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Revisiting Health Service and welfare in
Great Britain

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ABBREVIATIONS

AST : Ambulance Service Trust
CCS : Municipal Health Centre
CHD : Coronary Heart Disease
CHD : Departmental Health Centre
COHSE : Confederation Of Health Service Employees
CSA : Area Health Centre
DDSP: Public Health Departmental Directions
DHA: District Health Authorities
DOH: Department Of Health
ENIAB : Benin National School for Nurses and Nursing Auxilliary
FSS : Faculty of Health Science.
GP : General Practitioner
HZ : Health Zone
INMES : Health National Socio-Medical Institution
MHRA : Medecines And Healthcare Regulation Agency
MHST : Mental Health Service Trust
MSP : Department of Health
NATO : North Atlantic Treaty Organization
NHS : National Health Service
NICE : National Institute And Clinical Institution
OAP : Old Age Pension
ONS : Office For National Statistics
PCT : Primary Care Trust
PFI : Private Finance Initiative
PSP : Pensions Service Program
PM : Prime Minister
POP : Population
SHA : Strategic Health Authorities
SSP : Social Services Program
UK : United Kingdom
WHO : WORLD HEALTH ORGANIZATION



INTRODUCTION

INTRODUCTION

In 1948, in its constitution, the **World Health Organization** (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"³. Some years later, the statement has been modified to include the ability to lead a "socially and economically productive life.

Health is indeed human being frame of mind and body state. Being healthy is not only living without diseases but also and above all enjoying a total balance physically, mentally, socially, and economically speaking.

In the medical field, the technical term for health is *homeostasis*: an organism's ability to efficiently respond to challenges (stressors) and effectively restore as well as sustain a "state of balance".

In 1986, WHO OTAWA Charter for Health Promotion also updated the definition and said that Health is not the objective of living but the resource for everyday life. It is also a positive concept emphasizing social and personal resources as well as physical capacities.

Health is the most powerful lever in the development of any country. Despite the economic cost of two world wars and the decline of its empire in the latter half of the 20th century, the United Kingdom of Great Britain and Northern Ireland remains nowadays a significant economical, cultural, military and political influence and is also a nuclear power, with the second highest expenditure in the world. It holds a permanent seat on the United Nations Security Council, and is a member of the G8, NATO, the European Union and the Commonwealth of Nations. It's also the fifth largest economy in the world and the second largest in Europe after Germany.

³ World Health Organization Constitution 1948, UN, P :16

As a matter of paramount importance worldwide since centuries up to now, in the United Kingdom of Great Britain, health matters have never been neglected.

Being then at the core of any sustainable development issue, Health, nowadays, is no longer only doctors' business; but from the simple citizens to the central governments, everybody is fighting for good health in the United Kingdom. Placing public health: (the science and art of preventing disease, prolonging life and promoting health through organized efforts and informed choices of society, organizations, public and private communities and individuals based on population health analysis) at the first place can lead to a development process that can meet the needs of the present generations and be maintained indefinitely.

Having understood that, very early in the aftermath of World War II, based on the proposals of the Beveridge Report prepared in 1942 by the economist and social reformer William Beveridge, Clement Attlee's Labour government created the NHS (National Health Service) as part of the "cradle to grave" welfare-state reforms. Health is a devolved matter and each of the constituent countries of the United Kingdom has healthcare available to all of their citizens that is free at the point of need (being funded from general taxation). Nowadays, the NHS is one of the largest, cohesive and powerful health organizations of any type in the world.

In the concern to present what is done in the UK and suggest concrete proposals to give a boost to Benin medical apparatus this work is entitled ‘***Revisiting health service and welfare in Great Britain***’

Divided into three main parts, the first part of our work will present a general view on public health state in the UK. The second will be devoted to UK

successive and successful governments' actions for citizens' welfare above all the NHS and its impacts on UK citizens' health. Being a Beninese dreaming of better life for everyone in the nation, the last part will point out what we can concretely draw from this powerful health tool which the British Health System is to improve health care matters in our developing country.



PART ONE

General survey on public health state in Great Britain

Chapter 1: The birth of the Welfare State: a brief survey

1-1: Etymology and the welfare state different interpretations

The English term "welfare state" is believed by Asa Briggs (born 7 May 1921) a British historian: one of the most respected historians who has written on the Victorian era. He coined Archbishop William Temple (15 October 1881 – 26 October 1944): the second son of Archbishop Frederick Temple, a real defender the working-class movement. [http://en.wikipedia.org/wiki/Second Word War](http://en.wikipedia.org/wiki/Second_Word_War).

Known for his defence of classical liberalism and free-market capitalism against socialist and collectivist, being one of the most important economists and political philosophers of the twentieth century, Nobel Prize winner in Economics (1974), **Friedrich August von Hayek**, (May 8, 1899 in Vienna – March 23, 1992 in Freiberg) contends that the term derived from the older German word *Wohlfahrtsstaat*, which itself was used by nineteenth century historians to describe a variant of the ideal of *Polizeistaat* ("police state"). It was fully developed by the German academic *Sozialpolitiker*—"socialists of the chair"—from 1870 and first implemented through Bismarck's (who is he?) "state socialism". Bismarck's policies have also been seen as the creation of a welfare state. It's also important to notify here that there had been earlier attempts to use the same phrase in English, for example in Munroe Smith's text "Four German Jurists", but the term did not enter common use until William Temple popularized it.

As far as the interpretations of the idea of the welfare state is concerned, there are many: it can be firstly seen as the provision of welfare services by the

state. Secondly we can refer to Welfare state as an ideal model in which the state assumes primary responsibility for the welfare of its citizens. This responsibility in theory ought to be comprehensive because all aspects of welfare are considered and universally applied to citizens as a right. 'Welfare state' can also mean the creation of a "safety net" of minimum standards. It can thirdly be the provision of welfare in the society.

In French, the synonymous term "providence state" (*État-providence*) was originally coined as a sarcastic pejorative remark used by opponents of welfare state policies during the Second Empire (1854-1870).

In German, as it is said earlier, a roughly equivalent term (*Sozialstaat*, "social state") had been in use since 1870 in for example in Munroe Smith's text "Four German Jurists".

The Italian term "Social state" (*Stato sociale*) has the same origin. The Swedish welfare state is called *Folkhemmet* and goes back to the 1936 compromise between the Union and big corporate companies. It is a Mixed economy, built on strong unions and a strong system of Social security and universal health care.

In Spanish and many other languages, an analogous term is used: *estado del bienestar*; translated literally: "state of well-being".

In Portuguese, a similar phrase exists: *Estado de Bem-Estar-Social*; which means "well-being-social state".

First, a welfare state is not a state run economy. The welfare state refers to the programs paid by the government that provide basic temporary and conditional financial help to those legally unable to provide to themselves because of their current economic situation due to health problems, mental diseases, etc or because of a major natural disaster or terrorist attack.

1-2: “Welfare State”: towards a definition in the British concept:

In order to make sense of these competing variables, a working definition of the concept of the welfare state as applied to the British case might prove beneficial. Derek Fraser in his authoritative *The Evolution of the British Welfare State* gives the following outline: “ It is a system of social organization which restricts free market operations in three principal ways: by the designation of a certain groups such as children and factory workers whose welfare is protected by the community; by the delivery of services such as medical care or education, so that no citizen shall be deprived access to them; and by transfer payments which maintain income in times of exceptional need, such as parenthood or the interruption of earnings caused by such things as sickness or unemployment”

In Great Britain, Social welfare is administered in three ways: the National Health Service, the Social Services program, and the Pensions Service program all these play a part in the providing social welfare.

1-3: The Evolution of the Welfare State in the British society:

Since 1830s, it's possible to isolate three periods when the state intervention in British society significantly increased. These three periods form the essential scaffolding for the construction of what has been termed “British welfare state”. The first of these periods occurred between the 1830s and 1840s; the second during the Edwardian period at the turn of the 20th century and the third during the great expansion of the late 1940s.

●1830 - 1840

The 1834 Poor Law Amendment Act was introduced to replace what was increasingly seen as a wasteful and inefficient, parochial system of local poor relief. The former system had a number of local variations and the payments came from local taxpayers known as ratepayers. It for instance paid relief according to the current price of bread with labourers having their income supported on a sliding scale based on the price of an average loaf of bread. The

method was thought by many to encourage idleness and large families and could act to promote disincentive to economic development. The New Poor Law Amendment Act was created then and did reduce the rate from nearly £7 millions in 1831 to below £5 million by 1851: a reduction achieved despite a 30% increase in the size of the population.

●1900 – 1914 : EDWARDIAN ENGLAND

For most people living standard did rise during the course of the century. However, the major differentials still existed between the various social groups. The scale of the poverty experienced by large numbers of British people only became apparent to the end of the century. This experience was revealed both empirically by large-scale surveys and qualitatively by the writing of the new genre of social explorers like Jack LONDON and William BOOTH. Charles BOOTH in his book *Life and labor of people in London*³ published a survey of London's inhabitants carried out between 1880 and 1902. It showed 30% of Londoners living in poverty. He then defined poverty in this instance as having no surplus to provide for crisis situations like unemployment or sickness. Similarly ROWNTREE' investigations in York revealed 10% of the population to be living in primary poverty and 17% living in secondary poverty, in other words their income was just above the minimum to sustain life.

Such information and other political considerations gave rise to the first major welfare reforms carried out by the liberal ministry of 1906-1914 which really increased the state's role in the enactment and running of social policy. The reforms included the following:

- **OLD AGE PENSIONS ACT 1908** which provided for all those with incomes under £30 a year or over 70 years of age to have 5s per week up to £21; Anyone who had been on poor relief in previous years, in prison

³ BOOTH C., *Life and Labour of people in London*, 1903

in the previous ten years, or had failed to work habitually would not receive pension.

➤ **NATIONAL INSURANCE ACT 1911:** This Act was divided into two parts:

a- Health insurance: all workers earning less than £160 per year between the ages of 16 and 60 were included in the system.

b- Unemployment Insurance: Employer, worker and government each paid 2.5d in return for which the worker obtained £7s a week for up to 15 weeks a year when unemployed.

➤ **INFANT WELFARE**

Health visitors and compulsory notification of births was introduced in 1907 and 1915 respectively. Midwifery was also reformed, special maternity clinics were set up and maternity benefits were granted. The fall in infant mortality was spectacular, reducing the figure from 163 per thousand in 1899, to 95 per thousand in 1912.

➤ **CHILDREN'S WELFARE**

The children's Act codified 39 measures dealing with negligence, cruelty, and set up juvenile court and remand homes for children instead of prison. In 1906 the Provision of Meals Act provided a 5d rate and by 1910 some 96 local Education Authorities provided 9million school meals. The welfare state of the Edwardian period therefore coexisted with the Victorian voluntary sector and illustrates neatly the continuities and changes involved in the construction of a coherent welfare structure.

● **1944-1950: LABOUR'S WELFARE STATE**

The 1930s in particular, have been characterized as the black years in terms of welfare provision. The "Means Test" by which relief was only given to

those deemed worthy after an extensive investigation into family income, has remained the overriding image of a confusing and contradictory decade. In 1942, William Beveridge Report also identified five "Giant Evils" in society: squalor, ignorance, want, idleness and disease.

The war years heralded a major change in British social attitudes and culminated in the Labour victory in the 1945 general election. The reforms of the incoming Labour Government attempted to provide for the ordinary family from the "cradle to the grave". The major reforms are as follow:

The family Allowances Act of 1945 provided 5S per week for each child after the first and were paid directly through taxation to the mother.

The National Insurance Act of 1946 divided those employed into three categories: the employed, the self-employed and the unemployed. The scheme covered benefits including sick pay, unemployment benefit, pensions and other support.

The most enduring legacy of the 1945 Labour Government is the National Health Service (NHS). Set up in 1948 by the then Minister of Health: ANEURIN BEVAN, it was and remains the "jewel in the crown" of the Labour Party. It provided that all treatments and medical services should be included in one service; that all hospitals should be state run and funded; it also advocated that all doctors be brought in the system; and a network of family general practitioners be established to bring health care to the population. Let's remind that medical treatment also was now to be freely available to all regardless of wealth or social position.

- **BEYOND THE POST- WAR CONSENSUS**

The welfare state institutionalized by the Labour Government of 1945-1951 was broadly accepted by all the parties during the post war years. This

agreement sprang from the belief that the instigation of such policies represented the natural evolution of government, and also from the fact the Beveridge Report was ambiguous enough to allow various parties to place their own interpretation on social policy. It was during the late 1970s and 1980 that a fissure began to appear in this carefully constructed consensus. Thatcherism has been viewed as having broken this post-war, bi-partisan agreement. In fact the rising tide of economic problems of the mid 1970s forced the Labour Government to make substantial cuts in welfare provision as an increasingly ailing economy had difficulty in supporting an ever-expanding welfare state. The cost of pensions only increased from £8,563million in 1979 to £16,161million in 1985.

Thus, with the election of the Tories in 1979, these economic factors, combined with a new set of ideological principles, set in motion a major re-assessment of social policy. One of the leading conservative philosophical gurus of the early Thatcher period, Sir KEITH Joseph, claimed in 1974 that: “For the past 30 years in our party we have overburdened our economy. We have over-estimated the power of government to do more and more for more and more people, to reshape the economy and indeed human society, according to blueprints.

The Blairite “New Labour” project emerged during the 1990s and the new approach sees the welfare state rather as a low-hanging safety net based on Benthamite principles, which see work rather than welfare as the answer to economic division. The NHS was re-organized with specialist regional hospital, and targets for waiting lists and treatments were set and accounted. The NHS, however, has in parts remained immune to the reforms and changes in place elsewhere. Strong public attachment to the idea of universal free health care at the point of delivery has made reform of the service difficult.

The Welfare State of the United Kingdom was prefigured in the William Beveridge Report in 1942, which identified five "Giant Evils" in society:

squalor, ignorance, want, idleness and disease. A series of changes was put in place to deal with the 5 Evils figured out in the William Beveridge Report of 1942, after the Second World War. The changes meant that the government undertook to provide for the people of the United Kingdom "from the cradle to the grave".

This policy resulted in massive expenditure and a great widening of what was considered to be the state's responsibility. In addition to the central services of Education, Health, Unemployment and sickness allowances and so on, the welfare state included the idea of increasing redistributive taxation, increasing regulation of industry food and housing (better safety regulations, "weights and measures" controls etc.) The Welfare State was a commitment to health (in 1948 the National Health Service was created), education, employment and social security.

However the initial foundation of the National Health Service did not involve building new hospitals but merely the nationalisation of existing municipal and charitable foundations. The aim was not to substantially increase provision but to standardise care across the country; indeed Beveridge believed that the overall cost of medical care would decrease, as people became healthier and so needed less treatment. Instead the cost increased dramatically, leading to severe financial problems, and charges (for dentures, spectacles and prescriptions) were introduced in 1951 - by the same Labour government that had founded the NHS just three years earlier. Despite this, the principle of health care "free at the point of use" became a central part of the dogma of the welfare state, which later governments critical of the welfare state were unable to reverse. The classic Welfare State period lasted from approximately 1945 to the 1970s, although many features of it remain today.

The deeper reasons for the establishment of the welfare state are complex. Certainly governments who had seen the revolutionary wave of revolts after the First World War were keen to ensure that deep reforms reduced the risk of mass

social unrest after the Second World War. In addition, modern, complex industry had more need for a healthy and educated workforce than older industries had. Crucially, the experience of almost total state control during the Second World War had inured the population to the idea that the state might deal with wide areas of national life. Finally it seems likely that the social mixing involved in mass evacuation of children, and of service in the armed forces, had increased support for welfare among the middle classes. But the most important change was not in the people but the government; civil servants had become used to control of many aspects of civilian life during the war, and were reluctant to see a reduction in either their numbers or position. A centralised welfare state was an attractive way to ensure the dominance of the self-confident bureaucratic class.

Certainly, the Labour party, standing in 1945 on a programme of establishing a welfare state, won a very clear victory. However, since the 1980s the British government has begun to reduce some provisions: for example, free eye tests for all have now been stopped and prescription charges for drugs have constantly risen since they were first introduced in 1951. Providing a Welfare State is however still a basic principle of government policy in the United Kingdom today.

However, this aspect of the welfare state is the last remaining bastion of post-war British social democracy.

Chapter 2 : Some common diseases and treatments applied nowadays in Great Britain

2-1 Cancer:

" Cancer is a group of diseases in which cells are aggressive (grow and divide without respect to normal limits), invasive (invade and destroy adjacent tissues), and sometimes metastatic (spread to other locations in the body)"⁴. These three malignant properties of cancers differentiate them from benign tumors, which are self-limited in their growth and don't invade or metastasize (although some benign tumor types are capable of becoming malignant). Cancer may affect people at all ages, even fetuses, but risk for the more common varieties tends to increase with age. Cancer causes about 13% of all deaths. According to the ACS, 7.6 million people died from cancer in the world during 2007. Apart from humans, forms of cancer may affect other animals and plants.

In the UK nowadays, Cancer is one of the most common disease. There many kind of cancer among which we can quote skin cancer; ovarian cancer, prostate cancer and some others.

2-1-1: The skin cancer

“Skin cancer is one of the most common cancers in the UK, with the number of cases increasing every year. Find out how to prevent the disease in the first place and the signs of skin damage you should be looking out for”⁵; said Dr Rob Hicks.

There are two main types of skin cancer: melanoma (or malignant melanoma) and non-melanoma. Non-melanoma skin cancers include basal cell carcinoma and squamous cell carcinoma. They are usually slow growing and

⁴ Dr E. Schneider , *Health through natural factors*, ISBN 84-7208-285-7.2nd Ed: Sept 2004, Vol2, P247

⁵ Dr Rob HICKS, The Uk annual health report 2005

result from prolonged sunlight exposure over many years. BCC affects sun-exposed areas of the body. It starts as a small painless lump, pink/brownish-grey in colour, with a smooth surface with blood vessels and a waxy or pearl-like border. The lump grows, developing a central depression with rolled edges. SCC usually affects the face. It starts as an area of thickened, scaly skin and develops into a painless, hard lump, reddish brown in colour with an irregular edge. The lump becomes a recurring ulcer that doesn't heal. Melanoma skin cancer is usually pigmented or coloured and is more dangerous. The main cause is exposure to short periods of intense sunlight and it can develop anywhere on the body. It may appear as a quick-growing, irregular, dark-coloured spot on previously normal skin or in an existing mole that changes shape, size, colour, develops irregular edges, bleeds, itches, crusts or reddens.

Skin cancer is becoming more widespread: the number of cases has doubled in the past 20 years. Each year in the UK, there are more than 65,000 new cases of non-melanoma skin cancer and more than 8,000 new cases of malignant melanoma. Non-melanoma is nearly always curable if caught early enough. But about 1,800 people still die from malignant melanoma skin cancer annually. This is tragic, as four out of five cases are preventable.

Skin cancer is caused by overexposure to the sun's harmful UV rays. A suntan isn't healthy; in fact, it is a sign of skin damage. The results of sunbathing are skin that ages more quickly and an increased risk of cancer.

Everyone should take care in the sun but most at risk are those with fair skin, those who burn lobster red, those with moles on their skin and those who spend too long in the sun without protection. It's now believed that the most dangerous skin cancer (malignant melanoma) is caused by short periods of exposure to intense burning sunlight - the kind of exposure people get on a two-

week holiday. Malignant melanoma which is more common in women than men, is one of the most common cancers in people aged 20 to 35 and affects people who work indoors more than those who work outside. Non-melanoma skin cancer affects men more than women, as well as older people, particularly those who have spent much time working outdoors. Too much sun exposure and getting sunburnt in childhood and the teenage years can lead to skin cancer in later life, so children in particular must be protected.

In the UK nowadays, the treatment may include surgical removal, chemotherapy, radiotherapy or biological therapy, depending on the type of skin cancer.

“The best way to prevent skin cancer is to avoid spending too much time in the sun. You don't have to be sunbathing to get burned. You can get too much sun while walking to the shops or when driving a car with the windows down. And although the sun is strongest in a cloudless sky, you can still get burned under light cloud cover. The time of day and location are important too. The intensity of UV radiation increases during the middle of the day, between April to September, as you get nearer the equator and at higher altitudes.

To protect yourself and your children:

- Stick to the shade between 11am and 3pm
- Cover up with clothes, a wide brimmed hat and sunglasses
- Apply a high-factor sunscreen regularly
- Drink plenty of water to avoid overheating
- Avoid using sun lamps or sunbed"⁶ said Dr louis IGNARIO, of UCLA medical laboratory

2-1-2: The ovarian cancer:

⁶ See Dr Louis IGNARIO interview in *Herb@life monthly magazine*, May 2006 PP.17-18

In the early stages, ovarian cancer does not usually cause symptoms until the growing cancer begins to cause pressure or pain. Symptoms may include prolonged abdominal swelling, abdominal pain, poor appetite, weight loss, a need to pass water often, digestive problems such as indigestion, bloating, constipation, and unusual bleeding from the vagina.

Ovarian cancer is the fourth most common cancer in women in the UK. There are about 6,900 new cases in the country each year, most of them women who have gone through the menopause. More than 50 per cent occur in women over the age of 65. Ovarian cancer can run in families.

Women who have never been pregnant, or who take fertility drugs for a prolonged period without success, and those who have had breast cancer are at increased risk of ovarian cancer whereas breastfeeding and taking the oral contraceptive pill lowers the risk.

As far as the ovarian cancer treatment is concerned, a screening test may become available to detect ovarian cancer. Currently in the UK, the treatment includes surgery, chemotherapy and radiotherapy. Emotional support for both the patients and their relatives is very important.

2-1-3: The prostate cancer

The prostate gland is about the size of a walnut and produces the liquid that nourishes, protects and carries sperm on ejaculation. It's located below the bladder and in front of the rectum.

Prostate cancer is the most common male cancer in the UK, accounting for almost a quarter of male cancers. Each year, nearly 32,000 men in the UK are diagnosed and more than 10,000 die from the disease. Cases are rare in men aged under 50, but it becomes more common as they grow older.

Having a father or brother with prostate cancer increases the risk of a man developing the condition. The illness is more common in men of African-Caribbean or African-American descent and in western countries.

Often prostate cancer doesn't have any symptoms, but when they do occur they may include:

- The need to urinate more frequently
- Disturbed sleep because of the need to urinate
- Difficulty or pain when passing water
- Delay or hesitancy before urinating
- A feeling that the bladder has not completely emptied
- Pain or stiffness in the lower back, pelvis and hips

It's important to be aware that there are a number of other, non-cancerous medical conditions that may also cause these symptoms.

In advanced prostate cancer, the following symptoms may occur :

- Weight loss
- Bone pain
- Pain in the loins, pelvis or lower back
- Blood in the urine or semen

A healthy, low-fat diet may help to prevent prostate cancer, and vitamin E, selenium and lycopene (found in tomatoes) may offer protection. If diagnosed early, treatment can be quite successful. Therefore, it's important to be aware of the symptoms and to see a GP as early as possible. Currently in the UK there are no routine screening programmes for prostate cancer. A GP will perform a digital rectal examination (DRE) and arrange for any blood tests (for example, a prostate specific antigen or PSA test), or other tests, such as x-rays or scans, that may be necessary. A specialist may then arrange a biopsy of the prostate. This should indicate whether or not prostate cancer is present and, if so, whether or not it is aggressive. These results will influence the types of treatment available.

Treatment depends on a number of factors, primarily whether the cancer is contained within the prostate (localised) or has spread around the body (advanced). Localised disease, where the cancer is small and contained, is generally managed by observation ('watchful waiting'), surgery to remove the prostate (radical prostatectomy), Brach therapy (radioactive seeds implanted in the prostate) or IMRT (highly focused radiotherapy). Other new treatments include high-frequency ultrasound (HIFU) and cry therapy. Advanced disease is often treated using hormone therapy, reducing the amount of testosterone in the body to slow down or stop the growth of the cancer cells.

2-2 Diabetes

Diabetes is a chronic disease with no cure as of 2008. It is associated with an impaired glucose cycle, altering metabolism. Management of this disease may include lifestyle modifications such as achieving and maintaining proper weight, diet, exercise and foot care.

“It is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. Glucose comes from the digestion of starchy foods such as bread, rice, potatoes, chapattis, yams and plantain, from sugar and other sweet foods, and from the liver which makes glucose”⁷.

Insulin is vital for life. It is a hormone produced by the pancreas that helps the glucose to enter the cells where it is used as fuel by the body.

Diabetes types

There are two main types of diabetes. These are:

"Type 1 diabetes develops if the body is unable to produce any insulin. This type of diabetes usually appears before the age of 40. Type 1 diabetes is the least

⁷ Dr E. Schneider , *Health through natural factors*, ISBN 84-7208-285-7.2nd Ed: Sept 2004 vol1, P- 229

common of the two main types and accounts for between 5 – 15% of all people with diabetes"⁸.

"Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). In most cases this is linked with being overweight. There are currently over 2.3 million people with diabetes in the UK and there are up to another 750,000 people with diabetes who have the condition and don't know it."⁹

In Type 1 diabetes the signs and symptoms will usually be very obvious, developing quickly, usually over a few weeks. In people with Type 2 diabetes the signs and symptoms will not be so obvious or even non-existent in people with Type 2 diabetes. If you're older you may put the symptoms down to 'getting on a bit'. Taking early action is key so if any of the symptoms apply to you, ask your GP for a diabetes test. In both types of diabetes, the symptoms are quickly relieved once the diabetes is treated. Early treatment will also reduce the chances of developing serious health problems. Although diabetes cannot be cured, it can be treated very successfully.

Type 1 diabetes is treated by insulin injections and diet, and regular exercise is recommended. Insulin cannot be taken by mouth because it is destroyed by the digestive juices in the stomach. People with this type of diabetes commonly take either two or four injections of insulin each day. If you have Type 1 diabetes, your insulin injections are vital to keep you alive and you must have them every day.

Type 2 diabetes is treated with lifestyle changes such as a healthier diet, weight loss and increased physical activity. Tablets and/or insulin may also be

⁸ Dr E. Schneider , *Health through natural factors*, ISBN 84-7208-285-7.2nd Ed: Sept 2004 vol1. P-231

⁹ Dr E. Schneider , *Health through natural factors*, ISBN 84-7208-285-7.2nd Ed: Sept 2004 vol1. P-232

required to achieve normal blood glucose levels. There are several kinds of tablets for people with Type 2 diabetes. Some kinds help your pancreas to produce more insulin. Other kinds help your body to make better use of the insulin that your pancreas does produce. Another type of tablet slows down the speed at which the body absorbs glucose from the intestine. Your doctor will decide with you which kinds of tablet are going to work best for you and may prescribe more than one kind. Type 2 diabetes is progressive. If your diabetes cannot be controlled through lifestyle changes and tablets your doctor may recommend that you take insulin injections. The main aim of treatment of both types of diabetes is to achieve blood glucose, blood pressure and cholesterol levels as near to normal as possible. This, together with a healthy lifestyle, will help to improve wellbeing and protect against long-term damage to the eyes, kidneys, nerves, heart and major arteries.

2-3 Heart diseases:

Heart disease is an umbrella term for a number of different diseases which affect the heart. In CHD, the arteries that supply the heart with oxygen and nutrients become narrowed by atherosclerosis. This restricts the supply of blood and oxygen to the heart, particularly during exertion when there are more demands on the heart muscle.

The main symptom is angina, caused by insufficient oxygen reaching the heart muscle because of reduced blood flow.

Angina is a feeling of heaviness, tightness or pain in the middle of your chest that may extend to, or just affect, your arms (especially the left), neck, jaw, face, back or abdomen.

It is most often experienced during exertion - if you run for a bus, for example, or climb stairs. It may occur in cold weather, after a heavy meal, or when

you're feeling stressed. It can subside once you stop what you're doing and rest, or take medication.

2-4 Asthma

According to the charity Asthma UK, one in five households has someone living with asthma. No one knows for sure what causes asthma but it is known that you are more likely to develop it if you have a family history of asthma, eczema or allergies. You are twice as likely to develop asthma if your parents have it. Modern lifestyles, such as changes in housing and diet, may have also contributed to the rise in asthma over the last 30 years or so. Research shows that smoking during pregnancy increases the risk of your child developing asthma, and children whose parents smoke are more likely to develop it. According to Vikki Knowles from the charity Asthma UK, there are lots of theories about what has led to the increase in asthma. One of the most popular is the 'hygiene hypothesis'. "Asthma is more common in western societies and this theory says that because western society is becoming cleaner, we have less exposure to allergens and pathogens," Knowles says.

If your asthma is triggered by pets, studies do not show that getting rid of your animals makes your asthma better. In fact, the emotional upset of getting rid of your pet may even make your asthma worse. The best idea is to minimise exposure in certain areas, i.e. the bedroom, and when your pet reaches the end of its natural life, don't replace it.

Asthma is an inflammatory disease so the key message is that preventative treatment is vital and you should keep taking this even when your asthma symptoms aren't there. This is to ensure your asthma is well controlled.

Chapter 3- Public health concept and Life expectancy

3-1 Public health concept

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organisations, public and private, communities and individuals." It is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as small as a handful of people or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health has many sub-fields, but is typically divided into the categories of epidemiology, biostatistics and health services. Environmental, social, behavioral healths, and occupational health, are also important fields in public health.

The focus of public health intervention is to prevent rather than treat a disease through surveillance of cases and the promotion of healthy behaviors. In addition to these activities, in many cases treating a disease can be vital to preventing it in others, such as during an outbreak of an infectious disease. Vaccination programs and distribution of condoms are examples of public health measures.

3-2- Life expectancy

Life expectancy is a statistical measure of the average length of survival of a living thing. It is often calculated separately for differing gender and geographic location. Popularly, it is most often construed to mean the life expectancy at birth for a given human population, which is the same as the expected age at death. However, technically, life expectancy means the expected time remaining to live, and it can be calculated for any age.

Life expectancy is heavily dependent on the criteria used to select the group. In countries with high infant mortality rates, the life expectancy at birth is highly sensitive to the rate of death in the first few years of life. In these cases, another measure such as life expectancy at age 5 can be used to exclude the effects of infant mortality to reveal the effects of causes of death other than early childhood causes

Life Expectancy at Birth in Great Britain

January 2001 - December 2003

Males: 76.24 years

Females: 80.72 years

January 2002 - December 2004

Males: 76.55 years

Females: 80.91 years

January 2003 - December 2005

Males: 76.92 years

Females: 81.14 years

Source : The 2006 Public Health State in the United Kingdom



PART TWO

The British Governments' actions for the
citizens' welfare

Chapter 4 : NHS a powerful tool in the UK Health system

4-1 History

Created as part of the "cradle to grave" welfare-state reforms, the NHS was based on the proposals of the economist and social reformer William Beveridge.

The idea was that if Britain could work towards full employment and spend huge sums of money during the wartime effort, then in a time of peace equitable measures of social solidarity and financial resources could be redirected towards fostering public goods. This sentiment was widely shared, as the wartime hero Winston Churchill was decisively voted out in a landslide defeat in the 1945 elections. Although most of the British felt that Churchill's leadership during the war was commendable, there were a number of reasons which led to Conservative defeat in the elections following the war. One reason was that the public favoured a push for sweeping social changes that Churchill's Conservative Party vehemently opposed. The driving force behind this reformist agenda was so popular that it eventually constituted a Postwar Consensus which continued virtually unchallenged until the early 1970's, no matter which party controlled the government.

The first problem for Labour's reform agenda began when the U.S. war with Japan ended, and the United States subsequently withdrew the funding that had sustained Britain during the war. At this point, Attlee realized that his plans for the rebuilding of postwar Britain and enacting widespread reform were in serious financial trouble. It wasn't until the Cold War began to escalate that the

Americans initiated the Marshall Plan which helped rebuild Western Europe from physical and economic ruin. This allowed Attlee to continue moving forward with the "cradle to grave" reforms outlined in the Beveridge Report that his government had promised the British public.

Aneurin Bevan, the newly appointed Health Minister, was given the task of introducing the National Health Service. Bevan based his plan for the NHS on the Tredegar Medical Aid Society which was set up in his place of birth, and in fact, had been a member and later chairman of the Cottage Hospital Management Committee in the late 1920s. Doctors were initially opposed to the reform measure and even organized to fight against it. Bevan had to get them onside, as, without doctors, there would be no health service. Being a shrewd political operator, Bevan managed to push through the radical health care reform measure by dividing and cajoling opposition, as well as by offering lucrative payment structures for consultants. On this subject he stated, "I stuffed their mouths with gold." On July 5, 1948, at the Park Hospital in Manchester, Bevan unveiled the National Health Service and stated, "We now have the moral leadership of the world."

Dr. A. J. Cronin's highly controversial novel, *The Citadel*, published in 1937, had fomented extensive dialogue about the severe inadequacies of health care. The author's innovative ideas were not only essential to the conception of the NHS, but in fact, his best-selling novels are even said to have greatly contributed to the Labour Party's victory in 1945. Millions of citizens had been unable to afford the privatised system and were disenfranchised from access to health care before the NHS. Now, every single person has access to quality health care that is financed through progressive taxation, that is, from each according to his ability to pay, to each according to his needs as a patient. Up to

now, the Labour Party still considers the creation of the publicly-funded National Health Service as its proudest achievement.

4-2 NHS Principles

The NHS was born out of this long-held ideal that good healthcare should be available to all and regardless of wealth, at its launch; it had at its heart three core principles:

- that it meet the needs of everyone,
- that it be free at the point of delivery,
- that it be based on clinical need, not ability to pay

These three principles have guided the development of the NHS over more than half a century and remain. However, in July 2000, a full-scale modernisation programme was launched and new principles added. These require that:

- The NHS provide a comprehensive range of services. In this respect, it will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital-based care. The NHS will also provide information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after-care.
- The NHS shape its services around the needs and preferences of individual patients, their families and their carers. It must therefore be responsive to the needs of different groups and individuals within society. The NHS will treat patients as individuals, with respect for their dignity. Health services will continue to be funded nationally and be available to all citizens of the UK.

- The NHS work continuously to improve the quality of services and to minimise errors. Healthcare professional organisations will establish ways to identify procedures that should be modified or abandoned and new practices that will lead to improved patient care. All those providing care will work to make it ever safer and support a culture where we can learn from and effectively reduce mistakes.
- The NHS support and value its staff. The NHS will continue to support, recognise, reward and invest in individuals and organisations, providing opportunities for individual staff to progress in their careers and encouraging education, training and personal development. Public funds for healthcare will be devoted solely to NHS patients. The NHS is funded out of public expenditure, primarily by taxation. This is a fair and efficient means of raising funds for healthcare services.
- The NHS work with others to ensure a seamless service for patients. The health and social care system must be shaped around the needs of patients. The NHS will develop partnerships and co-operation at all levels of care:
 - ✓ between patients, their carers, families and NHS staff
 - ✓ between the health and social care sector
 - ✓ between different government departments
 - ✓ between the public sector, voluntary organisations and private providers in the provision of NHS services.
- The NHS help to keep people healthy and work to reduce health inequalities and focus efforts on preventing, as well as treating, ill health. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition. It will also

work with other public services to intervene not just after but before ill health occurs.

- The NHS respect the confidentiality of individual patients and provide open access to information about services, treatment and performance. Patient confidentiality will be also respected throughout the process of care. The NHS will be open with information about health and healthcare services. It will continue to use information to improve the quality of services for all and to generate new knowledge about future medical benefits. Developments in science, such as the new genetics, offer important possibilities for disease prevention and treatment in the future. As a national service, the NHS is well-placed to take advantage of the opportunities offered by scientific developments and will ensure that new technologies are harnessed and developed in the interests of society as a whole and available to all on the basis of need.

4-3 The National Health Service in England

4-3-1 NHS England Structure.

The National Health Service (NHS) is the publicly funded health care system of England; it is a separate system from the other three national health systems operating in the United Kingdom which are responsible to their own devolved governments and have developed under differing legislation resulting in a variation of management and practice. All four services co-operate without general discrimination toward citizens from any area.

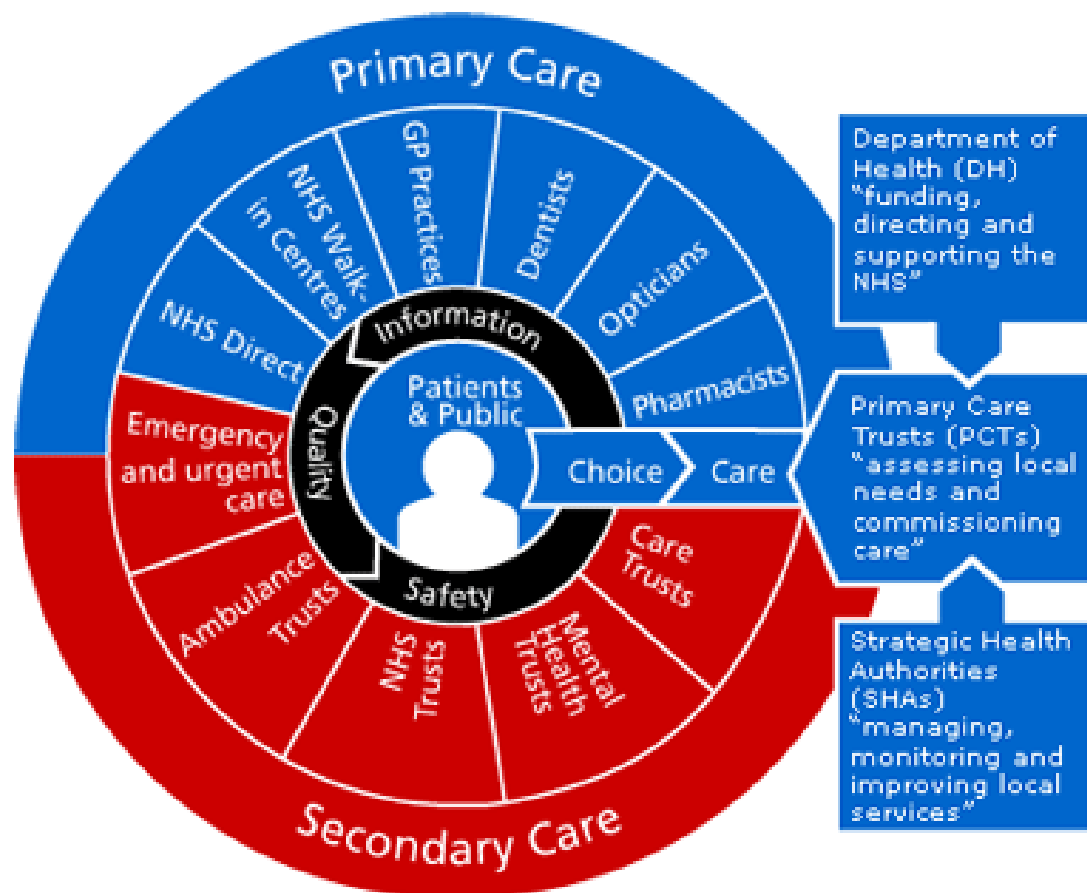
The NHS provides the majority of healthcare in England, including primary care (such as general practitioners), in-patient care, long-term

healthcare, ophthalmology and dentistry (NHS dentistry is done by dentists in private practice doing sub-contracted work for the NHS). The National Health Service Act 1946 came into effect on 5 July 1948. Private health care has continued parallel to the NHS, paid for largely by private insurance, but it is used only by a small percentage of the population, and generally as a top-up to NHS services. The large majority of NHS services are provided free at the point of use to the patient and without further charge for in-hospital treatment and associated medication; other medicine might involve the prescription fee described below. The costs of running the NHS (est. £104 billion in 2007-8 are met directly from general taxation : €132billion).

The UK government department responsible for the NHS is the Department of Health, headed by a Secretary of State for Health (Health Secretary), who sits in the British Cabinet.

The NHS is the world's largest health service and the world's third largest employer after the Chinese army and the Indian railways.

NHS' DIAGRAM



Source :

www.nhsdiagram.com

NHS' DIAGRAM : COMMENT

- **Primary Care Trusts** (PCTs) are in charge of primary care and have a major role around commissioning secondary care, providing community care services. Although their number has been reduced from 303 to 152, PCTs are now at the centre of the NHS and control 80% of the NHS budget. As they are local organisations, they are best positioned to understand the needs of their community, so they can make sure that the organisations providing health and social care services are working effectively. The PCTs oversee 29,000 GPs and 18,000 NHS dentists
- **Secondary care** is known as acute health care and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a General Practitioner (GP).

There are 290 NHS Hospital Trusts which oversee 1,600 NHS hospitals and specialist care centres. Foundation trusts are a new type of NHS hospital of which are currently 67 available across England.

Emergency vehicles are provided by the NHS Ambulance Services Trusts. There are thirteen ambulance trusts in England.

NHS Mental Health Services Trusts provide mental health care in England and are overseen by the Primary Care Trusts.

There are also agencies under the umbrella of the NHS. These include the National Institute for Health and Clinical Excellence (NICE)

There are several types of NHS trust:

Primary Care Trusts (PCTs), which administer primary care and public health. On 1 October 2006 the number of PCTs was reduced from 303 to 152 in an attempt to bring services closer together and cut costs. These oversee 29,000 GPs and 18,000 NHS dentists. In addition, they commission acute services from other NHS Trusts and the private sector, provide directly primary care in their locations, and oversee such matters as primary and secondary prevention, vaccination administration and control of epidemics. PCTs are at the centre of the NHS and control 80 per cent of the total NHS budget.

NHS Hospital Trusts. 290 organisations administer hospitals, treatment centres and specialist care in about 1,600 NHS hospitals (many trusts maintain between 2 and 8 different hospital sites).

- NHS Ambulance Services Trusts
- NHS Care Trusts
- NHS Mental Health Services Trusts
- NHS Direct Trust provides telephone and online support services

4-3-2 NHS Institutions and Organisations

The NHS in England is controlled by the UK government through the Department of Health. Some NHS agencies (e.g. NICE and SIGN) have influence in other parts of the United Kingdom.

The NHS is managed at the top by the Department of Health, which takes political responsibility for the service. It controls Strategic Health Authorities (SHAs), which oversee all NHS operations in an area of England. There are 10 SHAs, coterminous the nine Government Office Regions in most part, with the

South East region split into South East Coast and South Central SHAs. The SHAs are responsible for strategic supervision of the trusts in their area.

In addition, several Special Health Authorities provide services and, in some cases, to the devolved NHS administrations. These include the Information Centre for Health and Social Care, NHS Blood and Transplant, NHS Direct, NHS Professionals, NHS Business Services Authority, National Patient Safety Agency, NHS Connecting for Health, National Treatment Agency and the National Institute for Health and Clinical Excellence (NICE).

4-3-3 The Staff

A feature of the NHS, distinguishing it from other public healthcare systems in Continental Europe, is that not only does it pay directly for health expenses; it also employs a large number of the doctors and nurses that provide them. In particular, nearly all hospital doctors and nurses in England are employed by the NHS and work in NHS-run hospitals.

In contrast, General Practitioners, dentists, opticians and other providers of local healthcare, are almost all self-employed, and contract their services back to the NHS. They may operate in partnership with other professionals, own and operate their own surgeries and clinics, and employ their own staff, including other doctors. However, the NHS does sometimes provide centrally employed healthcare professionals and facilities in areas where there is insufficient provision by self-employed professionals. It should also be noted that NHS workforce figures provided by the Department of Health include not only employees of NHS divisions but also local authority social services workers. The full-time equivalent figure for 2005 was about 980,000 staff.

4-3-4 Funding

4-3-4-1 The commissioning system

The principal fund holders in the NHS system are the NHS Primary Care Trusts (PCTs), who commission healthcare from hospitals, GPs and others. PCTs disburse funds to them on an agreed tariff or contract basis, on guidelines set out by the Department of Health. The PCTs receive a budget from the Department of Health on a formula basis relating to population and specific local needs. They are required to "break even" - that is, they must not show a deficit on their budgets at the end of the financial year, although in recent years cost and demand pressures have made this objective impossible for some Trusts. Failure to meet the financial objective can result in the dismissal and replacement of a Trust's Board of Directors.

4-3-4-2 Patient charges and prescriptions

Except for set charges applying to most adults for prescriptions, optician services and dentistry, the NHS is free for all patients "ordinarily resident" in the UK at the point of use irrespective of whether any National Insurance contributions have been paid. Those who are not "ordinarily resident" (including British citizens who have paid National Insurance contributions in the past) are liable to charges for services other than that given in Accident and Emergency departments or "walk-in" centres.

NHS costs are met, via the PCTs, from UK government taxation, thus all UK taxpayers contribute to its funding.

4-3-4-3 Exemption for missionaries who work abroad for a UK based organisation

In England, from 15 January 2007, anyone who is working outside the UK as a missionary for an organisation with its principal place of business in the UK will be fully exempt from NHS charges for services that would normally be

provided free of charge to those resident in the UK. This is regardless of whether they derive a salary or wage from the organisation, or receive any type of funding or assistance from the organisation for the purposes of working overseas. This is in recognition of the fact that most missionaries would be unable to afford private health care and those working in developing countries should not effectively be penalised for their contribution to development/other work.

4-3-4-4 Exemption for others

There are some other categories of people who are exempt from the residence requirements such as specific government workers and those in the armed forces stationed overseas.

4-3-4-5 Prescription charges

In April 2007 the prescription charge for medicines in England is £6.85; people over sixty, children under sixteen (or under nineteen, if the child is still in full time education), patients with certain medical conditions, and those with low incomes, are exempt from paying. Those who require repeated prescriptions may purchase a single-charge pre-payment certificate which allows unlimited prescriptions during the period of validity. The charge is the same regardless of the actual cost of the medicine but higher charges apply to medical appliances. However, the rising costs of some medicines, especially some types of cancer treatment, means that prescriptions can present a heavy burden to the PCTs whose limited budgets include responsibility for the difference between medicine costs and the fixed prescription charge. This has led to disputes in certain cases (e.g. over Herceptin), as to whether such drugs should be prescribed.

4-3-5 NHS policies and programmes

4-3-5-1 Reforms under the Thatcher government

The 1980s saw the introduction of modern management processes (General Management) in the NHS to replace the previous system of consensus management. This was outlined in the Griffiths Report of 1983. This recommended the appointment of general managers in the NHS with whom responsibility should lie. The report also recommended that clinicians be better involved in management. Financial pressures continued to place strain on the NHS. In 1987, an additional £101 million was provided by the government to the NHS. In 1988 the then Prime Minister, Margaret Thatcher, announced a review of the NHS. From this review and in 1989, two white papers Working for Patients and Caring for People were produced. These outlined the introduction of what was termed the "internal market", which was to shape the structure and organisation of health services for most of the next decade.

In 1990, the National Health Service & Community Care Act (in England) defined this "internal market", whereby Health Authorities ceased to run hospitals but "purchased" care from their own or other authorities' hospitals. Certain GPs became "fund holders" and were able to purchase care for their patients. The "providers" became independent trusts, which encouraged competition but also increased local differences.

4-3-5-2 The Blair government

These innovations, especially the "fund holder" option were condemned at the time by the Labour Party; opposition to what was claimed to be the Conservative intention to privatise the NHS became a major feature of Labour campaigning in the 1997 and subsequent British elections. Although the incoming government of Tony Blair (1997) stated its intention to remove the "internal market" and abolished fund holding, in effect the market was

strengthened and fundholding reintroduced as part of Blair's ongoing reforms to modernise the NHS. Driving these reforms has been confronted with a certain number of factors. They include the rising costs of medical technology and medicines, the desire to increase standards and "patient choice", an ageing population, and a desire to contain government expenditure. Since the National Health Services in Wales, Scotland and Northern Ireland are not controlled by the UK government, these reforms have increased the differences between the National Health Services in different parts of the United Kingdom.

Reforms have included (among other actions) the laying down of detailed service standards, strict financial budgeting, revised job specifications, reintroduction of "fundholding" (under the description "practice-based commissioning"), closure of surplus facilities and emphasis on rigorous clinical and corporate governance. In addition medical training has been restructured. Some new services have been developed to help manage demand, including NHS Direct. A new emphasis has been given to staff reforms, with the Agenda for Change and the agreement providing harmonised pay and career progression. These changes have, however, given rise to controversy within the medical professions, the media and the public.

The Blair Government, while leaving services free at point of use, has encouraged outsourcing of medical services and support to the private sector. Under the Private Finance Initiative, an increasing number of hospitals have been built (or rebuilt) by private sector consortia; hospitals may have both medical services (such as "surgicentres"), and non-medical services (such as catering) provided under long-term contracts by the private sector. A study by a consultancy company which works for the Department of Health shows that every £200 million spent on privately financed hospitals will result in the loss of

1000 doctors and nurses. The first PFI hospitals contain some 28 per cent fewer beds than the ones they replaced.

In 2005, surgicentres (ISTCs) treated around 3% of NHS patients (in England) having routine surgery. By 2008 this is expected to be around 10%. NHS Primary Care Trusts have been given the target of sourcing at least 15% of primary care from the private or voluntary sectors over the medium term.

As a corollary to these initiatives, the NHS has been required to take on proactive socially "directive" policies, for example, in respect of smoking and obesity.

4-4 NHS Scotland

NHS Scotland is the official corporate style of the National Health Service in Scotland. It is one of the original three national health systems created in the United Kingdom after World War II; it remains a separate body from the other systems although co-ordination and co-operation with the other systems in the UK tends to hide the organisational separation from their users where "cross-border" or emergency care is involved. Healthcare policy and funding is the responsibility of the Scottish Government's Health and Wellbeing Directorate. The current Cabinet Secretary for Health and Wellbeing is Nicola Sturgeon and the Director-General for Health and Wellbeing, Dr Kevin Woods, is chief executive of NHS Scotland.



4-4-1 Origins and History

The service was founded by the National Health Service (Scotland) Act 1947 (since repealed by the National Health Service (Scotland) Act 1978). These Acts did not originate free public health services in Scotland (which had already existed in some form for many years without universal application) but provided a uniform national structure for services which had previously been

provided by a combination of local government, charities and private organisations which in general was only free for emergency use. The new system was funded from central taxation and did not generally involve a charge at the time of use for services concerned with existing medical conditions or vaccinations carried out as a matter of general public health requirements; prescription charges were a later introduction in 1951.

4-4-2 Health Boards

Current provision of healthcare is the responsibility of 14 geographically-based local NHS Boards and a number of National Special Health Boards. In April 2004 the NHS became an integrated service under the management of NHS Boards. Local authority nominees were added to Board membership to improve co-ordination of health and social care. Trusts were abolished and hospitals are now managed by the acute division of the NHS Board. Contracted services such as GP's and pharmacies are contracted through the NHS Board, but work in Community Health Partnerships based largely on local authority boundaries and serving up to 100,000 people and including local authority membership of their Boards. Some now also provide social care now called Community Health & Care Partnerships.

4-4-2-1 Elections to Health Boards

In January 2008, the Scottish Government announced plans for legislation to bring in direct elections to Health Boards, believing that such a measure would help restore public confidence.

4-4-2-2 Special Health Boards

Local Health Boards are supported by a number of non-geographical Special Health Boards providing national services (some of which have further publicised subdivisions), including:-

- NHS Health Scotland (Public health and health education)
- NHS Quality Improvement Scotland
- Scottish Ambulance Service (The single public emergency ambulance service in Scotland).

The Golden Jubilee National Hospital is a special NHS Board in Scotland with the purpose of reducing waiting times using a single modern hospital located at Clydebank. It was previously a private sector hospital built at a cost of £180 million, but was bought in 2002 by the Scottish Executive for £37.5 million after it failed to produce a profit despite being established with the help of a subsidy provided by a previous government.

The State Hospitals Board for Scotland is responsible for the State Hospital for Scotland and Northern Ireland at Carstairs, which provides high security services for mentally disordered offenders and others who pose a high risk to themselves or others.

- NHS 24 runs a 24 hour telephone helpline serving Scotland.
- NHS Education for Scotland (training and e-library)
- NHS National Services Scotland It is the common name for the Common Services Agency (CSA) providing services for NHS Scotland boards.

4-4-3- Other divisions

Other subdivisions of the Scottish NHS include: - Central Register, Patient Identification and Overseeing and Representative Bodies.

4-4-3-1 Central Register

The Central Register keeps records of patients resident in Scotland who have been registered with any of the health systems of the United Kingdom. It is

maintained by the Registrar General. Its purposes include keeping GPs' patient lists up to date, the control of new NHS numbers issued in Scotland and assisting with medical research.

4-4-3-2 Patient Identification

Scottish patients are identified using a 10 digit number known as the Community Health Index or CHI. This number is normally formed using the patient's Date of Birth followed by 4 numbers, 2 numbers generated at random, a number identifying Gender at Birth (men are odd, women are even) and a check digit. Uptake of this number varies throughout the Health Boards with the best being NHS Tayside with 99% usage and the worst NHS Dumfries and Galloway with 73% usage.

4-4-3-3 Overseeing and Representative Bodies

The Mental Welfare Commission for Scotland is an independent statutory body which protects mentally disordered people who are not able to look after their own interests. It is funded through the Scottish Executive Health Department, and follows the same financial framework as the NHS in Scotland. The Scottish Health Council took over from local Health Councils on 31 March 2005. <http://en.wikipedia.org/wiki/NHS/Scotland-note> 16

4-5 NHS Wales

NHS Wales is the official corporate style of the National Health Service in Wales; it was previously part of the same NHS structure as England but is now devolved. It is operated and managed by the Health and Social Care Department of the Welsh Assembly Government. Most people in Wales will have access to a District General Hospital which provides a range of services on an outpatient, inpatient and day case basis. Some of these hospitals also provide specialist services such as burns and plastics and cardiac surgery. NHS Wales

also provides community services which includes district nurses, health visitors, midwives and community based speech therapists, physiotherapists and occupational therapists.

4-5-1 Health Boards

Local Health Boards (LHBs) were created in 2003 to replace Health Authorities in Wales. A Welsh NHS Trust will typically administer all hospitals in a region, as well as all community care and mental health functions. There are 12 regional Trusts that cover groups of local authority areas, as well as one further Trust for the Welsh Ambulance Service and another, Velindre, for the operation of nationwide agencies and services. Wales has one main teaching hospital, the University Hospital of Wales, based in Cardiff, which is the largest hospital outside London and 3rd largest in the United Kingdom.

4-5-2 -Other NHS Wales bodies

Another important organisation in the structure is Health Commission Wales. This is an executive agency of the Welsh Assembly Government whose primary role is to centrally organise and fund all Tertiary care and other highly specialist services. It also provides advise and guidance about specialist services to other parts of NHS Wales.

NHS Direct is also available in Wales, with callers being given the option of talking in Welsh or English.

4-6 Department of Health of the United Kingdom

The Department of Health (DoH) is a department of the United Kingdom government but with responsibility for government policy for England alone on health, social care and the National Health Service (NHS). It is led by the

Secretary of State for Health with two Ministers of State and three Parliamentary Under-Secretary of States. Its headquarters are in Whitehall.

The DoH carries out some of its work through "arm's length bodies", including executive agencies such as the NHS Purchasing and Supply Agency (NHS PASA) and the Medicines and Healthcare products Regulatory Agency (MHRA).

In the rest of the United Kingdom, responsibility for health and the management of the NHS falls under the jurisdiction of the devolved governments of the other three constituent countries, namely.

4-6-1 History

The Department of Health was formally created in 1988, through The Transfer of Functions (Health and Social Security) Order 1988. Like many others, the department with responsibility for the nation's health has had different names and included other functions over time. In the 19th century, several bodies were formed for specific consultative duties and dissolved when they were no longer required. There were two incarnations of the Board of Health (in 1805 and 1831) and a General Board of Health (1854 to 1858) that reported directly into the Privy Council. Responsibility for health issues was also at times, and in part, vested in local health boards and, with the emergence of modern local government, with the Local Government Act Office, part of the Home Office. In the early part of the 20th century, medical assistance was provided through National Health Insurance Commissions. The first body which could be called a department of government was the Ministry of Health, created in 1919 through the Ministry of Health Act, consolidating under a single authority the medical and public health functions of central government. The co-ordination of local medical services was expanded in connection with emergency and wartime services, from 1935 to 1945, and these developments culminated in the establishment of the National Health Service in 1948.

In 1968, the Ministry of Health was dissolved and its functions transferred (along with those of the similarly dissolved Ministry of Social Security) to the newly created Department of Health and Social Security (DHSS). Twenty years later, these functions were split back into two government departments, forming the Department of Social Security (DSS) and the current Department of Health.

4-6-2 Location

The official headquarters and Ministerial offices are in Richmond House, Whitehall, London. Many staff are in Skipton House, Elephant and Castle, in London and were formerly in Alexander Fleming House and Hannibal House there. There are also many staff based in Quarry House in Leeds, in Wellington House near Waterloo station in London and in New King's Beam House near Blackfriars Bridge.

4-6-3 Permanent Secretary

The Permanent Secretary at the Department of Health was Sir Nigel Crisp from 2000 to 31 March 2006. Unlike his predecessors as permanent secretary, Sir Nigel Crisp was also Chief Executive of the NHS. Following his early resignation in March 2006, it was announced that the posts will be split. David Nicholson was appointed as Chief Executive of the NHS in September 2006. Hugh Taylor was appointed as the Permanent Secretary in December 2006 after serving as Acting Permanent Secretary following Sir Nigel Crisp's decision to retire.

4-6-4 Chief professional officers

The department has six chief professional officers who provide it with expert knowledge and also advise the Ministers, other government departments and the Prime Minister. The Chief Medical Officer and Chief Nursing Officer are also directors of the department's board.

Chapter 5 : Medical standard in Great Britain

nowadays.

The vast majority of health care in the United Kingdom is provided by the four National Health Services (commonly referred to in the singular as "the" NHS) which are funded by the taxpayer and do not form part of an insurance based system. Although the social medicine model prevails in the United Kingdom, there are also many private medical practitioners and private hospitals usually funded by insurance (paid either directly by the patient or, very commonly by employers as a fringe benefit).

5-1 With regard to the patients

Care by the NHS is provided to all permanent residents of the United Kingdom as the main instrument providing a nationally based universal health care system. The NHS is not funded by insurance. Instead, it is funded directly from taxation. The budget for 2007/8 is £104bn or £1,700 (approx US\$3,400) per capita per annum. NHS patients do not receive medical bills, although people of working age (except full time students) do pay a contribution towards their drug and dental costs.

A government minister, the Secretary of State for Health, holds political responsibility for the operation of each health service. However, day to day medical matters are managed by doctors not administrators.

5-2 With regard to childbirth

Most British people are born in an NHS hospital. The parents are not charged for pre-natal care, the birth, or any post-natal care. The parent(s) will

leave the hospital with the baby and often a free package of baby consumables sponsored by private companies.

5-3 Regarding access to general practitioners

All people are eligible for registration with a general practitioner (GP), usually of the patient's choosing. The only rule is that the GP must be local to the area in which the person lives. The GP cannot reject a patient except in very exceptional circumstances. He is a qualified doctor, typically working in a business practice dealing exclusively with NHS patients. The NHS pays the doctor a salary based on the number of patients under his or her care and other compensations for the different services provided under the GP contract. The doctor is not allowed to charge the patient for any services provided if those services are part of the NHS contract, which almost all care is.

The role of the GP is to manage the health care needs of his/her patients, keep full records, be the primary carer for the patient and only make referrals to other specialist of NHS services if that is necessary. If a person is ill, an appointment is made with the doctor. Most doctors also provide a walk in and wait service for urgent needs, with the patient waiting until the doctor is free. The GP will prescribe drugs and will follow the patient's progress treatment through to recovery. GPs do not usually follow their patients into hospital for elective treatment as is the practice in some countries, but they do get a comprehensive report from the hospital after discharge. In some cases the GP will be involved in the drawing up of a care plan for the patient before discharge if patient has special care needs.

5-4-With Regard to Pharmacies and cost control

Pharmacies are privately owned but have contracts with the NHS. Patients take the prescription to a local pharmacy. The pharmacy will check the prescription and issue the drug(s). In England, Northern Ireland and Scotland,

patients under 16 years old (19 years if still in full-time education) or over 59 years will get the drug for free. There are also exemptions for people with certain medical conditions, and those on low incomes. Prescribed contraception is also issued free of charge (e.g. contraceptive pills). Otherwise a fixed charge of £6.85 is paid (about US\$13). There are no prescription charges at all in Wales, and in Scotland the intention to abolish prescription charges has been announced but legislation has yet to be passed. The pharmacist bills the NHS for the prescriptions less the flat fees it has received from the patients.

As the service is free to use, costs are controlled via gatekeepers in the system. The function of the gatekeepers is to ensure that only people who are entitled to treatment receive it, and that medical or psychological need is genuine. The GP is the primary gatekeeper, but the hospital consultants, some nurses (e.g. triage nurses in the Emergency Department) and administrators managing waiting lists also have gatekeeper functions.

If a person asks his doctor for a test for some condition and the doctor does not believe that the test is necessary, the patient will be told to go to a private hospital or clinic and pay for the test him/herself. The NHS has strict guidelines as to what services the NHS will provide. For instance breast augmentation is almost certainly something that the NHS would not fund, but most normal medical or mental health services are covered. Cosmetic surgery is possible to correct congenital abnormalities or following injury.

The National Institute for Health and Clinical Excellence (NICE) sets guidelines for medical practitioners in the NHS as to how various conditions should be treated and whether or not a particular treatment is funded by the NHS. Factors such as cost and Quality-adjusted life years are used to determine whether a treatment is available on the NHS.

The NHS reserves the right to claim compensation for work it has to do as a result of the negligence of others. The main example of this is the Injury Costs

Recovery Scheme, where compensation is received from motor insurance companies following the determination of fault in motor accidents. It currently recovers approximately £11 million per month (approx US\$ 22 million) from the motor insurance industry.

5-5 With regard to investigations

If the GP judges that a blood, urine or other specimen needs to be taken, or if some other investigation is needed to aid diagnosis or management, the patient is referred to a hospital for the test. This may mean the patient will have to go to a hospital or clinic for the investigation to take place, or, as is usual in the case of a simple blood test, someone (the GP or a nurse) at the GP surgery will take the sample and it will be posted to a hospital laboratory for analysis. The results of the test are returned to the referring doctor.

5-6 With regard to Hospital care and dentistry

If the GP judges that the patient needs specialist care at a hospital or clinic he or she will inform the patient of the choice of hospitals and will help the patient to come to a decision on where to go. If the patient chooses a private hospital, the patient becomes liable for the hospital fees. However, there will always be a choice of free NHS hospitals and most people naturally choose an NHS hospital. The GP informs the hospital of the patient's condition and the hospital then judges how urgent the need is against those of other patients. If the need is urgent the patient will be seen almost immediately. If less urgent an appointment will be made in the future. The median wait time for a consultant led first appointment in English hospitals is a little over 3 weeks. The patient is initially seen as an out-patient at the hospital, but if the consultant judges that the patient needs to be admitted to the hospital, either for more investigations or for surgery or other treatment, then the patient will be admitted to the hospital as an in-patient. The timing of the in-patient admission is based on a combination

of medical need and the time waiting. Thus very urgent cases will result in immediate admission whereas minor issues will require a future appointment. However, even the most minor procedures will be dealt with eventually. At any time the patient can ask for a private hospital referral which may provide the treatment sooner, but this will be at full cost to the patient. For those not admitted immediately, the median wait time for in-patient treatment in English hospitals is a little under 6 weeks Ibid.

At one time there were accusations that some NHS trusts were fixing the queueing system by delaying the decision to put patients onto a queue. To prevent this from happening the government is introducing an 18 week guarantee that means that the hospital must complete all tests and start treatment within 18 weeks of the date of the referral from the GP. Trusts are now working towards achieving this target by December 2008. Some hospitals are introducing just in time workflow analysis borrowed from manufacturing industry to speed up the processes within the system and improve efficiencies.

Almost all NHS hospital treatment as hospital patient, either in-patient or out-patient, is free of charge as are all drugs administered in hospital, surgical consumables and appliances issued or loaned. In other words, the patient is never billed. However, if a patient has chosen to be treated in an NHS hospital as a private fee paying patient by arrangement with his consultant, the patient (or the insurance company) will be billed. This can happen because at the inception of the NHS, hospital consultants were allowed to continue doing private work in NHS hospitals and can enable private patients to "jump the NHS queue". This arrangement is nowadays quite rare as most consultants and patients choose to have private work done in private hospitals.

As far as dentistry is concerned, the NHS provides subsidized dental services through private dental practises. Private dentists accepting NHS funding for a patient can only charge the patient at the standard NHS rate. If the patient

opts to be treated as a private patient, he or she will not receive any funding for the treatment from the NHS.

Most dentists provide NHS care for children but not all dentists choose to do NHS work for adults. About half of the income of dentists comes from work sub-contracted from the NHS.

In recent months the amount of dentistry provided privately has increased to exceed NHS provision. This is due to several factors. The primary factor is the new NHS dental contract introduced in April 2006. Many dentists feel that this contract is ill conceived and unworkable and have chosen to reduce their commitment to zero (approximately 1200 dentists at the introduction of the contract). It remains to be seen how many dentists choose to continue to provide NHS care to patients under the new system post 2009 when funding will reduce even further. The second factor is patient demand for more complex and cosmetic procedures that due to increased expense (such as higher quality materials and laboratory procedures) and time spent mean that these procedures are not cost effective within the NHS constraints in general practice. Other factors such as increased costs placed upon dentists by regulatory bodies and increased litigation have also influenced the move from NHS to private dentistry.

5-7- Regarding emergency care and ambulance services

Emergency Department (traditionally known as Accident and Emergency) treatment is also free of charge. A triage nurse prioritizes all patients on arrival. Waiting times can be up to 4 hours if a patient goes to the Emergency Department with a minor problem or may be referred to other agencies (e.g. pharmacy, GP, Walk in clinic). Emergency Departments try to treat patients within 4 hours as part of NHS targets for emergency care. The Emergency Department is always attached to an NHS general hospital. Private hospitals do not provide emergency care services.

Concerning ambulance services they are not usually charged to the patient if the ambulance is called for a life-threatening emergency or is ordered by the hospital or GP because the patient needs the specialist transportation only available from an ambulance crew.

5-8 With regard to Clinics and walk-in centres

The NHS also provides local clinics where nurses and other practitioners can provide treatment. Most children are given vaccinations and check-ups at local clinics. Ophthalmology, sexually transmitted diseases, some dentistry, and nurse-administered care such as re-dressings, earwax removal, etc. are conducted at local clinics rather than at the hospital. Walk-in centres deal with regular issues such as fractures, sprains, and minor injuries. The services of clinics and walk-in centres are free of charge.

5-9 Concerning Home visits

Patients unable to get to the doctor or clinic because they are too ill to move, or because the case is urgent and the surgery is closed, may be seen at home, either by the GP or a nurse, or a doctor acting as locum for the GP. There is no charge for this service providing the call was one of genuine need. Home visits can be provided by District and Community Nurses as part of continuing care following discharge from hospital. Community Matrons have a caseload which he or she manages in order to prevent people from returning to secondary healthcare. Community Matrons, Community and District Nurses are usually (but not exclusively) attached to GP practices. GPs and hospitals commission their care based on individual patient needs.

5-10 Concerning advice services, records and palliative care

The English and Welsh NHSs run a 24 hour confidential advisory service called NHS Direct. There is a telephone-based service which is staffed by professional nurses and health advisors, an interactive digital TV service and a web site.

Prioritization throughout the NHS is based on patient need rather than ability to pay. Quality of life benefits and life expectation are examples of factors that may be taken into consideration. Thus a 99 year old man might not be offered a multiple coronary by-pass.

The NHS also provides end of life palliative care in the form of Palliative Care Specialist Nurses. The NHS can also commission the expertise of organisations in the voluntary sector to compliment palliative care. Such organisations include Marie Curie Cancer Care, Sue Ryder Care and Macmillan Cancer Support. Despite their names, these services are designed for all palliative conditions, not exclusively cancer. All palliative care services provide support for both the patient and their relatives during and after the dying process. Again, these are all free of charge to the patient. As for records, all treatments given at the hospital are reported back to the home GP, so there is a single record of a patient's medical history.

5-11 Concerning Quality of Healthcare, Accreditation and Private-sector medical care

There are various regulatory bodies in the UK, both government-based (e.g. Department of Health, General Medical Council, Nursing and Midwifery

Council) and non-governmental-based (e.g. Royal Colleges). Some of these organisations have high worldwide standing.

With respect to assessing, maintaining and improving the quality of healthcare, unlike in the USA and many other developed countries where hospital accreditation groups independent of central government are utilised, the UK government take on both the role of suppliers of healthcare and assessors of the quality of its delivery through groups organised directly by government departments, such as NICE and CHI.

This lack of separation of government from healthcare delivery is often seen as a weakness and has the potential to over-politicise healthcare, especially over issues of funding and geographical distribution of services. The fact that the bodies who are underwriting the bills (ie. the government) have a political stake in how the NHS runs is potentially divisive.

Parallel to the NHS is an active private sector in health care. The parallel system can provide the same treatments as the NHS, and the principal reason for using the private sector is often that waiting times can be less and that the hospital may be less "public" and more "personal".

The private sector is now doing subcontracting work for the NHS. Thus an NHS patient can be treated in the private sector as an NHS patient if the Health Services has subcontracted work to the hospital. This development is still in its infancy and quite rare. Some private hospitals are business enterprises and some are non-profit-making trusts. Some hospital groups also provide insurance plans (e.g. BUPA) and some insurance companies have deals with particular private hospital groups. Some private sector patients can be treated in NHS

hospitals in which case the patient or his/her insurance company is billed.

There is a wide range of private sector practitioners, especially in areas such as ophthalmology, dentistry, as well as in areas such as less mainstream areas such as chiropractic, herbal medicine, Chinese medicine, etc.

Chapter 6 : Health and the socio-economic development of Britain and how should Benin get inspired from the British model?

UK is part of the most populated countries of Northwestern Europe. World War II led to widespread recognition of social problems such as poverty and unemployment which were deeply affecting the kingdom. There was a strong feeling that the population should be rewarded for its sacrifice. This is the main idea which supported the birth of a National Health System.

When the Beveridge Report, 1942, was written and implemented, the structure and expectations of British society were different to what they are today. It seems clear nowadays that visible changes have been achieved in the field of Health and social security which had had great impacts and implications on the socio-economic development of the United Kingdom. These impacts can be seen through the population growth, and also the decline of the death rate. Furthermore, this is likely to increase the Gross Domestic Products in so far as people are supposed to be more productive at work when they are healthy.

6-1: Natural population growth

The Census of the population which is a count of all people and households is normally held on one particular day every ten years in the UK. The last one was held on 29 April 2001 and so the next one is due in 2011. It generally provides statistical information for the country as a whole, down to small areas enabling the planning and funding of public services, including education, health and transport :

Table 1: POPULATION, UK, 2001- 2006

NATION	Population (2001) census	Population (mid-2006) Estimation	%total UK POP
ENGLAND	49,138,831	50, 762,900	83.6
WALES	2,903,085	2, 965,900	4.9
SCOTLAND	5,062,011	5, 116,900	8.6
NORTHERN IRELAND	1,685,267	1, 741,600	2.9
UNITED KINGDOM	58,789,194	60,587,300	100

Source: Office for National Statistics (ONS), 2001 Census

COMMENT: According to the 2001 census, the total population of the United Kingdom was 58,789,194 - the third-largest in the European Union (behind Germany and metropolitan France) and the 21st-largest in the world. Its overall population density is one of the highest in the world, due to the particularly high population density in England where 49,138,831 lived.

Between 2001 and 2006 UK pop has since risen to 60,587,300 according to mid-2006 estimates by the Office of National Statistics. The increase is seen in all the Kingdom's four parts.

England Population Growth

Table 2: England Population Growth

Year	ENGLAND POP
1951	41,042,200
1961	43,983,300
1971	45,870,100
1981	46,623,500
1991	48,067,300
2001	49,138,831
2005	50,431,700
2006	50,762,900

Source: Office for National Statistics (ONS) 2001 Census

COMMENT : When we have a look at the table above, it's easy to notice England population growth. If we consider from 1951 to 2001 (50 years) we can assert that 8,096,631 people have added to England population. It's also important to remember here that the pill Act and the abortion Act which were respectively voted in 1964 and 1967 and also many other complex social and economic factors including women opting for a career, work pressures had a great effect and are still having impact on the evolution of the British population size.

In fact the welfare system is to be rewarded and particularly, the NHS which has played a great role because of better healthcare which is provided and health inequalities which are reduced in the United Kingdom by supplying universal and free healthcare.

6-2 The British Age structure

Table 3 : The British Age structure

Age Group (Years)	Population	Percentage of Population
0 – 4	2, 926,238	5.96
5 – 7	1, 838,668	3.74
8 – 9	1, 283,861	2.61
10 – 14	3, 229,047	6.57
15	623,767	1.27
16 – 17	1, 231,266	2.51
18 – 19	1, 177,571	2.40
20 – 24	2, 952,719	6.01
25 – 29	3, 268,660	6.65
30 – 44	11,127,511	22.65
45 – 59	9, 279,693	18.88
60 – 64	2, 391,830	4.87
65 – 74	4, 102,841	8.35
75 – 84	2, 751,135	5.60
85 – 89	637,701	1.30
90+	316,323	0.64

Source: Office for National Statistics (ONS) Census 2001

COMMENT : The most numerous age groups (at the 2001 census) were the 5-year group born in the years 1946-51 (the post-World War II baby boom);

the baby boom born a generation later in 1961-66 (the largest group of all); and a more modest boom a generation after that, born in 1986-91. The 1946-51 group reaches retirement age from 2006 onwards (women from 2006 and men from 2011), and the sudden increase in the number of people claiming the state pension has led politicians and political commentators to fear a "pensions crisis". The age groups are not evenly distributed around the country, with some areas having many young adults and children and some areas having large numbers of older people.

Table 4: A few population-related data

1-Gender ratio men/women	100/ 106
2-Infant mortality rate	5.5 deaths/1,000 live births (0,55%)
3-Birth rate	1.64children born / woman
4-Average age of mother at birth of first child	27years
5-Life expectancy at birth	Men:74 years Women 80 years
6-Under 16	20% of population
7-Over 60	21% of population
8-Over85	1.9% of population
9-Death rate	10.35 deaths/ 1,000/population (1.03%)
10-Yearly population growth rate	0.23%

Source: Office for National Statistics (ONS), 2001 Census

COMMENT : In every year since 1951, with the exception of 1976, there have been more births than deaths in the UK and the population has grown. The UK has an ageing population. This is the result of declines in the mortality rate and in past fertility rates. This has led to a declining proportion of the population aged under 16 and an increasing proportion aged 65 and over. Consequently, life expectancy at the same time has been increasing which is partly due to natural change, improvements in health care and living standard and the increase of the medical standard with the creation of the NHS. While from 1981 to 2001 the population aged over 60 increased from 16% to 21% of the total population, the proportion aged under 16 decreased from 24% to 20%. This meant that more and more British citizens are senior people and fewer and fewer are workers. This has important long-term implications in particular concerning the economics of social security (healthcare, pensions, unemployment, etc...).

Very soon after its launch the NHS has been confronted to many problems: the huge surge of demand for medical care from millions of people who previously had had little or no reliable free healthcare. Thus the NHS was in financial difficulties because also of the growth of the population after its creation. These problems had been aggravated by the increase of the population. Some hard, suitable and efficient measures were to be taken and they are the implications of the changes.

For the circumstance, additional strain was put on the NHS budget by the government. The year after coming to power Margaret Thatcher proclaimed “The NHS is safe with us” and proceeded to the introduction of the new Health Service Act in 1980 that reorganised the structure. Decentralisation measures were implemented and bureaucracy was reduced. Despite all the combats and the measures the socio-economical problems was mainly caused by the increase

of the population size, it is thought by the two-tier of the UK that Margaret rolled back the state during her eleven years as PM.

Once to power, the New Labour noticed the critical state of the economy and adopted a tough stance on welfare via the WELFARE REFORM and PENSIONS ACT, 1999. Among many things, the law demanded that all the benefits claimants must attend interviews within 3 days of making their first claim to discuss entitlement reasons for not working, and to obtain help in getting a job. Furthermore, means-testing of benefit entitlement continued and stakeholder pension schemes were introduced. Conversely, a minimum wage was introduced for the first time in the UK on 1 April 1999 at £3.60 an hour for workers aged 22 and over and £3.00 an hour for 18-21 year old workers.

The following year, the Labour Party's strategy regarding Welfare moved away from social security benefits to tax credits. There was a fundamental reform of the tax and benefit system transforming the way millions of people receive state support to bring up their children.

Regarding the unemployment in 1999, the New Deal was introduced for jobless young people. Under the New Deal for Youth programme, all people under 25 who had been unemployed for six months or more were required to choose to either follow government subsidised training, or carry out job placement, or do work in the voluntary environment sector, rather than remain on the dole. It became a key part of Labour's "Welfare-to-Work" strategy. In 2003 Labour extended the "New Deal", so now it covers different groups of mid to long term unemployed persons: 18-24, 25 plus, 50 plus, lone parents and disabled people.

6-3 : How should Benin inspire from british model?

- **Health issues**

Benin's constitution of the December 11th 1991 states in its eighth article that: **“Human being is hallowed and inviolable. The state has the absolute obligation to respect and protect him. His entire blooming has to be assured. Therefore, the state assures to all its citizens equal access to health, education, culture, information, professional training and employment.”**

LaLonde report suggested that there are four general determinants of health including *human biology, environment, lifestyle, and healthcare services*. Thus, health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual. A major environmental factor is water quality, especially for the health of infants and children in developing countries.

During the 1980s, less than 30 percent of Benin population had access to primary health care services. Benin had one of the highest death rates for children under the age of five in the world. Its infant mortality rate stood at 203 deaths for every 1000 live births. Only one of three mothers had access to child healthcare services. The Bamako Initiative changed that dramatically by introducing community-based healthcare reform, resulting in more efficient and equitable provision of services. A comprehensive approach strategy was extended to all areas of health care, with subsequent improvement in the health care indicators and improvement in health care efficiency and cost.

This emphasizes the major role that health plays in any country's development. Many hospitals have then been built to make medical cares available to everybody. From ENIAB, INMES to FSS, all these pedagogical

structures have been producing nurses, midwives, doctors and many other health professionals who are trained and recruited in our health centers to achieve that goal. Nevertheless, it is easy to notice that the constitution statement's objective as far as health matters are concerned is far from being achieved. It shows out through the state of public health in Benin, life expectancy which is low in the country and our observations in hospitals during our surveys. The current state of health issues in Benin is far from being favourable to a sustainable development if nothing is done.

How is BENIN current Public Health state nowadays? How are the reception facilities? What are the natural resources, the medical and financial means available in our hospitals?

- **Some national statistics:**

First of all national and global statistics dealing with some basic indicators: nutrition, public health demography, economy can help us have an idea about our national situation. Through this tables below, though the figures are not the most current ones, they can be compared to years ago' to appreciate if there is any progress on some fields. It may also help us be aware of how health matters have been dealt with and their current socio-economic impacts on Benin citizens.

Table 5 : Some statistical figures

Years		
Fields	1990	2006
Life expectancy: m/w	53/54	56/57
Under 1 death rate(1000)	111	88
Under 5 death rate(1000)	185	148
15-60 death rate(1000)m/w	438/390	349/306

Source: OMS BENIN Statistics 1990 & 2006

Comment: The table shows that the era 1990-2006 has witnessed life expectancy growth: from 53 to 56 for men and from 54 to 57 for women. As far as death rates are concerned there has been a fall in all the fields. We can then conclude that some efforts are made to make health care available.

Table 6 : Some statistical figures

Different social target	Rate(2006)
Pop using improved drinking water	67%
Pop using adequate sanitation facilities in urban areas	59%
Pop using adequate sanitation facilities in rural areas	11%
One year children immunization against TB	99%
One Year children immunization against DPT	99%
One Year children immunization against Polio	93%
One Year children immunization against Polio3	93%
One Year children immunization against Measles	89%
One Year children immunization against Tetanus	83%

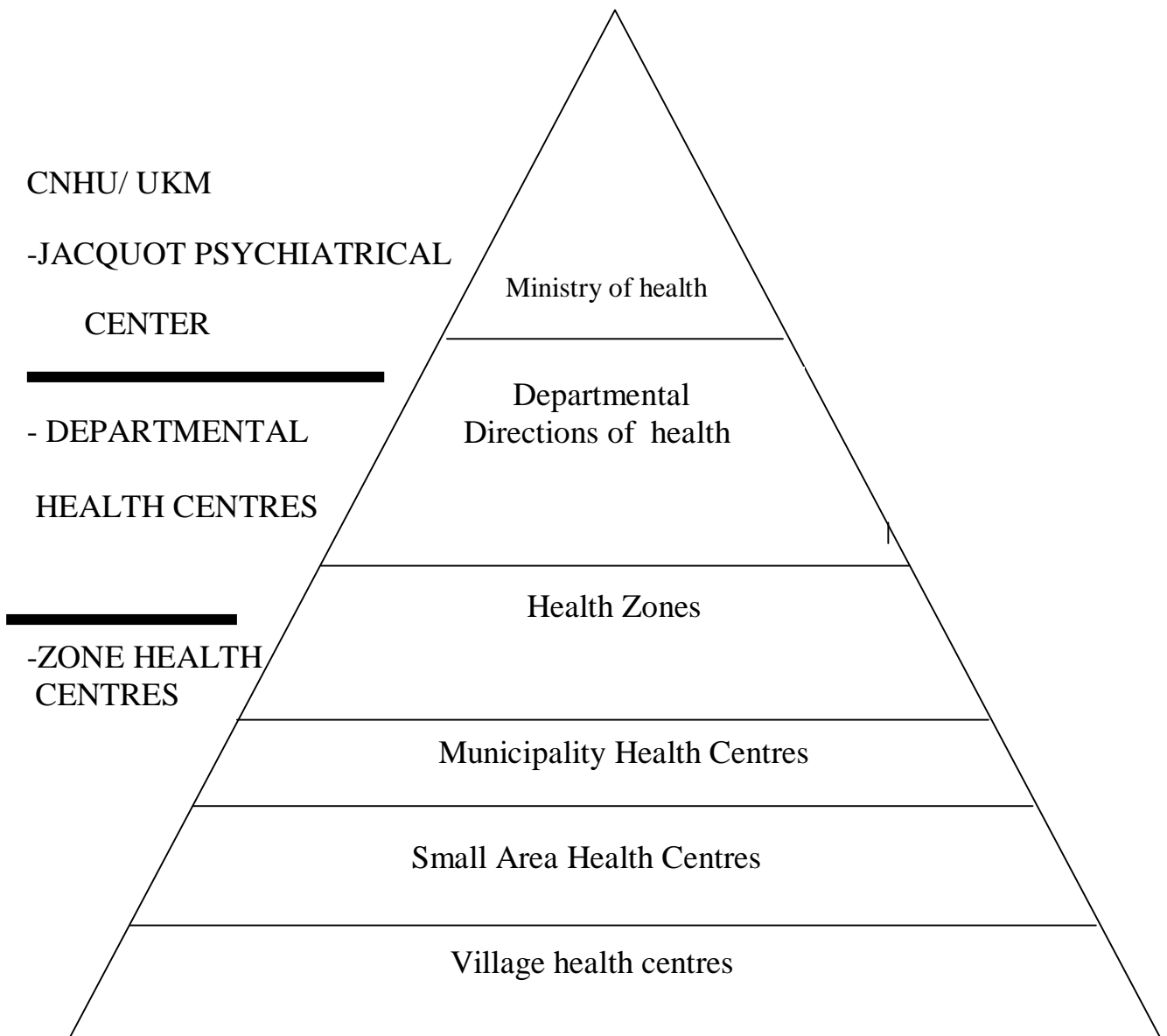
Source : UNICEF-BENIN 2006 Statistics

From this table, we can first notice that there is still 33% of the Beninese who doesn't have access to drinking water yet. We can secondly draw this conclusion: "Just the half of the urban population and only 11% of rural population has access to. As far as the children immunization against TB, DPT, POLIO, POLIO3, MEASLES, and TETANUS are concerned, Benin successive governments have made great effort and the rates are very high; but better can be done to reach 100%.

Benin's health structure is organised like a pyramid. See pyramid below.

From this presentation of the sanitation receptions in Benin, we can see that the national territory is entirely covered and patients mustn't get so much trouble to have access to health care. We then have the "Unité de village" which exist only in some areas nowadays, the "Centre de Santé d'Arrondissement" covering some villages in rural or urban area; the "Centre de Santé Communal" in each municipality; the "Hopital de Zone" which supervises about three municipalities; the "Centre Hospitalier Départemental" at a departmental level and finally the "Centre National Hospitalier" which is the reference and at the top position as far as health matters are concerned in Benin.

Benin' health structure is organised like a pyramid. See pyramid below.



Source : www.santébénin.bj

This diagram shows how Benin Health apparatus is organised.

Were this hierarchy respected, Benin health system would be more efficient. It is proved that patients never understand that and just walk in any hospital for many reasons. Some just go to the hospital which is the nearest to their house to be saved; some go where the fees are lower; some prefer where they are warmly welcome and quickly taken care of; others like being taken care of by a brother, a man of their community or simply a friend of them: they then

move to the hospital where he or she works. Sometimes then feeling just some headache, some patients who can be taken care of in small centres go to the National Health centre to see their relative working there and emergencies are neglected in favour of them.

Life expectancy is referred to as a statistical measure of the average length of survival of a human being. It is has been increasing in developed countries but lowering in the developing countries. It is a key indicator of Public Health State in a country. Is there better health care in a country, life expectancy is due to increase. Only some new reforms in the sector of health can save health matters and better them for the well being of all the Beninese and improve economy.

To solve some of the problems which we are nowadays confronted with in the Health sector in Benin, we can say that only political will is required because the political leaders can only make decisions and implement measures. But everybody can play a significant part in that process: the populations, the local authorities, the staff of health centres (midwives, doctors and all other governmental actors).

The populations, they must know that health comes before anything else in their life and take measures to prevent diseases. They shouldn't wait until they feel very weak and dying to run to hospital. They must take into account their care givers advice and not practice self-medication.

The local authorities, as to them, must be aware of the fact that they are the nearest responsible to the populations and must take care of them by involving themselves in the management of local Health Centres and the well being of the populations. Some municipalities which have some financial

income can give a help to the Health Centres which are really in need of public subsidies. NGO CBDIBA based in Bohicon has settled a system of insurance which has had a great success in some areas such as SETTO in the municipality of DJIDJA. In addition to the standard health cover provided by social security, some people contribute to complementary insurance schemes run by mutual benefit organisations. They reimburse some or all of the medical expenses that can help take other sick people in charge. Some populations also associate themselves and save money in order to come to the rescue of any member of the association in terms of medical expenses.

As far as health professionals are concerned they have the responsibility to back up the social security system by caring for the patients and see to their welfare. Only thus can the populations trust the system and become reliable stakeholders.

The central government has the paramount duty to make and vote laws that can provide the social security system a framework and make health care available to everyone. Even financially speaking, it can subsidise the health centres and provide them with the required equipment that can help the health givers suggest that the nurses working in the small central be provided with.

For life expectancy to really become a factor that can create and enhance sustainable development in Benin, some bold reforms need to be taken and implemented.

First of all, nowadays in our country there are some vital sectors which should no more be mixed with political affairs. It's high time the leaders released some sectors such as Public Health. Then there will be an independent national health structure of which staff will be elected among health

professionals to lead for a given period and can be changed. This can't replace the ministry of Health but rather the Ministry is the structure which will control their actions. The depoliticization of Health management is of paramount importance for the development of our country because as said earlier Health is the lever of any development matter.

Secondly, one striking remark made during our survey is that the attendance rate in our hospitals is still very low. One of the reasons is that, instead of being taken care of, patients are not well received, frightened and even abused by some health givers who prefer work in their private centres and some sometimes do not come to their work place.

Finally some hospital managers who are wrongly appointed fail in their mission because of a lack of experience not only in the medical field but also in management. Such situations are to a large extent likely to affect patients' health.

Nowadays it is easy to notice that a development process in any country depends on its citizens' ability to produce. Populations can work to produce wealth only if they are healthy. Consequently, no sick human being can produce wealth then there can be no development in a country of which citizens are sick.

A horizontal banner with a central rectangular box containing the word "CONCLUSION". The banner has a light gray background and a black outline. The central box is white with a black outline and contains the word "CONCLUSION" in a black, serif, all-caps font. The banner has a pointed left end and a pointed right end, resembling a ribbon or a decorative strip.

CONCLUSION

CONCLUSION

Playing the most important part in human beings' everyday life and being at the first stage in any country development process, health matters have been at the core of our study. Through this study of which objective is to show how health can contribute to a country' gradual growth which gets all the present needs and can be continued as long as possible, the British case has been chosen. During our researches we have come across many realities: in the UK, it is even before the Second World War that better well being for everyone was dreamt of.

“As early as 1940, Ernest Bevin, Labour Minister of labour, asked the liberal party member and Economist William BEVERIDGE to write a report. It was to be an assessment of existing schemes of social security and recommendations on the best ways of helping people on low or no income. It led to the famous Beveridge Report officially named the Report on Social progress through co-operation between the individual and the state”¹⁰.

The profound idea running through the report was that of the object of the government in war or peace is not the glory of its rulers or of races but the happiness of the common man. To achieve that dream, the birth of a state-run system of compulsory insurance: “a welfare state” was advocated. That is to say, a system of social security guaranteeing a minimum level of health and social services in which the government undertakes the chief responsibility for providing the basic social and economic security of its population. After the birth of the welfare state, in 1946, the National Health Service Act declared:

¹⁰ Pickard, Sarah, British Civilisation, CPI, 2007, PP.208

“Everybody, irrespective of means, age, sex, or occupation shall have equal opportunity to benefit from the best and the most up-to-date medical allied service available”¹¹. The Act led then to the creation of a National Health Service which provided universally and fully comprehensive medical care “free to all who want to use it”. This has had many positive impacts on British citizens.

Nowadays, the Kingdom is a member of the G8, an economical power, a nuclear one and the second largest European economy. These achievements have been possible because of the early value which has been attached to health issues by successive political leaders. The public health data and the censuses results that are published in the document easily show the impacts that better healthcare have had in the UK development.

Even though nowadays, the British system cannot be said to be the most powerful health system worldwide, it can be an example for the developing countries which can draw something to solve healthcare issues which are acute in these countries. When we have a look at some figures in those countries we notice that life expectancy is very low and economical development indicators are very low.

Through the last part of this research work which focusses on public health in our country, we have some statistics. These public health figures are unsatisfactory. When they are compared to some years later figures, we can notice a clear improvement. It means then that Benin’s successive governments haven’t taken health issues for granted. It shows that a minimum has been done as far as healthcare is concerned but we still have to do something to always better it. Here, not only political leaders but all Beninese have to think for public

¹¹ The National Health Service Act Report, 1946

health promotion which is the one of the first condition for a country's development.

We then think that the responsibility is to be shared: the central government, the local authorities, health professionals, and populations everyone has to play its part. Are this work's recommendations implemented something can change in Benin Health apparatus.



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