# NHS Scotland 60th Anniversary

**The SHA was founded in 1930 to campaign for a National Health Service. We are therefore particularly pleased to wish NHS Scotland a happy 60th birthday. In this paper we rightly celebrate the 60th anniversary of the National Health Service as one of Labour's greatest achievements in public office. However, the main focus of this paper is to look forward. To identify some of the major challenges facing the health of the nation and how our NHS and other public services can best respond to these challenges.**

## The creation of the NHS in Scotland

In the years immediately prior to the creation of the NHS, Scotland had pioneered new forms of organised health care that reflected a distinctive Scottish medical culture. These included the Highlands and Islands Medical Service [HIMS] (1913), and the Clyde Basin Experiment in Preventative Medicine (1941). Mainstream Scottish health care combined elements of voluntary, municipal, provident, private and government provision at both the hospital and community level.

The depression in the 1920s and 1930s, the lack of systematic provision for health care at that time, the experience of communal action in war and the efficiency of the wartime medical services all pointed to the need for a national health service. Julian Tudor Hart, a Welsh GP and SHA activist, believed that people who had experienced the effect of the market on services meeting basic human needs, and the revelation that in wartime the market could be overridden for great purposes, were resolved never to return to the old system. It took a visionary Minister of Health, Aneurin Bevan to deliver the wartime blueprint in the post war Labour government.

As a result of the National Health Service [NHS] (Scotland) Act 1947, the NHS came into being in Scotland on 5 July 1948. It aimed to meet all health needs free of direct charge to the citizen. It inherited over four hundred hospitals, with accommodation for around sixty-thousand patients, formally vested in the Secretary of State for Scotland [SSS] operating through the Department of Health for Scotland [DHS]. Five Regional Hospital Boards [RHB] were created to administer Scottish hospitals on a regional basis, through eighty-five local Hospital Boards of Management [HBM].

The DHS also assumed overall responsibility for twenty-five Local Health Authorities [LHA] which co-ordinated a variety of community based services. General practitioners [GP], dentists, chemists and opticians remained self-employed although they received payments for treating NHS patients and there was co-ordination through local and national committees.

In 1948, at the launch of the NHS, a leaflet was delivered to every home – the cover of which read:
"Your new National Health Service begins on 5th July. What is it? How do you get it?
It will provide you with all medical, dental, and nursing care. Everyone – rich or poor, man,

woman, or child can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness."

This perfectly captures what the NHS meant then and still means today. So 60 years of quality health care – 3 simple principles – free at the point of access; free for all; and based on need. Brought to us by a Labour government at Nye Bevan's insistence that: "It will be a great contribution to the wellbeing of the common people of Britain"

**NHS Scotland Today**

Over the last sixty years, 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. With its unique offer of healthcare free for all at the point of need, it has liberated all of us from the fears of unaffordable treatment and untreated illness.

Ten years ago people questioned whether the NHS could survive. It is a testimony to the extraordinary work done by all NHS staff, backed up by Labour's extra investment - that ten years on the NHS is now more firmly than ever part of the fabric of British national life. This includes support from across the political spectrum as reflected in the recent Scottish Parliament motion and debate on the anniversary sponsored by Labour MSP Bill Butler. This consensus goes further in that NHS Scotland is organised very differently from England with the emphasis on co-operation not competition, reflecting the geographic and cultural differences in Scotland.

Most people in Scotland now recognise the need to move the focus of NHS Scotland from being a reactive service for ill health, towards being a proactive service for health and wellbeing. That requires an NHS that provides an effective and comprehensive service delivered as local as possible and as specialist as necessary.

There remain many challenges for the NHS today. These include patient discharge from hospital following shorter stays coupled with elderly readmission rates and pressure on Accident and Emergency (A&E) with attendances reaching their second highest level in the last ten years.
Problems remain in accessing NHS dentist services in many parts of Scotland and charges are high. Smoking has reduced from 25% of the population to 22% in the past four years. However this figure rises to 41% in the most deprived areas of Scotland. In the last four years there has been a consistent downward trend in the number of suicides although they are still high. There is also a need to reduce the dependence on anti-depressants and reduce readmission rates to psychiatric hospitals.

Despite the additional funding Health Board's continue to operate in a tight financial envelope often using non-recurring income to support their revenue position. This tight financial position will get much worse next year with the SNP's real term cut in funding to Health Boards. In addition the new resource allocation formula replacing the Arbuthnott formula may not fully recognise the challenges of delivering services to deprived and remote communities. We need to focus spending on real need.

NHS Scotland is redesigning its services to face many of these challenges. Not least of these is an ageing population, which could see a rise of 81 per cent in the number of over

75s between 2006 and 2031, and an increasing number of people with a long-term condition, of whom there are estimated to be one million in Scotland.

Whilst there is an understanding of the need to shift resources into community settings and anticipatory care, the balance of expenditure between hospital and community services has not yet changed significantly. There are a number of barriers to moving resources, including the significant amount of resources tied up in secondary care and the need to maintain hospital services during periods of change. Community Health Partnerships (CHP) are a key element of this change but most are still at the early stages of development. Workforce planning will also be a key requirement to facilitate this change and more needs to be done.

NHS Scotland is also responding to increased demands for greater patient involvement. This includes implementing the new statutory responsibilities to consult over changes to services. Further change is being proposed through the Local Healthcare Bill including direct elections to Health Boards, a move warmly welcomed by SHA Scotland who have long campaigned for greater democracy in health care.

**Scotland's Health Challenges**

As we celebrate the achievements of the NHS over the last 60 years, it is also right that we look ahead and address Scotland's major health challenges.

SHA Scotland believes that we need to focus on the poverty and inequality that underlies poor health. Inadequate housing, low confidence and wellbeing, low pay and unemployment all impact on health. This is evidenced by the fact that children from poor backgrounds are more likely to leave school with no positive destination and this also affects their health. Furthermore, smoking, poor diets, excessive alcohol intake and drug use are more prevalent in areas of deprivation. We therefore need to take co-ordinated partnership working across policy areas if we are to make a real impact on Scotland's most persistent health problems.

These health challenges are reflected in our life expectancy which is still lower than the EU average by almost a year for men and almost two years lower for women. The gap between the council areas with the highest and lowest life expectancy has not decreased over the last ten years. Overall, 34 per cent 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. Mental health problems remain a significant challenge.

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

Obesity is increasing from 16% to 24% of men aged between 16 and 64, and from 19% to 27% for women between 1995 and 2003. Scotland has the second highest rate of obesity among the OECD countries, behind only the USA. Only 36 per cent of adults in Scotland meet the recommended level of physical activity per week. Levels of childhood obesity are building up even greater health issues for future generations.

Scotland is ranked 22nd out of 24 in a recent report on the wellbeing of children, with suicide rates, dental health and teenage pregnancy rates contributing to this low ranking. We have a high rate of teenage pregnancy. Scotland (and the rest of the UK) is the fourth highest among the OECD countries.

**Tackling Scotland's Health Challenges**

The major challenges facing NHS Scotland going forward are those of inequalities in health outcomes and inequalities in access to care.

The WHO (1986) Ottawa Charter remains a robust framework with which to address inequalities – if only we could fully implement it. It stresses the need to: build healthy public policy, encourage community action, develop personal skills, create supportive environments, and reorient health services in order to ensure effective public health actions.

This remains a useful framework to ensure the comprehensive range and levels of action on addressing issues related to health inequalities. In addition, the 'PESTLE' management tool may be a useful method also to analyse the complexity of the problem. It may provide a different perspective through which to consider the range of dimensions related to addressing the health inequalities challenge: political, economic, social and cultural, technological, legislative, and environmental. Recommendations will be provided for policy, public health, and practice.

**Policy**

- Policy needs to be directed toward tackling root causes of disadvantage. Crombie et al. (2004) set out a range of potential structural, social, and economic policies which could tackle the underlying inequalities. These include: taxation and tax credit measures, old-age pensions, sickness or rehabilitation benefits, maternity or child benefits, unemployment benefits, housing policies, labour market policy and developments, community developments, and care facility infrastructure. Many of these levers are devolved issues that the Scottish Government can act on.

- Legislative challenges include converting healthy public policy to law, but also to monitor all legislation, not only for health impact, but for impact on inequalities (to apply the 'inequality lens' to all policy and legislation).

- Major efforts to change social and economic conditions are necessary to eliminate inequalities in health. A hypothetical analysis undertaken in the US, published earlier this year, found that giving everyone the health of the highly educated would save more lives than those of medical services by a ratio of 8:1. Thus, education and opportunities for education are both integral and symptomatic of the wide social change advocated for.

 Globally, health policy also needs to continue to shift its direction toward tackling the root causes of poverty and inequalities, and the WHO Commission on Social Determinants of Health can be commended in driving this forward.

**Public Health**

 There needs to be a concerted shift in public health, health promotion, and health service action from a narrow focus on behaviours and lifestyles to one that addresses wider social factors.

 Rather than target interventions to deprived communities, activities should be undertaken with communities as full participants, partners and even leaders. To these ends, all public health programmes in Scotland need to embrace the recommendations of the Community-led Supporting and Developing Healthy Communities Task Group (2006) including: engaging with, working in meaningful partnerships with, building the capacity of, and providing funding for the sustainability of the community and voluntary health sector within Scotland. This approach will foster social networks and social capital and help create supportive healthy environments in communities.

 There remains a need to continue to develop the evidence base in relation to reducing health inequalities.

 It should be more explicitly recognised that public health strategies, and health services need to be appropriately targeted and resources allocated to addressing the problem in low socioeconomic groups and deprived communities where the greatest risk and need lies.

**Practice**

 Health services have a role to play in terms of ensuring access to all, irrespective of socioeconomic background, and also in relation to a shift towards a preventive, anticipatory model of care. Further technological solutions could also be pursued in relation to preventing conditions with a predisposition to those from low socioeconomic backgrounds.

 While continuing to develop approaches to address behavioural risk factors (such as continued smoking cessation and alcohol counselling services), these activities need to be undertaken with full appreciation and consideration of the underlying socioeconomic and cultural factors influencing these behaviours. However, efforts to reduce exposure to behavioural risk factors alone are unlikely to succeed unless they are supported by measures designed to improve socioeconomic circumstances and to reduce socioeconomic inequalities.

 One of the first goals is to create a mindset shift in clinical practice colleagues and public policy makers – described by Watt (2007) as shifting ‘from victim blaming to upstream action’.

 Health professionals and policy makers need to consider advocating for socioeconomic change in addition to health behaviour and service change.

## Conclusion

In summary, health inequalities, is a complex challenge. It needs a concerted effort to meet the challenge – building bridges and meaningful partnerships between and with: (i) policy and practice, (ii) research and development, (iii) multiple sectors, agencies, and organisations, and (iv) all communities. In addition, to take on the challenge of tackling inequalities, a fresh and enthusiastic approach is required, involving: passion and commitment, a willingness to take risks, and commitment to work with others – in short, a new 'can do' mindset.

To conclude, the following three quotes seem to capture in turn: the truth, the knowledge, and the challenge in tackling health inequalities as we look forward to the next 60 years of NHS Scotland.

'Massive poverty and obscene inequality are such terrible scourges of our times…that they have to rank alongside slavery and apartheid as social evils' (Nelson Mandela, 2005).

'The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social' (Geoffrey Rose, 1992).

'Economic injustice will stop the moment we want it to stop and no sooner, and if we genuinely want it to stop the method adopted hardly matters' (George Orwell, 1937).