UNISON

Open College

UNIT SWH.101

HEALTH AND HEALTH SERVICES

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Contents

Preface

In this block, we will be exploring a range of issues relating to health and health services. The National Health Service is undergoing a period of rapid organisational and cultural change following the Health Act 1999, the NHS Plan, and the Health and Social Care Act 2001, and the implications of some of these changes will be discussed.

Health issues can at times be quite personal and we need to acknowledge the ways in which health beliefs and behaviours affect us and our clients. Some of the activities in this block encourage you to look at **values** in relation to health

We begin by looking at a range of topics under the broad heading of Health, Society and Environment. We examine medical and social models of health, and some of the manifestations of inequality in health. This is linked to the role of health and health services in combating social exclusion

The next section looks at the National Health Service. WE examine its history and organisation, as well as the roles of the professionals who deliver its services. The ways in which NHS performance is evaluated are also discussed

Finally, some of the links between health and housing conditions are considered.

Outcomes

After completing this block, you should be able to:

- Explore factors affecting health, especially with regard to housing conditions;
- Identify professionals within primary and community health services and discuss their role in the partnership with housing workers.

SECTION A: What Is Health?

1. Introduction

In 1974, the World Health organisation produced the following statement:

> "Health is not merely the absence of disease, but a state of complete physical, mental, spiritual and social well-being"
>
> *World Health Organisation (1974)*
> ***Alma Ata Declaration***

At this point, you might feel the need to go and lie down in a darkened room for a while, as it would appear that none of us can aspire to the level of health in this definition. We need to ask ourselves how useful such a definition is. What is it based on? How does it inform health policy? How does it relate to our beliefs about health?

In making this ambitious definition, the WHO set the tone for health policies which go beyond a straight medical definition (the absence of disease) to a more holistic concept of health which covers spiritual and social factors as well as the physical and psychological.

Thus they were moving towards a **functional or social** definition of health, which suggests that health is about being able to fulfil our potential, to live our lives, to contribute to our society. It is this type of definition which has underpinned a lot of current social policy, from the concept of Social Exclusion to the government targets incorporated in "*Health of the Nation*" and "*Our Healthier Nation*", which we will be discussing later in this block.

2. The Sociology Of Health:

Health beliefs and behaviour

We started by asking "What is health?" In this section we will explore that concept a little further, and also look at the other side of the question: "What is illness?" How do beliefs about the nature of illness differ between cultures and between different historical periods in the same culture?

We have started to look at the difference between medical and social models of health and illness. A conventional Western medical model is disease-based, and in the 20th and 21st centuries it draws heavily on the "scientific" approach to health and illness. So, if your ECG trace is within normal limits, you haven't got heart disease.

But it can be argued that we are capable of being blinded by science if we adopt this model. If we become over-reliant on a purely medical model, we may fall into the trap of thinking that "Doctor knows best" and that if the medical profession can produce facts and figures, then we have to take their word for it.

However, when we stop and think about it for a moment, it becomes clear that the medical profession does not always know best. Medical knowledge changes and develops.

Some examples:

(i) **Cholera in London in the 1840s**. There was a massive epidemic of cholera in London. At this time, the idea that "germs" cause illness was unknown; bacteria and viruses had still to be discovered. It was believed that diseases such as cholera were caused by "miasmas" or "bad air". If you look at the origin of the word "malaria", you will find that it derives from the Latin for "bad air".

It was realised that the areas affected by cholera were served by the same water pumps. When the municipal authorities ordered the pumps closed down, the epidemic began to die down. We now know that the cholera bacillus was being transferred from sewage to drinking water.

This episode marked the beginning of the public health movement, which saw local authorities being given responsibility for public health measures including sewage.

(ii) **The theory of humours**: From Ancient Greece onwards, Western medicine has been influenced by the theory of "humours". In the Greek model, it was held that health derived from equilibrium between four humours: blood, phlegm, bile (choler), and black bile (melancholy). Although in the Western tradition these theories have been superseded by "scientific' explanations, their influence lives on in the language. We describe somebody who is not easily moved to emotion as "phlegmatic", and someone who is sad as "melancholy"

(iii) **Homosexuality**: When tempted to regard Western "scientific" medicine as the only acceptable explanation for theories of health and illness, it is wise to temper this enthusiasm by looking at the ways in which society has used "science" to enforce social order. For example, until the 1980s, homosexuality was listed in the International Classification of Diseases as a psychiatric disorder. This is an example of pseudo-science being used for non-medical purposes: gay people have been subjected to "aversion therapy' and other breaches of their human rights as a result of this.

3. The Impact of Health Beliefs on People's Lives

We have seen from the examples above that to some extent our belief about what is health and what is illness is a product of our society and culture.

Culture

English and to some extent Afro-Caribbean people have a set of health beliefs that centre on the bowels. Although this is less pronounced in younger generations, you may still find older people who believe they must open their bowels daily or all sorts of dreadful things will happen. French people on the other hand tend to focus on the liver as the main seat of health and illness. Where English people who are having an off day might say they are feeling "bilious" (those humours again), French people would say they were having a "*crise de foie*" (liver attack).

In a multi-cultural society, it is important to recognise that people may have different health beliefs, for example beliefs from Chinese traditional medicine or from the South Asian Ayurvedic tradition. These beliefs are not inferior to the Western scientific tradition, and they may influence how people define their health and how they make contact with medical services. An older woman influenced by the English beliefs about the importance of the digestive tract might go to the doctor complaining of constipation when she actually has depression.

The "Stress" Epidemic and Post Traumatic Stress Disorder

In the First World War, many soldiers were shot for cowardice in the face of the enemy. Many of these people were probably suffering from what we would call Post Traumatic Stress Disorder, or what was recognised towards the end of the war as "shell shock". For an account of the recognition and early treatment of shell shock, it is worth looking at the trilogy of novels by Pat Barker dealing with the pioneering work of Dr Rivers at Craiglockhart Hospital (Barker, P (1995) *Regeneration*, Penguin).

Nowadays, emotional distress or stress is recognised as a medical condition. The willingness to recognise emotional disorders has been influenced by the growth in the study of psychology throughout the 20th Century. But some people have argued that we have taken this too far: is it right to regard unhappiness as a medical condition?

Sun-Worshipping

For White European people up until the 1920s being suntanned was a sign of poverty. Agricultural workers were out in all weathers and were tanned or weather-beaten. Being pale was a sign that you were a member of the leisured classes. Then in the 20s, the fashion designer Coco Chanel popularised the suntan. From then on, having a tan became a sign that you had the leisure time and the money to go to a hot place and bask in the sun. Somewhere along the line, a belief developed that a tan was healthy. This belief persisted until the late 20th century when an epidemic of skin cancers among people of White European origin demonstrated that actively courting first-degree burns from the sun when your skin was not equipped with sufficient pigment to protect you was not a healthy activity. Many people still pay money for sunbeds to get sunburn because they believe they look better or healthier. This shows how much of an influence health beliefs can have on one's health and in some cases on one's chances of dying young.

4. Health inequalities

In this section, we will be looking at the factors that influence our chances of living long healthy lives and getting appropriate medical treatment when we need it. Before we go on, we need to identify some key terms.

Mortality: this refers to death rates. Standard Mortality Rate is the number of deaths per 1000 population. The Standardised Mortality **Ratio** is used to compare the standard mortality rate for a particular group against that of the population as a whole. This is one of the ways in which health inequality can be detected or described. **Infant** Mortality is the number of deaths per thousand children under one year old, while the **Perinatal** Mortality Rate counts stillbirths and deaths of children in the first 28 days of life, a key indicator of inequality

Morbidity: this refers to the incidence of disease. So for example, we might find that children in a particular area have a higher rate of asthma.

Social Class: This can be a bit of a minefield. However, for most statistical purposes, the definition of class is the system used by the Office of Population Census and Surveys for classifying people according to their occupation (or the occupation of the head of household). While this does not enable us to explore some of the finer gradations and can therefore be something of a blunt instrument, it nonetheless enables researchers to obtain a broad-brush picture and to compare different surveys. The Classification is as follows:

Class	Occupational Group	Example
1	Professional	Doctor, lawyer
2.	Managerial etc.	Teacher, housing officer
3a	Non-manual skilled	Secretary, draughtsperson
3b	Manual skilled	Miner, mechanic
4	Partly skilled	Machinist
5.	Unskilled	Labourer, packer

Life Expectancy: This is a commonly misunderstood term. Often, when people read that the average life expectancy in the Middle Ages was 35, they draw the conclusion that you were old at 32. What we have to bear in mind is that average life expectancy includes infant mortality. Therefore, if we are looking at a historical period such as the Middle Ages where infant mortality rates were astronomical, we cannot use that information to conclude that there were no people in their sixties. Occasionally, you will see life expectancy figures expressed for people of a certain age, but if the age is not specified, it means life expectancy at birth.

5. Types of Health Inequality

(i) Geographical Inequality

Activity 1

Which areas of the country would you expect to have poorest health? List them below.

What reasons did you have for believing that these areas would have poor health?

Comment: *For England, the areas with the worst health (as measured by Standard Mortality Rates) are:*

- *Tyne Tees*
- *Inner City boroughs of London*
- *Greater Manchester & Liverpool*
- *Humberside*
- *Parts of the West Midlands (Birmingham, Wolverhampton, Sandwell, Walsall)*

Most of these areas have a number of factors in common.

- *High unemployment*
- *Inner-urban areas*
- *Except for the London Boroughs, there is a history of heavy industry in these areas. The industry has to a large extent gone, but leaves a number of legacies in the form of unemployment, social dislocation, low investment, and pollution.*
- *However, it has been suggested that some of the differences may relate to personal behavioural factors such as diet. Scotland and Northern Ireland have some of the highest rates of coronary artery disease in the world, and this can be related to high-fat diets.*

(ii) Social Class Inequality

A child in Social Class 5 has more than four times the chance of dying in an accident than a child in Social Class 1.

Unemployed people have a greater chance of dying early than the employed.

While male life expectancy at birth has been rising throughout the century, there still exist disparities between the classes. Average life expectancy for a male in Social class 1 was 74.5 in 1987-91, compared to 69.5 in social class 5. Interestingly, although life expectancy has been steadily going up for most groups, it reached a plateau in 1980 for social class 5, and may even be going down.

(Dept. of Health 1999 *Our Healthier Nation*).

(iii) Comments

Having looked at the bare facts, it would be useful at this stage to explore some of the reasons why these inequalities occur, and to identify some of the sociological and political perspectives that can be applied to the study of health inequality.

It is possible to relate some of these inequalities to differences in **health beliefs and behaviour**. A classic example occurred in the 1980s when Edwina Currie, then a junior minister in the Department of Health, made a public criticism of the dietary habits of working class northern people. While there may be a sustainable argument to suggest that the poor health of these groups is at least exacerbated by high-fat diets with little use of fresh fruit and vegetables, there is a political perspective which underpinned Ms Currie's comments. This perspective is one that stresses individual responsibility and believes that state intervention is not the correct approach to problems of ill health or poverty. It links to Margaret Thatcher's famous comment that "there is no such thing as society". If we stress that the responsibility for health inequalities lies with individuals, then we fail to address the wider structural inequalities in society. This approach is sometimes known as "blaming the victim"

In the late 1970s, a working group was set up by the government with a brief to report on inequalities in health. Its report was published in 1980, shortly after the Conservatives had returned to power under Margaret Thatcher. The Black Report (named after the working group's chair Sir Douglas Black, president of the Royal College of Physicians, made a number of recommendations, including:

A series of measures for reducing child poverty

- The introduction of a disability allowance
- National health goals to be identified
- Shifting resources towards primary and community care
- An increase in local authority spending and responsibility under the 1974 Housing Act
- Establishment of a Health Development Council

(Jones, L (1994), *Social Context of Health and Health Work*, Macmillan, p.234)

While the Black Report was influential in many ways, most of its wide-ranging recommendations were sidelined by the government. Far from adopting the abolition of child poverty as a goal, the government which came into power in 1979 was committed to reducing the levels of benefit. A Health Education

Authority was set up, rather than a Health Development Council, and this could be said to reflect that government's belief in the responsibility of the individual to change their lifestyle; the role of government would be to advise, but the individual was free to ignore the advice.

It is interesting to note that some of the Black Report's recommendations have resurfaced in the 1990s as part of the 1997 government's health strategy, which will be discussed later in this block.

Another approach to these inequalities in health would be to look at them in the context of **structural inequality.** A structural inequality approach argues that inequalities are built into the very fabric of our society. Changing individual health beliefs and behaviour, even if that is possible, is insufficient if the underlying unequal structures are not addressed. For example, ill health associated with poor housing conditions has to be addressed in the context of the Thatcher government's commitment to reducing investment in social housing.

(iv) Racial Inequality

Black people are three times more likely to be diagnosed as having schizophrenia than other users of mental health services. Black people are also over-represented among patients compulsorily detained in psychiatric hospitals under the Mental Health Act and police admission.

There are differences in patterns of ill health between the majority and minority ethnic groups. For example:

> "Higher rates of coronary heart disease and non-insulin dependent diabetes amongst the Asian population. Here the death rate from heart disease of the 20-30 year olds is twice as high as that for the general population
>
> Haemoglobin disorders are also prevalent amongst many ethnic minority groups.
>
> Amongst the African-Caribbean and Bangladeshi populations instances of hypertension and strokes are higher than for other groups"
>
> (Alexander, Z (1999), Department of Health: *Study of Black, Asian and Ethnic Minority Issues*. http://www.doh.gov.uk/race_equality/ziggistudy.pdf)

Differences can also be observed in the uptake and use of health services. For example, Alexander cites evidence that Chinese communities, who tend to be more scattered than most Asian or African-Caribbean groups,

> '... have a lower use of dental services, primary care, preventive programmes such as cervical cancer screening than the rest of the population and that they are under-represented among psychiatric patients.'

What explanations can we find for some of these differences?

There is an argument based on culture. This would put the case that, for example, Chinese culture leads people to reject Western medicine, preferring "traditional" approaches. While there is some truth in this, it cannot be the whole story. Culley argues that an over-rigid application of the concept of culture leads health professionals to indulge in "victim-blaming". It can also lead, as implied in the article's title, to an approach which relies on developing lists of supposed facts about different cultures; this can result in stereotyping.

> "It tends to treat ethnic groups as homogeneous wholes and fails to recognise the significance of differences of socio-economic status, gender, and age within broadly defined ethnic groups"
>
> (Culley, L (2000) *Working With Diversity: Beyond the Factfile*, in Davies et al (eds.) *Changing Practice in Health and Social Care*, Sage.)

In addition, it is all too easy for an argument based on culture to turn into a "cultural deficit" argument, which explains the differences by a supposed failing of the particular culture in comparison with the majority norms.

Activity 2

To explore fully the nature and causes of racial inequality in health, it is important to take a multi-factorial approach.

For example, let us apply this to the problem identified above of African-Caribbean men being over-represented both among those diagnosed with schizophrenia and among those compulsorily admitted to hospital.

Try to develop an explanation based on culture, followed by an explanation based on structural inequality and black people's experience of racism.

Comment: *The culture/cultural deficit argument might suggest, among other things:*

Statistically, members of minority ethnic groups tend to present to health services when the course of their psychiatric problem is further advanced

Members of minority ethnic groups might have a different concept of mental health problems: they may be seen as social rather than medical problems, therefore people do not seek help from the NHS till it is too late

There may be difficulties in communication between the person and the mental health professionals

An argument based on an understanding of structural inequality and an acknowledgment of people's experience of racism might wish to acknowledge that there is some truth in the arguments above. However, people who take this position would want to add:

How accessible and appropriate are mental health services for people other than the majority culture? Are there specialist or outreach services targeted at these groups?

What is the influence of racism on the perceptions that mental health professionals use to inform their diagnosis and treatment? Are behaviours or ways of speaking which may be culturally appropriate being interpreted as symptoms? Does racism lead to black people being perceived as "dangerous" and therefore more in need of compulsory admission?

6. Disability: Medical and Social Models

There are many health issues where it is important to explore the power relationships between medical professionals and people who may need to use health services, and the ways in which concepts like health can be socially constructed. Illich (1976,*Limits to Medicine: The Expropriation of Health*, Penguin) talked about the "medicalisation of life". He discusses the way in which everyday processes of life such as bearing children and dealing with death have been removed from the control of ordinary people and placed in the hands of the professionals. Illich suggests that this "expropriation of health" is part of the wider processes of

inequality whereby power is taken from ordinary people and placed in the hands of "the university-educated elite" It could be argued that a similar process has happened in relation to disability. Disabled people have drawn attention to the fact that they are frequently defined purely by reference to their medical condition and many aspects of their lives are controlled by the medical system.

What does the medical model mean in practice? People with disabilities are seen as "victims", sometimes "tragic" victims. One of the disabled writers who have explicitly challenged this approach is Michael Oliver (1990, *The Politics of Disablement*, MacMillan); he states that this concept of disability is socially constructed and is a direct result of structural inequalities. Jenny Morris (1991, *Pride Against Prejudice*, Women's Press) gives an account of how a doctor dealt with her as a tragic victim after the accident in which she was paralysed. "I felt that there was only one person who could say it was a tragedy and that was me – and I wasn't prepared to say that".

A medical model defines people, and places a value on their lives, according to medical diagnosis and according to what they cannot do. Being unable to do something is seen as a direct result of the impairment.

A social model of disability on the other hand acknowledges the role of society in erecting barriers which prevent the disabled person's inclusion in society. This model does not deny the existence of physical impairments such as paralysis or sensory impairment, but points out that the main barriers are social rather than intrinsic to the disabled person.

For example, a person such as Jenny Morris or Michael Oliver has a physical impairment – a spinal injury. If they are unable to work, a medical model would see this as arising directly out of the impairment. A social model would argue that social barriers prevent people with spinal injury from participating in paid work. Inability to travel to work may be the result of inadequate transport; the inaccessibility of some workplaces reflects the low value that society places on the inclusion of people with disabilities. The social isolation of some disabled people reflects planning and housing policies that assume everyone is able-bodied. It is the environment which disables or handicaps, not the impairment itself. It is this social model of disability which is reflected, however imperfectly, in the Disability Discrimination Act.

From the 1980s, a movement of disabled people began to develop. This movement was based on a civil rights model. They have argued forcibly and carried out direct action, for example on the issue of accessible transport. A key feature of this movement has been a rejection of the public perception of disabled people as passive victims and recipients of the charity of able-bodied people. "Rights not Charity" has been one of the watchwords of this movement.

Activity 3

In the 1990s, some disability campaigners picketed the BBC fundraising event "Children in Need", arguing that it demeaned people with disabilities. In what ways do you think such events can be seen as demeaning or devaluing disabled people?

Comment: *This is what Jenny Morris had to say about her experience of challenging Children in Need.*

"Two men came up to us, thinking that we were part of the Children in Need event…(a man) offered a five pound note to someone behind me. She accepted it; she was fed up of explaining our message yet again (…) As he passed me by, he patted me on the head"

"It is this response which lies at the heart of the discrimination we face—in employment, in housing, in access to all the things non-disabled people take for granted.

It is this which lies at the heart of a refusal to accept that the denial of these things is a civil rights issue and not a result of individual inadequacies (…) we have an uphill battle for the resources which are the real determinants of the quality of our lives"

Self Test 1

1. *What are the main factors in health inequality?*

2. *What is meant by the terms "mortality" and "morbidity" in health statistics?*

3. *How would you define a functional model of health?*

Now turn to the Answers at the end of the Block.

SECTION B: History and Structure of the NHS

1. The Start of the National Health Service

The National Health Service (NHS) was established in 1948 as part of the post-war Welfare State. The**National Health Service Act 1948** set out the principles and framework for a healthcare system that would provide services, on the basis of need, that were free at the point of use. This was the start of the health service being funded by general taxation. Prior to the introduction of the National Health Service, health care was provided by private hospitals and doctors who charged for their time and medicine. Some hospitals were charitable organisations that were partly funded by donations and, in some cases, adjusted their charges to take account of their patients' circumstances. Some employees were also entitled to limited healthcare services through national insurance contributions. In short, large sections of the population were not able to access medical assistance in the event of illness. Women were least likely to be able to access medical care in the event of illness.

The creation of the NHS did not change the number and type of hospitals and general practitioners (GPs). It transferred the ownership of hospitals to the state and changed the working arrangements and payment methods for GPs. Everyone was entitled to free medical, dental and optical care, including any medicines, appliances, dentures and glasses that were prescribed.

Aneurin Bevan was the Minister for Health in the post-war government. He oversaw the complex negotiations with the medical profession that meant that the NHS would operate with the co-operation of doctors. The changes needed to have the support of the doctors if they were to be fully implemented. The medical profession represented by the British Medical Association was initially very hostile to the plans for a national health service. They argued that the introduction of a national health service which was free at the point of use would threaten their professional autonomy and jeopardise the quality of medical care. The result of these negotiations was that a number of compromises were made that would give doctors greater flexibility and financial incentives. GPs had worked as self-employed individuals, often as part of a practice or group. They did not want to become employees of the NHS. The result was that they became independent contractors who agreed to provide services to the NHS in return for a set fee per patient. Hospital doctors also wanted to retain their independence and scope to

work on a private basis. Consultants were given contracts that allowed them to continue private practice alongside working for the NHS. Indeed, provision was made for beds in NHS hospitals to be made available for private patients. Bevan referred to these compromises as 'stuffing their mouths with gold'. These compromises had a substantial impact on the structure and organisation of the NHS, and their impact can still be seen today.

At the time that it was established, the NHS was a source of national pride and admired by many other countries. Many European countries have social insurance based healthcare systems. In these countries, the system is subsidised and may be run by the government. In some cases, employers routinely provide health insurance. The healthcare system in the United States is primarily based on the private sector, although there is state funding for those on very low incomes and elderly people. There is also network of veterans' hospitals that provide free care for armed forces veterans and their families.

On 5th July 1948, when the NHS came into existence, there was a huge demand for services. People queued to access health care services that they had not been able afford. These included many people who had been living with severe and chronic conditions for many years who were now able to seek treatment. Very quickly it became apparent that demand for services was greater than anticipated and costs increased rapidly. In 1952, after many arguments amongst the members of government, prescription charges were introduced. In the first 20 years of the NHS, expenditure doubled in real terms. Spending continues to increase in real terms.

Activity 4

Suggest reasons for the rapid growth in spending on the NHS.

Comment
There are many reasons for the rapid growth in spending on the NHS.

- Population growth, especially the post-war 'baby boom'
- Rising expectations of health services
- Medical advances mean that it is possible to treat a wider range of conditions. At the point that the NHS was established antibiotics were available but expensive.
- Rising life expectancy leads to a greater demand for services for older people.
- Changing patterns of disease – the reduction in infectious diseases and the increase in chronic conditions, which leads to a greater demand for services and medicines.
- The NHS has been criticised for not having mechanisms to control rising budgets and not talking inefficiency.

Further information:
http://www.nhs.uk/england/aboutTheNHS/history/default.cmsx

2. Major Changes in the Health Service

The growth of managerialism

A range of approaches has been tried over the years to manage the unwieldy creature that the NHS had become. These included the setting up in the 1970s of a complex structure of regional and area health authorities and district management teams under the national control of the Department of Health. This structure continued until 1990. During this period, various approaches to reforming the management of the Health Service were also tried. The Salmon report in the 1970s created for the first time a management structure for the nursing profession, with the introduction of Nursing Officers and the death of the Matron (RIP Hattie Jacques). At the same time, the role of generalist managers was also gradually increasing, with a move from the old hospital "administrator" to the idea of hospital management. One of the effects of this was that some slight inroads were being made into the role of the medical profession in determining the management of the NHS and the allocation of resources within it.

This development of the role of management took a great leap forward with the Griffiths Management Enquiry in 1984. This reflected the political stance of the then government, which believed that private sector management techniques were the best way to reduce bureaucracy and increase the efficiency and cost-effectiveness of public services. They also held to the view that increased managerial control, combined with certain structures for consultation such as the Community Health Councils, would increase accountability of services to the public.

The Griffiths Management Enquiry introduced the role of the Unit General Manager, a non-medical person with a background in industrial, military or commercial management (one London hospital was surprised to find itself under the control of someone whose previous management experience was in Bomb Disposal). This development was effective to some extent in reducing the power the medical profession wielded over the NHS as a whole – whether it increased overall public accountability remains open to debate.

In addition, as Walsh points out (1995, *Public Services and Market Mechanisms*, MacMillan, p.150), the complexity of a system which introduced two parallel organisations with separate budgets, and the need to manage the process of developing contracts, resulted in an increase in the number of managers and accountants within the system. This, he argues, could actually reduce public accountability.

While at the time of writing, the market approach to social care services remains, the 1997 Labour government acted fairly rapidly to do away with the market in health care.

The Health Act 1999 embedded these changes in legislation. Briefly, the Act abolished the purchaser-provider split between Authorities and Trusts, and provides for the setting-up of Primary Care Groups and Trusts, which will be described later.

One of the most fundamental changes to the NHS was the creation of a purchaser/provider relationship between different organisations. The **NHS and Community Care Act 1990** gave health authorities the responsibility to plan and purchase the health services required by the people living in their area. General practices were also able to become fundholders. This meant that they had direct control of the budget for purchasing non-emergency hospital care and prescribing costs for their patients. Organisations such as hospitals, that provided healthcare services became trusts. These trusts were required to operate as businesses and develop contracts with health authorities and fundholding GPs. The introduction of this purchaser/provider split led to decisions about whether or not to pay for medical care

being made at a local level across the country. As was inevitable, different organisations made different decisions about which treatments to fund. This led to what was termed the 'postcode prescribing lottery' where some treatments were available on the NHS in some areas but not in others.

Following their election in 1997 the Labour government introduced a number of changes that sought to tackle the variation in healthcare across the country. They abolished GP fundholding. The responsibility for commissioning healthcare services was initially transferred to health authorities. Primary Care Groups, which became Primary Care Trusts (PCTs), were established to plan, provide and commission health services for their population. The National Institute for Clinical Excellence (NICE) was set up to consider the evidence and costs of treatments. NICE issues guidance to health organisations on whether or not it is appropriate to fund particular expensive treatments with the aim of avoiding the 'postcode prescribing lottery'.

3. The Current Structure of the NHS

The services provided by the NHS can be split into three categories:

- primary care
- secondary care
- tertiary care

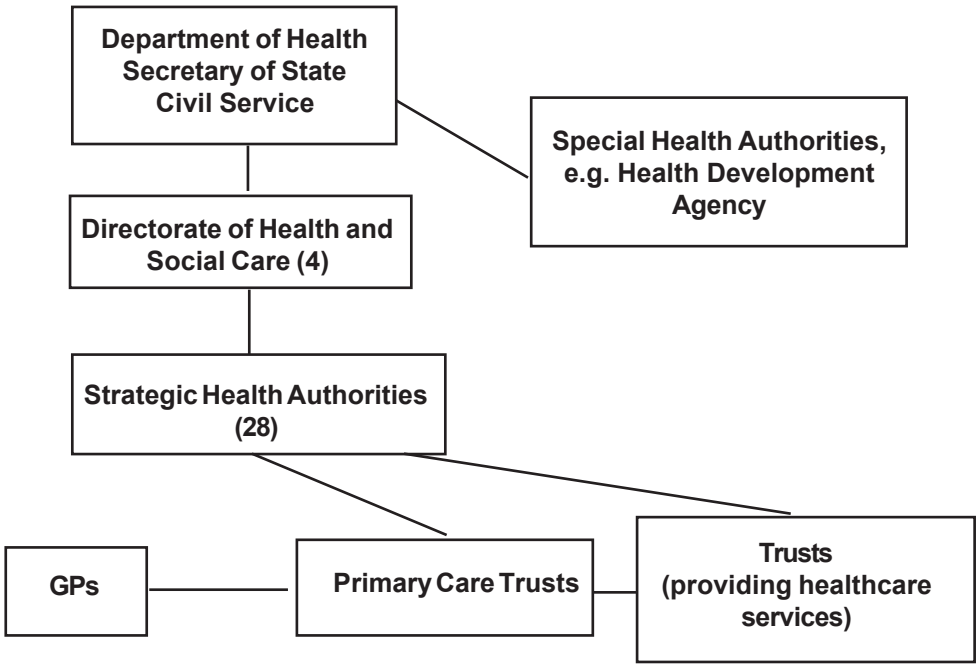
Primary care is the first level of health services that are based in the community. It includes GPs, local pharmacies, community and practice nurses and health visitors. Primary care is usually the first port of call in the event of illness. Secondary care services are those that you may be referred to if primary care is not able to deal with your problem. This includes most hospital services.

Tertiary care is more specialist care which is usually provided by teaching hospitals that specialise in particular areas. For example, you might go to your GP with a problem (primary care). They may refer you to your local district hospital (secondary care). In some circumstances, you may then be referred to a specialist in a larger, regional or teaching hospital (tertiary care). One organisation or hospital may provide more than one type of care. For example, a large teaching hospital will provide secondary and tertiary care for those people who living locally. They will also give tertiary care to people living in a larger catchment area.

Since the Labour government came to power in 1997, there has been a move to shift control away from secondary and tertiary care towards primary care. Historically, the NHS has been led and influenced by hospital medicine. This is partly due to the fact that GPs are independent contractors. It is only with the establishment of Primary Care Trusts that there has been an organisation that brings together all the GPs working within a particular area. However, GPs still retain their independence and do not have to follow the lead of the Primary Care Trust.

Despite this hurdle, it was thought that primary care should be more involved in planning and commissioning healthcare services. Most people have some contact with primary care services, whilst only a minority are using secondary and tertiary services. In addition, primary care is based in the community and is, therefore, more likely to have links with the people for which they are planning services.

Current structure of the NHS in England



The current structure of the NHS in England is set out in the diagram above. The Department of Health is the central government department that has responsibility for the NHS and health related policies. There are 28 Strategic Health Authorities across England. They oversee all NHS organisations within their area and provide a strategic view on the health needs of the population. This includes service planning, ensuring the financial integrity of and public confidence in NHS organisations. They also allocate money to Primary Care Trusts.

Primary Care Trusts (PCTs) are responsible for organising health care services for the people that live in their area. PCTs can use this money to purchase services from hospital trusts or mental health trusts. They contract with local GPs to provide primary care services. PCTs are also able to directly provide services by employing doctors, nurses and other health professionals. This has led to a broader range of services being available in primary care. Some PCTs are providing minor operations that would previously have been performed in hospital. These operations are performed by GPs who have undertaken further training and specialised in a particular area of medicine. Direct provision of services has the advantage of releasing capacity in hospitals for them to undertake more complex procedures. It also gives GPs an opportunity to expand their skills and develop the service that they provide.

PCTs have a role in promoting public health and improvements in the health of their population. They have a direct responsibility to try and narrow inequalities in health. PCTs vary considerably in size. They tend to have a population of about 200,000 although there are many that are considerably smaller.

Activity 5

Outline some of the advantages and disadvantages of PCTs planning and commissioning the healthcare services

Answer:

Some advantages
- *Local organisations tend to have a better picture of the circumstances and needs of communities*
- *PCTs have an overview of all the health services used by its population*

Some disadvantages
- *PCTs are relatively small organisations and may not always have the scope to make large changes*

The **Health and Social Care (Community Health and Standards) Act 2003** set out the legal framework for the creation of Foundation NHS Trusts. This was a controversial Act that led to many Labour MPs voting against the government. Foundation Trusts or Hospitals are hospital trusts that work within the NHS but have greater financial and managerial autonomy and are 'owned' by local people rather than the NHS. Foundations hospitals have been compared to the old-style co-op where local people, staff and patients are members of the foundation trust. The members will a board of governors that will manage the hospital. In theory, foundation hospitals will be more autonomous. They will have to be managed in line with Department for Health guidelines but they will be subject to fewer inspection visits. They will be able to borrow capital from banks to fund cover the capital costs of projects and pay staff more than the nationally agreed pay scales. This has led to a fear that foundation hospitals will increase salaries and 'poach' staff from other local hospitals. Concern has been expressed that as foundation hospitals have greater access to finance and the ability to provide higher salaries, they will provide a better standard of care. Some people have argued that they will create a 'two tier' system and widen health inequalities.

An independent inspector will regulate foundation hospitals. Bill Moyes, formerly the director general of the British Retail Consortium, has been appointed to this post. He will determine the "terms of authorisation" for each foundation trust and set a "prudential borrowing limit" for each one. He also has the power to intervene where trusts are failing and has the scope to sack the board of directors if required.

The long-term plan is for all NHS hospital trusts will eventually become foundation hospitals. Only hospitals that score three (out of three) stars in the annual performance rating have been invited

to apply for foundation status. These trusts have had to show that they have high clinical standards and sound finances. The first 10 trusts were awarded foundation status in April 2004 and a further 13 were awarded in July 2004. An additional 31 Trusts will become foundation hospitals in October 2004. However, a number of these Trusts failed to keep their three star rating in the 2004 performance assessment.

The NHS in Wales, Scotland and Northern Ireland

In Scotland, Health Boards operate in a similar way to Primary Care Trusts in England.

22 Local Health Boards in Wales perform the same functions as Primary Care Trusts.

In Northern Ireland, the structure of healthcare services is substantially different. Health and Social Services are not viewed as separate entities. Health Boards (the equivalent to Primary Care Trusts) are responsible for joint commissioning of both health and social care services. Health and social services are provided by health and social care trusts. This provides a 'seamless' service with no barrier between health and social services.

Care Trusts in England are modelled on this approach.

Self Test 2

1. *What is meant by Primary, Secondary, and Tertiary health care? Give an example of each.*

2. *What is a Primary Care Group/Trust?*

3. *What is meant by the term "postcode lottery" in health care? 4. What measures has the Government introduced to overcome this problem?*

Now turn to the Answers at the end of the Block.

SECTION C: Current Health Policy and its Implications for Housing

1. Health Targets

One of the key documents outlining current Government priorities for health is "Saving Lives: Our Healthier Nation" This document sets out targets and strategies. Below is an extract from the Executive Summary:

> *"...we are setting tougher but **attainable targets** in priority areas. **By the year 2010:***
>
> ***CANCER:** to reduce the death rate in people under 75 **by at least a fifth***
>
> ***CORONARY HEART DISEASE and STROKE:** to reduce the death rate in people under 75 **by at least two fifths***
>
> ***ACCIDENTS:** to reduce the death rate by **at least a fifth** and serious injury **by at least a tenth***
>
> ***MENTAL ILLNESS:** to reduce the death rate from suicide and undetermined injury **by at least a fifth.***
>
> *If we achieve these targets, we have the opportunity to save lives by preventing up to **300,000 untimely and unnecessary deaths.** To achieve **better health** for everyone and especially for the worst off we are:*
>
> - *putting in **more money:** £21 billion for the NHS alone to help secure a healthier population*
> - *tackling **smoking** as the single biggest preventable cause of poor health*
> - ***integrating Government,** and local government, work to improve health*
> - *stressing health improvement as a key role for the **NHS***
> - *pressing for **high health standards** for all, not just the privileged few."*

(Secretary of State for Health (July 1999)
Saving Lives: Our Healthier Nation, Cm 4386.)

It can be seen from this extract that the priorities for health are informed by a perspective that incorporates an acknowledgement of the ways in which social inequality influences health and life chances. Another feature of the paper is its emphasis on "joined-up working": an expectation that the NHS, local government, the independent sector and other key stakeholders will work in partnership to achieve change rather than defending their own institutional boundaries and budgets.

However much we may applaud the sentiments, we need to look at some of the mechanisms being put into place to achieve these targets.

The links between housing and health are not always straightforward and clear cut. People spend a large proportion of their time in their home. As a result, difficulties with housing can have an impact on all areas of someone's life, including their health. Those people who are more vulnerable to illness and poor health, such as older people and the unemployed, are more likely to spend the majority of their time in their home.

Activity 6

Think about how someone's housing circumstances might have an impact on their health. You might also want to think about some of the ways in which these problems might be alleviated.

Answer:

There are numerous things that you might have identified in this activity. Below are a number of possibilities.

- *A home without adequate heating can lead to illness, particularly in the elderly and young children. Installing heating systems would change this.*
- *Damp housing can exacerbate chest complaints. Solving the damp problem can improve this.*
- *Unsafe homes and those in a state of disrepair have a greater potential for accidents*
- *Stress resulting from uncertainty about housing circumstances or worries about meeting housing costs can have a negative effect on health.*

There is a large amount of evidence that shows that poor housing conditions and uncertainty can have a negative impact on health. Research commissioned by the Joseph Rowntree Foundation found that excess winter deaths were more likely to occur when people were living in homes without adequate heating (http://www.jrf.org.uk/knowledge/findings/housing/n11.asp). The Office for the Deputy Prime Minister published a review of the evidence relating to overcrowding and health. (http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_028618.hcsp). This found that people living in overcrowded housing were more likely to have poor physical and mental health. There is also evidence to show that people who are experiencing uncertainty over their housing circumstances are more likely to suffer from stress and poor health. This includes people who are facing repossession and negative equity.

1. Reducing Health Inequalities

When the Labour government came to power in 1997, it announced that it wanted to tackle inequalities in health. There have been a number of policies that have aimed either directly or indirectly to reduce inequalities in health. Moves have been made to reduce child poverty in the hope of improving the health of children. More direct initiatives have also been implemented. *SureStarts* are small locally-based programmes in areas experiencing high levels of deprivation. They co-ordinate childcare, education and training for parents and other services that will improve the lives of young children. Increases to winter fuel payments for pensioners and campaigns to encourage the take up of the Minimum Income Guarantee were partly introduced to improve the health of older people (See SWH.100).

During the 1990s, there was increasing concern that the healthcare services received depended on where you lived. In particular, 'post code prescribing' meant that some treatments were available in some parts of the country but not in others. The treatments under question tended to be expensive, or those where the benefit to the patient was uncertain. The National Institute for Clinical Excellence (NICE) (www.nice.org.uk) was set up to provide national guidance on which treatments should be available on the NHS. NICE investigates the evidence on the impact of treatments and their cost before issuing guidance on whether or not it is an appropriate use of resources for it to be widely paid for by the NHS. In theory, PCTs still have discretion on the funding of these treatments, but in practice they tend to follow the NICE's conclusion.

2. National Service Frameworks

In response to concern that the quality and quantity of care being received across the health and social care field varied considerably depending on were you lived, a series of National Service Frameworks (NSFs) were introduced.

There are two NSFs that have a clear link to housing – the NSF for older people and the NSF for mental health services. For further information on the NSF for mental health, see SWH.104 – Community Care.

National Service Framework for Older People

The National Service Framework (NSF) for older people was published on 27th March 2001. It set national standards and service models of care across health and social services for all older people, whether they live at home, in residential care, or are being looked after in hospital.

The NSF leads with plans to:

- tackle age discrimination to make it a thing of the past, and ensure that older people are treated with respect and dignity;
- ensure that older people are supported by newly integrated services, with a well co-ordinated, coherent and cohesive approach to assessing individuals' needs and circumstances and for commissioning and providing services for them;
- specifically address those conditions which are particularly significant for older people – stroke, falls, and mental health problems associated with older age; and
- promote the health and well-being of older people through co-ordinated actions of the NHS and councils.

The implementation of the NSF requires health, social care and housing agencies to work in partnership to meet the targets set out in the eight NSF standards. These standards are:

Standard 1 – Rooting out age discrimination

Standard 2 – Person centred care

Standard 3 – Intermediate care

Standard 4 – General hospital care

Standard 5 – Stroke

Standard 6 – Falls

Standard 7 – Mental health in older people

Standard 8 – The promotion of health and active life in older age

To meet Standard 1 and make sure that services treat people according to their need for services, all NHS organisations are required to have a written policy on age discrimination. Social care organisations and local authorities have also been issued with guidance on how to ensure that people receive the services and care that they require on the basis of their needs and risk factors, rather than their age.

Standard 2 sets out the importance of person centred care. NHS and social care services should treat older people as individuals and enable them to make choices about their care. This has led to the single assessment process. This means that any older person with care needs will have one assessment of their needs that will include care and social support services, equipment needs and continence services (which include things like installing grab rails in the bathroom and providing an adjusted toilet seat). This means that there will be a single point of contact for all social care needs. Older people will no longer have to go through numerous assessment processes for all their care needs to be met. As there is a single assessment, it is less likely that people's requirement will be missed. There is also scope for the assessment process to consider the interaction between an individual's needs during their daily life. The single assessment process should also reduce bureaucracy.

Standard 6 seeks to reduce the number of falls amongst older people. By April 2005, all local authorities working in conjunction with local NHS organisations should have an Integrated Falls Strategy. This will provide support for older people who have fallen, rehabilitation, and information on preventing falls. There is a close link between work to reduce the number of falls and the promotion of health and active life in older age (Standard 8). Local

authorities are encouraged to work with NHS organisations and undertake work that will encourage older people to be more active and promote healthier lifestyles. This might include exercise classes for older people and health promotion through social clubs.

Case Study: Encouraging active life

Rotherham Active in Later Life
The Rotherham Active in Later Life (RAILL) project aims to improve the health and activity levels among older people. It provides health promotion activities for older people in local leisure centres at six locations. It is managed by Age Concern and includes:

- keep fit sessions and line dancing
- health promotion speakers with question/answer sessions/debate/information
- a Consumer Committee and involvement regarding future planned activities

RAILL has a part-time manager, development worker, and administrative staff: Rotherham Borough Council provides the keep-fit instructors.

Clients pay 80p per attendance and this is paid to the leisure centres. Benefits include improved physical health with members reporting improved ability to climb stairs, and mental health through increased socialisation thereby reducing isolation. Consumer questionnaires demonstrate a high level of satisfaction with the service.

Leisure Centres are very supportive as they were underused during the day and now some older people have taken up mainstream leisure pursuits like swimming because of this initiative.

Further information

National Service Framework for Older People, Department for Health
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/fs/en

Quality and choice for older people's housing: a strategic framework, Office for the Deputy Prime Minister
http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_601723.hcsp

Preparing Older People's Strategies, Office for Deputy Prime Minister
http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_609052.pdf

3. The NHS Plan

In the summer of 2000, the government produced the NHS Plan. This document was preceded by a budget announcement of extra money to be allocated to the NHS.

The rationale for the Plan is that "the NHS is a 1940s system operating in a 21st Century world". In order to address this, the Plan announced substantial additional funding, to be targeted in the following areas:

- New hospitals and more beds in existing hospitals
- New one-stop primary care centres
- Modernisation of GP premises
- New equipment
- Modern IT systems
- Clean wards and better hospital food. Money was immediately sent to hospitals to be spent on improved cleanliness. Lloyd Grossman has been appointed as a consultant on hospital food (you should make up your own minds about this)

The payback for this extra investment is an increase in central government control over the workings of the NHS. The structures set up to ensure continuing improvement in the quality of care include:

- National Service Frameworks and performance Assessment Frameworks in a number of key areas e.g. Mental Health, Older People
- Bringing Health and Social Services Organisations together in Care Trusts (there is more on this in the Community Care Block)

4. Health and Housing

The crossover between health, housing and other aspects of social policy is complex. It is sometimes difficult to know what is a housing issue and what is a health or social security issue. For example, take the question of fuel poverty. While this is clearly a social security issue, it nonetheless impacts on people's health and on their ability to make best use of their housing. An approach to fuel poverty requires a three-pronged (at least) attack:

- Benefit levels and uptake need to be addressed
- People need information about the risks and symptoms of hypothermia and other health problems linked with fuel poverty
- Social landlords need to ensure the energy efficiency of their properties for example by means of insulation

There are a number of health problems and hazards linked with housing. An article by Julie Wagstaff in *Housing* outlines some of these, and the article is reproduced below.

HEALTH & HOUSING - POTENTIAL RISKS

A new report on Britain's 'health gap' has attracted attention not just from the specialist media but also from the mainstream press. While the report may be new, however, the debate is not. **Julie Wagstaff reports**

The Building Research Establishment in its 1995 report, *Building Regulation and Health*, identifies 18 different health hazards relating to housing and assesses the degree of risk posed by each. The main ones are:

- **mould and fungal growth** which is widely accepted as contributing to asthma
- **cold** causing perhaps as many as 50,000 extra deaths every winter
- **radon** which is thought to be responsible for 2,500 deaths from lung cancer each year
- **carbon monoxide poisoning** from badly installed and serviced gas appliances leading to fatalities every winter, particularly in houses in multiple occupation (HMOs)
- **inadequate security** and the effects of crime with as many as one million people a year coping with the physical and psychological effects of burglary
- **overcrowding** leading to increased susceptibility to infections such as tuberculosis.

Health inequalities research

In November 1999, the Townsend Centre for International Poverty Research at Bristol University published *The Widening Gap: health inequalities and poverty in Britain.* Drawing on a range of statistics, including recent censuses and the Office for National Statistics' yearly mortality data, the authors conclude that the health divide between the richest and the poorest in Britain, first identified in the Black Report, (see below) is continuing to widen. Comparison of parliamentary constituencies at the extremes of the health divide found:

- infant mortality in the 'worst health' constituencies is twice that of the best
- in the 'worst health' constituencies more than four times as many households with children live in poverty
- the 'best health' constituencies have more than six times as many households with seven or more rooms

The widening gap is the latest in a series of investigations into the relationship between poverty and health, most of which has included some assessment of the impact of housing on health. The Black Report, commissioned by the Labour Government in 1980, was one of the most influential. It found that health inequalities had been widening since the 1950s, and called for a programme of higher social security benefits, more equal distribution of income and improved housing and social services. In 1997, the new government set up an Independent Inquiry under the chairmanship of Sir Donald Acheson to look again at inequalities in health; it recommended that any policy likely to have an impact on health should be evaluated in terms of whether it has the potential to reduce current levels of health inequality. More specifically it called for action to:

- improve the availability of social housing
- improve access to housing provision and health care for homeless people
- improve the quality of housing by creating safe environments, increase minimum space standards and tackle fuel poverty with initiatives on heating and insulation.

The Government's response

The Government's White Paper, *Saving lives: our healthier nation* (1999), acknowledges that good quality housing is vital to health, stating that cold homes are implicated in up to 20,000 to 50,000 extra deaths every year, and that asthmatics are two to three times more likely to live in damp properties. The English House Condition Survey (1996) has already highlighted the 4.3 million 'fuel poor' homes (where more than 10 per cent of household income is spent on adequate heating). Legislation on fuel poverty is before Parliament. The Government is also reviewing the current housing fitness standard which would encompass health and safety risks. The aim is to identify more quickly those homes which pose the greatest risks to health and the appropriate action to remedy them. A new licensing system for houses in multiple occupation (HMOs) is also to be introduced to tackle the worst housing conditions.

Joint working - what's happening

Social landlords are often well placed to assist in the development of initiatives to reduce health inequalities. There are many examples of housing and health agencies collaborating. These are just a few:

- Preston Borough Council – working jointly with North British, Eavesbrook and New Progress housing associations, the health authority and social services – is funding a free mediation service to help resolve disputes between neighbours; the agencies involved believe it will reduce stress and help improve mental health.
- The London Borough of Croydon and Croydon Health Authority have set up two multi-agency 'Health Think Tanks' to work on the causes of ill-health in particular parts of the borough. Their action plan included energy efficiency improvements, promotion of renovation grants, a home safety and security service and stricter enforcement of HMO legislation.
- North British Housing Association in partnership with Zion Community Centre jointly manages a primary care centre funded by Manchester Health Authority. It offers a range of services including counselling, dentistry, community psychiatric nursing and social services.

References

- *Inequalities in health: the Black report and the health divide*, Black, D. & Whitehead, M., Penguin, 1988.

Building regulation and health, Building Research Establishment, 1995.

- *Good practice briefing: housing and health*, Chartered Institute of Housing's Good Practice Unit , June 1998.
- *Independent inquiry into inequalities in health*: report Department of Health (Chairman: Sir Donald Acheson), TSO, 1998.
- *Saving lives: our healthier nation*, Department of Health, 1999.
- *Differences in mortality by housing tenure and by car access from the OPCS Longitudinal Study*, Filakti, H & Fox, J. Population Trends, Autumn 1995, 27-30.
- *English house condition survey 1996*, DETR, TSO, 1998.
- *The widening gap: health inequalities and policy in Britain*, Shaw, M, Dorling, D. et al, Policy Press, 1999.

From your reading of the Wagstaff article, you will see that some of the links between housing and health are what might be described as "technical", e.g. radon gas, mould. Others, however, operate on a macro-social level and include the lack of availability of social housing.

Initiatives in Health and Housing

Two examples of initiatives seeking to overcome housing-related health problems are listed above. There are many such initiative throughout the country, many of which can be found on the Our Healthier Nation website (http://www.ohn.gov.uk/database/database.htm).

Activity 7

*Access the **Our Healthier Nation** website if at all possible and identify housing-related initiatives in your local area.*

What are the partnerships involved?

How do the partners work together?

How does the initiative link to the targets in Our Healthier Nation?

Comment: *It is not possible to comment comprehensively on what you might have found. However, if you have been able to access the website, you will have seen the tight specification for reports and the emphasis that is placed on partnerships in obtaining access to funds.*

Case Study: health and housing

Mr. and Mrs. Jones are 87 and 83. They live in a two-bedroomed, privately-rented house which has been their home for 40 years. The property is in a poor state of repair and the landlord has not responded to requests to improve it. There is both rising and penetrating damp, old lead pipes, and no central heating. The roof is leaking and the window frames are rotting to the extent that there are draughts blowing through gaps.

What impact could these housing conditions have on the health of Mr. and Mrs. Jones?

What remedies are available?

Comment

- *Mr. and Mrs. Jones will be highly vulnerable to hypothermia*
- *The housing conditions will worsen their arthritis*
- *They may also be susceptible to depression as a result of the extremely difficult conditions in which they are living*
- *Their ability to live independently in the community is severely compromised by these conditions.*

The remedies available would include packages of care provided jointly by health and social services:

- *adaptations to the home*
- *home care*
- *respite care*
- *assistance in enforcing improvements to their existing property or access to more suitable, possibly sheltered, housing*

Conclusion

We have seen in this block the ways in which attitudes to health can vary across cultures and historical periods. The development of health services in the UK have mirrored some of these changes in attitudes. In addition, we have seen how political factors can affect the priorities in public health policy, with current policy being clearly linked to the social exclusion agenda. The links between health and housing have been explored, and the role of housing providers in such initiatives as Health Action Zones highlighted.

Answers

Self Test 1

1. Poverty, class, geographical location and ethnicity are all associated with inequalities in health.
2. Mortality = death rates, often expressed as Standard Mortality

   Morbidity = the incidence of disease.
3. A functional model is one which looks at the whole person and their social context. Health is measured by the ability to be a full member of society, rather than by purely physical disease or its absence

Self Test 2

1. Primary care services are the first point of contact for most health problems. These include GPs, community pharmacists and district nurses. Secondary care is general hospital services that would be provided by a district hospital. Tertiary care is more specialist care that is provided in larger teaching hospitals or regional centres.
2. Primary Care Groups are groups of local healthcare and social care professionals who together with patient and Health Authority representatives take devolved responsibility for the healthcare needs of their local community.

   - Primary Care Trusts are free-standing bodies accountable to the Health Authority for commissioning care, and at Level 4 they have added responsibility for the provision of community services for their population.
3. This term refers to geographical differences in access to treatment, arising from variations in policy between different purchasers/commissioners of healthcare.

   Among the proposed remedies for this variation are the NICE, the CHImp, increased inspection and accountability to central government