by mortality rates). Even though people of different social class background appear to have equal access to medical services, they do not appear to benefit to the same extent.

SOME BROADER ISSUES

The research reported here also raises some broader issues. Firstly, we may question the sense of continuing progress which is implicit in the assumptions to which we have addressed ourselves. Indeed, the notion of progress is of limited utility in the study of increasingly complex social structures with many competing values and the paradox of poverty in the midst of affluence, or, of more relevance to this study, equal access to health care yet widening class inequalities in levels of health. For how are we to measure progress? If by access to medical care, then perhaps this was eased with the introduction of the National Health Service--certainly the barriers to obtaining care under the service seem few. But if we mean improved levels of health and a narrowing of class differences in this respect, then progress is doubtful.

We may also question the utility of a dominant emphasis on class conflict as providing the dynamic for social change. In understanding the emergence of new social structures, the importance of new,

technologically or institutionally based interest groups must also be recognized. This study has indicated the importance of the varying interests of consultants, general practitioners, and hospital administrators in excluding middle class patients from the best hospital care until 1948, and it has also shown the role of the various professional groups in shaping the National Health Service during the negotiations preceding the introduction of the new service. In these ways, we have highlighted the importance of institutionally and technologically based interest groups, with conflicts between them cutting across class interests. In seeking more consciously directed change, the challenge is one of creating goals which transcend such sectional interests and creating institutional structures which might reduce the conflict of interests.

Moreover, the research reported here leads us to question whether class inequalities in health can be reduced simply by ensuring easy access to medical care. Indeed, the National Health Service appears to have made little contribution to reducing class inequalities in health and, even with a considerably greater emphasis on preventive medicine, it would have been waging only a partial war on sickness. For morbidity and mortality are affected by factors over which medicine has no control. Soon after the introduction of the National Health Insurance Act in 1911, Stewart Johnson wrote:

> . . . the conclusion forced upon us is that whereas medical attendance upon the insured class may do much to prevent such poverty as has been caused in the past by sickness, little can be accomplished by medical treatment to prevent sickness among the uninsured until they are first raised out of poverty. The remedy for ill-health among the very poor is not medical, but social and economic.[3]

This comment may still be appropriate. Class differences in health are intimately linked with other class inequalities--in income, wealth, education, standard of living, etc. Until these inequalities are reduced, inequalities in health are likely to remain. A major problem facing Britain--and most other capitalist societies--is that of extending the benefits experienced by the majority of the population to the lower class. Clearly, the health service alone cannot hope to eradicate these problems. But neither, it seems, can the welfare state as a whole. The efforts of the National Health Service to reduce inequalities in health have for many years been buttressed by a free state education system, public housing projects, and social security programmes. Yet none of these appear to have had any marked impact on those class inequalities which produce variations in levels of health.

Though we argue that inequalities in income, wealth, working and living conditions must be reduced before we can expect a marked reduction in health inequalities, this does not deny the importance of medicine and of easy access to medical care. In fact, we have throughout this study assumed that the health of patients is improved if their access to medical care is facilitated and they are able to consult a doctor whenever necessary. In so doing, we have adopted the premise underlying many critical analyses of health systems in advanced industrial society. In these, improved access of working class patients to health care is viewed as an important goal, and this is seen as being achieved by a variety of means which include better education about health problems, changes in the organization and

delivery of medical care and a reduction in the costs of care. As Rossdale argues: ". . .health has become equated with the right of every man to have access to an honest professional opinion. . . ."[4] And in other institutional areas also, changes are urged which would facilitate the access of the working class to the full benefits of the educational system, to legal counsel, and to other services more readily enjoyed by middle class families. Such critical analyses are essentially supportive of these institutional areas for they reaffirm the value we place upon the education our children receive, or the health care we obtain among other things.

But we may question such a premise. One of the most recent and challenging analyses of modern medical care systems criticizes these goals and their underlying values. In Medical Nemesis, Illich argues that medicine creates as well as cures illness.[5] He attributes advances in the health of populations largely to improvements in the quality of life--better nutrition, improved sanitation, etc. And while the development of modern medicine has played but a small role in reducing infant mortality and increasing life expectancy, it has succeeded in creating illness, and a dependency on drugs and on the medical profession. We have surrendered our autonomy. Autonomy, he argues, emerges from an acceptance of the realities of our existence--of pain, sickness, and death. Instead, we readily surrender ourselves to doctors and accept the dependency of the patient role. Thus, the problem we must face is not that of providing people with more medical care, but with less. And that which is provided must ensure the autonomy of the patient.

The challenge which Illich presents deserves comment. The autonomy of which he writes might equally well be labeled as fatalism--a less appealing label, given our contemporary sensitivities. It evokes images of the situation described in earlier chapters of this study--of illnesses endured at home while people waited and prayed for God's help. An image which if viewed positively may be seen through the glow of romanticism. His discussion of the poor of India and Mexico certainly suggests a romanticism and even the arrogance of those who can live more comfortable lives:

> The poor in Mexico or India have learned to survive by making do on their own, and they can survive because their environment does not yet impede them from fending for themselves.[6]

His vision of what might be achieved is sufficiently radical and far removed from present realities as to be of little use as a guide in the practical decisions which produce change. The goals towards which we seek to move cannot be totally removed from the realities of our present lives. But here lies a paradox. For it is such visions that we lack. Visions which help us to question those things we take for granted and which help us to conceive of changes which represent more than a simple elaboration of existing institutional structures; which enable us to create a series of steps or intermediate goals linking the present with future images and which move towards qualitatively different social forms. For while critical analyses of advanced industrial society have become more frequent in the last decade, we lack clear images of a new type of society towards

which we might strive. It is the absence of such visions which helped to ensure that the National Health Service was little more than an organizational and administrative change. While unrealistic, Utopian visions help us articulate qualitatively different forms of social organization, and may facilitate more than minor elaborations of existing organizational forms and almost imperceptible changes in the quality of our lives. At the least, Illich's arguments open to question one assumption on which this study is founded--that access to medical care is of significance for people's health.

FOOTNOTES

[1]Great Britain, General Register Office, The Registrar General's Decennial Supplement: England and Wales, 1961. Occupational Mortality Tables. (London: H.M. Stationery Office, 1971), p. 35.

[2]Ibid., Table E1, pp. 37-38.

[3]Quoted by B. Benjamin, "The Urban Background to Public Health Changes in England and Wales, 1900-1950," Population Studies, Vol. 17, Part 3 (1964), pp. 234-235.

[4]M. Rossdale, "Health in a Sick Society," New Left Review, No. 34, (1965), p. 89.

[5]I. Illich, Medical Nemesis (Toronto: McClelland and Stewart, 1975).

[6]Ibid., p. 65.

APPENDIX A

THE LOGIC OF ANALYSIS AND SOURCES OF DATA

Because of the breadth of the issues we have touched upon in this research, we have made no systematic use of primary sources. Instead, we have largely relied upon secondary analyses. And the data we present has not been such as to systematically test the validity of the assumptions contained in both marxist and pluralist theory concerning the sources and impact of the welfare state. Rather, we have indicated data which leads us to doubt the validity of these assumptions and have drawn attention to the absence (in secondary sources, at least) of data which would help to affirm these assumptions.

So, for example, there is no evidence in the sources consulted in this study of strong working class pressures for reform of the health services prior to 1948. But rather than systematically searching primary sources such as union publications and reports of trade union conferences for evidence of such pressures, we have instead drawn attention to pressures for reform from those professionals employed within the health service. Future research should pursue both these themes, seeking to determine through more rigorous analysis of primary material the source and nature of pressures for reform of the health system. We have simply cast doubt on the assumption that such pressures emanated from the working class, and at the same time raised the possibility that pressures for change originated among those whose professional interests lay within the health system. More

detailed research has been beyond the scope of this research since this is but one of several issues to which we have directed our attention.

It is for such reasons that this research must be viewed as a preliminary step in questioning assumptions concerning the sources and impact of the welfare state. The arguments we have developed in relation to the National Health Service remain at the level of hypotheses. And we have simply raised the possibility that assumptions concerning the welfare state in general are open to doubt, and indicated the need for more systematic study of this major, yet much neglected, institutional area.

We have, at various points in the preceding chapters, indicated the limitations of the data upon which we have relied. Generally, we may note here that the nature of many of the sources which we have consulted means that we are bound by the accuracy of other's research, the validity of their interpretations, and their definitions of sociologically significant data. In the research, we have, therefore, been bound by the issues which others have already defined as important. But while operating within these limits, we have, nevertheless, been concerned with the extent to which the data, ideas, arguments, we have encountered are reliable. To what extent, for example, is the Webb's analysis of health care at the turn of the century credible? In seeking to resolve such problems, we have been guided largely by a concern with the plausibility of the arguments developed, their internal consistency, and whether they are independently

corroborated by other sources. Fortunately, we have been faced with relatively few instances of contradictory sets of data. In such cases--for example in studies of the use made of hospital services by patients of different social class--we have indicated the nature of these discrepancies.

These more general limitations inherent in the data and the arguments developed in the preceding chapters must be borne in mind by the reader. More specific problems associated with the data which are presented are discussed, when appropriate, in the text.

APPENDIX B

SOCIAL CLASS

In this study, we have defined social class largely in occupational terms and have distinguished between middle class and working class in terms of non-manual and manual occupations. This does not imply a unity or consciousness of class. Such a definition can be criticized from a variety of viewpoints,[1] but given the nature of the material with which this study is concerned, a more sophisticated definition of social class would have been impracticable. The sources we have used, most especially those relating to the period prior to 1948, do not provide us with sufficient information to make more rigorous distinctions in terms of occupation, income, education, and styles of life.

Our analysis of class variations in levels of health and access to care under the National Health Service makes frequent use of the Registrar General's classification which is based largely on occupation, but which also takes into account "standing within the community," and the correlation of occupational position with similarities of "social, cultural and recreational standards and behaviour."[2] Generally, class I may be seen as comprising higher professional and managerial occupations; class II, lower professional; class III, clerical and skilled manual occupations; class IV, semi-skilled manual occupations and class V, unskilled manual occupations. Unfortunately, therefore, no clear distinction is made between manual and non-manual occupations. This has meant that we have been largely

concerned with distinguishing negative and positive class gradients rather than making clear contrasts between middle class and working class.

FOOTNOTES

[1]For a discussion of such criticisms see: W.G. Runciman, Relative Deprivation and Social Justice (London: Routledge and Kegan Paul, 1966), pp. 45-51.

[2]Great Britain, General Register Office. The Registrar General's Classification of Occupations 1960. London: H.M. Stationery Office, 1960.

BIBLIOGRAPHY

BIBLIOGRAPHY

BOOKS

Abel-Smith, B. The Hospitals 1800-1948. London: Heinemann, 1964.

_____, and Gales, K.E. British Doctors at Home and Abroad. Welwyn: Codicote Press, 1964.

_____, and Titmuss, R.M. The Cost of the National Health Service in England and Wales. Cambridge: Cambridge University Press, 1956.

Ackers, J., et al. What's Wrong with General Practice. London: Bow Publications, 1965.

Airth, A.D., and Newell, D.J. The Demand for Hospital Beds. Newcastle-upon-Tyne: University of Durham, King's College, 1962.

Andersen, R., and Andersen, O.W. A Decade of Health Services: Social Survey Trends in Use and Expenditure. Chicago: University of Chicago Press, 1967.

Atkinson, A.B. Poverty in Britain and the Reform of Social Security. London: Cambridge University Press, 1969.

Badgley, R.F., and Wolfe, S. Doctors Strike: Medical Care and Conflict in Saskatchewan. Toronto: Macmillan of Canada, 1967.

Balint, M. The Doctor, his Patient and the Illness. New York: International Universities Press, 1957.

Bendix, R. Work and Authority in Industry. New York: Harper and Row, 1963.

_____, and Lipset, S.M. Class, Status and Power. 2d ed. New York: The Free Press, 1966.

Bevan, J.M., and Draper, G.J. Appointment Systems in General Practice. London: Oxford University Press, 1970.

Birnbaum, N. The Crisis of Industrial Society. London: Oxford University Press, 1969.

Braithwaite, W.J. Lloyd George's Ambulance Wagon. London: Methuen, 1957.

Browne, K., and Freeling, P. The Doctor-Patient Relationship. Edinburgh: Livingstone, 1967.

Bruce, M. The Coming of the Welfare State. London: B.T. Batsford, 1966.

Bulman, J.S., et al. Demand and Need for Dental Care: A Socio-Dental Study. London: Oxford University Press, 1968.

Butler, N.R., and Bonham, D.G. Perinatal Mortality. London: E. and S. Livingstone, 1963.

Butterfield, W.J.H. Priorities in Medicine. Oxford: Nuffield Provincial Hospitals Trust, 1968.

Cartwright, Ann. Human Relations and Hospital Care. London: Routledge and Kegan Paul, 1964.

_____. Patients and Their Doctors: A Study of General Practice. London: Routledge and Kegan Paul, 1967.

Coates, K., and Silburn, R. Poverty: The Forgotten Englishmen. Harmondsworth: Penguin Books, 1970.

Coe, R.M. Sociology of Medicine. New York: McGraw Hill, 1970.

Cox, A. Among the Doctors. London: Christopher Johnson, 1950.

DeGroot, L. (ed.). Medical Care: Social and Organizational Aspects. Springfield, Illinois: Charles C. Thomas, 1966.

Domhoff, G.W. The Higher Circles. New York: Vintage Books, 1971.

Douglas, J.W.B., and Blomfield, J.M. Children Under Five. London: Allen and Unwin, 1958.

_____, et al. All Our Future. London: Peter Davies, 1968.

Eckstein, H. The English Health Service. Cambridge, Mass.: Harvard University Press, 1958.

Ehrenreich, B., and Ehrenreich, J. The American Health Empire. New York: Vintage Books, 1971.

Evang, Karl. Health Service, Society, and Medicine. London: Oxford University Press, 1960.

Field, M.G. Soviet Socialized Medicine. New York: The Free Press, 1967.

Forder, A. (ed.). Penelope Hall's Social Services of England and Wales. London: Routledge and Kegan Paul, 1971.

Forsyth, G. Doctors and State Medicine: A Study of the British Health Service. London: Pitman Medical Publishing Company, Limited, 1966.

_____, and Logan, R.F.L. Gateway or Dividing Line?: A Study of Hospital Outpatients in the 1960's. London: Oxford University Press, 1968.

Frankel, H. Capitalist Society and Modern Sociology. London: Lawrence and Wishart, 1970.

Fraser, D. The Evolution of the British Welfare State. New York: Harper and Row, 1973.

Freidson, E. Patients' Views of Medical Practice. New York: Russell Sage Foundation, 1961.

Fry, J. Medicine in Three Societies: A Comparison of Medical Care in the U.S.S.R., U.S.A., and U.K. New York: American Elsevier Publishing Company, 1970.

Gemmill, P.F. Britain's Search for Health. Philadelphia: University of Pennsylvania Press, 1960.

Herbert, S.M. Britain's Health. Harmondsworth: Penguin Books, 1939.

Hodgkinson, Ruth G. The Origins of the National Health Service. London: The Wellcome Historical Medical Library, 1967.

Illich, I. Medical Nemesis. Toronto: McClelland and Stewart, 1975.

Jay, D. Socialism in the New Society. London: Longmans, 1962.

Jefferys, M. An Anatomy of Social Welfare Services. London: Michael Joseph, 1965.

Jewkes, J., and Jewkes, S. The Genesis of the British National Health Service. Oxford: Basil Blackwell, 1962.

_____, and _____. Value for Money in Medicine. Oxford: Basil Blackwell, 1963.

Kolko, G. Wealth and Power. New York: Frederick A. Praeger Inc., 1962.

Kosa, J., et al. Poverty and Health. Cambridge, Mass.: Harvard University Press, 1969.

Leff, S. The Health of the People. London: Victor Gollancz Ltd., 1950.

Lenski, G. Power and Privilege. New York: McGraw Hill, 1966.

Levy, H. National Health Insurance. Cambridge: Cambridge University Press, 1944.

Lindsey, A. Socialized Medicine in England and Wales. Chapel Hill, N.C.: University of North Carolina Press, 1962.

MacKenzie, N. (ed.). Conviction. London: MacGibbon and Kee, 1958.

Marsh, D.C. The Changing Social Structure of England and Wales 1871-1961. Revised edition. London: Routledge and Kegan Paul, 1965.

Martin, J.P. Social Aspects of Prescribing. London: William Heinemann Ltd., 1957.

Mass Observation. Meet Yourself at the Doctor's. London: Naldrett Press, 1949.

Mechanic, D. Medical Sociology: A Selective View. New York: The Free Press, 1968.

Mencher, S. Private Practice in Britain. London: G. Bell and Sons, 1967.

Meredith, J.S., et al. "Hostels" in Hospitals?: The Analysis of Beds in Hospitals by Patient Dependency. London: Oxford University Press, 1968.

Miliband, R. The State in Capitalist Society. London: Quartet, 1969.

Miller, F.J.W., et al. Growing up in Newcastle-upon-Tyne. London: Oxford University Press, 1960.

Mills, C.W. The Power Elite. New York: Oxford University Press, 1956.

McLachlan, G. (ed.). Problems and Progress in Medical Care. London: Oxford University Press, 1964.

Platt, R., and Parkes, A.S. (eds.). Social and Genetic Influences on Life and Death. Edinburgh: Oliver and Boyd, 1967.

Political and Economic Planning. Family Needs and the Social Services. London: Allen and Unwin, 1961.

Porter, J. The Vertical Mosaic. Toronto: University of Toronto Press, 1965.

Poynter, F.W.L. (ed.). The Evolution of Hospitals in Britain. London: Pitman Medical Publishing, 1964.

Pringle, M.L.K., et al. 11,000 Seven-year-olds. London: Longmans, 1966.

Pryor, F. Public Expenditures in Communist and Capitalist Nations. London: Allen and Unwin, 1968.

Roberts, F. The Cost of Health. London: Turnstile Press, 1952.

Roemer, M.I. The Organization of Medical Care Under Social Security: A Study Based on the Experience in Eight Countries. Geneva: International Labour Organization, 1969.

Rose, A. The Power Structure. New York: Oxford University Press, 1967.

Ross, J.S. The National Health Service in Great Britain. London: Oxford University Press, 1952.

Runciman, W.G. Relative Deprivation and Social Justice. London: Routledge and Kegan Paul, 1966.

Scott, W.R., and Volkart, E.H. Medical Care: Readings in the Sociology of Medical Institutions. New York: Wiley, 1966.

Somers, H.M., and Somers, A.R., Doctors, Patients and Health Insurance. Washington, D.C.: The Brooking Institution, 1961.

Spence, J., et al. A Thousand Families in Newcastle-upon-Tyne. London: Oxford University Press, 1954.

Stevens, R. Medical Practice in Modern England. London: Yale University Press, 1966.

Strachey, J. Contemporary Capitalism. London: Victor Gollancz, 1956.

Susser, M.W., and Watson, W. Sociology in Medicine. London: Oxford University Press, 1971.

Taylor, S.J.L. Good General Practice. London: Oxford University Press, 1954.

Titmuss, R.M. Birth, Poverty and Wealth. London: Hamish Hamilton Medical Books, 1943.

_____. Income Distribution and Social Change. Toronto: University of Toronto Press, 1962.

_____. Essays on the Welfare State. London: Unwin University Books, 1963.

_____. Commitment to Welfare. London: Pantheon Books. Allen and Unwin, 1968.

_____. The Gift Relationship. London: Allen and Unwin, 1970.

Webb, S., and Webb, B. (eds.). The Break-up of the Poor Law: Being Part One of the Minority Report of the Poor Law Commission. London: Longmans, Green and Company, 1909.

Webb, B., and Webb, S. The State and The Doctor. London: Longmans, Green and Company, 1910.

Weinstein, J. The Corporate Ideal in the Liberal State. Boston: Beacon Press, 1968.

Wilensky, H.L. The Welfare State and Equality. Berkley: University of California Press, 1975.

_____, and Lebeaux, C.N., Industrial Society and Social Welfare. New York: The Free Press, 1965.

Willcocks, A.J. The Creation of the National Health Service. London: Routledge and Kegan Paul, 1967.

Wolff, R.P., et al. A Critique of Pure Tolerance. Boston: Beacon Press, 1969.

Woodroofe, K. From Charity to Social Work. London: Routledge and Kegan Paul, 1962.

Young, A.F., and Ashton, E.T. British Social Work in the Nineteenth Century. London: Routledge and Kegan Paul, 1956.

ARTICLES AND PERIODICALS

Alderson, M.R. "Referral to Hospital Among a Representative Sample of Adults Who Died," Proceedings of the Royal Society of Medicine, Vol. 59, No. 2 (1966), 719-721.

_____. "Terminal Care in Malignant Disease," British Journal of Preventive and Social Medicine, Vol. 24, No. 2 (1970), 120-123.

_____. "Social Class and the Health Service," The Medical Officer, Vol. 24, No. 3 (1970), 50-52.

Arie, T. "Class and Disease," New Society, Vol. 7, No. 174 (January, 1966), 8-12.

Ashford, J.R., and Pearson, M.G. "Who Uses the Health Services and Why?" Journal of the Royal Statistical Society, Series A (General), Vol. 133, Part 3 (1970), 295-345.

Ashley, J.S.A., et al. "Case Fatality of Hyperplasia of the Prostrate in Two Teaching and Three Regional Board Hospitals," Lancet, ii (1971), 1308-1311.

Backett, E.M., et al. "Studies of a General Practice: II, The Doctor's Job in an Urban Area," British Medical Journal, Vol. 1, (1954), 109-115.

Barr, A. "Hospital Admissions and Social Environment," The Medical Officer, Vol. 100, No. 23 (1958), 351-354.

Benjamin, B. "The Urban Background to Public Health Changes in England and Wales 1900-50," Population Studies, Vol. 17, Part 3, (1964), 225-248.

Bennett, A.E. "Case Selection in a London Teaching Hospital," Medical Care, Vol. 4, No. 3 (1966), 138-141.

_____. "The Care of the Chronic Sick--The Problem in the Community," Proceedings of the Royal Society of Medicine, Vol. 65, No. 2 (1972), 202-203.

_____, et al. "Chronic Disease and Disability in the Community," British Medical Journal, Vol. 3 (1970), 762-764.

Bradbury, F.C.S. "Minimal Requirements for Mass Radiography," Lancet, ii (1948), 293.

Bradford-Hill, A. "The Doctor's Day and Pay," Journal of the Royal Statistical Society, Series A (General), Part I, Vol. 114 (1951), 1-34.

Butler, J.R. "Illness and the Sick Role: An Evaluation in Three Communities," British Journal of Sociology, Vol. 21, No. 3 (1970), 241-261.

Buzzard, R.B., and Shaw, W.J. "An Analysis of Absence Under a Scheme of Paid Sick Leave," British Journal of Industrial Medicine, Vol. 9 (1952), 282.

Cartwright, A. "General Practitioners and Family Planning," The Medical Officer, Vol. 120, No. 3 (1968), 43-46.

_____, and Marshall, R. "General Practice in 1963," Medical Care, Vol. 3 (1965), 69-87.

_____, et al. "Community Aspects of a Mass-Radiography Campaign," The Medical Officer, Vol. 101, No. 23 (1959), 313-317.

College of General Practitioners. "Chronic Bronchitis in Great Britain," British Medical Journal, Vol. 2 (1961), 973-979.

Collings, J.S. "General Practice in England Today," Lancet, i (1950), 555-585.

Cook, P.J., and Walker, R.O. "The Geographical Distribution of Dental Care in the United Kingdom: Part I, Sources of Information; Methods of Presentation; Distribution of Dentists," British Dental Journal, Vol. 122, No. 10 (1967), 441-447.

_____. "The Geographical Distribution of Dental Care in the United Kingdom: Part 2, Changes Between 1952 and 1962," British Dental Journal, Vol. 122, No. 11 (1967), 494-499.

Crawford, M.D., et al. "Mortality and Hardness of Local Water Supplies," Lancet, i (1968), 827-831.

Cutwright, P. "Political Structure, Economic Development, and National Social Security Programs," American Journal of Sociology, LXX (March, 1965), 537-551.

Daly, C., et al. "Social and Biological Factors in Infant Mortality: III, The Effect of Mother's Age and Parity on Social Class Differences in Infant Mortality," Lancet, i (1955), 445-448.

Douglas, J.W.B., and Waller, R.E. "Air Pollution and Respiratory Infection in Children," British Journal of Preventive and Social Medicine, Vol. 20, No. 1 (1966), 1-8.

"Draft Interim Report of the Medical Planning Commission," British Medical Journal, Vol. 1 (1942), 743-753.

Feldstein, M.S. "Effects of Differences in Hospital Bed Scarcity on Type of Use," British Medical Journal, Vol. 2 (1964), 561-564.

Feldstein, P.J. "Research on the Demand for Health Services," The Milbank Memorial Fund Quarterly, Vol. 44, No. 3, Part 2 (July, 1966), 128.

Floyd, C.B. "Car Service," British Medical Journal, Vol. 1 (1966), 1423.

Fry, J. "A Year of General Practice; A Study in Morbidity," British Medical Journal, Vol. 2 (1952), 249-252.

_____. "Why Patients Go to Hospital," British Medical Journal, Vol. 2 (1959), 1322-1326.

Garrad, J., and Bennett, A.E. "A Validated Interview Schedule for Use in Population Surveys of Chronic Disease and Disability," British Journal of Preventive and Social Medicine, Vol. 25, No. 2 (1971), 97-104.

Gemmill, P.F. "An American Reports on the National Health Service," British Medical Journal, Supplement (July 5, 1958), 17-21.

Gill, D.G. "The British National Health Service: Professional Determinants of Administrative Structure," International Journal of Health Services, Vol. 1, No. 4 (1971), 342-353.

Gray, P.G., and Cartwright, A. "Choosing and Changing Doctors," Lancet, ii (1953), 1308.

Hadfield, S.J. "A Field Survey of General Practice 1951-2," British Medical Journal, Vol. 2 (1953), 683-706.

Hart, J.T. "Data on Occupational Mortality 1959-63," Lancet, i (1972), 192-193.

Heady, J.A., et al. "Social and Biological Factors in Infant Mortality: II, Variation of Mortality with Mother's Age and Parity," Lancet, i (1955), 395-397.

_____, et al. "Social and Biological Factors in Infant Mortality: IV, The Independent Effects of Social Class, Region, the Mother's Age and her Parity," Lancet, i (1955), 499-502.

"Health and Social Class," Lancet, i (1959), 303-305.

"Health Care: Supply, Demand and Politics," Time (June 7, 1971), 62-68.

Holloway, S.W.F. "Medical Education in England, 1830-1858: A Sociological Analysis," History, Vol. 49 (October, 1964), 299-324.

Illsley, R. "Social Class Selection and Class Differences in Relation to Stillbirths and Infant Deaths," British Medical Journal, Vol. 2 (1955), 1520-1524.

Jefferys, M., et al. "Consumption of Medicines on a Working Class Housing Estate," British Journal of Preventive and Social Medicine, Vol. 14, No. 2 (1960), 64-76.

Kay, D.W.K., et al. "Some Medical and Social Characteristics of Elderly People Under State Care," Sociological Review Monograph, No. 5 (July, 1962), 173-193.

Kedward, H.B. "Social Class Habits of Consulting," British Journal of Preventive and Social Medicine, Vol. 16, No. 3 (1962), 147-152.

Kegeles, S.S. "Why People Seek Dental Care: A Test of a Conceptual Formulation," Journal of Health and Human Behaviour, Vol. 4 (1963), 166-173.

Kessel, W.I.N. "Psychiatric Morbidity in a London General Practice," British Journal of Preventive and Social Medicine, Vol. 14 (1960), 16.

Kessel, N., and Shepherd, M. "The Health and Attitudes of People Who Seldom Consult a Doctor," Medical Care, Vol. 3, No. 1 (1965), 6-10.

Kilpatrick, G.S. "Prevalence of Anaemia in the General Population: A Rural and an Industrial Area Compared," British Medical Journal, Vol. 2 (1961), 1736-1738.

Last, J.M. "The Iceberg: Completing the Clinical Picture in General Practice," Lancet, ii (1963), 28-31.

Lawrence, J.S., et al. "The Epidemiology of Rheumatoid Arthritis in Northern Europe," Proceedings of the Royal Society of Medicine, Vol. 54, No. 1 (1961), 454-462.

Lee, J.A.H., et al. "Primary Medical Care: Prescribing in Three English Towns," Milbank Memorial Fund Quarterly, Vol. 43, No. 2 (1965), 285.

Lees, D.S. "Private General Practice and the National Health Service," Sociological Review, Monograph No. 5 (July, 1962) 33-47.

Lewis, O. "The Culture of Poverty," Scientific American, 215 (October, 1966), 19-25.

Logan, W.P.D. "Illness, Incapacity and Medical Attention Among Adults, 1947-49," Lancet, i (1950), 773-776.

_____. "Mortality in England and Wales from 1848 to 1947," Population Studies, Vol. 4, No. 2 (1950).

_____. "Social Class Variations in Mortality," British Journal of Preventive and Social Medicine, Vol. 8 (1954), 128-137.

Lunn, J.E., et al. "Patterns of Respiratory Illness in Sheffield Junior School Children: A Follow-up Study," British Journal of Preventive and Social Medicine, Vol. 24, No. 4 (1970), 223-228.

MacGregor, J.E., et al. "Cytopipette in the Diagnosis of Early Cervical Carcinoma," Lancet, i (1966), 252-256.

Mair, A., and Mair, G.B. "Facts of Importance to the Organization of a National Health Service from a Five Year Study of a General Practice," British Medical Journal, Supplement (June 20, 1959), 281-284.

Meadows, S.H. "Social Class Migration and Chronic Bronchitis," British Journal of Preventive and Social Medicine, Vol. 15 No. 4 (1961), 171-176.

Merrett, A.J., and Monk, D.A.G. "The Structure of U.K. Taxation, 1962-63," Bulletin of the Oxford University Institute of Economics and Statistics, Vol. 28, No. 3 (August, 1966), 145-162.

Morris, J.N., and Heady, J.A. "Social and Biological Factors in Infant Mortality: I; Objects and Methods," Lancet, i (1955), 343-349.

_____. "Social and Biological Factors in Infant Mortality: V, Mortality in Relation to Father's Occupation, 1911-1950," Lancet, i (1955), 554-559.

Morrison, S.L., and Riley, M.M. "The Use of Hospital Diagnostic Facilities by General Practitioners," Medical Care, Vol. 1, No. 3 (1963), 137-142.

"The National Health Service Act in Great Britain," The Practitioner, Vol. 163 (1949).

Nicholson, J.L. "Redistribution of Income in the United Kingdom in 1959, 1957 and 1953," in C. Clark and G. Stuvel (eds.), Income and Wealth, Series X. London: Bowes and Bowes, 1964.

Oppenheim, A. "Dental Charges: A Survey of the Means Test at Work," Cambridge Poverty, No. 3 (January, 1972), 4-5.

Osborn, G.R., and Leyshon, V.N. "Domiciliary Testing of Cervical Smears by Home Nurses," Lancet, i (1966), 256-257.

Peterson, O.L., et al. "What is Value for Money in Medical Care? Experiences in England and Wales, Sweden and the U.S.A.," Lancet, i (1967), 771-776.

"The Planning Commission's Report," British Medical Journal, Vol.2 (1942), 112.

Rein, M. "Social Class and the Health Service," New Society, Vol. 14, No. 373 (November 20, 1969), 8.

_____. "Social Class and the Utilization of Medical Care Services," Hospitals, Vol. 43 (July 1, 1969), 43-54.

Richards, N.D., et al. "A Survey of the Dental Health Attitudes Towards Dentistry in Two Communities," British Dental Journal, Vol. 118 (1965), 199-205.

Rosenbluth, D., and Bowlby, J. "The Social and Psychological Backgrounds of Tuberculous Children," British Medical Journal, Vol. 2 (1955), 946-949.

Rosenfeld, A. "Private Group Practice in Sweden," Medical Care, Vol. 2 (1969), 62-71.

Rosenstock, I. "Why People Use Health Services," The Milbank Memorial Fund Quarterly, Vol. 44, Part 2 (1966), 94-127.

Ross, D. Reid. "National Health Service in Factorytown: A Survey of the Demand for Medical Care in an Industrial Community," Medical World, Vol. 78, No. 2 (1953), 125-138.

Rossdale, M. "Health in a Sick Society," New Left Review, No. 34 (1965), 89-90.

_____. "Socialist Health Service?" New Left Review, No. 36 (1966), 3-25.

Scott, R., et al. "Just What the Doctor Ordered: An Analysis of Treatment in a General Practice," British Medical Journal, Vol. 2 (1960), 293-299.

"Social Class and Biological Tests," Lancet, i (1970), 1343.

Stein, L. "Morbidity in a London General Practice: Social and Demographic Data," British Journal of Preventive and Social Medicine, Vol. 14, No. 1 (1960), 9-15.

Stein, Z., and Susser, M.W. "Hypothesis: Failures in Medical Care as a Function of the Doctors' Situation," Medical Care, Vol. 2, No. 3 (1964), 162-166.

Stewart, A., and Hughes, J.P.W. "Tuberculosis in Industry: An Epidemiological Study," British Medical Journal, Vol. 1 (1949), 926-929.

_____. "Mass Radiography Findings in the Northamptonshire Boot and Shoe Industry," British Medical Journal, Vol. 1 (1951), 899-906.

Stockwell, E.G. "Infant Mortality and Socio-Economic Status," Milbank Memorial Fund Quarterly, Vol. 40 (1962), 101-111.

Titmuss, R.M. "Role of the Family Doctor Today in the Context of Britain's Social Services," Lancet, i (1965), 1-4.

Topp, S.G., et al. "Influence of Environmental Factors on Height and Weight of School Children," British Journal of Social and Preventive Medicine, Vol. 24 (1970), 154-162.

Thwart, J. "Evidence on Private Practice," On Call, (July, 1971), 4.

Werkö, L. "Swedish Medical Care in Transition," The New England Journal of Medicine, Vol. 284 (1971), 360-366.

White, K.L. "International Comparisons of Health Services Systems," Milbank Memorial Fund Quarterly, Vol. 46, Part 1 (1968) 117-125.

Willcocks, A.J. "'A Process of Erosion?': Pressure Groups and the National Health Service Act of 1946," Sociological Review, Monograph No. 5 (July, 1962), 9-19.

Wolfendale, M., and Handfield-Jones, R.P.C. "The Prevention of Cervical Cancer: Who Takes the Smears?" Lancet, ii (1964), 901.

PUBLIC DOCUMENTS

Great Britain. Central Statistical Office. "The Incidence of Taxes and Social Service Benefits in 1963 and 1964," Economic Trends, No. 154 (August, 1966), i-ix.

Great Britain. Department of Education and Science. The Health of the School Child; 1962 and 1963. Report of the Chief Medical Officer of the Department of Education and Science. London: H.M. Stationery Office, 1964.

Great Britain. Department of Education and Science. The Health of the School Child: 1964 and 1965. Report of the Chief Officer of the Department of Education and Science. London: H.M. Stationery Office, 1966.

Great Britain. Department of Health and Social Security. Multiple Health Screening Clinic, Rotherham, 1966. Reports on Public Health and Medical Subjects, No. 121. London: H.M. Stationery Office, 1969.

Great Britain. General Register Office. Census 1961, England and Wales, Socio-Economic Group Tables. London: H.M. Stationery Office, 1966.

Great Britain. General Register Office. General Practitioners' Records, by W.P.D. Logan. Studies in Medical and Population Subjects, No. 7. London: H.M. Stationery Office, 1953.

Great Britain. General Register Office. General Practitioners' Records. Studies in Medical and Population Subjects, No. 9. London: H.M. Stationery Office, 1955.

Great Britain. General Register Office. Hospital Morbidity Statistics, by D. MacKay. Studies in Medical and Population Subjects, No. 4. London: H.M. Stationery Office, 1951.

Great Britain. General Register Office. Mass Miniature Radiography, by M.A. Heasman. Studies in Medical and Population Subjects, No. 17. London: H.M. Stationery Office, 1961.

Great Britain. General Register Office. Morbidity Statistics from General Practice, by W.P.D. Logan and A.A. Cushion. Studies in Medical and Population Subjects, II, No. 14, Occupation. London: H.M. Stationery Office, 1960.

Great Britain. General Register Office. Regional and Social Factors in Infant Mortality, by C.C. Spicer and L. Lipworth. Studies in Medical and Population Subjects, No. 19. London: H.M. Stationery Office, 1966.

Great Britain. General Register Office. The Registrar General's Classification of Occupations 1960. London: H.M. Stationery Office, 1960.

Great Britain. General Register Office. The Registrar General's Decennial Supplement: England and Wales, 1951. Occupational Mortality, Part II, Vol. 2, Tables. London: H.M. Stationery Office, 1957.

Great Britain. General Register Office. The Registrar General's Decennial Supplement: England and Wales, 1961. Occupational Mortality Tables. London: H.M. Stationery Office, 1971.

Great Britain. General Register Office. Sickness in the Population of England and Wales, 1944-47, by P. Stocks. Studies in Medical and Population Subjects, No. 2. London: H.M. Stationery Office, 1949.

Great Britain. General Register Office. Social and Biological Factors in Infant Mortality, by J.A. Heady and M.A. Heasman. Studies in Medical and Population Subjects, No. 15. London: H.M. Stationery Office, 1959.

Great Britain. General Register Office. The Survey of Sickness, 1943-52, by W.P.D. Logan and E.M. Brooke. Studies in Medical and Population Subjects, No. 12. London: H.M. Stationery Office, 1957.

Great Britain. Government Social Survey. Adult Dental Health in England and Wales in 1968, by P.G. Gray et al. London: H.M. Stationery Office, 1970.

Great Britain. Government Social Survey. General Practice Under the National Health Service, by P.G. Gray and A. Cartwright. Reports, New Series, 197. London: H.M. Stationery Office, 1961.

Great Britain. Government Social Survey. Some Effects of Using a Two Month Memory Period on the Survey of Sickness, by P.G. Gray and A. Cartwright. Methodological Series, Paper No. M41. London: H.M. Stationery Office, 1951.

Great Britain. Government Social Survey. Survey of Sickness: October, 1943 - December, 1945, by P. Slater. London: H.M. Stationery Office, 1946.

Great Britain. House of Commons, Expenditure Committee. National Health Service Facilities for Private Patients. London: H.M. Stationery Office, 1972.

Great Britain. Ministry of Health and General Register Office. Reports of Hospital Inpatient Enquiry for the Two Years 1960 and 1961. Part III, Commentary. London: H.M. Stationery Office, 1967.

Great Britain. Report on Social Insurance and Allied Services, by Sir William Beveridge. Cmd. 6404. London: H.M. Stationery Office, 1942.

Great Britain. Royal Commission on the Poor Laws and Relief of Distress. Vol. I, Report. London: H.M. Stationery Office, 1909.

U.S. Department of Health, Education, and Welfare, Public Health Service. National Centre for Health Statistics. "Conceptual Problems in Developing an Index of Health." Vital and Health Statistics Series 2, No. 17. Washington, D.C.: Government Printing Office, 1966.

PUBLICATIONS OF LEARNED SOCIETIES

AND OTHER ORGANIZATIONS

Andersen, R., et al. Medical Care Use in Sweden and the U.S. Chicago, Center for Health Administration Studies, Research Series 27. Chicago: University of Chicago Press, 1970.

The Beveridge Report and the Public. London: British Institute of Public Opinion, undated.

Buchanan, J.M. The Inconsistencies of the National Health Service. London: Institute of Economic Affairs, Occasional Paper 7, 1965.

Cartwright, Ann. Parents and Family Planning Services. London: Institute of Community Studies, Reports (19), 1970.

Charles, Sir J.A. The Social Context of Medicine. London: Nuffield Provincial Hospitals Trust, 1962.

The Dawson Report on the Future Provision of Medical and Allied Services. London: King Edward's Hospital Fund for London, 1950.

Draper, P., et al. The N.H.S.: Three Views. London: Fabian Society Research Series, No. 287, 1970.

Forsyth, G., and Logan, R.E.L. The Demand for Medical Care. London: Nuffield Provincial Hospitals Trust, 1960.

A General Medical Service for the Nation. London: British Medical Association, 1930.

The Health Service and the Welfare State. London: Socialist Medical Association, undated.

Lee, M. Opting out of the National Health Service. London: Political and Economic Planning, June, 1971.

Nuffield Provincial Hospitals Trust. Waiting in Outpatient Departments: A Survey of Outpatient Appointment Systems. London: Oxford University Press, 1965.

Nuffield Provincial Hospitals Trust. Casualty Services and Their Setting: A Study in Medical Care. London: Oxford University Press, 1960.

Report of the Voluntary Hospitals Commission. London: British Hospitals Association, 1937.

A Socialized Medical Service. London: Socialist Medical Association, 1933.

Stark, Murray D. Medical Care: Who Gets the Best Service? Fabian Occasional Paper, 6. London: Fabian Society, 1971.

Townsend, P., and Bosanquet, N. (eds.). Labour and Inequality: Sixteen Fabian Essays. London: Fabian Society, 1972.

Young Fabian Group. General Practice. Young Fabian Pamphlet, 9. London: Fabian Society, 1965.

NEWSPAPERS

Lewis, A. "The True-Blue Middle Class," The Montreal Star, July 9, 1974.

The Times (London), July 5, 1948.

Walker, M. "Housing: The Meanest Test of All," The Guardian (Manchester), December 28, 1972.