

This assignment provides a brief outline of the history surrounding the healthcare service and seeks to demonstrate a timeline of events that occur within the system. Primarily, this assignment will discuss the creation and continuation of the National Health Service in England and Wales. In addition, this assignment will also discuss the paradigms of healthcare used over the many years and explore the issues faced in most recent years by the lesbian, gay, bisexual and transsexual community (LGBT), providing an overview of the policies in place to protect their characteristics. Furthermore, this assignment will discuss the projection of the future population within Carmarthenshire and on a larger scale, the United Kingdom, looking to the future and seek to identify the implications this will bring to the healthcare system. The effects of the imminent Brexit deal on staff from the European Union in healthcare will also be explored.

The history of hospitals and healthcare can be dated as far back as 1066 following the Norman conquest (The Health Foundation, 2018). Following the refusal of the Pope to grant Henry VIII a divorce to his wife, Catherine of Aragon. The Act of Supremacy came into force in 1534 and therefore, Henry VIII took it upon himself to destroy the monastic system through reformation (The Health Foundation, 2018). This resulted in the closure of many hospitals, leper houses and Almshouses which had been developed around religious institutions (The Health Foundation, 2018). A decade later, the King refounded St Bartholomew's hospital and within a couple of years the hospital was given to the city of London. However, although gifted to the city, insufficient funds meant that the hospital remained closed and citizens of London were left to raise the monies which would allow them to re-open the hospitals (The Health Foundation, 2018). By 1552, further hospitals opened, including Christ Hospital which was occupied by orphans, lepers, the aged, blind and lame. St Thomas and Bartholomew's occupants were wounded soldiers and those bearing grievous diseases. Bridwell became an institution for the undeserving poor, which eventually became a combined prison, workhouse and hospital (Rivett, 1986). Whilst the hospitals were self-sufficient in their income, they had no desire to appeal to the public for any further investment and became known as 'endowed' hospitals (Rivett, 1986).

It was not until the eighteenth century that interest in founding hospitals became increasingly common. In 1815, the Apothecaries Act was passed in Parliament for the United Kingdom (Rivin, 1977). This Act became the foundation of regulation of the medical profession in Great Britain and introduced compulsory apprenticeship and formal qualifications, which required apothecaries, now known as general practitioners, to undertake a five-year apprenticeship (Rivin, 1977). Later, in 1832, the British Medical Association (BMA) was founded by Sir Charles Hastings (British Medical Association, 2018).

Jewson, (*cited in*, Haralambos and Holborn, 2008) suggests that, modern medicine has evolved through three stages prior to its present biological model. Firstly, he describes the first stage as ‘bedside medicine’, which continued from the middle ages into the eighteenth century. He describes this procedure as, the doctor conversing with the patient in order to identify their ailments and symptoms, thus allowing the doctor to make a prognosis which would then allow him to treat the patient and therefore seek to cure. In using this method, the doctor was able to make a diagnosis based on the information relayed by the patient. The second stage Jewson, (*cited in* Haralambos and Holborn, 2008) describes as, ‘hospital medicine’. In this stage, which he identified in the nineteenth century, he explains how following the knowledge of the professionally trained doctor who has made a diagnosis on the patient upon questioning and knowledge received of the symptoms, the patient then enters hospital. The treatment provided to the patient is based on symptoms and the doctor’s training associated with the symptoms rather than the patient’s voiced opinions (Haralambos and Holborn, 2008). The third stage, Jewson, (*cited in* Haralambos and Holborn, 2008) reported, ‘laboratory medicine’, a method by which the doctor carries out tests which are scientifically analysed by technicians and machines. The results of which would identify if the body functioning was recorded as normal or abnormal. This method disregards both the doctor’s and patient’s view, and treatment would be based on the test results (Jewson, *cited in*, Haralambos and Holborn, 2008).

Dogar, (2007) suggest that the biomedical model of medicine has been around since the mid-19th century and is the principal model used by doctors in diagnosing diseases. According to the biomedical model, health constitutes the freedom from disease, pain, or imperfection, resulting in the normal human condition as healthy. The model's focus on

the physical processes does not take into consideration the role of social factors such as environmental, or individual subjectivity. Unlike the biopsychosocial model, the biomedical model does not consider diagnosis which affects treatment of the patient (Dogar, 2007). Haralambos and Holborn, (2008) believe that sociologists take the view that health and illness are social paradigms as well as medical paradigms. Haralambos and Holborn, (2008) explain that the biological model of health and illness is seen as real, and that the medical/ biological model largely determines the format in which health services are delivered, further suggesting that, the only way to understand health and illness is to be placed within social, political and historical circumstances.

Through many restructures and reforms, and following the second world war, under the guidance of William Beveridge who identified five major social problems and believed that ‘the population of the United Kingdom should be protected from the cradle to the grave’(Sir William Beveridge Foundation, 2018) and the ideology of the Minister of Health, Aneurin Bevan, who argued that ‘Healthcare should be available to all, regardless of wealth’, (NHS choices, 2010) The National Health Service (NHS) was introduced in 1948 under the Labour Government, with Clement Attle at the fore (NHS, n.d). This was to be financed purely by taxation from people’s pay which was taxed according to their means (NHS choices, 2010). Whilst NHS Wales was originally formed under the same NHS structure, powers and responsibility for NHS Wales, supported by the Welsh Office, was taken over by the secretary of state in 1969 and later devolved to the Nation Assembly for Wales in 1999 (NHS, n.d).

Throughout history the health services have seen many developments, one of which being the declaration of Alma-Ata in September 1978. This declaration expressed the need for urgent action to be taken by all Governments along with Health and development workers globally, in order to protect and promote the health of all the people of the world. One of the goals was to afford people the right and duty to participate individually and collectively in the planning and implementation of their health care (World Health Organisation, 1978). In January 1989, under the ruling of Prime Minister Margaret Thatcher, the British Government published the White Paper *Working for patients*. The Paper proposed some of the most significant reforms in the history of the National Health Service (DOH, 1989). One of the main objectives of the paper was to deliver improved healthcare along with

greater choices of care for the patient. This allowed the general practitioners and local hospitals the responsibility to respond to patients' care locally (DOH, 1989).

With continuous efforts to improve healthcare and reduce inequities, the National Health Service introduced '*Patient choice*' into England, with an aim to allow patients the freedom of choice and enable them to choose their General Practitioner practice, the choice of which hospital they wished to attend, services available in the community and maternity services, amongst other choices (Gov.uk, 2016). The National Health Service constitution advised that, 'The patient will be at the heart of everything the NHS does' (National Health Service, 2015). In addition, they claim the NHS to be;

Fair to all of us and personal to each of us by offering *everyone* the same access to, and the power to choose from, a wide range of services of high quality, based on clinical need, not the ability to pay (DOH, 2004).

The National Health Service, (2015) further states that, services should be coordinated and delivered to the patients' needs according to their preferences and the support available to them from family members and carers. In addition, the framework of the constitution report that, the service is committed to working jointly with other local authority services, including the public, private and voluntary sector organisations in order to deliver improvements in health and well-being. However, decisions made were to be taken by each local authority (NHS, 2015).

Nevertheless, not all services are available outside of the local area by choice, and not all persons are able to exercise their legal rights. For example, services available for prisoners on temporary release from prison, serving members of the Armed Forces, or persons detained in a secure hospital setting or detained under the Mental Health Act 1983, would depend on what services were put in place locally (Gov.uk, 2016). In contradiction, The Equality Act (2010), states that public bodies, including local authorities, hospital trusts and police authorities have a duty, known as 'The Public Sector Equality Duty' to prevent discrimination, promote equality of opportunity and adopt good relations whilst working diversely amongst the public (Gov.uk, 2015). Likewise, the Act also has a duty to protect the lesbian, gay, bisexual and transgender (LGBT) community in taking positive steps in

preventing and responding to discrimination and poor treatment. Furthermore medically, GPs cannot refuse to treat a patient because of their gender identity and therefore, they must be assessed fairly for the treatments they require (Stonewall, 2017). *The Human Rights Act 1998* further states that public authorities must follow human rights law which underpins (LGBT) equality.

An article published by ‘The Independent’ newspaper in 2015 state that, ‘The National Health Service is failing transgender people and is not treating them equally with other patients’ (The Independent, 2015). The report further states the comments made by Dr John Dean, chair for NHS England committee on gender identity services, in saying that, Clinicians receive very little training in dealing with gender identities and development and recommend that the General Medical Council make awareness of trans issues a “fundamental part of medical training” (The Independent, 2015).

Office for National statistics (ONS), (2018), claim that, in recent years there has been a decrease in fertility, with women bearing fewer children later in life than previous years (ONS, 2018). It could be argued that the reason people are having less children may be due to several factors such as, increased female participation in higher education and the labour force, the rising importance of a career, the growing costs of raising children, uncertainty of the labour market and housing factors (ONS, 2018). A further possible reason could also be that, most recently the Government withdrawing the payment of child benefit for families consisting of more than two children unless under special circumstances. For example, a child or children born by multiple birth, adoption, children living with friend or family carers and children who are likely to have been conceived as a result of a non-consensual sexual act including rape or through coercive behaviour by the other biological parent (Gov.uk, 2018).

Whilst there are approximately 185,100 people currently living in Carmarthenshire, with the over 40’s age group accounting for 56 per cent and 23 per cent over 65’s, it is projected that by 2021, the population will be primarily in the over 65’s age category (Carmarthenshire Well-Being Assessment, 2017). With the increasing population and people living longer, statistics and projections produced by the Office for National Statistics (ONS) reveal that, in fifty years’ time, the population will see an increase of over

8.6 million in the UK in the over 65's age category (Office for National Statistics, 2018). Government office for Science, (2016) forecast that the ageing population will bring with it certain implications. With the increasing ageing population and decreasing birth rates, the need for care and support for the ageing will foresee a substantial increase, however, the UK will have proportionately less people to provide it. The projection figures reveal that the amount of people needing care between 2007-2032 for over 65's will increase by over one million (Government office for Science, 2016). Furthermore, the report suggests that, population ageing will result in a greater prevalence of age-related conditions and will therefor place further pressure on health and care systems to adapt in order to meet the changing demands. They suggest that new and emerging technologies have the potential to change care in the home and community (Government office for Science, 2016).

On considering the facts that people are living longer, healthier lives, in the detailed study of morality rates in England and Wales from the early nineteenth century, McKeown, (1979) argued that improvement in health was essentially due to the improved provision of food, resulting in nutritional improvement and development in hygiene which has accounted for around one-fifth of the decline in death rates from the mid nineteenth century (McKeown, 1979). This would support part of Maslow's requirements in his theory of needs, which he suggested to be fundamental in order to survive, the first being, 'physiological needs', which he considers to be basic needs including, breathing, water, food, warmth, sleep and rest, Secondly, 'safety needs,' which he includes, security of body and health (Maslow, 1943). And also Beveridge's 'giants of evils', which he believed prevented people from improving themselves, are what he describes as, firstly, 'want', caused by poverty, secondly, 'ignorance' caused by lack of education, thirdly, 'squalor', caused by poor housing, next in his report, he describes, 'idleness' caused by lack of jobs or the lack of ability to gain employment and lastly, 'disease' caused by inadequate health care provision (National archives, 2015).

In the continuing efforts to improve health care in both England and Wales, The *Health and Social Care Act 2012* was introduced in England, it provided the most extensive reorganisation of the structure of the National Health Service in England since its creation in 1948, in addition, it removed responsibility for the health of citizens from the Secretary of State for Health (Health and Social Care Act, (2012). In addition to this, 2014 saw the

introduction of The *Social Services and Well-being (Wales) Act 2014* by the National Assembly for Wales, this Act allowed Wales to reform Social Services Law which provided a legal framework to allow the provision to improve wellbeing outcomes for people needing care and support. The Act also gave rights for carers who may need support which had not been addressed previously and introduced a new legal framework for safeguarding vulnerable adults (*Social Services and Well-being (Wales) Act 2014*).

In a speech delivered by Rt Hon, Damian Green at the Reform's conference on welfare, Green, (2016) argued that 'Welfare is the work of every political party that has held office', both on the left and right and belongs to no political party alone. He further argued that, in history, there has been no single party that has created the current welfare system, nor will it ever reach a point that no further reform will be needed (Green, 2016). It could be argued that Aneurhan Bevan and William Beveridge were the main contributors to the development of the Health Service.

Hervey et al., (2018). suggest that the current debate the United Kingdom are facing on leaving the European Union (Brexit) has raised concerns within Health and Care services. They further state that due to the Governments' failure to provide security to European Union nationals, figures in 2017 revealed that registrations of nurses in the Royal College of Nursing in England has already been faced with a 92 percent decrease. Prior to the election in 2017, the Government promised to ensure and prioritise staff within EU countries to continue making their vital contribution to the Health and Care system during Brexit negotiations (Hervey, et al, 2018). However, information on the Joint Report on progress, article 50 on the United Kingdom's orderly withdrawal from the European Union, negotiated between negotiators of the European Union and the United Kingdom Government revealed that, protection would only be provided for those already employed and did not extend to future employees (Europa, 2017). Hervey, et al., (2017) further express that 'There is clearly a trade-off between patient safety as served by restrictions on healthcare professions and patient safety as served by having a workforce sufficient to meet the country's needs.'

Therefore, it can be concluded that although the Government are working in partnership with the various sectors with the aim to improve and advance the healthcare service, there will always be a need for continuous improvement and development. This is in agreement with the Rt Hon Damian Green, who stated that ‘the welfare system will never reach a point that no further reform will be needed’. Additionally, evolution in medicine and the increasing population will always need modernising and restructuring in order to keep up with society’s needs. At this present time, the negotiations being made around Brexit leaves a state of uncertainty for the future of the United Kingdom’s healthcare services. There is speculation on the possible limitations with regards to the levels of staff and healthcare professionals within the services as restrictions will be placed on working outside of the EU. Furthermore, with fertility rates decreasing and the ageing population progressively increasing, this also leaves a gap in the level of care that will be available to the older generations.

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