Policy & Information team

Briefing on ...

Celebrating the 60th anniversary of the NHS in Scotland

Good health for everyone

Introduction

The National Health Service celebrates its 60th anniversary on 5 July 2008. For six decades, NHS Scotland has provided everyone with access to health care free at the point of use, funded by general taxation. The NHS has undergone many changes throughout its history, and continues to face challenges, but it remains vital to the lives of the whole population. UNISON is proud of our NHS as it turns 60. The nearly 60,000 UNISON members who work in NHS Scotland, and many more in local government and the voluntary sector, are key and committed players in the teams delivering the nation's health, and all of our 160,000 members, their families and their communities benefit from the public health ethos of the NHS.

The creation of NHS Scotland

The National Health Service in Scotland was established on 5 July 1948 – the same appointed day as the NHS in England and NHS Wales - by the radical postwar Labour government. Minister of Health and Housing Aneurin Bevan fought opposition from vested interests including the BMA to introduce the bills which founded the NHS on three essential principles which endure to this day: services would be provided free at the point of use; the NHS would be financed from central taxation; and everyone would be eligible for care.

Before the NHS, there had been a patchwork of medical services across the UK. There was no universal provision. National Insurance, introduced in 1911, afforded limited health care for some and many others relied on charity. Some of the important precursors of the NHS were Scottish. The Highlands and Islands Medical Service which was established in 1913 effectively provided a free health service in the distressed areas in Northern Scotland, and the Clyde Basin Experiment in Preventative Medicine, set up in 1941, provided war workers in industrial areas with free access to doctors.

The National Health Service [NHS] (Scotland) Act 1947 created a Department of Health for Scotland working under the Secretary of State for Scotland. Although formally a separate institution, NHS Scotland operated closely with the NHS south of the border to deliver a seamless service free at point of use throughout the UK. The NHS began with a tripartite structure: hospitals; primary care (general practitioners, dentists, etc); and community services (including those managed by local authorities).

More than four hundred hospitals were brought together in the new NHS Scotland, which were administered by eighty-five local Hospital Boards of Management under five Regional Hospital Boards. GPs and dentists remained self-employed but were paid by the NHS for treating patients. There were 25 Local Health Authorities which co-ordinated community services. In 1948, the NHS Scotland staff included 22,062 nurses, 646 consultants, 2,647 GPs and 1,200 dentists.

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Six decades of public health care

Although formally separate, the NHS in Scotland and in Wales continued to be run along broadly the same lines as the NHS in England until the devolution settlement in 1999. A major reorganisation in the early 1970s was reflected in NHS Scotland. This change saw the hospital boards and community services regrouped into 18 area health boards, which largely removed the direct role of local government in provision; and an increasing focus on primary health care teams.

The issue of funding has been political throughout the history of the NHS. Prescription charges were controversially introduced in 1952, a mere few years after it was established, prompting Bevan to resign from the Labour government. They have been abolished, reintroduced and varied since then. Prescription charges have now been abolished in Wales and there is a plan to phase them out in Scotland by 2011.

Demand for health care grew through the 1960s and 1970s, and costs increased due to demographic changes and medical innovations. The election of the Thatcher government in 1979 which was manifestly not committed to the fundamental principles of the NHS 1979 led to a period of crisis and seemingly permanent reform. The traditional system of consensus management was replaced by a business model of management.

At its 40th anniversary in 1988 the NHS faced the imposition of the internal market, a reform designed to introduce competition and open up the system for privatisation. From 1991, 'purchaser' health authorities had to buy healthcare from 'provider' hospitals and other health organisations, which became NHS Trusts. The combination of ideological reform and chronic underfunding meant that the NHS across the UK, including in Scotland, was struggling to provide adequate care for its patients (now renamed 'customers'). Hospitals were short of staff and delays for treatment were long. By 1994 a BBC/Mori poll found that only 35% of people thought the NHS would still exist in ten years' time.

Saving the NHS

Health unions, including UNISON and its predecessors, were are the forefront of the campaign to save the NHS. It was the main issue in the 1997 election which led to the return of a Labour government. Labour brought in plans to abolish the internal market and increase funding dramatically.

In 1998, the same BBC/Mori poll found that 69% of people thought the NHS would exist in ten years' time. In this case the majority were right.

In the first ten years of the Labour government, spending per head on health in Scotland was doubled. More than 700 extra doctors and 5,000 extra nurses plus other health team members have been added since devolution in 1999.

As a result of this investment, patient treatment has become faster and better. Waiting times are now the lowest ever despite a big increase in the number of operations. There has been a focus on tackling Scotland's "big killers": cancer, heart disease and strokes. Since 1997, deaths among the under-75s from cancer have been reduced by 15%, from strokes by 40% and from heart disease by 45%.

Meanwhile there has been a new focus on promoting healthier lifestyles, and explicit objectives of ending health inequalities and improving mental health have been adopted.

With devolution to Holyrood since 1999 including health, Scotland's NHS has become more distinctive within the UK. The Scottish model has remained one of public healthcare provision, even as 'patient choice' and privatisation measures are increasingly implemented by the Westminster government. In contrast with the internal market which has been redeveloped in England, there is no longer a purchaser/provider split within NHS Scotland. The Trusts were abolished in 2004. The main privatisation measure in Scotland has been the funding of 13 hospital projects by PFI. UNISON continues to oppose PFI as a wasteful system and welcomed the announcement of traditional public financing for the new Glasgow Southern General hospital by the present Scottish government in April 2008.

Perhaps the major single measure to improve public health in Scotland since devolution has been the groundbreaking ban on smoking in public places introduced in 2006, which was controversial but has proved popular and is expected to save lives. Moves towards a ban on smoking followed in England and Wales. (Similarly, in contrast with other parts of the UK, a policy of free personal care for the elderly was introduced by the previous Scottish administration in 2001 and remains in place.)

The positive achievements of a publicly funded service

The establishment of the NHS caused a complete transformation in the lives of ordinary people. For most, before 1948, being ill did not just mean suffering but also facing the agony of whether you could afford the cost of private health care. For many, there was not even the choice of charitable provision. The NHS meant that everyone was treated free, regardless of ability to pay.

In the first decade of the NHS, infant mortality in Scotland was nearly halved, from 44.7 to 27.7 deaths per 1000. Infectious diseases which had been widely feared were taken on and largely conquered. The tuberculosis death rate in Scotland was cut from 66 to 12 per 100,000 in the first ten years of the NHS.

And the benefit of universal healthcare free at the point of need has helped people to live longer, healthier lives. Average life expectancy in Scotland in 1948 was 64 for men and 69 for women. In 2006, the average for men was 75 and for women 80.

Over the last six decades, the NHS in Scotland has cared for millions of people and saved many hundreds of thousands of lives. It has been at the forefront of innovation in healthcare too, pioneering advances in medical treatment, surgery and imaging. In the fifties Professor Ian Donald and colleagues at the Glasgow Royal Maternity Hospital developed ultrasound scanning for unborn babies. The first kidney transplant in the UK took place at Edinburgh Royal Infirmary in 1960.

Scotland's health challenges

Although we are on average healthier and live longer, in large part as a result of six decades of the NHS, many health challenges remain. The ageing population profile means the pattern of demand for health care is changing.

Scotland's reputation of being the "sick man" of Europe which stemmed from extremely high rates of cancer and coronary heart disease has been mitigated by successes tackling these illnesses, but we still have a long way to go.

Health inequalities remain intractable. Poverty is a recognised cause of ill health, and poor people continue to suffer more ill health than their better off compatriots. Indeed, many measures of health inequality show that the gap is increasing.

Projections indicate that Scotland's population will rise to 5.37million 2031 and decline thereafter in the longer term, falling below 5 million by 2076. The challenge for health care comes from the increasing age of the population as the number of younger people declines. The number of people of pensionable age is projected to increase by 31% from 980,000 in 2006 to 1.39 million in 2031; and the number of over-75s is projected to increase by 81% from 380,000 to 690,000 in the same time period.

Despite overall improvements in general health and amongst older people, on average older people will still tend to have more chronic disease and more long term conditions and this will change the kind of demands the NHS will need to fulfil.

Life expectancy continues to increase for the whole population. On average, men's life expectancy rose from 72.1 years to 74.6 years between 1994-96 and 2004-06. The figure for women went from 77.8 years to 79.6 years in the same period. However, average life expectancy remains lower in Scotland than the European average by almost a year for men and almost two years for women. Meanwhile, within Scotland, the gap between the council areas with the highest and lowest life expectancy has not decreased at all over the last ten years. For men living in East Dunbartonshire average life expectancy is 78.0 years, whereas in Glasgow City it is only 70.5 years. This gap of 7.5 years is a clear indicator of health inequality.

Mortality rates for coronary heart disease and cancer have decreased substantially for both men and women since 1999, with the gap between the higher male and lower female rates reducing greatly for coronary heart disease. However, in 2005 there were still around 500,000 people with coronary heart disease, of whom 180,000 were being treated at any one time. Mortality rates for stroke have also decreased, though less markedly.

Higher deprivation is related to higher incidence and higher overall mortality for these key diseases. Overall, 34% of all premature deaths can be attributed to deprivation. At a younger age suicide and drug-related problems are more prevalent for people in deprived areas; at an older age key diseases are more prevalent.

We also face more contemporary issues: drug and alcohol abuse, sexual health issues, and obesity.

The proportion of women in Scotland who reported that they consume more than the recommended weekly limit of alcohol rose from 13% in 1995 to 17% in 2003. Men remain more likely to report this, though the proportion which did so fell in that time period from 33% to 29%. Alcohol-related discharges

from hospital and deaths increase with higher levels of deprivation. Mortality rates from chronic liver disease have also risen over the last 20 years, and the increase has been more pronounced for the most deprived areas.

Drug-related deaths increased by 25% between 2005 and 2006, from 336 to 421. Thirty-eight per cent of these deaths occurred in the NHS Greater Glasgow and Clyde area.

Scotland, with the UK, has one of the highest rates of teenage pregnancies amongst developed nations, and the rate has remained steady in recent years despite being targeted for reduction.

There has been a long term rise in sexually transmitted infections, amongst both men and women, including chlamydia and genital herpes.

AIDS diagnoses and AIDS related deaths have fallen since the introduction of effective therapies in 1996, but the incidence of acute sexually transmitted infections such as syphilis amongst men who have sex with men continues to grow, despite awareness-raising campaigns.

Scotland has the second highest rate of obesity among the OECD countries, behind only the USA. 24% of Scottish men aged 16-64 were obese in 2003, an increase from 16% in 1995. Amongst women over that time period, the increase in obesity was from 19% to 27%. Only 36 per cent of adults in Scotland meet the recommended level of physical activity per week, a figure which has changed little in the last ten years.

Current health policy framework in Scotland: Better Health, Better Care

With these health challenges facing the NHS, there is also a new political environment. The SNP administration which was elected in May 2007 has now instituted its 5 Year Action Plan following consultation around the Better Health, Better Care discussion document. The aim is stated as being a "mutual NHS" involving patients and carers in partnership in order to meet the government's objective of "Healthier Scotland - with its three main components of health improvement, tackling health inequality and improving the quality of health care."

Building on existing policies including development of Community Health Partnerships and Managed Clinical Networks, the plan envisages improved patient rights and consideration of direct elections to Health Boards and aims to continue the tradition of collaborative working. It sets broad targets for improving Scotland's health:

- Increase healthy life expectancy in Scotland
- Break the link between early life adversity and adult disease
- Reduce health inequalities, particularly in the most deprived communities
- Reduce smoking, excessive alcohol consumption and other risk factors to a healthier life

A Ministerial Task Force on Health Inequalities has been set up by the government to report on policy implementation (see below).

In response to the discussion document, UNISON Scotland broadly welcomed the government's proposals that build on existing policy. NHS Scotland has

faced considerable change over recent years and staff need stability in the delivery of services. The response also included these comments:

- UNISON Scotland supports greater involvement of patients in the design and delivery of care, and has long standing support for direct elections to health boards. However, the 'patient voice' must complement and not replace the 'staff voice'. The 'staff voice' in partnership is the key to informed policy making and effective implementation.
- Scotland has a decade of partnership working which has a proven track record in delivering a better NHS Scotland. The new Scottish Government should capitalise on 'partnership working' as a key delivery mechanism for its plans. Partnership working with the staff side is the best means for the Scottish Government to achieve its objectives for NHS Scotland.
- Best use of public money can be achieved through promoting and developing the Scottish NHS model based on co-operation not competition. There is no place for the private sector in capital investment such as hospitals, GP surgeries; for clinical services delivery (such as at Stracathro); for community services (such as the 'Keep Well' pilots); or the provision of Facility Management Services.
- UNISON fully supports the strategy of addressing health inequality. We also welcome the recognition within the consultation document of the link between poor health and other social factors. We strongly support joint working to reduce the inequalities in people's environments, income, employment, educational attainment, skills, housing and other issues that have the biggest impact on their health.
- UNISON Scotland supports the abolition of prescription charges, as we believe them to be inherently unfair, inequitable, illogical and inconsistent.

Health inequalities

From the very beginning, the NHS has sought to address health inequalities. The founding principles of free access to publicly funded health care for all at point of need were an acknowledgement of and an attack on inequality in health. However, in the 1970s it became increasingly clear that although rising living standards and universal health care had improved average life expectancy, there continued to be a wide disparity between the health of the wealthiest and the poorest in society.

The Black report and its outcomes

The Black report, Inequalities in Health, was commissioned before Labour lost the 1979 general election and published in 1980 after the new Conservative government took office. The report showed that although overall health in the UK had improved with the NHS and the welfare state, there were widespread health inequalities. It also found evidence that the main cause of these inequalities was poverty. Though its recommendations were largely ignored by the Tories in government, the Black report remains a seminal document.

The recommendations included: a comprehensive antipoverty programme – with a central aim of abolishing child poverty - based on a fairer distribution of resources, and active social participation through provision of the necessary educational and employment opportunities; tax changes, benefit increases, and restrictions on the sale and advertising of tobacco.

Its findings were updated and reinforced by the Independent Inquiry into Inequalities in Health, the Acheson report, which was commissioned after Labour returned to power in 1997. Almost 20 years after Black, health inequalities continued to worsen.

The Labour government's bold aim announced in 1999 of abolishing child poverty in Britain by 2020, inspired by the Black and Acheson reports, has been underpinned by redistributive tax credits and other targetted measures but it now appears unlikely that the interim aim of halving child poverty by 2010 will be met. Similarly, the target in England of reducing health inequalities is said now to be "challenging" despite a range of specific measures. The two key indicators chosen – infant mortality and life expectancy – show that the gap between the poorest fifth of local authorities and England as a whole has actually increased between the baseline period 1997-99 and the period 2004-6.

Meanwhile in Scotland, the previous administration's social inclusion policy, Closing the Opportunity Gap, set a target in the 2005-2008 spending review to "reduce health inequalities by increasing the rate of improvement across a range of indicators for the most deprived communities by 15%, by 2008". Six health specific indicators were selected and targets set for reductions in: smoking during pregnancy; adults smoking; coronary heart disease mortality (for under 75s); teenage pregnancy (aged 13-15); suicides in young people (aged 10-24); and cancer mortality rates (for under 75s).

These targets have not yet been reported on, but figures quoted above indicate that health inequalities have not been reduced in Scotland. So, in England as in Scotland, despite a decade of continuous economic growth and policies aimed at reducing them, health inequalities have not improved or have even got worse. Meanwhile the economic gap between rich and poor also continues to widen, both in the UK and in Scotland.

International comparisons

This is consistent with the findings of health academics like Richard Wilkinson, who has done extensive work for, amongst others, the World Health Organisation, on international comparisons of health inequalities. The evidence strongly suggests that economic inequality causes health inequalities, and a range of other social ills. In his recent book The Impact of Inequality: how to make sick societies healthier (2005), Wilkinson writes:

> "In societies where income differences between rich and poor are smaller, the statistics show not only that community life is stronger and people are much more likely to trust each other, but also that there is less violence – including substantially lower homicide rates, that health is better, life expectancy is several years longer, prison populations are smaller, birth rates among teenagers are lower, levels of educational attainment among school children tend to be higher, and lastly, there is more social mobility. In all these fields, where income differences are narrower, outcomes are better."

In societies like Sweden and Japan, where the gap between rich and poor is comparatively low, people enjoy better overall health and longer healthy lives. In countries like the USA, Portugal and Britain which have much larger (and in the case of Britain, growing) gaps between the richest and the

poorest, overall health measured by standard indicators such as life expectancy is poorer. This is consistently the case even if per capita income is much higher in the less equal country.

The evidence which has been found to link social inequality with poor health not only explains health inequalities, but it explains why so many attempts to deal with health inequalities fail – including policies such as targetted healtth projects, area regeneration, and health promotion initiatives. And it helps us to understand why even an institution like the NHS, founded on a principle of equal free access to healthcare, has not been able to redress the health inequalities which exist in Britain or Scotland.

The growing economic inequalities need to be reversed for health inequalities to be succesfully addressed. This is a wider problem than can be addressed by a single policy strand like health. To the extent that health policy in Scotland moves in that direction, it will be welcome.

Ministerial Task Force on Health Inequalities
Under the Better Health, Better Care proposals a Ministerial Task Force on Health Inequalities was set up in October 2007 to consider factors that influence people's health, from individual characteristics, through people's lifestyles and behaviours, to wider influences such as education, employment, living conditions and environmental influences with a focus on health outcomes. The most significant inequalities have been agreed as:

- Children's very early years, where inequalities first arise and may influence the rest of people's lives.
- The high economic, social and health burden imposed by mental illness, and corresponding requirement to improve mental wellbeing.
- The "Big Killers" including cardio-vascular disease and cancer. Risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular and where inequalities are widening.

The Task Force is due to make a final report to cabinet in summer 2008.

Joint Communiqué with STUC on Health Inequalities
The Scottish Trades Union Congress, in which UNISON plays a leading role, and the Scottish Government agreed a joint communique on Health Inequalities in January 2008. This statement makes an important mutual acknowledgement of fundamental issues relating to health inequalities and commitments to address these. Bi-annual meetings of the STUC and the government are scheduled under the Memorandum of Understanding agreed in December 2007. The Health Inequalities communique indicates agreement between STUC and Government on the following:

- There are too many people in Scotland living in relative poverty
- Poverty is a key contributor to health and social inequality, and to reduced life expectancy and more years in poorer health
- Reducing inequalities in health between the most and least affluent areas of Scotland must be a priority
- Individuals must take responsibility for making choices that impact on their health, particularly around smoking, drinking alcohol, healthy eating and taking exercise

- However, it is recognised that life circumstances, such as employment, housing and environment, also play a role in the health that people will experience and in their health behaviour choices.
- For most people of working age work is a good route out of poverty, improving household income;
- For most people work is good for health, improving self-confidence and self-esteem, building social networks, and giving people a sense of place in society
- While work is, generally, good for health, good work is better
- Employers need to recognise that making provision for promoting the health and wellbeing of their workforce is good business sense as well as being good for the workers, improving attendance, motivations, productivity and profitability

The statement also makes the following commitments for joint action to:

- Identify how we can work together to successfully implement the recommendations of the Ministerial Task Force on Health Inequalities
- Continue to work in partnership to promote workplaces that promote health, safety and wellbeing, in particular to implement the Scottish Action plan on Health & Safety
- Work with the Partnership on Health and Safety in Scotland
- Develop policies that will keep the Scottish workforce safe and healthy, provide access to services to prevent loss of work through illness or injury and will support back into work those who are currently unable to do so because of illness or injury"

Work and health

Work can make you healthy or unhealthy, depending on circumstances. As Scotland's largest trade union, UNISON supports the increasing emphasis being placed on health and wellbeing in the workplace and takes a much broader view of workplace health than just traditional occupational health issues. Evidence presented at the UNISON Scotland conference on Health & Safety in October 2007 highlights the importance of workplace health to improve the health and wellbeing of workers in the public sector in Scotland.

Many employers are coming to recognise that addressing some of these wider issues can create a more productive workforce, with less absenteeism and greater retention of employees, whilst at the same time enabling their workers to lead more full and satisfying lives. Despite this the UK has the lowest level of occupational health provision in the developed EU and one of the worst records in Europe for the return of employees to work after long-term illness.

Creating a healthy workplace can be of great benefit to both employees and the organisations they work for. How healthy a person feels affects their productivity and how satisfied they are with their job affects their own health, both physical and psychological.

To improve the health of their workers, employers might use counselling services; adopt stress policies (which may incorporate the HSE Stress Management Standards); or engage in health promotion activities such as healthy eating and fitness programmes. They may also adopt policies on:

Bullying and harassment; Domestic violence; Alcohol and drug use; Mental health provision; Suicide prevention strategies; Driving at work; as well as Health & Safety policies.

Where the working environment is proactively improved by organising work in ways that promote health, all adverse health-related outcomes, including absence and injuries, are found to decrease. The many benefits to both employees and employers of a healthy workplace, include:

- Fewer injuries and accidents, leading to lower insurance and compensation claims
- Reduced absenteeism
- Improved employee morale and staff retention
- Employees more receptive to and better able to cope with change

Good occupational health schemes have a major part to play in preventing ill health through work and a greater priority and higher profile needs to be given to them. Public bodies must ensure that their employees have reasonable access to occupational health services that are not only cost effective but also maintain staff confidence in both their quality and independence.

Of course, no job will be conducive to good health unless it has decent pay and conditions, and inequalities in health cannot be eliminated until work of equal value is rewarded properly. UNISON will continue to ensure public sector employers meet these challenges.

How public services can respond to the challenge
Public services – including the NHS, councils and government – can make an impact on the challenges of the future health of the nation with practical policies which have been championed by UNISON.

Housing
Decent, safe and affordable housing is a basic requirement of all. If your home is damp, cold, overcrowded or insecure your health will suffer. An expansion of council housing with new, more environmentally friendly and better designed housing would lead to an expansion in the social base of tenancy and would give many more people a wider choice for meeting their housing needs than has been the case over the past few years.

Food for good (including free school meals)
The Food for Good Charter developed by UNISON argues that sustainability should be at the heart of food policy. It urges that universal free school meals should be a major part of the Scottish Food Policy, contributing to health and tackling childhood obesity. The Charter covers Sustainability, Health, Social Justice, Excellence and Skills. East Ayrshire Council's pioneering sustainable school meals work has shown how it is possible to meet key criteria within the price local authorities currently pay. All public services can use the Food for Good principle to ensure good health for all of their workers and all of the communities they serve.

Conclusion – the future of health without inequalities

In this NHS anniversary year more than ever, UNISON is committed to effective measures to combat health inequalities.

This means first of all, an improved and strengthened NHS which remains publicly owned, democratically controlled and not subject to privatised interests.

After that, the best ways to address the social and economic inequalities which caused poor health and health inequalities will be to ensure high quality, safe and healthy work for all who need it; and well funded public services complementary to health which can guarantee decent life circumstances, including housing and a safe environment for all including the poorest in society.

And not least, it requires active policies by government at all levels, using redistributive progressive taxation and benefits to reduce the growing social and economic inequalities which are fundamental causes of ill health and many other disbenefits in society. In this way we can make sure the NHS in Scotland can deliver excellent health care for a happier, healthier nation for at least another 60 years.

UNISON Scotland