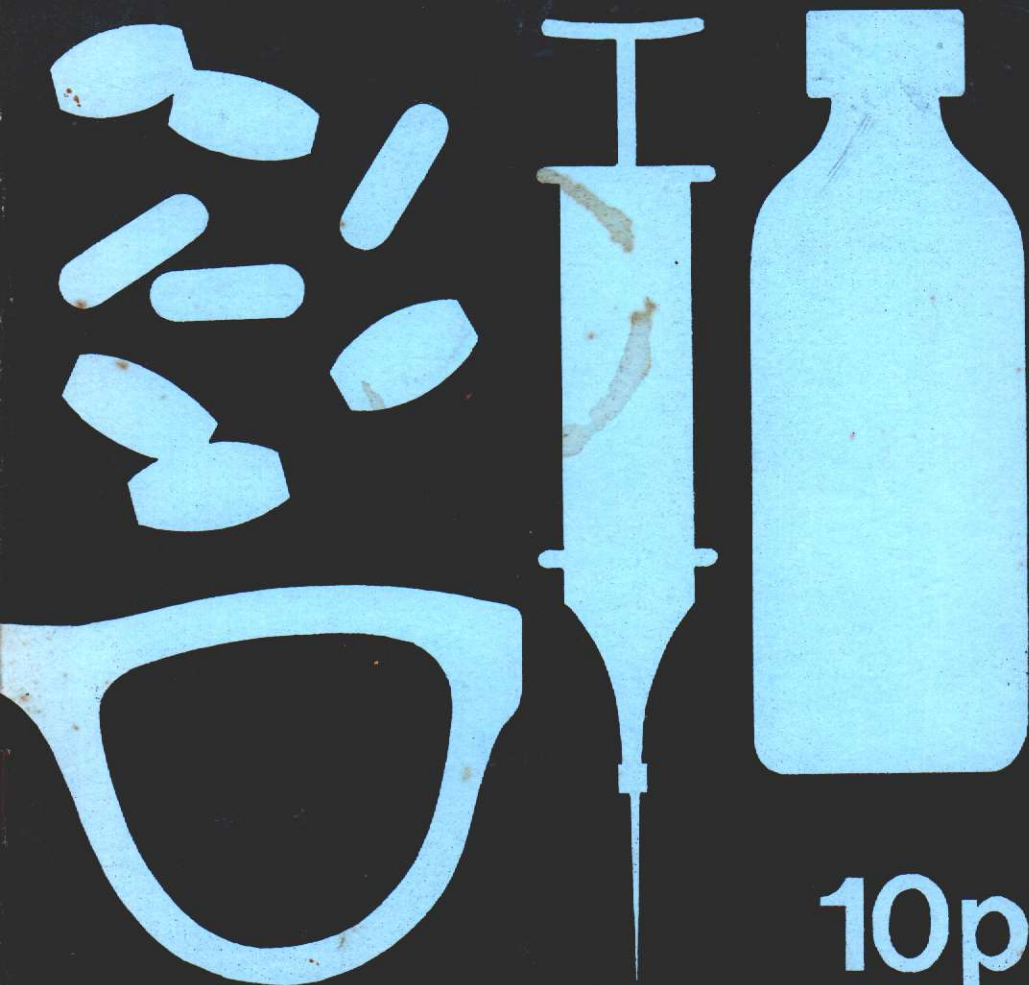


Health

The Working-Class fight



10p

INTRODUCTION

The health of a nation is a reflection of the level of its organisation - of the consciousness of its people that no man is an island. Britain, the first industrialised country, and the most proletarian, now has a relatively high level of health services, amongst capitalist countries. This has been brought about by two main agents.

First - The Working Class:

which in its mass organisations has transcended Christian neighbourliness - indeed, as the early Trade Unions arose, as illegal organisations in struggle, often their front was a sickness benefit, or funeral society: 'he lived hard, but at least he went in style!'

Second - Medical Workers:

themselves - a section of the working class. We use the term to include nurses, doctors, technical and ancillary staffs, and social and welfare workers; in all, nearly one million people.

A significant stage in this history was the development of the N. H. S. after the Second World War. The aims were high - "It shall be the duty of the Minister of Health to promote the establishment of a comprehensive health service; ... designed to secure improvement in the physical and mental health of the people ... and in the prevention, diagnosis and treatment of disease."

We will show in this pamphlet the achievements undoubted but also the inherent failures of a reformist ideal in a society, capitalistic, and therefore destructive in its production.

THE PAST

PRE N. H. S. DAYS

Before 1947, a totally inadequate and haphazard system had existed. There were two kinds of hospital:

a) Voluntary - often of monastic origin, supported by charity. They dealt with between 30-40 per cent of the work. Advances in medicine, and the enormous increase in diagnostic services had rendered the majority of these bankrupt by 1939.

b) Municipal - these arose from the workhouses of the Poor Law. Although many provided a very good service, they were held in scant respect by patients and professions. They were staffed by full-time salaried doctors. These were the poor relations of the voluntary hospitals - the care of the chronic sick, the dying, the 'long term' patient was mainly here - and there was widespread feeling that the voluntary hospitals took only 'interesting' cases.

Nurses in all these hospitals were extremely poorly paid; and their choice had to be marriage or nursing, not both.

In 1912, following the experience of 'call-up' for the Boer War, when the majority of would-be soldiers were found unfit, Lloyd George introduced a national insurance scheme, compulsory for all workers earning less than £150 a year. This figure was raised to £450 between the wars. Originally the worker paid 4d, the employer 5d and the State 2d per week - and, in return, treatment 'on the panel' - at the local G. P. ', drugs and sickness benefit were provided; their dependents received none of these things.

No provision had been made for children or expectant mothers. Surveys of the gross nutritional disease in depressed areas spurred the development of school medical and infant welfare services between the wars. Again, like the municipal hospitals, staff working in these were full-time, fully salaried, with no private practice.

This patchwork did not provide care for the aged, and those dying of diseases requiring much care and treatment - e.g. cancer.

For those entering hospital, waiting lists were enormous and out-patients had no appointments system and were always crowded.

THE PRESENT

THE WORK LOAD OF THE N. H. S.

The following statistics give some idea of the enormous increase in the work of the system.

	<u>1949</u>	<u>1954</u>	<u>1970</u>
In patients (millions)	2.9	4	6.1
Private patients	no figs. avail. but higher than 1954	72,000	112,000
Beds (thousands)	453	483	426
Length of stay (per patient av.)	no figs. avail.	42 days	25 days
Waiting lists (thousands)	no figs. avail.	589	607
New out-patients seen (millions)	6.1	8	9.2
Casualty patients (millions)	no figs. avail.	5.4	8.8
Pathology invest- igations (millions)	no figs. avail.	17	41
Pints of blood donated (thousands)	384	no figs. avail.	1,500

COSTS

There is much idle talk on the enormous cost of running the N. H. S., ignoring the fact that Britain spends a lower proportion of the Gross National Product on health than the U. S. A. or West Germany. The figures shown below are misleading in that no account is taken of devaluation of money and of the bankruptcy of the old days with totally inadequate buildings, now being replaced.

	<u>1951</u>	<u>1970</u>
Running Costs: in £ million	477	2,000
Capital construction: in £ million	501	2,000

In 1970 this total represented 4.9% of the G. N. P. and 9.2% of all Government spending.

In the same year, the Government spent 11.7% on war.

The most significant feature for us is the enormous increase in the work done - and the reduction in length of stay is a sensitive index of the increase in hospital work. Truly the conveyor belt is being speeded up!

What has been achieved?

The Industrial Revolution was the most important step in the development of humanity since women discovered agriculture. It occurred in Britain first and was marked by the most appalling holocaust of the nascent English working class and their families. In the early nineteenth century, population of industrial cities was increased only by people coming from the land - the 'immigrants' of that time; so high was infant mortality that in Liverpool and Salford it was higher than the worst areas of Bengal. The whole history of Britain's industrial development shows the murder of a class here and exploitation and warfare overseas.

The slow realisation of the importance of clean water, embryonic preventive medicine, and the introduction of the Factory Inspectorate, with continuing struggle by the class itself, gradually improved upon this dreadful beginning.

The statistical section that follows is important as the figures show the decimation of the working class. Much of the information is taken from the Registrar General's reports, and census information. We would emphasise that the division into social classes I to 5 does not imply that we recognise five classes or even strata within one class - but they are closely correlated with income and, therefore, housing, food, etc.

1. Maternal Mortality

This refers to the number of mothers dying during pregnancy or from disease related to pregnancy. Maternal Mortality is now lowest in class 3; the skilled workers. The biggest improvement since 1948 has been in classes 4 and 5 (semi-skilled and unskilled).

Maternal Mortality relates to the availability and level of medical care. Social and economic features are less important than a conscientious ante-natal and hospital service. The age of the mother is another important factor.

In contrast, consider PERI-NATAL MORTALITY.

The definition of Peri-natal mortality is stillbirth or death in the first week of life. This is a social disease, closely affected by nutrition, housing and maternity leave from work. Bluntly, the less money you have, the greater chance your baby has of dying. The national figure in 1969 was 23 deaths in every 1,000. Only in Scandinavia and amongst certain Socialist countries does a better situation obtain. But consider the wide differences:

(1) Geographically

1969	London	18-19	(per thousand)
	Lancs.	29	" "
	The Welsh Valleys	33	" "

On the whole, North and West Britain is worse off than the South and East: and, it is interesting to note how closely these differences correlate with wage rate levels. Wages for the Confederation of Shipbuilding and Engineering Unions show an average 10-20% lower in these areas.

(2) Class

Mortality is lowest in I and highest in 5. More significant and in contrast to the maternal deaths is the increasing difference. Between 1954 and 1964 peri-natal mortality fell by:

41% for I and 2 combined
23% for 4 and 5

An important lesson can be drawn from this - the basic contradiction facing health workers in a capitalist society - whenever they try to deal with problems and diseases relating to the social factors inherent in an exploiting society, they fail. Capitalism has no interest in health, only in profit. Where health breeds profit, then and then only, will it be supported.

Harder to quantify and assess is the question of psycho-geriatric medicine. No statistics of life or death obtain here, only misery. Everyone knows the importance of loneliness - poverty - isolation. These things are increasing in modern Britain. The vaunted closing of custodial Psychiatric hospitals returns patients to a society ever more inimical to the helpless - and an increasing overload of acute medical and orthopaedic wards.

This is a most important factor in the demoralisation of already over-stretched nursing and social services. "The Chronically Sick and Disabled Persons Act" now being implemented has virtually no backing of resources.

In one central London Borough, plans are being made for the provision of facilities for the disabled - officially estimated at 3,000. Any social worker in the field would reckon on 10,000 - a figure including elderly people, in need of home helps, 'meals on wheels' and so on.

The Dialectics of Disease

In microcosm, this contradiction is seen where western i. e. capitalistic societies, impinge upon previously self-sufficient primitive ones. Greenland has seen the development of a very high level of medical services, financed by Denmark. The small towns have first class hospitals and equipment and certainly the reduction in Peri-Natal Mortality and maternal mortality is great. The young Greenlanders are taller and stronger than their parents - but the greater the facilities, the more the alcoholism, neuroses and V. D. Despite an extensive programme of education about childbirth, and the provision of free contraception, the number of child mothers continues to rise. These ills are worst in the most westernised township - where the interdependence of the old community, innumerate and co-operative has been replaced by a new factory system of hired "hands", the imposition of a bourgeois way of life on a primitive communist one.

In contrast, compare Vietnam. Victorious in 30 years of devastating warfare, latterly against the most barbaric foe of all time; yet with a health service the envy of neighbours and the despair of the U. S. A. bombers who have repeatedly attacked the Leprosaria

and T. B. sanatoria, the most advanced in Asia, in a vain attempt to spread demoralisation and plague. Truly Revolutionary Man has triumphed over brutal technique - in the health field as on the battleground.

Diseases of capitalism cannot be cured by building more hospitals. "A pill for all ills" - hence thalidomide - is an ideal fostered by drug companies in search of profit - aided and abetted by doctors and patients alike - partners in a comforting self-delusion.

Staffing - Health Workers

The N. H. S. is one of the biggest employers in the country and it is an expanding one.

	<u>Total</u>	<u>Increase over 1948</u>
1. Nurses	300,000 (2/3 whole time)	100%
2. Doctors	70,000 (25,000 G. Ps.)	100%
Dentists	10,000	
Pharmacists	12,000	
Opticians)		
Ophthalmists)	6,500	
3. Ancillary and Domestic	200,000 (2/3 whole time) (1/3 part time)	50%
4. Technical	35,000	150%

A very large number of these are not organised in either Trade Unions or professional organisations. There are at least 10 major mass organisations for those who are. The division into 'professional' and general unions is often overemphasised. The British Medical Association, including about three quarters of all doctors, the British Dental Association, and the Royal College of Nursing act in many ways as mass organisations, craft unions which can take progressive action, such as opposition to 'sliding scale' charges for drugs, and support for free family planning.

Of the general trade unions, the National Union of Public Employees has the greatest number of nursing and ancillary workers. It is also the most militant union. In contrast, the National Association of Local Government Officers is the 'sleeping giant'.

NURSING

1. Nature of the Work

Total care of the patients, which varies with different types of wards and hospitals. It can mean heavy manual work, on geriatric and short-staffed wards. Washing, feeding, bed-making, giving bed pans, observing charts of the patients' progress, i. e. largely done by students, auxiliaries, staff nurses and enrolled nurses, supervised by the ward sister: the trained staff, i. e. enrolled and state nurses give drugs and injections, and in specialist units apply minute to minute care using highly sophisticated technical equipment.

In their training, the importance of the nurse's ability to talk to the patients and treat them as individuals is stressed; however, in most hospitals there is a staffing crisis which lowers care, intensifies work, and makes many nurses feel that they are working in a collapsing system. The 'speed up' is exemplified by the number of patients admitted to a bed in an acute ward throughout the year - this has risen from 18.7 to 25.3 over the last decade.

2. Conditions of Work

Hours - Ostensibly a 40 hour week. There is a claim for a 38 hour week. A normal 3 shift system is not operated although hospitals are open 24 hours a day, because of staff shortages. Breaks are unpaid: e. g. 1 hospital group: typical of many.

Days

(i)	7.45 - 4.30 p.m.	-	breaks	$\frac{1}{4}$	$\frac{1}{2}$
(ii)	12.30 - 9.15 p.m.	-	"	$\frac{1}{4}$	$\frac{1}{2}$
(iii)	(7.45 - 12.30 p.m.	-	"	$\frac{1}{4}$	
	(4.30 - 9.15 p.m.	-	"	$\frac{1}{2}$	

Worked 5 days in 7.

Nights

(i) 9.00 p.m. - 8.00 a.m. - break $\frac{1}{2}$ $\frac{1}{2}$

Worked as 4 or 8 in succession, with 3 or 6 days off.

Holidays

6 weeks (including public holidays)	Sister and up
5 " " " "	3rd year student & up
4 " " " "	Juniors

This irregularity and short notice of rota causes married women to leave.

Overtime - New to the general hospital, although it existed before in psychiatric hospitals where there are more male nurses and which are more unionised. Supposed to be paid back in time, but staff shortage prevents: many hospitals do not pay up, and the attitude of senior staff, whose approval is necessary, is often antagonistic. Not equivalent either in rate or certainty to industrial overtime.

Sick pay and superannuation schemes give some degree of job security.

Pay Examples -

Pupil nurses start at £621 a year at the age of 18 yrs.

Auxillaries start at £621.

Enrolled nurses: £954 - £1,134.

Staff nurses (S. R. N.): £1,089 - £1,299.

Sisters: £1,407 - £1,821.

The highest grades rise to over £4,000. Students pay tax, superannuation and examination fees.

3. Training

- A. Basically two types - General and Psychiatric, although there is increasing interlinking.

3 years for S. R. N. s and midwives (= 40% of all nurses working)

2 years for S. E. N. s (= 20% of all nurses working)

Entry qualifications vary from region to region, but for S. R. N. s a minimum of five '0' levels and one - two 'A' levels is not unusual.

- B. Auxiliary. 20% of all nurses. These nurses receive little or no tuition. They learn on the job as uniformed laymen. They represent dilution of the skill of the fully trained nurses. They form a large proportion of nursing staff because of the high drop-out rate of students and the many trained nurses who leave never to return.

Briggs and Salmon

The Salmon Report on reorganisation of nursing means that a career structure is to be separated from nursing the patient, and the administrators of the future will be S. R. N. s - the 'practical nurses' will typically be S. E. N. s. However, the training is largely practical, with work on the different types of wards taking the bulk of time, and formal lectures the remainder. The ward work is arduous and responsible with often inadequate guidance, this with the shortness of academic tuition leads to frustration; the combined student/worker role is difficult.

The Briggs report, the recommendations of which have not been applied, proposes changes in nursing training. These include a basic eighteen months for all, to be followed by a further eighteen months for those willing and able - to be followed by specialised training for some.

Although this would seem to standardise, and unify, nursing training, implicit in these proposals is the division of nurses into two levels, with qualifications and training more widely separate than the present S. E. N. - S. R. N. distinction.

Obstacles in the way of organising Nurses

1. Most are women, so their position and problems reflect those of women in society. Pay is low, decisions are taken by others and there are feelings of inferiority to male workers.
2. The divisions amongst nurses. The ranking S. R. N. /S. E. N. itself represents job dilution on one hand and unequal pay for equal work on the other.

Agency Nursing

The 'lump' labour of nursing is another division. Whilst hourly rates are higher, agency nurses lose all 'fringe benefits' such as sick pay, leave, etc.

3. Nursing work is very transient: students are always changing wards; nurses leave to get married; traditionally one has to move to get promotion. Finally, the drop-out rate is high, 37% during training.
4. The professional organisation, the R. C. N. is active at national level, and seems to be dominated by upper ranking nurses. It has an 'establishment' air, viz. its three patrons, the Queen, her mother and sister. However, like all such bodies, it has progressive aspects and is becoming increasingly involved in militant demands for better pay.

Nursing is very hierarchical and this leads to a confusion about enemies - criticism being focussed on senior nurses, who are objectively in the same position as all nurses. A similar problem arises in the unequal doctor-nurse relationship, and this inequality leads to feelings of intellectual frustration for many nurses.

5. There is a real fear of authority, and plenty of examples of what, in other places, is called victimisation reinforce this.

POSITIVE FACTORS

- (1) Grievances are widely felt, and discussed, particularly with trained staff - who are more permanent and more committed to the trade. The issues include pay, facilities, staff shortage, administrative lack of concern and authoritarian attitudes, and anger at the poor quality of work and their equipment, and at failures in nursing and medical treatment. This last was dramatically demonstrated by the courage of student nurses in Ely and Whittingham hospitals who persistently spoke out against maltreatment of patients, alone amongst all medical, administrative and relatives who must have known of it.
- (2) Nurses are in constant contact with all types of people, mainly working class patients and ancillary workers, and are held in high regard by them.
- (3) The objective situation current today with ever-increasing staff shortages and the vital nature of the work gives nurses a potential whip hand in protecting each other from victimisation and in negotiations.
- (4) Their work is combining of manual and mental - and engenders a practical outlook. They work hard and have a capacity for it in organising.
- (5) The 'shop floor' of the ward, involving all nurses from sister down, and auxiliaries and ancillaries, engenders a solidarity - and a feeling of them and us.
- (6) Trade unionism is spreading to general nursing, already well developed in psychiatric nursing
- (7) Nurses' feelings of 'apathy' can disappear if conditions are right - in that grievances are shared, talked about, and a mass tactic devised, such as a boycott of canteen meals, which cannot hurt individuals. With leadership in such circumstances there is a readiness to act as a mass - and disregard 'proper' channels, which may give confidence for future more decisive battles.

DOCTORS

'Correct ideas come from the masses'. A most vivid illustration of this is the attitude of old physicians, trained in astrology and theology, to such diseases as malaria or scurvy. English seamen noted the link between malaria and mosquitoes in 1572 - yet this was ignored by doctors for three centuries. The Elizabethan mariners' experience of scurvy, and the preventive value of citrus fruits was similarly ignored.

A metaphysical outlook dominated in training - and for them, concepts over-ruled reality. From a class point of view, they were truly 'petit-bourgeois' in that they worked independently as individual craftsmen in competition. They operated firmly in the market place, and for the barber-surgeons and bone setters, at least, were held in scant esteem.

Times have changed. Whatever their outlook, and it is usual for this to lag behind changes in economic status, the great majority of doctors are part of the working class in that they are neither owners of capital nor exploiters of others' labour. The majority do not employ the health workers with whom they work. This change has occurred most markedly in hospitals and local authority work. The factors bringing this about fall into groups.

Firstly:

(1) Advances in the understanding of disease have bred a materialistic approach, with the recognition of physical and not ethereal causes. Growing appreciation of the dynamic nature of specific disease is bound to lead to a dialectical view.

(2) Advances in treatment have brought about an enormous development of the collective approach to illness. No doctor can work in isolation now, either from other doctors, or from the nurses, technicians, social workers, involved in patient care.

This was most marked in the war years, with the establishment of specialised centres for the burned, paralysed and other war cripples. It is occurring now in the development of 'flying casualty squads' and in some general practice with the increase in health centres and attachment of nursing staff and social workers.

Secondly:

External factors include the change in employed status with the inception of the N. H. S. There was a transformation from independent individual craftsmen - to men and women employed and paid by the State.

There was a great change in attitudes in the struggle to bring about the N. H. S. - for instance, the great majority of doctors opposed the first insurance scheme in 1911, yet the majority, particularly young and army doctors voted for the N. H. S. in referenda organised by the British Medical Association in 1947. So astounded were the B. M. A. chiefs that they accused the Socialist Medical Association of ballot-rigging. The failures of the then Government in carrying out a full reorganisation of the health service, root of so much trouble since, are due solely to the cowardice of the Labour Government which, having a massive mandate, ignored the majority and intrigued with the cabal.

ANCILLARY WORKERS

A most incorrect title. This vital section of the health workers paralysed the hospitals during the recent strike - the first in the history of the N. H. S.

Ancillary workers have been the most underpaid section of the working class. Their basic wage rates are insufficient to maintain life. This situation is overcome by working overtime, for the men, or by working to obtain a supplement to the family income, for many women. It is commonplace to work ten or more hours overtime to earn a 'living wage'.

Whence this state of affairs? Divisions - between men and women - as unequal pay, or as differing job descriptions. Divisions - racial - in many hospitals, the majority of the ancillary workers are immigrant, reluctant to join unions for fear of victimisation.

Their fight this year, for a living wage, pushed a Trade Union leadership into a confrontation with the Government wage freeze - an economic fight was transformed into a political one.

The struggle will undoubtedly develop as a form of guerilla warfare - a protracted fight - striking where you are strong - for as long as solidarity can be sustained - and giving no notice! Pit ten against one!

It is no coincidence that this, the youngest organised section of our class, should take on the State, together with the oldest - the engineers.

One can paralyse the means of production - the other can paralyse the means of maintaining the producers.

CONCLUSIONS

HEALTH OF THE CLASS IS OUR BUSINESS

1. Therefore: Promote Trade Unionism in a notoriously unorganised section of the working class, for self-defence, for the improvement of pay and conditions. Trade Unions are mass organisations but they are not revolutionary. There is no future in forming new ones; 'Red Unions' have been tried before - and they do not work. Support the ancillary staff demand for a living wage; a wage freeze will mean frost bite for some this winter. Demand Equal Pay. Support the fight of doctors against the authoritarian and reactionary G. M. C. - which has never fulfilled its supposed function of training but has managed to oppose most reformers, starting with Marie Stopes.
2. Promote the Health Worker Team. Aim for the Medical Workers unity - to increase initiative and self-reliance. This is going to be much easier with the proposed Union for the students of health work.

With such unity - oppose attacks on the N. H. S.; it is deficient but it is better than what went before.

Oppose the introduction of charges.

Oppose the extension of private practice, with its ridiculously out-dated ethic of the bazaar - and its divisive effects on the mass.

Prepare for struggles with the upper echelons of the new man management - 'Selected for their managerial skill', in a selection procedure devoid of any pretence of democracy.

Whilst this re-organisation will serve to remove some of the veils between people and State, it represents the establishment of a bureaucracy answerable only to the Government, and there will be no benefit for patient or health worker from this.

Much disease in this country stems from the intrinsic violence of capitalism, its industry, its pollution, its exploitation.

The solution to this is a class fight, of the whole working class led by its own party.

THIS PAMPHLET IS BASED ON A SCHOOL ON HEALTH AND THE NATIONAL HEALTH SERVICE ORGANISED BY THE HEALTH WORKERS IN THE C. P. B. M-L. IT DOES NOT PRETEND TO BE A COMPLETE DESCRIPTION OR ANALYSIS. HOWEVER, WHAT IS INCLUDED, IS BASED ON THE EXPERIENCE OF OUR COMRADES - AND THEIR COLLEAGUES.

AS CHAIRMAN MAO TSETUNG WROTE:
"HEAL THE WOUNDED, RESCUE THE DYING,
PRACTISE REVOLUTIONARY HUMANITARIANISM."

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