HEALTH CARE AND THE STATE:
Britain and the United States

Andrew M. Kirby

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Introduction

This paper is an attempt to contrast two distinct traditions in the analysis of medicine. The first places its emphasis upon the organisation of health-care at the national scale; the second focuses more firmly upon the distribution of resources at the local scale.

In the first category can be found several distinct strands of emphasis. Alford, for example, has discussed in the American context the role of health institutions in the shaping of national policy (1975). Illich, in a more populist vein, has aimed his invective at the medical profession, in an attempt to argue that the latter's members are in fact counter-productive in the attempt to reduce levels of mortality and morbidity within advanced societies (1975). A more recent perspective has been pioneered by Navarro, who harnesses materialist state theory to the provision of medicine; more will be said of this perspective below (e.g. Navarro, 1976b).

This type of literature is in contrast to the localised focus of much health-care debate. Many studies of local funding, state-local jurisdictional financial transfers, the organisation of provision and the geographical distribution of particular facilities have little to say regarding the nature or role of medicine within society, but far more to contribute concerning the relationship between health-care and individual health histories or futures (Shannon and Dever, 1974; Pyle, 1979).

In the next section, an attempt is made to sketch the organisation of health-care in both the USA and the UK, in order to begin to reconcile these two distinct strands of medical and more general social science literature.

Health and health-care in the USA and UK

It would be possible to caricature the health economies of the USA and the UK as private and public respectively. As Figures 1 and 2 indicate however, this would be only partially correct. As Alford has argued, the increasing technology residing within American medical practice, and the tendency for demand to fall in step with the resultingly higher price of care, produced in the 1960s a political climate within which the state subsidy of health provision was possible. The introduction of Medicare and Medicaid, plus a long series of organisations and items of legislation, has clearly increased the use made of professional services by the poor, but has in no way reduced medical expenditure (Rice and Wilson, 1976). We thus find that the American case is now represented by a mixed health economy (Figure 3), in which the public input is expected to carry on growing (Figure 4: Mitchell, 1981). The corollary is the case in Britain. In the recent past, the structure of health provision has been virtually exclusively via state organisations (Figure 5). However, private health, financed via individual medical insurance, is growing rapidly. The most recent data for 1977 indicate that in excess of 2 million persons are so insured, and that approximately $250m. was being spent annually on care and treatment (Lee, 1978, pp.7-9). Although this total represented only some 2% of total state expenditure on health, this should not be taken as an indication of the unimportance of private medicine. In one sense, the data

on costs and expenditure are not strictly comparable, as the private sector does not have to bear the costs of training its staff, most of whom receive qualifications overseas or at the expense of the state. Similarly, much high-cost equipment is bought by the state services, but used relatively cheaply by private practitioners. Finally, there is evidence that recent trends have been towards a major upturn in private insurance registration, whilst the use of private abortion facilities is still on the increase.

Medicine and the state in capitalist societies: ideology

Our ability to characterise these tendencies -- which have been portrayed here as converging -- depends clearly enough upon our theoretical perspective. As already argued, many interpretations focus upon the medical profession itself, with the results that both the nature of medicine and the role of the state (which is spending extremely heavily upon the latter) tend to become lost (see for example Weller, 1977).

This problem is partially solved by Navarro, who inverts the focus of interest, so that the differences between public and private health-care are played down (Navarro, 1976; 1977b). He achieves this by directly considering the role of medicine within capitalist societies. Using O'Connor's typology of social expenditure, social consumption and social expenses, or Navarro's own trichotomy of the infrastructure of production, the defense of the capitalist system, and control against internal and external threats (Navarro, 1976, pp.268-269; O'Connor, 1973), we can identify an important role for medicine

In other words, it has always been in the state's interests for the medical profession to promote a mechanistic view of health, in which the

onus of day-to-day living is placed upon the individual, and the responsibility for aberrant symptoms is borne by the physician. This Flexnerian perspective (Navarro, 1976, p.277), is of course at odds with much that we know about the etiology of disease, which is generally environmental in its creation (Giggs, 1979). However, it is also equally obvious that a perspective upon health that focussed upon structural problems would both undermine the role of medical professionals and the economic system that either directly (via the negative externalities of production) or indirectly (via the failure of urban and regional planning) produces such etiologies. It is therefore not against the state's interests to support the medical profession if "the cause of the problem is perceived as individual and the nature of intervention is individually oriented" (Navarro, 1976, p.278). As a consequence, medical expenditure has a key ideological role:

> from the point of view of the capitalist system, this is the actual utility of medicine: it contributes to the legitimation of capitalism.
>
> (Navarro, 1976, p.279)

Of importance too with such a perspective is that it negates the distinction between public and private health economies:

> the ideological influence of the state far transcends what we usually refer to as the public sector. And medicine is very much a part of it, regardless of whether those medical institutions are, largely speaking, private or public.
>
> (Navarro, 1976, p.283)

Navarro's interpretation is valuable therefore insofar as it encourages us not to become mesmerised by the public/private health distinction. This notwithstanding, it would be unsatisfactory if we did not attempt to account for the different historical paths that have been taken by the UK and the USA with regard to health-care.

Medicine and the state: reproduction and accumulation

Although health-care is most easily categorised as an aspect of consumption -- part of the social wage -- it would be negligent to overlook the fact that provision is also part of the accumulation process within capitalism; in other words medicine is not simply a service, but also a commodity. That said, it becomes less surprising that private medicine should be increasing within the United Kingdom; simply, it exists as a profitable alternative to the public arena in a sector of financial stringency. Indeed, it is probably more sensible to ask why it is that the British medical economy has been so slow to follow the American model, which has long had a tradition of large financial returns (see Klein:1981 for a sarcastic evaluation).

Any discussion of the British case must of course confront the existence of the National Health Service, which has assumed shibboleth status in the annals of British political history (Navarro, 1978). What is clear however is that the NHS was not a major concession wrung from the state by working class action. Not surprisingly, in an era of deep unemployment, trade union activity between the wars focussed primarily upon issues in the factory, not the home: production and not consumption. Most importantly, the real beneficiaries of the NHS proved to be the middle

classes, who had not enjoyed free hospital and practitioner care previously. The innovation stimulated by the NHS, namely the emergence of general practitioners as the key to primary care (rather than hospitals and clinics), has ever since been exploited far more widely by middle-income groups (Walters, 1980).

A more fundamental point lies beneath these interpretations. Apologists for the NHS imply that the arrival of a publicly-provided health-care service can be equated with the arrival of good health for all. This is of course over optimism. As Harvey observes:

> a national health-care system which defines ill-health as inability to go to work (to produce surplus value), is very different indeed from one dedicated to the total mental and physical well-being of the individual in a given physical and social context.
>
> (Harvey, 1981, p.116)

In other words, medicine is also a key part of the reproduction of labour. Although Navarro, as we have seen, emphasises the ideological factor, it is self-evident that health-care is important in the maintenance of certain health standards, both public and private. This then becomes the key to the interpretation of the creation of the NHS immediately after the Second World War. Although it is possible to promote spurious claims concerning organisational goals ("efficiency was emphasised above all else": Walters, 1980, p.106), it is clear that the standard of adult health during the war had -- once again -- taken the Government by surprise. There exists a direct parallel between the introduction of public housing in 1919 and the introduction of public health provision -- the NHS -- in 1946. As

Burnett has chronicled, the deplorable standard of army recruits during the First World War was a particularly important strand in the justification of state housing provision, as one way of improving living standards and thus wellbeing (Burnett, 1978). Similarly, the recurrent problem in the Second World War had indicated that more direct steps were required to ensure suitably fit men and women in the troubled era ahead should another war become a reality: as a Minister of Health stated in 1944, the NHS was "a plan to raise national health to a higher plane" (quoted in Walters, 1980, p.105).

This interpretation does of course conflict with the more usual argument -- such as that provided by Navarro -- which emphasises the importance of class struggle at a national level to the achievement of working class gains:

> the level of militancy of the working class and the far-reaching demands put forth by Labour clearly represented once again a threat to the British establishment and its political arms, the Conservative and Liberal parties.
>
> (Navarro, 1978, pp.28-29)

Navarro's argument is unsubstantiated; as he himself however goes on to demonstrate, whilst the question of the success of labour's demands remains speculative, it is clear that the British Medical Association was keen to restructure the state support of medical finances, because economic circumstances were reducing profitability within the profession. It is interesting that both the BMA and the AMA (with it ; support for the Blue Shield package) were moving in similar directions. If this facet of

analysis is added, it thus becomes possible to see state intervention in order to maintain profitability levels, or to maintain standards of labour reproduction. Either or both of these elements is thus more convincing than the assertion that working-class struggles alone have obtained health provision as part of the social wage (a point to which I return below).

To bring this section to some conclusion, two inferences will be made. The first is that some understanding of the state is vital to an interpretation of health-care. Discussion here has focussed upon ideological issues, and the role of public provision in both the accumulation process and the reproduction of the labour force. In this, I follow Navarro:

> if we are to understand the nature, composition, distribution and function of the medical care sector in Western developed capitalist societies, we must first understand the distribution of power in those societies, and the nature, role and instrumentality of the state.
>
> (Navarro, 1976, pp511-2).

The second inference is less clear-cut, and returns us to the theme of this paper, ie. does one analyse medical provision solely from the top down, or also from the bottom up? I reintroduce this question here because it is clear that as one focusses upon reproduction (rather than, say, accumulation or ideological issues), then the emphasis shifts from the state -- the national scale -- to the local state: the point of reproduction.

Health-care at the local scale

It is no exaggeration to state that the debates concerning the issues of health and health-care at the national scale tend to focus upon morbidity and mortality data, disaggregated by socio-economic type (typically in the UK) or by race (more typically in the US). It is an accepted -- and recurrent -- finding that low-income groups (and hence racial minorities) have higher rates of illness and lower life expectancies; these findings need not be rehearsed here (Walters, 1980).

Counterintuitively however, there is also evidence that the national level of health-care expenditure does relatively little to diminish these differentials. Despite the fact that, for example, medical expenditure in Britain has increased dramatically between the First World War and the present, the mortality rates of the different socio-economic groups remain noticeably differentiated; indeed for the lowest income groups, the differentials have actually widened (Walters, 1980, p.121).

The thrust of these statistics is clear; health-care expenditure in total is not a redistributive agent ie. the gift of good health extended over a longer lifetime is not passed down to those who need it most. Indeed, there is evidence that, overall, increased levels of spending have limited marginal utility. A study of 18 developed countries has for example noted that quite large variations in expenditure (as a proportion of the GNP: from 4.7% to 7.1%), are not reflected in positive outcomes in terms of infant or adult health. The authors argue that "the overall conclusion. . . is that health service factors are relatively unimportant in explaining the differences in mortality between our 18 developed countries" (Cochrane et al., 1978).

One major determinant of persistent inequalities between groups is the very fact that overall levels of expenditure are addressed, when it is the sub-national distribution of funds that is of importance. In advanced societies like the USA and the UK, socio-economic groups have fairly predictable spatial distributions: at the regional scale, between metropolitan and non-metropolitan areas, within urban areas. In consequence, inequitable spatial distributions of health expenditure will produce equally inequitable outcomes for identifiable social groups; (it will also result in inequitable outcomes for identifiable spatial groups, a point to which I will return below).

This issue has been most directly addressed in the British context, due to the way in which the financial organisation of the National Health Service focusses attention explicitly upon the different geographical units (see Figure 5). During the early 1970s, major financial discrepancies emerged between the largest units of organisation, the Regional Health Authorities; indeed, the rate of expenditure varied per capita by a factor of approximately two (Kirby, 1982). Moreover, there is superficial evidence that the RHAs with the highest rates of expenditure were also the ones with, in the main, the most favourable SMRs: i.e. the lowest standardised mortality ratios corrected for the age and sex balance within the area. As Table 1 indicates, the range of SMRs between regions is on the whole as large as the range between socio-economic categories.

Interestingly, these relationships have now become officially linked, as a result of the work of the Resource Allocation Working Party (1976). As a means of 'rationally' distributing scarce financial resources, SMRs are used as a target against which to direct funds; it is also intended that

the allocations within individual Regional Health Authorities will take place a similar basis, despite the extreme unreliability of the data (Palmer and West, 1980).

As can be expected, the variations in both financial provision and SMRs at small spatial scales are large. Vetter et al. have examined both inputs and outcomes for counties in Wales, and these data are reproduced in Table 2. (Given the essentially low economic status of the country, the range of variation is not as large as if a wider range of counties had been chosen; nor unfortunately does the restricted sample size permit statistical testing).

More interesting data, although they do not include financial inputs, are shown in Tables 3 and 4, which reveal SMRs and other indicators for a progression of spatial scales. Table 3 begins this process with a contrast of SMR data for the Merseyside Regional Health Authority (which receives approximately 5.6% of the national health allocation), and the Liverpool Area Health Authority. As may be expected, the extremes of the SMR data are to be found in Liverpool, which as a metropolitan centre possesses concentrations of deprivation (DOE GB, 1977). These are highlighted in Table 4, which shows variations about the city average for selected indicators; the data relate to a social area analysis undertaken by Scott-Samuel (Kirby and Scott-Samuel, 1981).

It has already been suggested that parts of this argument concerning class inequalities and medical care need little rehearsal, and this is also the case with inner area deprivation. In Table 4, column 1 highlights the concentrations of disease and medical need in Liverpool's inner city, a finding which is broadly replicated throughout cities in the developed

world (Paine, 1978). In the American case, inner urban health problems are discussed by Pyle (1979), and the paucity of health-care in such areas has been well documented; a recent study for example illustrates the way in which poor hospital standards in Washington D.C. have been responsible for high neo-natal mortality levels amongst the black population (Madans, 1981).

A framework for analysis

It should be clear from this illustrative material that any analysis of health and medicine must focus upon scales other than the national, if any understanding of particular life chances is of importance. Strangely however, there is little evidence -- in terms either of academic or community concerns -- of such a focus.

As a broad generalisation, the majority of social science studies of local health-care focus upon either the basics of provision, ot the attendant patterns of consumer use. Once more, this material is readily accessible, and need not be reevaluated at length here (for reviews, see Kirby, 1982; Knox, 1982).

In both the British and American cases, attention has been aimed at the variations in provision that exist at different spatial scales. These essentially descriptive studies document the concentrations of facilties in particular locations: such as hospitals in central cities; general practitioners on the fringes of British inner areas; or in high-status neighbourhoods, and the shortage of health-care in other contexts -- such as rural areas and public housing neighbourhoods. At the broader scale, major regional disparities are also evident, in step with economic performance.

In addition, the structuring of space has been examined, notably the ways in which catchment systems operate (see Dear, 1981; Knox, 1979; Shannon et al., 1979).

This research (which has also involved this author), may be faulted at various levels. The first is that it has been slow to demonstrate the importance of the patterns that it describes; ie. the relationships between health-care and health have not been made explicit, which leaves some of the work upon to charges of relative triviality. More importantly, little has yet been said about the underlying structures of health-care location. Accounts of geographical distributions have tended to focus upon descriptions; such as either central place theory or the ways in which indiviual perceptions (of perhaps general practitioners) produce a particular residential location decision.

What is clear is that these do not add up to an explanation of the structuring of space by health-care professionals. Underlying the latter's motivations is the commodification of health, which reduces all locations to potential sources of personal and corporate profit. Similarly absent is any mention of the ways in which local political demands shape and manipulate locational outcomes, in the manner that is normal in the contexts of other services such as education. The only studies which attempt a political economy of local health-care have focussed upon negative responses: exclusionary politics practised by communities which do not require particular facilities in the neighbourhood. Dear has articulated this with respect to mental illness and attendant facilities, (Dear, Taylor and Hall, 1980), and preliminary examinations in Britain suggest that these hypotheses may be equally valuable there (Jones and Kirby, 1982).

This paucity does not reflect however a glaring weakness of research per se. Rather, it constitutes a mirror image of the reality it seeks to understand. In other words, the inability to address health, in the way that other services have been subsumed into analyses of urban politics, represents the reality of health-care within the local state. Essentially, the preoccupation with the organisation of health at the national scale extends throughout the system. In the USA, the dramatic failings of medicine in particular neighbourhoods has been fought out over the funding of Medicare and Medicaid. In Britain, health has been taken out of the local government system in such a way that it is merely tangential to the latter; in consequence, the political links between the two systems are tenuous in the extreme (see Figure 5). Not only does this mean that direct political pressure upon health professionals is extremely difficult (with the result that the consumer (or group of consumers) is hard pressed to complain effectively about levels of provision or standards of care); it means moreover that localised shortages within the public sector, of services such as abortion (due to localised decisions against such a service) can only be reconciled in one of two ways: via national campaigns relating to women's rights, or the use of private facilities, which emerge to fill the demand.

In addition, one further point is to be stressed vis-a vis the British case. Although mention has been made of the predictable relationships that exist between social groups and spatial areas, it is important to note that the spatial organisation of care is essentially - in Sayer's phrase -- "a chaotic conception". The Regions, Districts and Areas employed within the NHS do not constitute 'meaningful' spatial units: note for example the way in which London's inner areas, with their distinctive health needs, are parcelled out amongst four quadrants of suburban areas (Paine, 1978). In

these contexts, concerted poltical responses to service shortages are not to be expected.

The American situation is necessarily different from the British case, although the same general remarks can be made about the political response. In the first instance, local shortages of supply have been resolved at a higher level, typically via the courts, and ultimately via the Supreme Court. Abortion legislation has been challenged, and the cases of Roe in Texas and Doe in Georgia have both succeeded in securing the right to abortion; this does not of course cover the availability of suitable medical facilities (Kemp et al., 1976).

This of course remains at the core of the American dilemma: why is it that local political struggles have been so ineffective in securing what one might regard as basic levels of medical provision? Recent accounts attempt to point to the achievements of innovations like the Regional Medical Program and Comprehensive Health Planning (set up as part of the Great Society initiative), and the Health Task Force, which was created by the National Urban Coalition (Silver, 1973; Mooney, 1977). In each case, it is clear however that energy has been directed into financial matters (which as we have noted stimulates demand but does not necessarily improve supply), and that initiatives have been handed down, not created in response to specific bouts of community activity:

> in sum the Urban Coalition undertook to give communities a voice in program design for health services, by setting up a power centre (the Health Task Force) and giving the poor and deprived an important role in its deliberations. The coalition then proceeded to to use the power of this community structure to

> influence existing health decision-making bodies . . . community action created health programs.
>
> (Silver, 1973, pp.128-129).

Moreover, it is worth noting that the health programs in question are token programs, depending in large measure upon voluntary inputs rather than federal or local funds. In short, neither the community action, nor the state response, is particularly significant.

The paucity of community response to health-care shortages (particularly in the US, where a greater tradition of neighbourhood activism is typical) must be explained and can be addressed in two ways. First, the weakness of response in working class communities is typical, and extends across fields of public provision from housing to transportation. An inability to access the political machine is usual (see Kirby, 1982, chapters 6, 7), although in this context it is also the case that working class neighbourhoods have traditionally attempted to solve their own health problems; the localised provision of unlicensed (and illegal) abortions has always been a common feature of British cities, whilst of course the use of 'patent medicines' has a long history on both sides of the Atlantic.

Second, the question of community attitudes to health-care in wealthier areas is to be explained in the context of a rather different interpretation of the relationship between health and provision. Historically, it has been the middle classes who have been responsible for the development of <u>public health</u> legislation, as a result of their recognition of the relationship existing between poor standards of social control (vis-a-vis housing density, refuse disposal, water quality) and levels of

both endemic and epidemic disease. Schwartz, for example, shows in great detail how middle class communities in the Eastern United States reacted to the threats of cholera and tuberculosis:

> the public health movement of the nineteenth and early twentieth centuries was one of the earliest expressions of the desire of the upper and middle classes to impose a rational structure dictated by business values and practices on what appeared to be an increasingly unruly and threatening society.
>
> (Schwartz, 1977, p.81)

This development, often fallaciously discussed as one aspect of the increased enlightenment of city governments at the end of the nineteenth century, was of course achieved at the expense of a great deal of social disruption (following the removal of tenements without their replacement by alternative accommodation); interestingly, it was also achieved in the teeth of fierce opposition by the medical 'profession' at that time, which resented the (correct) implication that its ability to deal with urban health problems was strictly limited. It is not surprising that the Flexnerian view of medical practice discussed above can be traced back directly to this period, when many physicians regarded epidemic disease as an indicator of moral failing on the patient's part, rather than a professional failing of their own.

In my view, this precedent of emphasising the origins of health problems -- rather than the need for health-care professionals to pick up the pieces -- can still be identified within middle class communities. The preparedness of the latter to contest stresssful externalities, like roads,

airports or nuclear power plants is well documented, and does of course reflect a great maturity of causal reasoning. Navarro is quite right to point out that human health problems are essentially the byproducts of capitalist organisation -- stress, pollution and contamination. He fails to follow his own inexorable logic however when he emphasises the need for "a change in the sex and class composition and the system of governance of the agencies in the health sector and its institutions" (Navarro, 1976b, p.176). What is of course necessary is the reorganisation of the problem, not the symptoms; in other words a radical alteration of attitudes to stress, industrial safety, drug consumption (particularly alcohol) and food production, rather than simply a rejigging of those responsible for caring for those already sick. In this sense, the emphasis upon public or community health indicates the way in which struggles over collective consumption should most usefully be directed; this in turn dictates also the most useful focus of academic attention.

Conclusions

In the Introduction, I argued for the need to reconcile two very different strands of research, which can be summarised as the 'top-down' and 'bottom-up' approaches. The argument presented here is that the former is vital for an understanding of the relationship between the state and the medical economy: in other words, medicine is part of the capitalist process vis-a-vis accumulation, reproduction and ideology. This notwithstanding however, it is also vital to examine the relationship between health and health-care within the context of the local state, for it is here that provision is organised, and inequalities engendered. Most importantly, it is at the local scale that individual life chances can be changed. The

experience of the different underclasses in both the UK and the USA is that battles over medicine are not won within the national political arena. Even a radical restructuring of the health profession and its institutions will not achieve any alteration in the general environment (in its widest sense), which is responsible for health problems. It is through the medium of public health that this can be done, and at the local scale that this must necessarily be attempted: in other words, the route to better health lies in the reorganisation and control of the environment via local political struggles.

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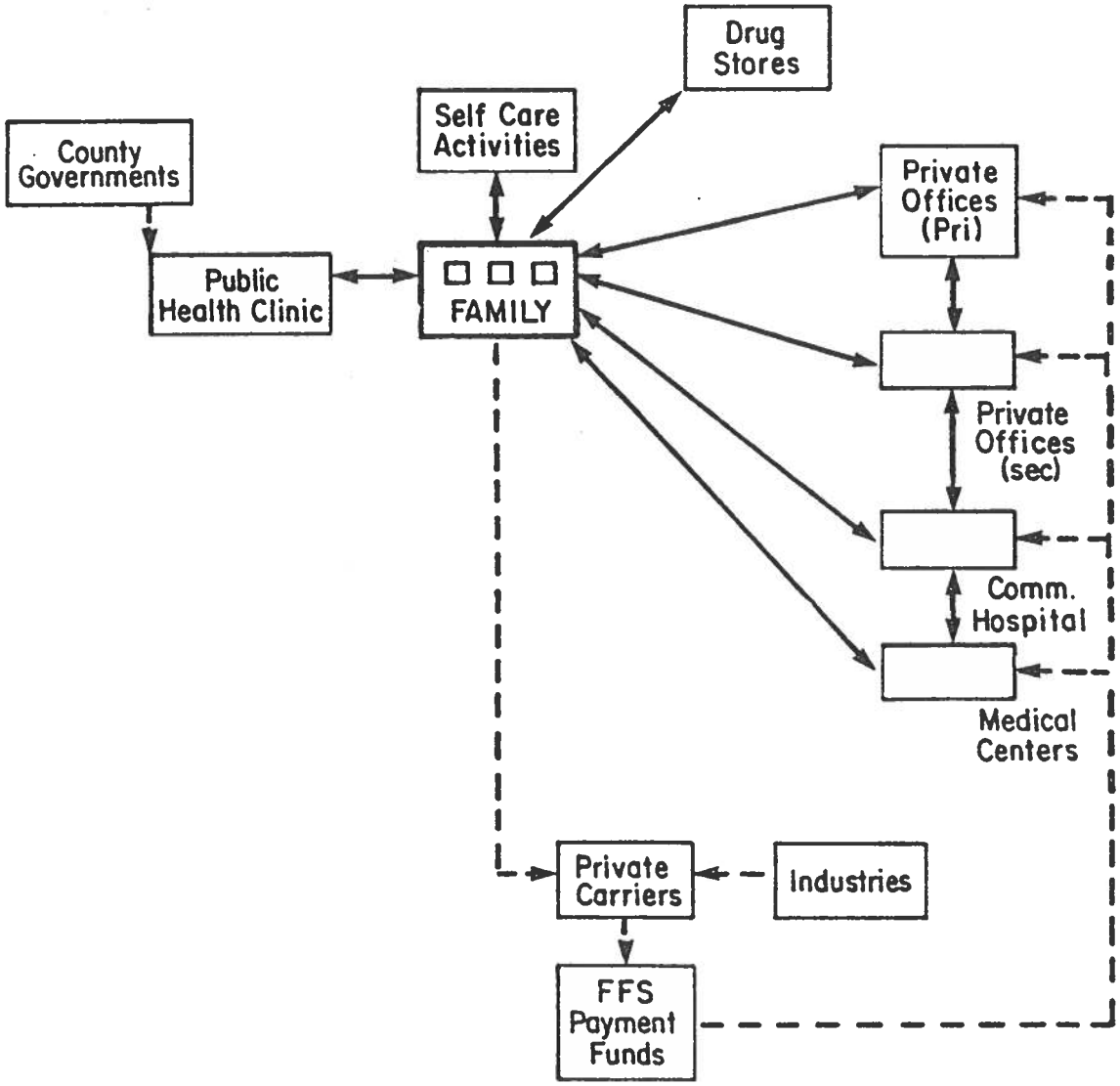
Figure 1.

U.S. HEALTH CARE SYSTEM (1935-65)

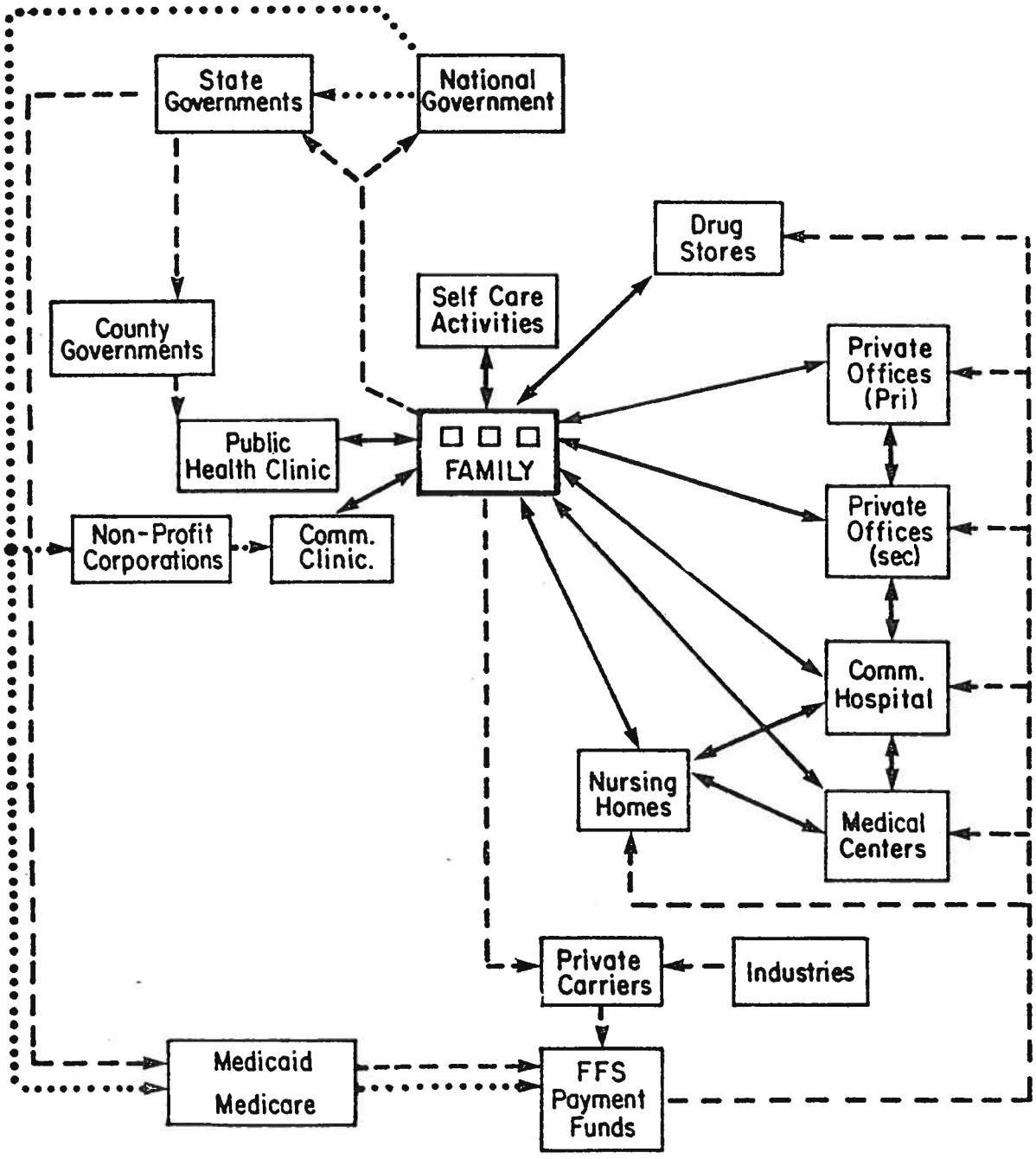


——— Patient and Payment Flow
------- Payment Flow

Source: Mitchell, 1981

Figure 2.

U.S. HEALTH CARE SYSTEM (1965-75)



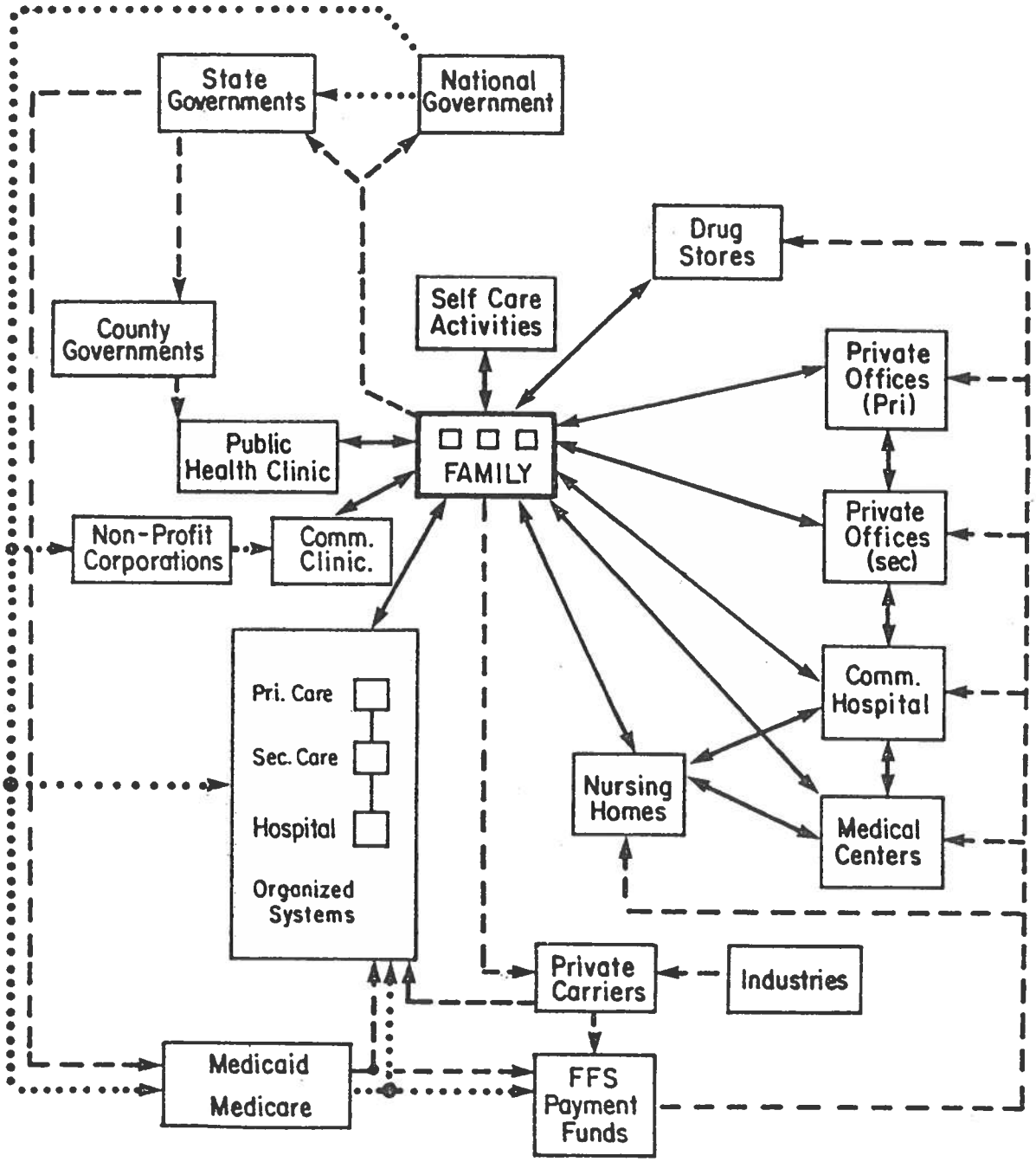
——— Patient and Payment Flow

----- Payment Flow

Source: Mitchell, 1981

Figure 3.

U.S. HEALTH CARE SYSTEM (1975-80)

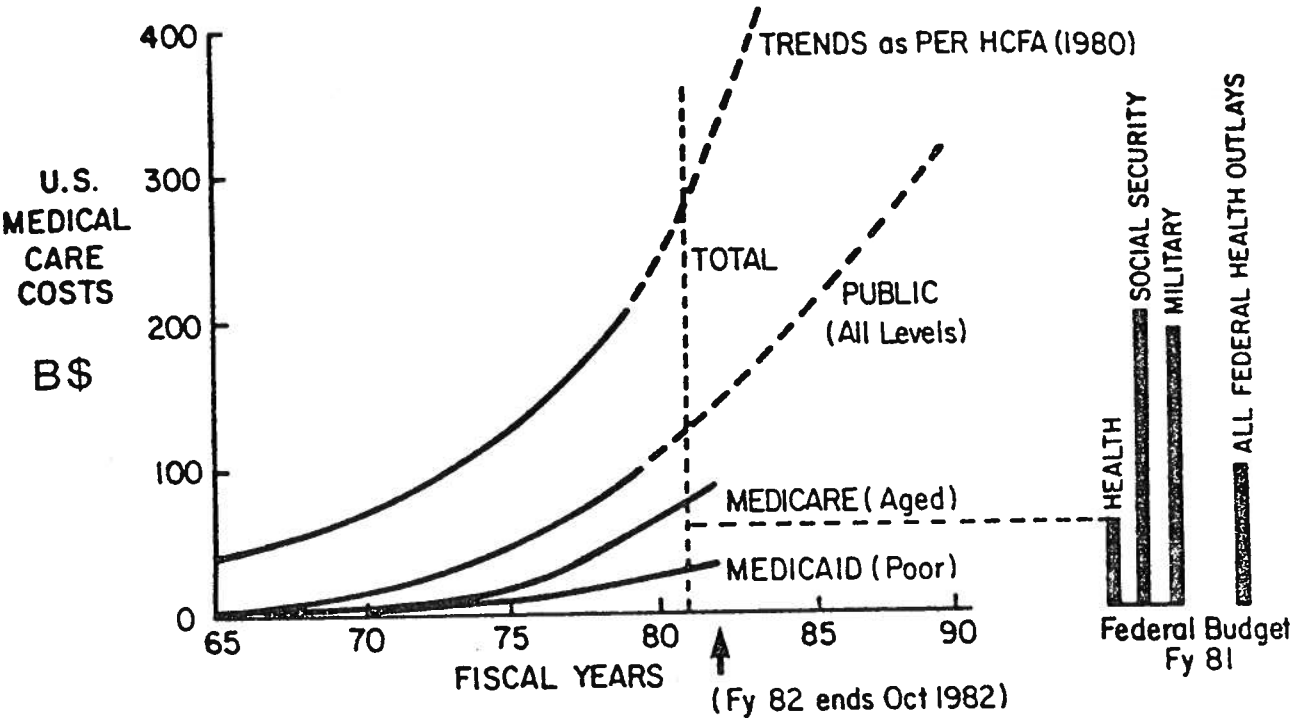


——— Patient and Payment Flow
------ Payment Flow

Source: Mitchell, 1981

Figure 4.

U.S. HEALTH CARE COSTS



Source: Mitchell, 1981

Figure 5.

THE REORGANISED HEALTH SERVICE

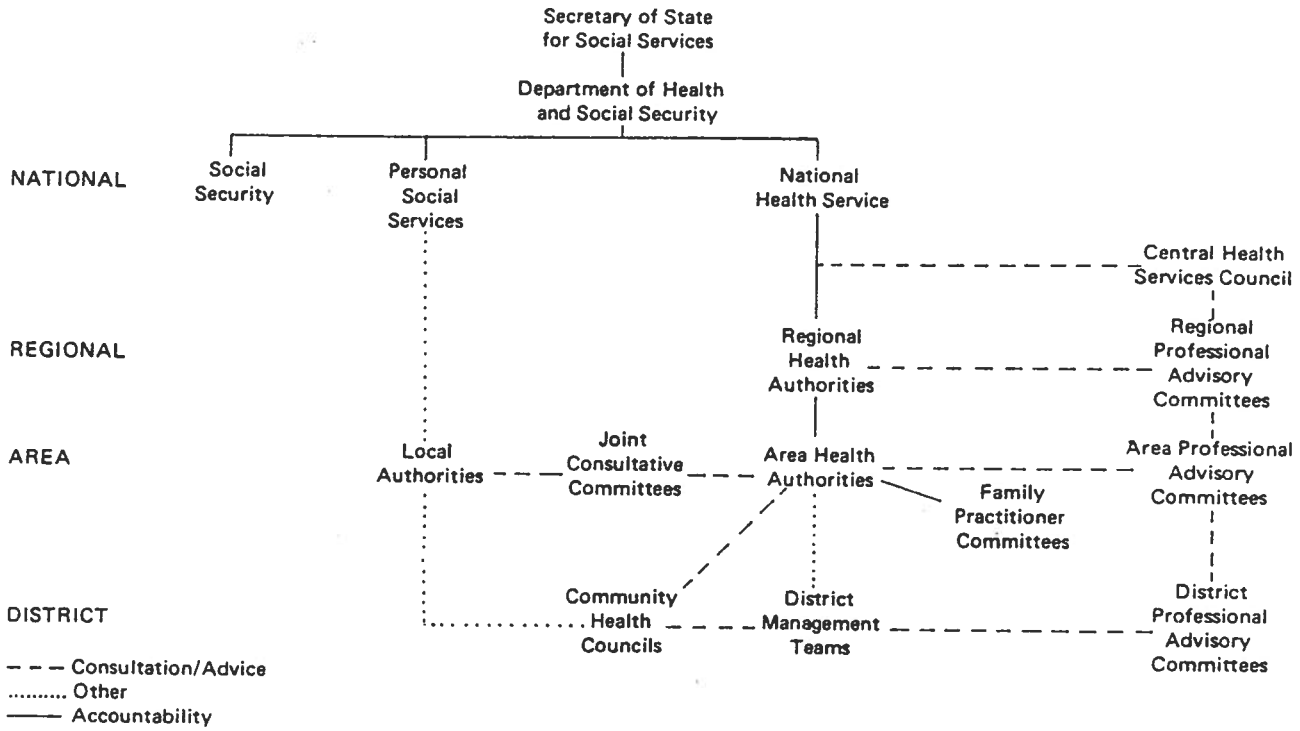


Table 1.

A COMPARISON OF STANDARDISED MORTALITY RATIOS
BY SOCIO-ECONOMIC GROUP (a) AND BY REGION (b)

(a) Socio-Economic Groupings: 1972 and SMRs

	I	II	III (non-manual)	III (manual)	IV	V
Respiratory TB	26	41	84	89	124	254
Stomach Cancer	50	66	79	118	125	147
All Causes	77	81	99	106	114	137

(b) Range of Regional SMRs and Standard Deviations

Nervous System	87-119	3.4-5.0
Circulatory	86-116	0.8-0.5
Respiratory	77-122	0.9-1.4
Digestive	86-117	2.2-3.5
Perinatal	76-115	3.8-5.4

Source: Extracted from Walters, 1980; Palmer, et al., 1980.

Table 2.

INPUT, PROCESS AND OUTPUT VARIABLES FOR THE ELDERLY
by County, Wales 1977

	Clwyd	*Dyfed*	*Gwent*	*Gwynedd*	*Mid Glamorgan*	*Powys*	*South Glamorgan*	*West Glamorgan*	*Wales*
Population aged 65 and over (thousands)	60·5	53·3	59·4	39·3	72·7	17·4	54·8	54·8	412·2
INPUT VARIABLES									
Managerial S.E.G. (%)	12·7	13·3	10·6	16·1	9·2	14·1	14·4	10·5	12·0
Semi and unskilled S.E.G. (%)	9·2	7·6	9·7	7·3	8·4	6·2	7·8	9·9	8·6
Health and social services expenditure: local authority (£)	15·6	13·7	16·0	19·6	21·8	16·3	21·8	18·9	18·3
National Health Service (£)	92·1	92·1	101·5	95·0	97·6	95·6	150·5	96·1	103·7
PROCESS VARIABLES									
GPs/1000 population over 65	2·6	3·0	3·3	3·3	3·2	3·6	3·5	3·0	3·2
Sheltered housing places/ 1000 population over 65	53·3	31·0	56·9	52·7	24·2	62·8	9·8	15·9	35·4
Geriatric beds: rate/1000 population over 65	10·4	10·6	8·7	10·3	10·7	14·7	8·3	7·6	9·8
Percentage of persons 65+:									
in local authority homes	1·5	1·8	1·6	2·1	1·7	1·8	1·7	1·4	1·7
in voluntary and private homes	0·3	0·1	0·1	0·1	0·1	0·1	0·2	0·1	0·1
Percentage of persons 65+ who:									
were seen by health visitors	7·7	5·2	5·7	8·9	13·4	6·1	20·6	16·4	10·9
were seen by home nurses	23·6	18·9	14·0	20·8	16·5	39·7	15·3	14·5	18·5
received chiropody treatment	17·9	18·6	22·7	22·5	25·7	22·2	19·2	22·6	21·5
received home helps	6·2	5·3	10·4	5·9	12·6	5·1	9·0	8·2	8·4
received meals on wheels	2·8	0·9	2·0	3·9	9·2	2·9	2·3	4·2	3·8
OUTPUT VARIABLES									
Standardised mortality ratio (over 65s)	99	100	101	98	108	94	94	99	100
Standardised L.S. disability ratio	90	87	109	94	133	81	94	116	100

Source: Vetter, et al.

Table 3.

SELECTED SMRs*

Liverpool AHA(T) and Mersey RHA, 1974-76

CONDITION**	LIVERPOOL Male	LIVERPOOL Female	MERSEY Male	MERSEY Female
Infectious diseases	150	99	105	110
Cancers	140	120	107	103
Anæmia, etc.	136	122	121	115
Respiratory diseases	144	129	119	115
Digestive diseases	130	105	109	96
Arthritis	129	146	71	88
Accidents	131	147	94	95

*Standardised Mortality Ratios, taking into account demographic characteristics; 100 is the norm.

**Based on International Classification of Diseases

Source: DHSS, unpublished data

Table 4.

SOCIAL AREA ANALYSIS, LIVERPOOL AHA

	Indicator	1	2	3	4	5	6	7
1.	Illegitimacy	2.04	0.13	0.23	1.43	0.66	1.01	1.02
2.	Infant Mortality	1.51	0.28	0.81	0.33	0.37	4.00	1.01
3.	Long-Term Unemployment	2.29	0.15	0.30	1.27	0.70	0.88	1.68
4.	Higher Education Grants	0.37	2.70	2.65	0.65	0.81	0.72	0.94
5.	Population Aged 75 +	0.74	0.67	1.17	0.93	1.16	0.99	0.67
6.	Crude Birth Rate	1.31	0.72	0.72	1.04	0.89	0.95	2.74

Ratio: (city = 1.00)