Privatisation by stealth?

'Government lights the fuse for privatisation' blazed the Health visitor journal's front cover when the NHS and Community Care Act was passed in 1990. Since then the debate on the future of the NHS has raged. In the first of a series in which different authors look at policy issues, ALLYSON POLLOCK argues that the introduction of charges for dentistry, eye tests and long-term care - is undermining the principle of a universal national healthcare service, free at the point of use.

Prior to the setting up of the NHS in 1948, high street and municipal hospitals operated for profit. Each was separately administered; there was duplication of services as they vied for patients; most were expensive below. Rich areas had better services and hospitals; poor areas had none. Rich patients had ready access to care but poor patients did not. Doctors and hospitals competed against each other and the patient was caught in the middle; none were caught at all.

Over time, the NHS has raised with increased taxes and fees. It introduced a planned service which was designed to respond to need and to allocate resources accordingly. Need not means to pay was the essence of provision. The NHS was built on a national consensus that it should provide a service for everyone from the cradle to the grave; above all that it should be free at the point of delivery.

Until 1991 the NHS largely succeeded in this, despite chronic underfunding from year one. The tension created to find the huge pool of potential patients to meet the increasing demand and expenditure has been perpetuated by successive governments, including at the current time. Virutely the only answer required to ensure that the NHS keeps pace with technology and the growing needs of an ageing population was much provision, beds have closed because of underfunding and political decisions not to expand health care. Purists have left providers with the option but no choice in order to meet their budgetary targets.

Faced with decreased NHS capacity and long waiting lists in the public sector, other purchasers such as GP fundholders now have a choice to either transfer business into the private, waiting private sector. The private sector can usually do this quickly, lower in prices and wait, the good will with clients when the NHS supply dries up. The private sector has outpaced its competition, taking business from the NHS, but it still has plenty of patients waiting.

Patient charging

Local health authorities are increasingly looking at introducing patient charges for some treatments and services. Patient charges now make up four per cent of NHS income. But in dental care, eye tests and charging is now the rule.

Patient charges made up one third of the £12 billion spent on NHS dental care. Each person of NHS dental treatment requires an annual expenditure of £12 billion and it has increased the costs of administration from five per cent to over 14 per cent. The market has forced the pace of closure of NHS dentists. They have closed not because of the state of the buildings or because there is too much provision, beds have closed because of underfunding and political decisions not to expand health care. Purists have left providers with the choice but no choice in order to meet their budgetary targets.

Purchasing power means re-registrars and new entrants are the result of increasing NHS demand. Some dentists will only take children on the NHS in exchange for their private income. The current situation of dental charges are universal and local services which point to a growing polarisation of dental care and a reversed trend to improved access to care which has taken place since the 1980s. The outcome of dental disease occurs in the most disenfranchised groups and those which have the poorest access to services and the same are often in young children. These disadvantages are the greatest determinants of their dental health and welfare inequalities.

Dental care charges have led others to act as a deterrent to seeking help and care at an early stage, but they also mean that duration is and less likely to set up practice where they are unable to make a good income from private patients. The best example is another example of the failure of government in the current trend towards introducing charges. The right test is only the outcome of screening potential users for
Special feature

Preventing criminal disease

After 30 years in policing, I am convinced that policing has much to contribute to health and health visitors can make an important contribution. But police cannot work alone. Police officers, health visitors and the public need to work together to prevent crime.

There are many ways in which health visitors can help to prevent crime. They can identify young people who are at risk of becoming offenders and help them to develop positive life skills. They can also help to prevent domestic violence by providing support and advice to victims.

Many people with mental health problems are at risk of becoming offenders. Health visitors can help to prevent this by identifying people who are at risk and providing them with support and guidance.

Conclusion

In conclusion, health visitors should think about the consequences of their actions and how they can contribute to preventing crime. They can provide support, advice and guidance to people who are at risk of becoming offenders. They can also help to prevent domestic violence and help people with mental health problems to develop positive life skills.

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