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Public health services – endangered species?

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Michael Skjelderup

Michael is a publication series named after professor *Michael Skjelderup* (1769-1852), one of the fathers of Norwegian medicine. He was born in Hof, Vestfold in Norway as the son of a priest, and was raised in the Norwegian countryside. Because of severe speech disturbances as a boy he did not get proper schooling, but was at last accepted as an apprentice in an apothecary's dispensary in the city of Fredrikstad at the age of 16. During his youth he tried through hard work and by means of an intensive self-discipline to overcome his handicap, and he really succeeded, except for in stressed situations.

Lacking a student examination, an academic training seemed out of question, in spite of his obvious bright mind. However, in 1789 he was admitted to the new Surgical Academy in Copenhagen, where academic qualifications were not required.

From now on, his career flourished. He passed the surgical examination with the highest grade in 1794, entered positions in Copenhagen hospitals and at the University, where he defended his doctoral thesis in 1803 and was appointed professor in 1805.

The first University in Norway was founded in Christiania (now: Oslo) in 1811. Medical teaching was supposed to commence from the very beginning, and from 1814 the new medical faculty could offer medical training. Michael Skjelderup was appointed its first professor 1813, and started his teaching, mainly in anatomy in the fall of 1814, after a dramatic war time sea voyage from Denmark across the waters of Skagerrak where hostile Swedes fired at his swift sailing vessel.

As a University pioneer, he became active in several medical fields. Among other achievements, he published an authoritative textbook in forensic medicine in 1838. When he resigned in 1849, eighty years old, he had seen all Norwegian trained medical doctors in his lecture room.

Skjelderup was instrumental in building a scientific medical community in Christiania. Together with his University colleague Frederik Holst (1791-1871) he founded the first Norwegian medical journal *Eyr*, named after a norse medical goddess, in 1826. A reading club of physicians established in 1826 was formalized into an association in 1833, the still existing Det norske medicinske Selskab (The Norwegian Medical Society), which over the decades to come played an important role in the development of the health services and of a national medicine.

Michael is devoted to the memory of the man who first realized the importance of a regular, national medical publication activity in Norway and implemented his ideas in 1826. *Michael* is published by the same association as was founded by Michael Skjelderup and his colleagues – Det norske medicinske Selskab.

The editors

British health care reforms and Norwegian health care

Michael Quarterly 2011;8:423–7.

The British government's white paper entitled, Equity and excellence: Liberating the NHS, *suggests radical reforms to the National Health Service. The reforms open up the provision of health care to private competition, and introduce more market orientation of health services. The proposals are seen by many as a serious threat to the core values of the universal health care system established in 1948. As the NHS has been a role model in many ways for the Norwegian health care system, this development might have consequences for us. If the NHS fails, we will have to look for other sources for inspiration to help keep the ideals of publicly funded national health care alive in Norway.*

Both medicine and health care are international, and just as Norwegian medicine is strongly influenced by international research, our health care system is influenced by trends and developments in health care systems in other countries. The development in countries that have served as role models for us is of particular relevance, which is why we have followed the National Health Service (NHS) in the United Kingdom (UK) so closely in Norway.

After it was established in 1948, the NHS quickly became an important institution in the UK. Its status has recently been described in *The Lancet* in this way: "The UK's National Health Service (NHS) has been called the national religion. Perhaps it is better described as a totem: a symbol of the state's duty to care for its people, and of its right to their loyalty. [….] Perhaps, since most British people cannot remember life before the NHS, we have forgotten how remarkable it is. Knowing that, if one falls sick, one will be treated, irrespective of ability to pay or personal background, is priceless" (1).

Four papers – one opinion

The British government has recently proposed a radical restructuring of the NHS. England's existing primary care trusts will be replaced by groups of GPs called general practice commissioning consortiums, which will have their own budgets. These consortiums will negotiate and agree to contracts with hospitals and other health care providers. This restructuring will include a shift from geographically based populations to the provision of more membership- and insurance-based pools as we have come to know them from the United States. The British government's policy of letting "any willing provider" offer health care paid for by NHS funds could lead to a considerable privatization of the British health care system. It can be said that the Secretary of State for Health will no longer have the responsibility of providing comprehensive care for the population since it will be left to individual units and the market. The providers may even be allowed to reintroduce user charges.

The current debate on British health care reforms was the reason for a seminar in Oslo on September 21, 2011, which was jointly arranged by The Norwegian Medical Society, the Norwegian Knowledge Centre for the Health Services and the Norwegian Directorate of Health (Figure 1). Four papers from this seminar are published in this issue of *Michael*, with all of the authors seeing the suggested reforms as a threat to the ideals of the NHS.

Sally Sheard, a senior lecturer in history at the University of Liverpool, describes the circumstances of the NHS' creation. "It could only have happened in this brief window of opportunity at the end of the Second World War" (2). She argues that, "the British love affair with the concept of a universal free healthcare service has prevented, until now, any serious erosion of its function". This love affair seems now to have weakened. Sally Sheard suggests that a closer look at the historical context of the NHS can help to understand its current crisis.

Steinar Westin examines the common ideals of health care in Norway and the UK, as well as the impact that the suggested British reforms may have on Norwegian health care. He concludes that a broader discussion about the general principles for the public funding of health care is needed (3).

"The whole world has a living example of what an already commercialized, and fast becoming industrialized care system does to people, and fails to do for people, in the USA, the richest country in the world", writes Julian Tudor Hart, former general practitioner and a pioneer in family medicine in the UK (4). Tudor Hart is a name known to generations of GPs, including in Norway. He is the author of the 1971 milestone paper, *The inverse care law,* which states that "the availability of good medical care tends to vary inversely with the need for it in the population served" (5).

Figure 1. From the seminar on the decline of the UK NHS and its possible international consequences in Oslo on Sept 21, 2011. Professor Magne Nylenna is the moderator, and on the first row can be seen (from left) the speakers, Professor Steinar Westin, Dr. Julian Tudor Hart and Dr. Sally Sheard. Professor Allyson M. Pollock is sitting to the right on the second row. (Photo: Ø. Larsen)

According to Hart, the inverse care law still thrives 40 years later. He reminds us that it is not a law of nature, but a law of the market, and writes, "The further health care gets from the market, the less this law applies, but for most of those 40 years, all political parties have been trying to drag the NHS back to the marketplace" (4). He points to the basic human behaviour of seeming to seek our own advantage, thus leading, among many other consequences, to the tendency of doctors to work with people who are rich and healthy, while avoiding working with the poorer and sicker.

Allyson Pollock and David Price compare universal health systems with market systems (6). Universal systems, such as the NHS, pool their financial risk at the government level. Therefore, their administrative functions focus on needs assessments and resource allocation across geographic populations. In market systems, however, financial risks are allocated across different parts of the system through market contracting. The administrative functions in these systems focus on risk pricing and segmentation among providers and members. Pollock and Price argue that information systems constructed for risk segmentation not only lead to more bureaucracy, but also provide additional impetus for further market reform.

Neither the presentations at the seminar nor the papers in this issue of *Michael* represent a balanced political view of the British reforms. The British health secretary, Andrew Lansley, has political backing for his shakeup of the NHS in the British Parliament. But reactions to the reform plans have been unusually strong, particularly among professionals as reflected in a series of papers in the *BMJ* and *The Lancet*.

Could it happen here?

The National Health Plan for Norway for the next four years states, "that there is a public responsibility to promote health and prevent disease, and to ensure appropriate health care services for the entire population. Everyone should have an equal access to health care regardless of diagnosis, place of residence, personal economy, gender, ethnic background and the individual's life situation" (7).The political agreement on a publicly funded national health care system in Norway is overwhelming. There are differences as to which extent private providers should be involved, but thus far the basic concept of a national health service has not been challenged.

This does not mean that the situation is uncomplicated. All institutions, whether private or public, must adjust to general developments in society. This refers of course to health care as well. Hence, there have been several reforms over the last decade, with the most important being the specialist service reform of 2000, which established the regional health enterprises, in addition to the list patient system in general practice, which was introduced in 2001. As of 2012, a collaboration reform will be launched that aims at better cooperation between the various levels of care. A continuous update of health care systems is as important as continuous updates of clinical guidelines. This updating should be undertaken with due respect to the core values that underpin our health care, as well as the treatment of individual patients.

The best guarantee for our publicly funded health services is a high level of acceptance and satisfaction among patients and professionals alike. In the seminar discussion, Dr. Tudor Hart pointed to trust as a basic value of health care. Patients must trust their doctors and the health care system, while professionals must trust their leaders and the political system – and the other way round. The maintenance of trust is one of the most important tasks we have. As most politicians seem to be in favour of the national system of today and patients have a fairly high level of satisfaction, in spite of media reports, it is a paradox that parts of the profession may represent a threat. Among general practitioners in particular, there is a tendency to advocate a more market-oriented health care system.

Economically, we are better off in Norway than in the UK these days. Nevertheless, it should be remembered that the establishing of national health services with universal coverage in both Britain and Norway took place under much poorer economies than those of today. As Steinar Westin puts it: "When foreigners look to Norway or the other Nordic countries with some admiration for the welfare legislation and universal free health care, their usual response is "it must be the oil". It is not. It is about ideas (3). These ideas must be kept alive.

Having looked to Britain for inspiration for our national health care for two generations, we are grateful for what we have achieved. As for the future, we may have to search for other ideals. Perhaps we should set even higher goals and, as quoted by Steinar Westin, have the ambition to bring a message to the world that we ourselves have developed a health care model worth looking at for others (8).

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Sally Sheard

A creature of its time: the critical history of the creation of the British NHS

Michael Quarterly 2011;8:428–41.

The British National Health Service was formed in 1948, and has since been internationally admired and emulated. This paper seeks to understand the circumstances of its creation: why it could only have happened in this brief window of opportunity at the end of the Second World War. It argues that the structural weaknesses and chronic under-financing in its first few years have been difficult to rectify, but that the British love affair with the concept of a universal free healthcare service has prevented, until now, any serious erosion of its function. It suggests that closer examination of the historical context of the NHS, especially the negotiations that created it, and the concept of policy 'path dependency' can help to understand its current crisis.

A scenario

Picture a developed country, experiencing an economic recession, significant expenditure on fighting overseas wars, and social unrest. Struggling independent hospitals are failing to balance their budgets. General practitioners are increasingly unsure about where to refer their patients: to these stressed private institutions, groaning under the weight of recent costly capital projects, or to what are perceived as second class public institutions? The public understand that the government is duty-bound to provide them with some basic health care, but are confused as to where the boundaries lie. The government knows something has to change, but is constrained by funding crises and lack of expert advice. The setting is not Britain in 2011 but Britain in the 1930s. To understand the contemporary debates on the future of the British National Health Service [NHS], it is necessary to understand the circumstances of its creation. Never has history been so critical to the future. It is a tale of personalities, politics and, of course, money.

The British NHS came to life on 5 July 1948 – the 'Appointed Day', as it was advertised. This paper will demonstrate why the NHS is a creature of its age: it could not have been created in 1938 or 1958. It exploited a small window of opportunity at the end of the Second World War. I say 'creature', as if the NHS is a sentient being. To the British people it perhaps is. The chronology is important – it is 63 years old. Although it is now showing signs of wear and tear, it is still very much alive and the focus of considerable affection. For this reason, it will not die peacefully.

Before the NHS

Health care in Britain before 5 July 1948 was dependent on the wealth of the individual. The state had progressively taken on responsibility for some aspects of health, especially public health, and the health of those deemed worthy of welfare support. One can date this back to the Victorian Poor Law and to the sanitary reforms that initiated compulsory vaccination schemes and disease surveillance. It was ostensibly the pressure of the newly enfranchised working class men after 1867 that prompted the existing political parties – the Liberals and the Conservatives – to appeal to concerns about ill-health (now firmly associated with poverty since the work of Engels and Chadwick), and to offer a more robust state health security net.

This took shape under the reforming Liberal government between 1906 and 1911, which saw the institution of school medical inspections, infant and maternal welfare clinics, and a National Health Insurance [NHI] scheme, part-plagiarised from Bismarck, and tempered by a concern for its cost, and a desire by the government not to be seen as a 'nanny state'. Panel Doctors were appointed from independent general practitioners [GPs] who owned their own practices. They received a capitation fee from the government for providing basic health care to the working men who had paid the compulsory contribution to the scheme. Most men also continued to pay into the private health insurance and friendly society schemes which covered their wives and children, and who were cared for by the same GPs.[1] A Ministry of Health was established in 1919, which helped to institutionalise the philosophy that certain health issues were the natural responsibility of the state. Yet this steady expansion of state-funded health services, which required medical staffing, did not sit well with the medical profession. For many, it was a 'thin end of the wedge' attack on their freedom from control and ability to determine their own incomes.

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[1] For more information on the pre-NHS health insurance schemes see Gorsky M, Mohan J, Willis, T. *Mutualism and health care: British hospital contributory schemes in the twentieth century.* Manchester: Manchester University Press, 2006.

Medical practitioners in Britain had become increasingly professionalised during the nineteenth century. The British Medical Association [BMA] was established in 1832 and was closely involved with the passing of the 1858 Medical Act, which created a Medical Register to record those practitioners who held approved qualifications. The General Medical Council, also created by the Act, provided a self-regulatory quality control system for the profession. Other medical professional associations were also formed to represent specific interests, such as hospital consultants, but it was the BMA that usually took on the main role of negotiating with the government on proposed changes to health care services.

Although there had been discussion of going further than the Liberal welfare reforms, the inter-war period saw little change. There had been an innovative report prepared by Lord Dawson in 1920 for the Minister of Health's Consultative Council on Medical and Allied Services, in which he used his military expertise to propose a reorganisation of Britain's diverse health care providers into regional hierarchies of primary and secondary facilities (primary being general practice, and secondary referring to hospitals and specialist treatments – the first time these terms were applied to health care).[2] The general proposal – that 'the best means of maintaining health and cutting disease should be made available to all citizens' was backed up by the report of the Royal Commission on National Health Insurance in 1928, which suggested 'divorcing the medical service entirely from the insurance system and recognising it along with all other public health activities as a service to be supported form the general public funds'.[3] This would have forced the pace on greater collaboration between the state's health care services (mainly municipal hospitals and clinics – some of them former Poor Law institutions) and those provided for the majority of the population through private general practitioners [GPs] and voluntary (independent) hospitals.

By the mid-1930s many of the independent hospitals were experiencing financial crises. Their income, mainly from health insurance schemes and charitable donations, could not keep pace with the costs of medical treatment. In 1891 some 88 per cent of their income had come from gifts and investments; by 1938 this had reduced to 35 per cent and patients now contributed 59 per cent of voluntary hospital income either out of their own pockets or through insurance schemes. It left these hospitals vulnerable to economic conditions. Of the 145 voluntary hospitals in London in

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[2] Ministry of Health, *Interim Report on the Future Provision of Medical and Allied Services*, Cmd.693. London: HMSO, 1920.

[3] Royal Commission on National Health Insurance, *Report* Cmd.2596. London: HMSO, 1928.

1932, 60 failed to balance their books, and by 1938 these hospitals were pleading with the government for state grants. The plaintive cry: 'funds urgently needed: beds closed' suggested to many people that the voluntary hospital sector might not be worth saving.[4]

Other proposals were emerging, which reflected their authors' primary concerns. The BMA in 1930 had proposed extending the insurance coverage to the whole population and a co-ordinated regional hospital service. The Socialist Medical Association [SMA] in 1933 proposed a more radical solution – that all healthcare should be provided free at the point of use through one scheme, funded either by taxation or national insurance, and administered by local government.[5] This was adopted as official Labour Party policy in 1934. In 1937 the *Report on the British Health Services* by the think tank PEP [Political and Economic Planning] proposed similar nationalised services, to extend primary health care from the 43 per cent who were currently covered by Panel doctors under NHI to the whole population. This would also have suited many GPs who were not well off, and who supplemented their panel work with sessions in hospitals and occupational health services.

Catalysts for change

From 1938 senior civil servants within the Ministry of Health began to hold discussions on the future of the health services. The Chief Medical Officer, Sir Arthur MacNalty, articulated the need to involve the medical profession from the outset in any change – rather than being seen to impose a system on them. There was lengthy debate led by the Permanent Secretary Sir John Maude on what the most efficient solution would be: extending national insurance cover, or increasing local government involvement. What is remarkable, as Rudolf Klein has pointed out, is the seeming lack of interest of the politicians in generating these policy initiatives. According to the archived correspondence, all the impetus came from the civil servants.[6]

At the outbreak of the Second World War in 1939 the government temporarily commandeered all hospitals to form an Emergency Medical Service [EMS], to provide free medical care for certain groups, and to fund the independent hospitals. As the war progressed its remit was extended to cover the majority of British people. The EMS was organised by regions

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[4] Timmins N. *The Five Giants: A Biography of the Welfare State.* London: Fontana Press, 1996, p.104.

[5] British Medical Association, *A General Medical Service for the Nation.* London: BMA, 1930; Socialist Medical Association, *A Socialised Medical Service*. London: SMA, 1933.

[6] Klein R. *The New Politics of the NHS.* London: Pearson Educational Limited, fourth edition, 2001, p.7.

– a good test of the applicability of Dawson's 1920 model. To facilitate this, the Ministry of Health had commissioned what has since been called the 'Doomsday Book' of British Hospitals (a study by the Nuffield Provincial Hospitals Trust) which for the first time collected information on all types of hospitals – their bed capacities, staffing, and funding. This gave some indication of the regional disparities in health care provision. There were 1,545 municipal hospitals run by local government and led by Medical Officers of Health with a total of 390,000 beds. These were often the remnants of the Poor Law, still known by patients under their old names of Workhouse Infirmaries, which often triggered bitter memories of poor quality health care and the lingering whiff of social stigma. There were 1,143 voluntary (independent) hospitals providing 90,000 beds (which ranged from small cottage hospitals with less than 10 beds to the largest and most powerful teaching hospitals in the country).[7] There was little effective co-operation between the voluntary and municipal sectors, and their respective management styles were very different.[8] The 'system', if it could even be called that, was irrational. Specialists were attracted to the wealthier parts of the country that could support their private practices (their honorary hospital consultancies were usually unpaid), but these areas often had the least need of their services. History, not logic, determined that Birmingham had 5.7 beds per 1,000 population while Liverpool had 8.6.[9]

Further evidence of the extent of ill-health that existed within British society came from the war-time evacuation strategy, in which one and a half million people (including 827,000 children) were moved out of their urban homes, which were at risk of bombing, to lodge with families in safer rural areas. Many of them were from working class families, and they personified the deficient welfare state – malnourished, poorly clothed, rotten teeth. For wealthier host families it was the first time that many of them had encountered real life examples of Britain's hidden poverty.

Further, and partly as a publicity exercise to life war-time spirits in the depths of the Blitz, the national coalition government commissioned a Liberal academic and civil servant William Beveridge to produce a report on the potential for a post-war welfare reform. Beveridge went further than his brief allowed, and his 1942 report, *On Social Security and Allied Services*,

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[7] Committee of Enquiry into the Cost of the National Health Service, *Report* Cmd.9663. London: HMSO, 1956, paragraph 153.

[8] Edwards B. *The National Health Service: a manager's tale 1946-1994.* London: Nuffield Provincial Hospitals Trust, 1995.

[9] Klein R. *The New Politics of the NHS.* London: Pearson Education Limited, fourth edition, 2001, p.3.

was an instant public hit – selling over 600,000 copies – unheard of for a dry government publication. The Treasury were dismayed. They had thought he was engaged to tidy up the existing administration, rather than to propose new policy. What Beveridge had produced was a blueprint for tackling what he called the 'five giant evils' that currently damaged Britain: squalor, ignorance, want, idleness and disease. The state's responsibility for the welfare of its citizens should be 'from cradle to grave'. For health he proposed a comprehensive service, 'without a charge on treatment at any point'. This egotistical 62 year old civil servant remarked after his report was published:

> 'This is the greatest advance in our history. There can be no turning back. From now on Beveridge is not the name of a man; it is the name of a way of life, and not only for Britain, but for the whole of the civilised world.'[10]

The Conservatives, led by Winston Churchill, the coalition government's Prime Minister, had been unhappy to be pushed into action by Beveridge's audacious and over-remit report, but they had no choice but to allow a series of White Papers to be produced. The one proposing a National Health Service was prepared by Sir John Hawton in 1944, and bore the mark of the Conservative Minister of Health, Henry Willink's desire (and possibly the ethos of the civil servants involved) to work with existing systems rather than to attempt to plan a new health service from scratch.[11] However, the White Paper proposed central rather than local government management, while retaining the fundamental principle of free treatment for all. This would require a radical reform to the role of central government – the Ministry of Health would have to move from being an 'advisory and supervisory and subsidising department' to become the direct provider of health services.[12] The issue of how to integrate GPs into a national system was equally challenging. The White Paper acknowledged that a more equitable distribution of GPs was required, but the logic of placing them under local government control was in opposition to the logic of appeasement – the medical profession were clear that they wished to remain free from any sort of state control. Nobody was entirely happy with the 1944 White Paper, but, crucially, no party felt totally alienated by it.

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[10] Beveridge to Harold Wilson shortly after his report came out. Recounted in Wilson H. *Memoirs: the making of a Prime Minister 1916-1964.* London: Weidenfeld and Nicolson, 1986, p.64.

[11] Ministry of Health, *A National Health Service* Cmd.6502. London: HMSO, 1944.

[12] The National Archives, MH 80/24. A. McNalty (Chief Medical Officer) Minutes of the first of a series of office conferences on the development of the Health Services, 21.9.1939.

Bevan: divide and conquer

At the end of the Second World War the National Government was dissolved, and at the May 1945 general election the Labour party won an unexpected landslide victory. The new Minister of Health was a Welshman, Aneurin – known as Nye – Bevan (1897-1960). A 45 year-old Welsh former miner, he was one of Labour's most charismatic and visionary politicians, and at the Ministry of Health proved to be 'an artist in the uses of power'.[13] His new proposals went much further than any of the interwar discussions or Beveridge's proposals. He wanted a national takeover of all hospitals, a health service to be available to all without charge, the end of selling GP practices, and funding primarily by central taxation, with only a small contribution from National Insurance.[14] The key principle enshrined in the March 1946 Bill was that health was a right, not a commodity to be bought or sold, or subject to market forces.

After many months of negotiation on issues of finance, structure and management, and opposition from Bevan's Labour Cabinet colleagues, especially Herbert Morrison who championed the cause of local government, the 1946 NHS Act was passed. It was essentially a compromise, and one which set up fundamental structural weaknesses, especially by divorcing medical care (hospitals and some GP work) from health care (local authorities and some GP work).[15] As John Stewart has noted, 'much of the profession itself was at this stage at best indifferent, at worst actively hostile, to preventive medicine, social medicine and public health'.[16] The Appointed day was set as 5 July 1948: that left only two years in which to set up the administration for Bevan's planned thirteen regions for England and Wales (and five for Scotland under a separate but parallel Act). Yet this was only the beginning of the battle to create the NHS. Bevan entered into further discussions with the medical profession. He had already established a strategy of divide and conquer, offering substantial concessions to the hospital specialists represented by the royal medical colleges, to try to break their solidarity with the BMA, which drew its strength from the general practitioners. The Act confirmed that teaching hospitals would have their own

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[13] Morgan KO. *Labour People – Hardie to Kinnock.* Oxford: Oxford University Press, 1992, pp.204-5.

[14] For further discussion of the funding options see Gorsky M, Mohan J, Willis T. Hospital contributory schemes and the NHS Debates 1937-46: the rejection of social insurance in the British welfare state. *Twentieth Century British History.* 2005; 16(2):170-192.

[15] See Stewart J. Ideology and process in the creation of the British Health Service. *J. Policy History*, 2002; 14 (2): 113-34, for more details on issues of boundaries, co-ordination and integration with local government.

[16] Stewart J. The Political Economy of the British National Health Service, 1945-1975: Opportunities and Constraints? *Medical History* 2008; 52: 463.

boards of governors, reporting directly to the Minister of Health; that private patients could be treated in nationalised hospitals; that regional health authorities had executive not just advisory status and would have medical representation, and that hospital specialists would have a new system of merit awards to enhance their NHS salaries.

The BMA, with the popular radio doctor Charles Hill as its articulate spokesman, initially opposed the NHS Act, fearing that it would be too intrusive on professional freedom, and turn all healthcare into a local government service. At the first vote its members rejected it. Bevan held out, choosing to use his Chief Medical Officer, Sir Wilson Jameson, to hold the face to face meetings with the profession's representatives. It is interesting that Bevan himself credits the successful formation of the NHS to the work of Jameson, but he is seldom remembered.[17]

The BMA won concessions which further undermined the structural integrity of the planned NHS. General practitioners were to be on contracts to local Executive Committees, not employees of local or central government; the proposed local government-managed health centres were to be subject to a 'controlled trial' and GPs would not be forced to take up residence within them; GPs would be paid on a capitation basis, not the part-salary scheme the 1944 White Paper had proposed. The BMA defeated Bevan's plans for a Medical Practices Committee, which would have prevented more GPs setting up practice in areas which already were well supplied, and ended the sale of practices. As late as April 1948, the BMA's members voted not to work within the imminent NHS. In the final plebiscite (which balloted all members of the medical profession) 54 per cent were against further discussions with the Bevan (the consultants were split evenly, the GPs rejected at nearly two to one). As with all large democracies, it is often easier to mobilise general opposition than to secure agreement on specific proposals.[18]

The early years

After some last minute negotiations, Bevan got the commitments from the medical profession that he needed. He was later to recall, in his most famous quote, that he had 'stuffed their mouths with gold'.[19] The NHS was there-

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[17] See Sheard S, Donaldson L. *The Nation's Doctor: the role of the Chief Medical Officer 1855-1998.* Oxford: Radcliffe Medical, 2005 for further details on Jameson's career and his role in the creation of the NHS.

[18] Klein. *New Politics of the NHS*, p.19.

[19] Brian Abel-Smith (1926-1996) the health economist and special adviser recalled being told this by Bevan when he had dinner with him at the House of Commons in the mid-1950s. BA-S archive at London School of Economics. BA-S to Julian Tudor Hart 5.11.1973.

Figure 1: Aneurin Bevan (1897-1960) on the first day of the NHS – 5 July 1948 at a hospital in Manchester.

fore born, on its due date, 5 July 1948. Bevan commented on the scale of his achievement: ‘This is the biggest single experiment in social services that the world has ever seen undertaken’ (Figure 1).

The public reaction was one of overwhelming relief. For the working classes the threat of doctors’ and hospital bills had been a chronic concern. Now there were no more bills (unless of course the patient opted to jump the NHS queue and pay for private treatment). Although many of the nationalised hospitals were not fit for purpose, there was at least now a government commitment to a more equitable allocation of resources between regions. And the regional health authorities, with their mandate to plan services for populations which ranged from one to five million, were able to develop effective data collection systems, and provide specialist services not required at the district health authority (250,000 population) level. It was an extraordinarily efficient system, and from its outset the focus of international envy.

But it was now the government that worried about the bills, and they had good cause, despite the inherent logic of this part-integrated system. During planning in 1945, the estimate for the annual cost of the NHS had been £170 million. In its first full year of operation – 1949 – it cost

£305 million.[20] A later Minister of Health, Enoch Powell, writing with the hindsight of 1961, referred to this as a 'miscalculation of sublime dimensions'.[21] Although some of this 'overspend' must surely have been tackling the previously hidden reservoir of ill health, the staffing costs were also higher than predicted. It substantiated some political views that Britain should not have attempted such an ambitious scheme so soon after the costly Second World War, which had required an American bail-out and left the country on the verge of bankruptcy.[22] What must also be factored into the immediate assessment of the relative cost of the NHS are the other demands that were pressing on the UK budget, especially the escalating cost of developing a nuclear 'deterrent' and the Korean War rearmament. It was decided that the public should be asked to make some contribution towards paying for 'the cascades of medicine pouring down British throats' (Bevan's phrase).[23] Bevan supported the introduction of a one shilling prescription charge. However, he could not tolerate the plan in 1951 to introduce charges to cover glasses and dental treatment and he resigned as Minister of Health.

Arrested development

At the October 1951 general election Clement Attlee's Labour government fell, and Churchill returned with a Conservative administration which seemed intent on unpicking the new welfare state. They discussed various options, including moving from the taxation based scheme to a fully contributory insurance based one. Rodney Lowe has explored why this did not happen, suggesting that the NHS as a service provided free at the point of delivery was already too entrenched in the British psyche to be withdrawn.[24] Health was also not one of the Conservatives' priorities: the Minister of Health was deprived of a seat in Cabinet, and there were no less than seven Ministers responsible for the NHS between 1951 and 1964.

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[20] See Cutler T. Dangerous yardstick? Early cost estimates and the politics of financial management of the National Health Service. *Medical History* 2003; 47 (2): 217-38. for more discussion on aspects of the budget, especially how pharmaceutical costs were massively in excess of the pre-NHS predictions.

[21] Powell E. Health and wealth. Lloyd Roberts lecture. *Journal of the Royal Society of Medicine* 1962: 55; 1-6.

[22] Fox DM. The administration of the Marshall Pan and British Health Policy. *J. Policy History*, 2004; 16 (3): 191-211.

[23] Quoted in Williams PM. *Hugh Gaitskell.* London: Jonathan Cape, 1979. Gaitskell was then Chancellor of the Exchequer, and one of Bevan's main political opponents.

[24] Lowe L. Financing care in Britain since 1939, in Gorsky M, Sheard S. (eds). *Financing Medicine: The British experience since 1750.* London: Routledge, 2006, pp.242-251.

Instead, they did as so many governments have done when faced with politically unpopular decisions, they appointed a Parliamentary committee in April 1953 to enquire into the cost of the NHS. Claude Guillebaud was the nephew of the Cambridge economist Alfred Marshall. He also had studied economics at Cambridge, and made his academic career there. It has been suggested that he was chosen to head the inquiry into the cost of the NHS precisely because 'of his unexceptionable middle-of-the-road record. His reputation as a "professional just man" was arguably more valuable for disarming Labour critics than for determining that the committee should be economy-minded.'[25] Guillebaud's committee of four took their time on the inquiry, not publishing their report until January 1956.[26]

Guillebaud could not have accomplished such a wide-ranging and intellectually innovative review of the NHS without research assistance. Brian Abel-Smith, a young health economist, was appointed to support the committee's work. He analysed the cost of the NHS (in England and Wales) for the period 5 July 1948 to 31 March 1953 in social accounting terms. He adapted statistics from the Ministry of Health to measure the cost of the service in terms of current productive resources. He analysed the capital expenditure, and assessed the rate of hospital building by comparison with pre-war construction and contemporary American data. He calculated the expenditure required to maintain the present hospital infrastructure (it was estimated that 45 per cent of hospitals predated 1891 and 21 per cent 1861).

Abel-Smith's analysis showed that whereas the factor cost of the services expressed in actual prices had increased from £375.9 million in 1949-50 to £435.9 million in 1952-3, the cost expressed in constant (1948-9) prices increased only from £374.9 million to £388.6 million. This relative increase in costs was due to additional services and inflation, not, as the Treasury wished to believe, to inefficiency and extravagance. Expressed as a percentage of the gross national product (GNP) the cost of the NHS had actually declined from 3.82 per cent in 1949-50 to 3.52 per cent in 1952-3.

The somewhat unexpected Guillebaud committee's conclusion was that the NHS was actually very good value for money, and that it demanded a greater share of GNP rather than the current retrenchment, as some politicians were suggesting. The report was explicit: 'We are strongly of the opinion that it would be altogether premature at the present time to propose any fundamental change in the structure of the National Health Service. It

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[25] Webster C. *The Health Services since the War Vol. I Problems of Health Care. The National Health Service before 1957.* London: HMSO, 1988, p.205.

[26] *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmd.9663, (London, HMSO,1956).

is still a very young service and is only beginning to grapple with the deeper and wider problems which confront it. We repeat what we said earlier – that what is most needed at the present time is a period of stability over the next few years…'[27] But the Guillebaud enquiry did admit that there were problems with the system. Sir John Maude, one of the committee members, and a former Ministry of Health senior civil servant, used the report to register what has become a chronic complaint: that the original tripartite structure for the NHS was its major flaw, and that no amount of additional funding would correct this. After the initial news had sunk in, there was growing government dissatisfaction that actually Guillebaud had taken three years to tell them little that was new, but that the report had bolstered the public's love affair with the new service. The Treasury naturally found it 'highly disappointing and indeed unsatisfactory'.[28] The government was forced to accept that dismantling the NHS was not a politically feasible option.

There were further initiatives aimed at curbing the cost of the NHS, especially the pharmaceutical bills. The Treasury and Public Accounts Committee successfully lobbied for the creation of the Voluntary Price Regulation Scheme [VPRS] in 1957. Another policy that the Conservatives exploited was to raise the National Health Insurance contribution to the NHS – from the flat rate of 10d. per week for each contributor introduced in 1948 to 1s.8d. in 1957. There was remarkably little opposition to this move, as both politicians and the public recognised it as ring-fenced money for the NHS. In fact, a second increase to 2s.4d. was adopted only a year later. Thus by 1958 the income from direct charges and from the NI 'stamp' contribution totalled almost 20 per cent of the gross cost of the NHS.[29]

Some Ministers of Health were more creative than others in developing policies that could be seen as improving the NHS, whilst also strengthening accountability of its constituent parts and achieving efficiency savings. Enoch Powell's Hospital Plan is a prime example.[30] Yet, when viewed in the context of Bevan's vision, and of other western countries in the post-war period, Britain's record is less than exemplary. The planned health centres failed to materialise, due not only to financial constraints but also to ongoing medical professional obstruction. Only ten were built during the first

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[27] *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmd.9663. London: HMSO, 1956, paragraph 148.

[28] Webster C. *The Health Services since the War.* p.220.

[29] Webster C. Conservatives and consensus: the politics of the National Health Service, 1951-1964, in Oakley A, Williams AS. (eds). *The Politics of the Welfare State* (London, UCL Press, 1994), p.67.

[30] Powell JE. *A New Look at Medicine and Politics.* London: Pitman Medical, 1966.

twelve years of the NHS.[31] In health expenditure league tables, Britain occupied a mid-position, notably behind Germany, France, Denmark, Sweden, Italy and the Netherlands. Britain's NHS could never claim to be in the 'vanguard of health promotion'. [32] Charles Webster sees the Conservative's term of office between 1951 to 1964 as a 'substantial attack on the NHS, while resource starvation and lack of commitment to improving services prevented the emergence of the range and quality of care intended by the original architects of the service.'[33] Yet other services such as education, defence, housing and nuclear power did not endure the same attacks.

An integral part of the British psyche

There is not space in this paper to discuss the subsequent changes and reforms (the two words are not synonymous). This historical context of the creation and early years of the British NHS has raised three key issues which are critical to understanding its position and future in 2011. First, the increasing frequency of changes to health care systems in Britain. Lloyd George's national insurance based system lasted some 37 years; Bevan's NHS lasted for 26 years until the first major re-organisation in 1974. The more recent chronology demonstrates increasingly shorter periods of experimentation. The 'system' is never left long enough to be fully tested, and the experiments are rarely historically informed.

Second, this brief study of the role that various groups – politicians, civil servants, medical professionals – played in the formation of the NHS highlights that we need to understand their respective histories. Even 63 years later, the attitude of the medical profession to change in the NHS remains coloured by the experiences of its predecessors in the 1940s. Although few British doctors today could accurately recount the details behind the formation of the NHS, many will be familiar with Bevan's quote about stuffing their mouths with gold. This is not the first time that doctors have opposed the government's health care plans, and we can learn a lot about how to manage such dialogue by looking at the way in which it has been conducted at other flash points: limited prescribing lists, contracts, the introduction of general management, to name some of the most contentious.

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[31] Webster C. Conservatives and consensus: the politics of the National Health Service, 1951-1964, in Oakley A, Williams AS. (eds). *The Politics of the Welfare State.* London: UCL Press, 1994, p.57.

[32] Stewart J. The Political Economy of the British National Health Service, 1945-1975: Opportunities and Constraints? *Medical History* 2008: 52; 453-470.

[33] Webster C. Conservatives and consensus: the politics of the National Health Service, 1951-1964, in Oakley A, Williams AS. (eds). *The Politics of the Welfare State.* London: UCL Press, 1994, p.69.

Third, the concept of 'path dependency' – that policy journeys begun in one direction are subsequently very difficult to alter course – is a very useful framework for analysing why Britain has retained the NHS.[34] Perhaps it would be more helpful to call it history dependency. The NHS's history has been the subject of considerable public attention, with the decadal birthdays marked by national celebrations and retrospectives. This should be exploited in a more rigorous way to improve public understanding of potential change.

According to some commentators, the NHS has been in some form of chronic crisis since 5 July 1948. The current NHS crisis is but another variant on previous political themes, all rooted in issues of finance, accountability and efficiency. Yet the way in which the British government is handling this one is different, as the papers by Julian Tudor-Hart and Allyson Pollock in this volume will discuss. What cannot be ignored is the scale of achievement of the NHS: the first health system anywhere in the developed world to give free medical care to the whole population, and paid for not through insurance, which might require a test of contribution, but through general taxation. It remained a beacon through the post-Second World War international recessions, a very visible demonstration of how risk-pooling and might co-exist with a market economy. Its development generated international interest and emulation. It is not the same NHS that Bevan launched, and some have claimed that it was never a 'health' service, but a nationalised hospital and sickness service. But it continues to generate unprecedented affection from the millions of Britons who have been cared for by its various parts, from 'cradle to grave'.

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[34] See Pierson P. The new politics of the welfare state. *World Politics* 1996:48, 143-79.

Julian Tudor Hart

Which future for the UK National Health Service (NHS)?

Michael Quarterly 2011;8:442–59.

The National Health Service (NHS) became quickly the nation's most loved and most respected institution. There have been many open attacks on the NHS after it was established in 1948, but all have failed. The "reform" programme of today could succeed only if it was presented not as an alternative to the NHS, but as vital to its rescue, after many years of under-funding. The NHS is now close to death.

In spite of everything, medical science and professional thought will continue to advance, continually adding to our long-term advantage as advocates of open and evidence-based rather than covert and populist policies. Of course, we may fail. Even then, there will still be the more civilised countries of Scandinavia to fight for a more human world. One way or another, we shall win.

I was born in 1927, and qualified in medicine in 1952. I was reared in an intellectual culture based on ideas developed in the two decades preceding World War 1. This assumed that modern history was a social progress, wherein social, cultural and material inequalities would diminish, and democratic society would advance from passive consent toward active participation. This culture had powerful enemies, but we knew who and where they were. From the mid-1930s onwards, we learned how to fight them. After 1945, with fascism out of our way, most arguments between intellectuals within this culture concerned not where we wanted to go or who were our friends, but how fast we could get there. The institutional vehicle for this progress was the social-democratic welfare state. Its apex was the NHS.

In the UK, this era closed in 1979, with election of Margaret Thatcher. She had a simple but perceptive mind. Sooner than her colleagues, she recognised that for the owners and controllers of the UK economy, and for the state acting on their behalf, most of the welfare institutions created before World War 1, and greatly enlarged after World War 2, had become optional. Collapse of the Soviet experiment in command socialism, China's transition to command capitalism, and abdication of responsibility by our own Democratic Socialists as soon as ideological competition with communism came to an end, had eliminated the threats which begat the welfare state in the first place. Simply to defend capitalist laws and institutions against Bolshevism, state welfare institutions were no longer necessary. Educational, medical and social services needed for any complex industrialised society could be run as well, probably more efficiently, and certainly more profitably, by commercial providers rather than the state. Consumer choice in competitive markets might be more popular than bureaucratic accountability to citizens in state monopolies. How consumers chose to spend their money was probably a more effective and comprehensible form of accountability than voting for politicians, so democracy could be redefined as an economic rather than political process. Capitalism equated with democracy, and socialism equated at best with authoritarian government, at worst with dictatorship. We have to admit that experience in the USSR, China, Vietnam, Cuba and West Bengal all gives some support to that argument.

This set of views, and the post-modernist philosophy and consumerist culture derived from it, swept all before it among the most powerful and influential sections of the UK intelligentsia, including most of those who began as Marxists. After she was deposed in favour of a less socially divisive and more electable leader, Thatcher was asked what she believed was her greatest achievement. Her answer was "New Labour". In less openly aggressive forms, the advocates of Tony Blair's New Labour accepted all her social and economic policies in principle. By the UK parliamentary Labour Party and the shadow cabinet, they have still not been repudiated. All national UK political parties now share a new consensus, first defined by Thatcher in the 1970s, within which disagreements concern not direction, but how far and how fast the UK can be returned to 19th century conceptions of society, decorated, disguised and fortified by 21st century technology. And not only politicians: several generations of high-flying economic, administrative, scientific and medical graduates have grown up ignorant of any other philosophy.

However, this powerful and still dominant Neo-Liberal view is weakened by three gigantic flaws. They will ultimately prove fatal.

Three fatal flaws

The first flaw is that though these views have been either embraced, or at least regretfully accepted as inevitable, by all leading politicians and a large majority of media commentators, they have never been opened to honest public debate in the seven areas of greatest potential contention: health care, social care, education, housing, transport, control of industry and finance, and distribution of wealth. Providing they can find a publisher or gain access to broadcast media, anyone can say what they like about any of these, but no significant national political party presents any fundamentally different policies for any of them, comparable to their differences before 1945, and consolidation of the welfare state. Thatcher's rule was never supported by more than about one-third of voters. Dominance of her simplistic ideas always depended more on the weakness of her Liberal, Labour and Social-Democrat opponents, than on truly popular support. The Neo-Liberal programme has never been put to a clear popular vote for any of the social institutions to which it is being applied. People who still retain intuitive belief in socially inclusive neighbourhood schools and free university education, and in free, regionally or nationally planned health care, in generous social care, in social housing for need rather than profit, in nationalised railways, in democratised industry, in regulated financial services and in progressive taxation, now have no major party to vote for. The Labour Party, which once proclaimed all these policies as its aims, has opposed them in practice ever since it won power in 1997 with its largest-ever majority. In the greatest economic and social crisis of capitalism since 1929, all it can offer is a slower and more cautious retreat to *laissez-faire* economy than is promised by the Conservative Party. Numerous public opinion polls over the past three decades have confirmed either large majorities, or at least minorities larger than the one-third who voted for Thatcher, opposed to all these Neo-Liberal "reforms". There is a potentially powerful alliance of middle-class and working class voters available to support any credible politician with enough courage and imagination to lead them. The global crisis of capitalism initiated by the bank failures of 2007, still accelerating today, will promote growth of this unrepresented dissenting majority, though a widespread decline in political literacy means that at least some of this dissent may well slide terrifyingly towards various forms of neo-fascism.

The second flaw is less obvious, but more important. The entire Neo-Liberal programme rests on an assumption that all production of wealth will function most efficiently, with greatest productivity, through industrialised (and, so far as possible, mechanised) labour. This will have a commodity product, promoted and sold to consumers by providers motivated by profit and competing for highest apparent quality at lowest apparent price. For simple commodities like automobiles or baked beans, experience has shown this assumption is correct, but these are no longer major growth industries, either for employment, or for generation of wealth. Commodity manufacture is stagnant. Deregulated growth of financial services, the alternative industry most valued by leading UK politicians but most despised by the public, is what got us into this crisis. Only conformist politicians or economists could believe that this industry could get us out of it, even supposing that foreign investors are likely ever again to trust its judgement.

So where is economic growth, in employment or production of wealth, to come from? The two obvious candidates are education and health care. They are both increasingly labour intensive. The quality of their product, and their staff morale and motivation, both depend mainly on staff having enough time to use their skills as they have been taught. They both produce the products most valued by most of the public, healthier and more educated people.

Thatcherised politicians and economists are unable to recognise this. For them, these two industries are not wealth-producers, but wealth-consumers. They produce not more profitable commodities, but higher taxes. So for them, progress and "reform" mean remodelling of both educational and health care systems on industrial lines, as if education and health care were commodities, transferred from competing corporate providers to consumers exerting market choice. From this, they believe higher productivity is bound to result. Whole lives devoted to teaching or health care, serving communities long enough to learn from seeing the results of their work, will be things of a past which never, for most people, resembled the sentimental picture of kindly young teachers or devoted old GPs. Instead, hitherto self-serving professionals will enter the same states of permanent insecurity as all other workers in a fully industrialised society. Their jobs will survive only if they contribute to victory of their own employing authority over its competitors, in a race to reduce labour costs; so say the NeoLiberals. They will not be believed.

Thirdly and finally, Neo-Liberal economics and post-modern philosophy increasingly violate the rules of scientific thinking and evidence-based decision, setting them on a collision course against our finest exponents of innovative science. In science, the validity of any theory depends on its explanatory and predictive power, tested against representative data from the real world. Neo-Liberal economics has spectacularly failed to pass either test. Post-modern philosophy simply evades testing, by denying even the possibility of useful analysis of evolving society. This alienates a growing and increasingly powerful class of highly skilled professionals, essential to continued development of capitalism in the new age of intellectual property.

This entire sequence of reasoning is fallacious. It hopelessly misunderstands the nature of wealth production in these two essentially similar forms, education and health care. Neither pupils, students nor patients are ever consumers, except in particular, transient and isolated circumstances (1). The success of both education and health care depend on their active cooperation with professionals: not simply on doing what they are told, but on understanding and interpreting what they are told, and linking it with their own personal experience. In this way a wealth product (but not a commodity) is created, valuable both to the individual and to society. Successful outcomes of both educational and medical processes depend on agreement between students/ patients on one hand, and staff professionals on the other, about the nature of the problems they address, and the relevance and feasibility of their solution. Definition of problems, and relevance and application of solutions, both depend on evidence, commitment and hard work from both sides. Simple division between providers and consumers is a trading concept irrelevant to all but a few crisis situations in medical care. Increasingly, productivity (of outcome, not process) in both education and health care depend on long-term, sustained personal relationships, so that both staff and students/patients can learn from experience of the consequences of their decisions. Preconditions for this, stability, continuity, and personal commitment, are all most easily created and sustained in a public service gift economy aiming to meet needs rather than make profit (2).

The Neo-Liberal programmes for "reform" of education and health care industrialise professional decisions, dividing educational and clinical processes into rational sequential tasks, which can then be delegated to a wider ranged of more specialised but often more narrowly trained (and cheaper) performers. The result has been loss of continuity and imagination, an unstoppable rise in fragmented box-ticking (deplored by thoughtful professionals and hated by the public) and all the disjointed thinking that results from separating staff from the consequences of their decisions.

For example, we know from good evidence that about 85% of the evidence used to reach a medical diagnosis derives from what patients tell us. Only 7% comes from physical examination, and another 7% from diagnostic investigations (3, 4). Ignoring such evidence, with rapid growth in new diagnostic technologies there was recently a suggestion that it is more efficient and cost-effective to employ a technician to undertake a battery of investigations rather than have an expensive clinician spending time listening to patients (5). In the present state of credulity for every whim from business management, even that could happen.

These "reform" programmes will fail on all measures of outcome, without which any improvements in process are meaningless. In terms of health outcome, they will reduce productivity and efficiency from levels already attained, even within the very imperfect gift economies intuitively developed in UK schools, universities, health centres and hospitals. When the nature of public service gift economy is fully understood and embraced, both by UK professionals and the public, gains in productivity will be possible on a scale not seen since the first industrial revolution.

The Neo-Liberal offensive rides on despair

Outlines of this divergence in public service, between regressive industrialisation and progress towards co-operative gift economy, were emerging in the early 1980s (6). By the early 1990s they were obvious (7). Today, more than 30 years later, commercialisation and industrialisation of the NHS is recognised and detested by a large majority of both staff and public. Yet however regretfully, most accept this process as inevitable, a price that has to be paid for efficient and effective application of technical progress. This is precisely what the most intelligent advocates of "reform" intended and hoped for: not a frontal attack on an immensely popular and comparatively cost-effective public service, but stepwise attrition, using every element of mean-spirited vulgar mythology ("The trouble with the NHS is abuse by patients with trivial, imaginary or self-inflicted problems, which would all go away if they had to pay for it") (8).

There have been many open attacks on the NHS as a gift economy since 1948, but all have failed. The NHS was much more than popular, it quickly became the nation's most loved and most respected institution. The "reform" programme could succeed only if it was presented not as an alternative to the NHS, but as vital to its rescue, after 26 years of under-funding. According to the Wanless report, £267bn less was invested in the UK NHS than the EU average over the years 1972-1998 (9).

And so it is, that after more than 30 years of treatment with increasing doses of this "reform", the patient is close to death. We do, at last, have a well organised movement of doctors and academics in KONP (Keep Our NHS Public), thanks to whom leaders of the British Medical Association (BMA) have been compelled to oppose the latest government proposals for "reform", a hastily prepared jumble of new laws, requiring more pages than the original NHS Act of 1946, which few if any members of parliament had read when they voted for it in September 2011. No effective action has yet been taken by NHS trade unions, though this is one of the few fields in which their membership is still strong. The “reformers” still hold the initiative. Leaders of the Labour Party dispute the extent and pace of commercialising and industrialising “reforms”, but not their nature or direction of travel. As for the public, it is bewildered and in despair. The NHS seems to have only one future, the same as us all: finally to succumb to the market, wringing our hands, but seeing no way to use them to make anything better.

An alternative vision

Apart from predictable support from virtually all news media and capitulation from politicians, the greatest asset for commercialising “reformers” has been pessimism and despair among the public, and passivity from most NHS staff. Nobody working in the NHS ever thought that it delivered the full potential of contemporary medical knowledge to all who needed it, only that it had opened up new opportunities to come closer to doing so. The whole world has a living example of what an already commercialised, and fast becoming industrialised care system does to people, and fails to do for people, in USA, the richest country in the world, USA. We knew the old NHS helped to lead us away from that, and nobody with real experience of the NHS either as staff or patients, ever believed in a golden age. We were just beginning to learn what might be possible through continuing on that new path entirely (as Nye Bevan once called it). The gift economy NHS was a direction of travel, not a destination, but this was enough to sustain high morale at the leading edge of innovation, both for primary generalists and for hospital specialists.

In the first 15 years or so of its existence, the centrally planned NHS achieved roughly equal distribution of medical and nursing staff throughout the UK, a feat the US care system has never even attempted. This was an important step towards social equality, but not nearly enough. Needs for medical and nursing care are not distributed equally.

We have a correlation between numbers of caring professionals and numbers of people, but virtually no correlation between the numbers of caring professionals and numbers of sick people. If professional carers try to meet all needs throughout the populations they serve, they get much higher caseloads and almost impossible workloads, wherever rates of limiting chronic illness are high. According to the vulgar mythology beloved of “reformers”, much of this limiting chronic illness is not real, but a proxy for claimed benefits. Morbidity so measured is closely related to age-standardised mortality (r=0.84) (10). Death is never imaginary, and people who feel unwell usually are unwell indeed.

The Inverse Care Law still thrives, 40 years after it was described (11). And naturally so. It is not a law of nature, but a law of the market. The further health care gets from the market, the less this law applies, but for most of those 40 years, all political parties have been trying to drag the NHS back to the marketplace. The "reformers" have an answer to this too. The Inverse Care Law (which, while wringing their hands, they frequently deplore in rhetoric) concerns human behaviour. The marketplace, they say, represents the highest form of human behaviour possible for the general run of consumers, in the ordinary course of their lives. While we all admire and celebrate the human spirit, for most days of the week we are steeped in original sin, each seeking his own advantage. So though it may be deplorable, the tendency of doctors to work where people are rich and healthy, and to avoid work where they are poorer and sicker, is inevitable, a manifestation of unchangeable human nature.

As the authors of their very significant work, Mary Shaw and Danny Dorling, say: "…comparing provision of informal unpaid care over 50 hours a week with population indicators of general health and limiting long-standing illness…*Where no market forces apply, where people give up their time for free to provide care* [for people they know], *an almost perfectly positive care law is found to apply.*" (my emphasis)

Of course it is not quite true that "no market forces apply" to families faced with responsibility to provide more than 50 hours of unpaid care each week for a sick person, and also to stay alive themselves. But to the extent that a family can preserve human rather than market relationships, people seem to behave both humanely and rationally, giving care where it is needed rather than selling it where it is profitable. On this evidence, human nature seems pretty good.

Unfortunately it is not true that human nature is unchangeable. If it were, the advertising and promotion industries would be wasting their time. Responsible citizens can eventually be changed into thoughtless consumers, if enough work is put into degrading them downwards, and none is put into helping them to understand the world they live in, and how to change it. To sustain caring human relationships in capitalist society, where almost any action can be justified as long as it makes money, people must at least have a vision of some better way to live. The NHS gave, and could give again, not just a vision of a more human society, but opportunities to learn in practice how to extend the best present family behaviour throughout a society we can all really believe in. Most of all, this applies to doctors and nurses, who can readily understand that their work should be distributed according to the needs of the communities they serve, as informal carers already do.

How could the Inverse Care Law of professional care bring itself into line with the Positive Care Law of functional families? This should be the real stuff of UK politics. If it were, we would not have to wring our hands and deplore the apathy, indifference and cynicism of voters. For a start, we might remember that the origins of all health care lie not with professionals or the state, but in the care of people for one another, in families, in neighbourhoods, and in shared labour.

Deep and shallow ends

The behaviour and career choices of doctors depend mainly (not entirely) on how they are paid and organised. Though the number of NHS GPs has been increasing, apart from a brief improvement in 1990/91, they have settled disproportionately in areas of lower mortality, lower morbidity, and lower workload, a trend accelerated by concentration of training practices in already well-doctored areas (12). Graham Watt, who first devised this effective metaphor, called it the Drowning Pool.

The depth of this pool is proportional to age-standardised mortality rates, ranked by social class. At the deep end, GPs serving social class 5, the poorest people with highest rates of unemployment and limiting long-term illness, need to deal with about two and a half times more ill health than the most affluent people in social class 1, at the shallow end (13, 14). Their workload is consequently much higher. They exhaust themselves trying to keep afloat, and their patients drown.

As there are only 24 hours in a day, they must work much harder, and have less time to give to each patient. Face-to-face time is the main determinant of quality in primary care, and therefore of appropriate referral to specialist care (15). Time is the currency of primary care (16). We have never had enough of it, and this is the main reason that for most chronic health problems, roughly half have never been recognised by a doctor (even in an NHS where virtually everyone has access to a personal doctor), half of those recognised are not being treated, and half those treated are not well controlled (the Rule of Halves) (17).

Our team in Glyncorrwg reorganised and resourced our work to add systematic proactive anticipatory care in an attempt to delete the Inverse Care Law in a deprived population, essentially by applying what was already known fully to our entire community (how we got those extra resources is an interesting story, too long to tell). After 20 years of that policy, we compared age-standardised mortality over 5 years in Glyncorrwg with that in a socially similar village about 10 km away in the same valley, with good traditional reactive care. Mortality was 28% less in Glyncorrwg for deaths under 65, and 30% less for deaths at all ages (18). If what we already know were fully applied, there could be a huge rise in productivity, measured by outcome.

Redistribution of resources, wealth, and power

Full application of existing knowledge requires new professional attitudes, accepting that the aims of primary care must be set by public health, not just the sum of all personal complaints, and that primary medical generalists are a subset of social workers, not a separate species. Those are necessary but not sufficient preconditions for full application of knowledge. To these must be added appropriate resourcing, so that teams working at the deep end have the staff time needed to work at least at the same pace as their colleagues serving more affluent populations. Outlines of this strategy have been developed by Graham Watt's Deep End project, from experience of staff in practices serving the 100 most deprived communities in Scotland (19–22).

This implies a major shift in resources toward areas with greatest needs, comparable with that achieved after 1948, with equal doctor/patient ratios throughout the UK – both substantial redistributions of wealth. If, as it surely must, this were accompanied by recognising the role of patients and communities as active participants rather than consumers, it would also entail a redistribution of power. Such mighty shifts would depend on two necessary elements now wholly absent: first, a level of political will and understanding not seen in Britain since the high days following victory in1945 – victory not only over fascism, but over all the complacent assumptions of our ruling class, by a furious tide of popular discontent resulting in a landslide vote. Secondly, it would require an expanding rather than stagnant or contracting NHS staff workforce, so that redistribution of resources could proceed through selective expansion, rather than by reducing resources which less impoverished communities already have. Any such development would require social solidarity across presently assumed class divisions, a new broad alliance. No such dual earthquake is currently anticipated or welcomed by any established UK political party.

Prospects for earthquakes

However, earthquakes do happen, and at unpredictable times. There are necessary, but not sufficient, preconditions for big earthquakes. There must be huge rising tensions beneath the visible surface, potential cleavages waiting to spring apart, furnaces waiting to explode. Such tensions have long been obvious. Since accurate data became available in 1929, real wages of a majority of the employed US workforce never fell until 1973. Over the following 20 years they declined by 11%. Entry of wives into the workforce kept median family incomes rising more slowly until 1989, but even median family incomes then started to fall, by more than 7% from 1989 to 1993. The US became not only the most unequal industrialised society in the world, it also grew more unequal faster than anywhere else, with the UK close behind (23). Such reality as there ever was to sustain the American dream that anyone who worked hard could get rich, vanished long ago. The dream still continued until 2007-8, only sustained by a new and even more profitable industry; lending to people in deepening debt, and borrowing from China to pay for imported goods from the world's cheapest industrial workforce, largely created by US, UK and EU investment, and destroying their own manufacturing base. Corrected for inflation, average hourly wages in USA in 2000 were still 8% lower than their level in 1973, 27 years earlier, and 40 million citizens had no health insurance. In 1970, average household income for the richest 5% was 16 times as much as for the bottom 20%. By 2000 this difference had increased to 25 times as much. In 1970, average earnings for Chief Executive Officers exceeded average pay in their workforce 39-fold. By 2000, this difference had increased to 1000-fold (24). Finally, by the eve of the world banking crisis of 2007-8, average household debt was 20% higher than disposable income in USA, and 40% higher in UK (25).

The first tremors of an earthquake are now upon us, with a global financial crisis since 2007-8 which threatens to be even more profound than the global depression starting in 1929, which was ended only by preparations for the second world war. All the causes of this new earthquake remain in place. Far from diminishing them, the treatments so far proposed by all the main political parties are more likely to reinforce those causes.

So far, no other treatment has seemed available. People and ideas which caused the crisis retain dominant power, because no coherent or credible alternative seems to exist.

People learn only from their own experience

Until they happen, only seismologists really believe in earthquakes. Then, when a global socio-economic earthquake occurs, people must look for some way to make sense of it. The first, most readily available ways to make sense will always be irrational, because no rational explanation has a public hearing within the established paradigm.

Beginnings of an alternative paradigm have in fact been on the shelf for at least 130 years, with more explanatory and predictive power than either the simple but honest ideas of Adam Smith in 1762, or any of the increasingly tortuous sophistries derived from them since. Karl Marx's analysis of the social relationships of production and capital investment provides the beginning for any rational analysis of capitalist economy at any stage of its development, in the same way that natural selection provides the beginning for any rational analysis of development of species. Marx's analysis of capitalism in mid-19th century Britain is not sufficient for useful analysis of global capitalism 150 years later, but this is the beginning. And it is hardly any guide at all to socialism which lay in a future yet to be discovered in practice. Those who exclude Marx from the mainstream of developing socio-economic analysis are as absurd as biologists who try to exclude Darwin. Marx's analysis of social class, derived from the social relations of production and ownership and control of capital, have in every way been reinforced rather than weakened by historical experience.

This includes the impossibility of building sustainable socialized human relationships on industrialized commodity production essentially unchanged, as in the USSR and China, a fact brutally denied by the dominant guardians of Marxism from 1917 to 1990. Socialized human relationships begin to be feasible only when commodity production has already reached a level of abundance, and burdens of over-production, under-consumption and unemployment are imposed on whole populations, locked into industrialization and with no means of escape to subsistence economy: obvious poverty alongside obvious potential wealth, in a literate population, and in a country able to defend its independence.

In North America, Western Europe, and Australia that point was reached in the early 1970s. In all these areas, potential foundations for socialist society now exist. Their populations lack only the understanding .and confidence they need to make use of them.

All these areas, particularly those furthest into a post-industrial phase of development, now face growing structural unemployment on a scale not seen since the 1930s. Advocates for a capitalist economy, in which production for use is only a byproduct of production for profit, celebrate the creative destruction of periodic crises, as necessary preparation for a new round of expansion. Each crisis of overproduction prompts elimination of old, more labour-intensive industries. Each recovery replaces these with new, less labour-intensive industries. Productivity rises, and more people become redundant to the commodity production process. Economic recovery, measured by profit for shareholders and salaries, bonuses and pensions for top executives, will therefore become increasingly dissociated from social recovery, measured by real wages, stable employment, and non-commodity production in homes, communities, and public services developed as extensions of this value production outside the market(26). To restore even sufficient stability to maintain profitable commodity production as it was, people discarded from old industries and redundant from new ones must be allowed some creative role in society, recognized by dignified earnings, health care, and improving education for their children.

The obvious areas for expanding employment are health care and education, in which productivity (measured by outcome) rises as they become more labour-intensive, not less. Both these fields of production resolve the division between providers and consumers essential to commodity markets; their productivity depends on that resolution. So these fields of activity should expand at the expense of commodity production for profit. They are also essential to the social stability necessary for profitable and sustainable commodity production to continue. All the factors necessary for first steps toward transition from a capitalist society to a socialist society therefore already exist in the fully industrialized economies now in crisis. All that is still lacking is recognition of this opportunity, by the large majority of people who could gain from it.

Such recognition is held back by ignorance and fear. Ignorance is becoming hard to maintain, now that virtually everyone can read what they want through the internet. Fear is founded mainly on past experience of attempts to found socialist societies, all of which failed to move beyond the command structures necessary to create and defend them in undeveloped economies, not at the end of capitalism, but at its beginning. Interestingly, there are just two fields in which this primitive command socialism was remarkably successful, health care and education. But for commodity production they failed, replacing the despotism of competing employers by the more powerful despotism of coercive states.

Democratic socialism will depend on a level of responsible and critical citizenship far beyond the grasp either of credulous consumers at the bottom of capitalist society, or of casino players at the top. Education, health care, and the arts and sciences which support them provide spaces in which everyone can learn how to evaluate evidence, take rational decisions, and learn from their mistakes, within rules of behaviour that respect and value diversity of opinion. If they have any self-respect at all, people who call themselves democratic socialists should be able to conceive of these fields as potentially liberated areas within capitalist society, growing within a culture wholly distinct from the culture of business, and aiming to replace it (27).

Possibilities in the British Isles

The only major progressive step undertaken by Blair's New Labour administration was creation in 1999 of regional parliaments in Scotland and Northern Ireland, and an Assembly government in Wales. These all have administrative and policy powers over education and the NHS. Except in Scotland, they have no control of taxation, and all still depend on allocation of resources from central government in London. This central power will certainly be used, by a Conservative/Liberal Democrat government wholly committed to a NeoLiberal agenda, against regional governments all more or less committed to the old Social Democratic agenda. Projected NHS per capita spending is already planned to fall by 2013-2015: in England by -0.9%, in Northern Ireland by -2.2%, in Scotland by -3.3%, and in Wales by -10.7%, despite an expected rise in the costs of care exceeding general inflation, and ageing populations. Civil servants in Wales and Northern Ireland (but not Scotland) still pursue their careers on a UK stage, influenced more by attitudes in England than by any rebellious views at the periphery. Finally, only Scotland has a really powerful political party independent from any party in England. Parties in Northern Ireland are still hopelessly divided on religious sectarian lines. Plaid Cymru in Wales has failed to take root outside the 20% minority who speak the welsh language. The Welsh and Scottish Labour Parties have not hitherto dared to break openly with the predominantly English UK Labour Party, which has still not renounced the Neo-Liberal policies of New Labour in office.

Despite all these *caveats*, fundamental steps have been taken in all three Celtic regions, away from the Neoliberal agenda. In 2005, Prof. David Kerr, chair of National Framework Advisory Group set up to plan NHS Scotland over next 20 years, made it clear that the English NHS reform agenda of choice and competition would not be followed, and indicated a marked shift from hospital to community care, reducing need for hospital admissions (28). In 2008 health ministers from Scotland, Wales and Northern Ireland launched a joint attack on London government about NHS pay negotiations taking place behind their backs, and issued a joint communiqué affirming their support for principles of an NHS firmly in the public sector, and that all national ministers must be involved in any definitive negotiations on staff pay (29). All three regions have taken practical steps since then to eliminate the purchaser-provider split, established in 1990 as a foundation for eventually full exposure of the NHS to market forces. All three have abolished all prescription charges, which in England now stand at more than £7 per item for all except groups exempted by age, specific disease, or destitution. In Scotland, where both private education and private medical practice have always been weak, MPs in the Scottish parliament (MSPs) have voted to make it illegal for any commercial organisation to run any part of NHS primary care. Answering Conservative MSPs who claimed that independent contractor status of GPs showed that primary care was already privatised, so commercial operators would make no difference, Nicola Sturgeon, health minister in the Scottish Nationalist government, replied that of course GPs were already independent contractors, but they were also directly involved in frontline delivery of care. "The problem of existing law", she said, "is that it leaves it open to a health board to award a contract to a body in which none of the individuals are registered medical practitioners or healthcare professionals." (30)

Scotland is even committed to the Glyncorrwg model of anticipatory primary care (31). This is as yet only an unresourced aspiration. So far, none of the UK regional governments has actually redistributed wealth or power in the NHS on a significant scale, to address gross inequalities in health. Wales, ruled by a Labour Assembly government nominally bound to the policies of its central UK Party, has in practice pursued policies directly opposed to central leadership, but so quietly that even in Wales most people are hardly aware of the growing difference between NHS Wales and NHS England. As the chief opposition in the London parliament, Labour has yet to oppose Conservative policies in principle, and is obviously evading any commitment to reverse them if it regains power. This position is still endorsed by most Welsh Labour MPs, though not by Members of the Wales Assembly.

Those are the weaknesses, and they are serious. All three Celtic nations face much heavier burdens of sickness and care workload than England, all three face diminishing budgets (much worse in Wales), none of them as yet show much evidence of any return to political awareness and activism, and the general fear of impending mass unemployment seems so far to have had a paralysing rather than spurring effect. By July 2011 UK unemployment reached 2.51 million (7.9% of the workforce) and is still rising. It is worst in the young age group 16-24 at 973,000, more than three times the rate for all adults (32). In Wales unemployment reached 8.4% of the workforce by January 2011, about the same as in Scotland and Northern Ireland. This was similarly concentrated in the 16-24 age group, at about 22% of the workforce. On the other hand, union membership, at 38% of employed workers in Wales, 35% in Scotland, and 39% in Northern Ireland, is substantially higher than England's 28%, and both Wales and Scotland can look back to strong traditions of radical dissent (33). In Scotland, all the running has been made by the Scottish National Party in government, with the Scottish Labour Party scarcely to be seen.

With such weak foundations in principle and in public awareness, some other explanation is needed for the firm stand taken by governments in all three Celtic regions. Probably the most powerful force stimulating resistance has simply been the obviously impossible cost of following the English example, at a time of rapidly increasing austerity. Prof. Allyson Pollock estimated in 2009 that if NHS England followed Scotland and Wales by abandoning the NHS internal market, and returned hospital and primary care Trusts to control by area planning authorities accountable to elected government, it could save between £6bn and £24bn a year (34). The wide limits of this estimate derive from the fact that since 1991, when the internal market began, neither Conservative nor New Labour governments had published, or perhaps even known, or wanted to know themselves, the additional costs incurred by billing, invoicing, enlarged finance departments, marketing, management consultants, lawyers, and commercial contracts.

What about our assets? Unlike Scotland or Northern Ireland, the Labour Party is in government in the Wales Assembly, in control of NHS (and educational) policy. The Labour Party in UK is profoundly divided. The present leader, Ed Miliband, was narrowly elected in a contest with his brother David, mainly because of trade union support. He is an unconvincing, vacillating leader, who looks ever less likely to be electable. Brother David represents continuity with Blair and New Labour, and lost the trade union vote for that reason, but he is a much more confident and therefore convincing leader. Like Blair, he looks very electable. If and when Ed's leadership is challenged, the right wing of the Party will endorse David. Almost certainly, the left will then support the present shadow finance minister, Ed Balls. He is a vigorous performer in parliament, who is clearly moving left and positioning himself for leadership. As voters begin to suffer the full consequences of the present Conservative/Liberal Democrat coalition's slashing attack on all benefits and welfare institutions as well as on higher education, there will certainly be a massive politicisation of the middle and working class electorate: probably most will move to the left, but at least some will move toward neo-fascist groups. In this situation, Wales could become a much more important player in UK politics, as the only region where Labour holds power, and can defend and develop further the NHS as a socialising part of our economy. By the time of the next general election, Wales could be the only area with concrete experience of applying democratic socialist principles to real people in real communities, learning as we go. As the NHS is still the most loved UK institution, those who betrayed it could pay a heavy price at the next election, and those who defended it could make corresponding gains. This could be a powerful influence on MPs and shadow ministers.

Everything will depend on whether Welsh political leaders, and Welsh medical and nursing professionals, recognise these opportunities and rise to this occasion. On this question, the jury is still out. We have several very strong political players among Labour members of the Assembly (mostly women) and in the Wales Assembly government, though weaklings and vacillators are still well represented. They won't lead, but as the heat rises, they may follow.

Finally, in spite of everything, medical science and professional thought will continue to advance, continually adding to our long-term advantage as advocates of open and evidence-based rather than covert and populist policies.

Of course, we may fail. Even then, there will still be the more civilised countries of Scandinavia to fight for a more human world. One way or another, we shall win.

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The break up of the English NHS: the new market bureaucracy needs information systems based on members and not geographic populations

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Universal health systems are characterized by administrative functions that focus on needs assessment and resource allocation across geographic populations so as to ensure comprehensive coverage that is country and system-wide. This is because in universal systems financial risk is pooled at government level. In market systems, however, financial risks are allocated (spread) across different parts of the system through market contracting. Administrative functions in these systems focus on risk pricing and segmentation among providers, members or enrollees. Using the example of the English National Health Service (NHS), we argue that the information systems required to enable risk segmentation are different from those underpinning comprehensive care. Administration is non-geographic in market bureaucracies and geographic in comprehensive systems. This leads to a shift in information requirements that poses difficulties for resource allocation and service planning, and therefore for universalist goals.

Introduction

Since 1948, the NHS has assumed the responsibility for the risks and costs of health care for all its citizens. However, a succession of statutory changes dating back to 1990 and culminating in the Health and Social Care Bill currently before parliament (1) have increasingly undermined this national responsibility. If the latest bill becomes law, risks and costs will be spread among government funders, local authorities, insurers, providers, the public and ultimately patients.

The Bill introduces new structures taken from the American health maintenance organisation (HMO) industry in which commercial organizations insure and provide care for a selected membership rather than geographic populations (2). The introduction of these structures to the NHS is accompanied by a major overhaul of administrative structures involving the substitution of market for public bureaucracies. The new market bureaucracies will give discretion to commissioners to define the scope of NHS services and to some extent to select the population for which they purchase care. They will also allow providers to select the publicly financed services for which they tender. Deregulation of this type facilitates the emergence of business strategies based on risk selection.

Such has been the strength of public opposition to the Bill that in April 2011 the prime minister suspended the legislative process for three months and instigated a special forum to hear and respond to public and professional concerns. However, as the Bill now continues its passage through parliament, and in spite of three hundred significant amendments by the Government, criticism continues. The government proposes to abolish the Minister's duty to provide comprehensive care throughout England and to create an independent body, the NHS Commissioning Board, to oversee commissioning. The fundamental concerns is that abolition will result in a loss of the universal and comprehensive character of the NHS and pave the way for a switch from taxed-based to insurance-based financing and user charges (2).

In this paper we focus on the new administrative bureaucracy which is necessary to support market reform of this type. We show that information is key to our understanding, specifically the change in the unit of analysis associated with a shift in responsibility from area-based populations to membership-based systems akin to insurance pools. This analytical change also facilitates a transfer of risk from government to patients.

Market bureaucracies

For the last 25 years, in common with many health systems, NHS reform has been profoundly influenced by market theory (3–9). Among the most widely pursued policies internationally are the substitution on economic grounds of competing, commercial providers for publicly administered government units and the introduction or extension of competition among third party payers and insurers of health care.

The introduction of these markets has implications for public health bureaucracies in terms of their control over the various components of health systems. Whilst the impact of markets on public health functions such as workforce planning and financial incentives has attracted considerable research (10–13), less attention has been given to their impact on population data. However, market systems require a different analytical framework from publicly integrated ones and this in turn affects the data systems and the information that is used.

Universal health systems are characterized by administrative functions that focus on needs assessment and resource allocation across geographic populations and system-wide. This is because in universal systems financial risk is pooled at government level and the whole population must be comprehensively covered. The NHS is a prime example of the geographic focus that has grown up around a virtually monopolistic provider of health care and encouraged extensive data collection and analysis on population health, health inequalities and access to health care by social class and ethnicity.

These are the data that the market analytic threatens. In market systems financial risks are allocated across different parts of the system through market contracting and there is no duty to provide services on a comprehensive basis or to collect data on a geographic basis. Instead, administrative functions in market systems focus on risk pricing and segmentation among providers, members or enrollees. In advocating market or "strategic purchasing" as an important tool for improving heath system cost efficiency, the authors of the World Health Report 2000 (14) largely overlooked the implications for information of this different analysis.

The impact of markets on some public health functions is relatively well understood. For example, market-related, unmanaged outflows of health workers are known to damage health systems, undermine planning projections and erode the skills base, according to the WHO (10). The workforce crisis among trained personnel in resource-poor countries has recently been recognised as an issue in international aid (11–13). Following the World Health Report 2006 (12) which estimated a staffing shortfall of 4 million in developing countries, the first global forum on workforce issues was held in Kampala in 2008.

Another example are the lack of routine data in marketised health systems which have under-developed population-based information systems because public authorities do not have planning powers or resources to justify their collection (15) or because large proportions of the population are not covered. The efficiency of planning systems depends to a large extent on routine data collection and the power of public bodies to require data returns from providers. Loss of this capacity can be seen very directly in the UK's long-term sector where in 1991 the private sector and local authorities were allowed to pass risks back from the NHS to the public via new eligibility criteria involving a means test. The planning, resourcing and provision of care of older people to this day is left to the market and it is now impossible to assess on a population basis the scale and distribution of resources devoted to the various elements of care because data that would allow these assessments are no longer available.

The effect of privatization on data availability for long term care suggests a wider question, namely the role that data can play when governments seek to withdraw from universal policies. In long-term care, planning data did not merely cease to be available; it was no longer officially needed because the government had largely relinquished responsibility and thus financial risk for care. Normative change of this sort is undoubtedly assisted by absence of evidence of unmet need and hardship.

The shift from integrated public to market health care systems requires innovations in the identification of risk which in turn change the basis of health information. For example, markets require incorporation of providers so that risk can be allocated through commercial contracting; they involve changes to revenue and capital accounting so that commercial loans can be substituted for government grants; they typically include revised reimbursement mechanisms based on price signals in which case- or activity-based payments to providers are substituted for block grants (16–19); and to facilitate 'consumer choice' or incentivize providers they are commonly associated with new performance management frameworks with a focus on firms or providers rather than whole populations living in contiguous areas (20, 21).

How the integrated approach of risk pooling is achieved in a universal public bureaucracy

Throughout most of its sixty-three year existence the NHS has had a duty to employ administrative structures that promote equity and redistribution through resource allocation, service planning and needs assessment. The issue of how government deals with catastrophic risks and costs on behalf of its citizens was the normative problem addressed by the introduction of the welfare state in the UK and the systems of benefits which underpinned it (22). Accordingly, the structures of the NHS were originally based on contiguous or seamless geographic tiers of administration designed to ensure universal coverage. Service providers were directly administered and integrated into the organisation with responsibility for meeting needs and planning services. There was no billing, invoicing or contracting and, crucially, no selection or denial of care on basis of place of residence or ability to pay. Instead, resource allocation methods and service planning dealt with universal populations. The denominator was always all the citizens living within a geographic area drawn from census or census estimates; the numerators comprised the subgroups of specific interest which always related back to the whole population. These methods proved to be highly efficient and the NHS was one of the lowest cost universal systems in the world (23).

The risk allocation approach of a market

Market and business strategies focus on individuals or groups of individuals as customers or members of insurance pools. The denominators here are members or enrollees, a provider's customer list or an insurer's list of potential claimants. Under the new Bill, it will be patient registrations belonging to the lists of general practitioners (family doctors). To maximize income and profit, market actors must now engage in complicated risk selection strategies that enable them to avoid contracting for high risk patients and treatments or markets with low profitability. Examples of risk selection methods include the differential premiums charged by insurance companies or the range of tiered benefit plans offered to consumers: a minimum package, or higher benefits price with risk sharing or coinsurance; time limits on care or an annual cap on attendances for example. Risks are identified in market contracts which function as the legal means by which risks are allocated and paid for. There is little or no empirical verification of the cost efficiency claims made for market structures (24–26) whilst their effect on equity is largely unevaluated (27, 28).

The Risk shift

Under the NHS Bill risk analyses will become central to both the public and private side of contracting. Private firms require services and patient lists to be unbundled so that they have the ability to select on commercial grounds. Meanwhile, in an attempt to counter risk selection of this type, or its consequences, the government will seek to risk adjust provider incentives (for example, through adjustments to diagnosis related group (DRG) reimbursement) or to equalize risk among different payer organizations with disparate, and not necessarily equally high risk, memberships (29, 30).

A shift to market bureaucracies requires a change in the information which underpins the methods for funding and financing In the first three of five examples we show how the information requirement changes and in so doing the unit of analysis from comprehensive area based populations to members or providers which do not provide comprehensive care to all. In the last two examples we show the implications of this change in information for performance measurement and comparisons of health systems.

1. Changes in system of resource allocation: from areas to members

(i) The current system of resource allocation

Since 1948, area-based funding has been the method of allocating resources across England for the NHS. Area-based formulae have been used since the 1970s to distribute resources fairly among the "local populations", "catchments" or "resident populations" of PCTs (31):

> "Primary care trusts (PCT)s are responsible for funding NHS hospitals, GPs and other health care services for their local populations.
>
> The Government, through the Department of Health, provides the money to all of the 151 PCTs across the country to fund these health services.
>
> The Department sets PCTs' budgets in advance, mainly on the basis of a formula to calculate each PCT's fair share of the total available budget for England.
>
> In 2011-12, the total health budget for PCTs was £89 billion and the Department has to find a way for allocating this between PCTs in a fair way."

Since its inception, the NHS has been based on the principle of equal access for equal need. This principle is embodied in two longstanding objectives for resource allocation from the centre to local health services:

i) To distribute resources based on the relative need of each area for health services. Currently, this objective is to enable PCTs to commission the same levels of health services for populations with similar needs;
ii) In addition, to contribute to the reduction in avoidable health inequalities (32, 33).

The resource allocation formulae devised to meet these objectives includes

- the age profile of the population (localities with more elderly populations have higher needs, all else being equal);
- additional need over and above that relating to age (localities with less healthy populations and higher levels of deprivation have higher needs, all else being equal); and
- unavoidable geographical differences in the cost of providing services - the Market Forces Factor (MFF) (it costs more to provide the same level of services in high cost areas such as London and the South East).

The formulae have been the subject of revision for many decades.

ii) How the resource allocation system will change under the Bill

Under the Health and Social Care Bill 2011 the Secretary of State's principal duty remains unchanged and under Clause 10[2] the duty to "arrange for the provision of services to such extent as it considers necessary… to meet …. reasonable requirements" (1) is transferred to commissioning groups. Commissioning groups however will not be contiguous geographic area based administrative structures, they will be membership organisations.

Moreover, the Department of Health Memorandum to the Delegated Powers and Regulatory Reform Committee (34: paragraphs 53 and 57) states that the intention of Clauses 10 and 11 is to allow commissioning groups discretion with respect to the selection of patients and services and that this discretion will be limited by regulation.

Thus responsibility for provision will no longer be to all persons in an area but only "persons for whom it [the CCG] has responsibility" (1); nor will it involve purchasing all services deemed part of a comprehensive health system.

The Bill has been anticipated and so too have the new structures for quite some time. For the last few years behind the scenes the civil services has been at work to effect that transformation. In 2010, and well in advance of the legislation the Secretary of State instructed the Advisory Committee on Resource Allocation (ACRA) from 2013 to switch from PCT and area-based populations to GP registrations in deriving its new formulae (35). This is in recognition that CCGs will not have the same geographical basis as PCTs, because they are able to include patients registered with GP practices anywhere in England. They are only required to have *"a sufficient geographic focus"* to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities" (36, p. 29). However, "sufficient geographical basis" is not otherwise defined.

'Fair allocation' objectives need to be embodied in the new NHS system, but it is made almost impossible by the loss of responsibility for a defined geographic population. It is unclear, for example, if and how a measure such as DFLE could be derived for clinical commissioning groups, given their irregular, non-geographic overlapping mosaic of footprints.

Since CCGs will no longer be geographically focused, the loss of area-based population responsibilities has serious implications for the stability and accuracy of measurements of need and the equity of resource allocation and funding. In the absence of area-based planning information, CCGs will be able manage their risks and costs in different ways.

2. Capital planning protocols –from area-based needs to provider's affordability under resource accounting and the private finance initiative

i) From capital grants to debts and private finance

The problems of fairness of funding highlighted in the Bill are not new to the NHS. They have already been played out in capital allocations for new hospitals under the private finance initiative (PFI), a policy introduced in 1991 according to which new capital is distributed among hospitals on the basis of provider finances rather than area needs criteria. Before PFI NHS capital budgets were allocated as block grants on the basis of need and regional development plans. Financial reforms in 1990 effectively transformed grants into loans that local service providers were responsible for repaying to the Treasury. PFI exploited this development by transforming debts to the Treasury into debts to private consortiums with local service providers still responsible for repayment. The result was that budgetary allocations for new building were no longer awarded to areas on behalf of the whole population on the basis of need but to providers to finance loan repayment (16–19) on the basis of what commissioners thought they could afford to pay from their revenue budgets.

NHS hospitals award PFI contracts to the private sector to design, build, finance and operate new facilities. Because investment and operating costs are paid for out of hospital operating budgets, PFI required before its introduction the creation of a special revenue stream that could be directed to pay for capital. This in turn required the government to change its financing method for hospital building from capital grants to loans, and it required hospitals and services to put their accounting on a commercial basis in order to reflect the new element of capital charging in their financial management.

ii) Shifting the risk

Crucially the impact of the PFI was to shift risk of capital budgets from national and regional level to local providers, making them responsible for the affordability of capital.

This type of risk devolution impairs the geographic focus underpinning service planning because it makes providers' debts and debt servicing a higher priority than funding capital health care needs (17). In early PFIs planning took place outside public health as teams of management consultants were brought in to model bed closures using implausible productivity targets in order that the clinical budget could be redirected to pay for capital at the expense of clinical care. Thus PFI planning and allocations for capital turns on the question of what a hospital can afford to pay (or rather borrow), and not on the health care needs of a geographic population for capital (16–19).

PFI is also based on a form of revenue unbundling necessary for risk allocation. A typical PFI contract involves separating out revenue streams for capital, maintenance and some ancillary services in order that risks can be transferred or allocated in different proportions and to different parties. This is because the PFI contract involves specifying and pricing risks that the private sector is paid to undertake instead of the public sector.

PFI is a good example of the new market analytic at work. It shows how the information requirements changed from capital needs to the affordability of debt repayment at provider level and displace the role of area-based needs data in capital allocation . It also highlights difficulties in provider-level calculations of cost efficiency arising from the arbitrary or contentious nature of risk pricing and the way in which risk was shifted.

3. Commissioning and contracting with private providers: the case of the ISTC

(i) risk segmentation through patient selection

The UK's 4 billion pound independent sector treatment centre (ISTC) programme provides a third example of how a non comprehensive provider focus erodes area-based population data, in this case as a result of selection bias in the allocation of patients to and non-recording of data by the commercial sector.

In 2000, the UK government announced a plan to contract-out elective surgery under the ISTC programme (37). The opportunity to purchase care from the commercial sector under this scheme represented a major departure from the original model of the NHS as virtual monopoly provider of publicly-financed hospital services. In order to facilitate commercial participation two important risk management measures were adopted. In the first place, elective surgery was unbundled (or cases differentiated according to criteria of complexity such as age and co-morbidity) so that more complex and potentially higher cost cases could be left with NHS facilities and commercial providers could concentrate on high volume, low risk operations. The separation was achieved by making it mandatory to risk select patients through treatment protocols. Secondly, demand risk was retained by the state via the adoption of "take or pay" contracts according to which contractors were to be paid for a set number of operations whether or not this number of patients actually materialized.

(ii) loss of population data

With providers not bound by the same data collection duties as the NHS and standards of collection largely unmonitored or poor, the intrusion of risk selection was to have a profound effect on public health data. Mason and colleagues (38) at the University of York have shown that ISTCs do not collect good timely data, but that such data as are collected show that ISTCS recruit and select from a healthier patient population. This selection will of course affect hospital league tables and general performance data (see below). It also undermines routine data collection, which ceases to be comprehensive.

Evaluation of the ISTC programme was itself a victim of these new weaknesses for the data were not available to carry out a reliable assessment (37). Strikingly, evaluation in Scotland was carried out by the management consultants that had helped the government set up the programme.

This example shows that data collection is fundamentally affected when patient selection is allowed. In the first place, data integrity and continuity are undermined. Secondly, aggregate output or outcome data ceases to have meaning because it reflects risk selection not relative performance.

4. How international comparison of health system performance obscure risk selection and ignore differences in population – the case of Kaiser Permanente

It is possible to see risk selection play out in comparisons of health system performance both at provider level and internationally. In 2002 Richard Feachem and colleagues (39) published a paper purporting to compare the cost efficiency of the NHS with that of Kaiser Permanente, an American HMO. In fact it illustrates the way in which risk selection undermines health system comparison. HMOs are of course premised on patient and service selection, they combine insurer and provider functions and their populations comprise members or enrollees. The populations are unstable due to high enrollment and disenrollment rates, coverage is not universal not does it serve contiguous areas and risk selection is rife.

Accordingly, aggregate performance data will reflect relative success in selection not relative success in attaining comprehensive cover within areas, which is the goal of the NHS.

Health system comparison has become an important tool in the political management of market reform. Frequently used to evaluate performance among systems at different stages of marketisation (40), international comparison are increasingly used to assess the relative effectiveness from a cost containment perspective of different structural elements. Comparisons of this type are fraught with methodological difficulties because health care systems can be more or less selective. Comparisons between universal and non-universal systems is deeply problematical because like is not being compared with like.

Measurement and reporting issues can also confound results because of differences in the definition of health spending, under-reporting and over-reporting and variation in methods for measuring the size of the informal sector. Price comparison is also problematic. Prices can be compared by converting into US$ dollar equivalents using current exchange rates or by estimating 'purchasing power parities' (PPP), also referred to as the 'international dollar rate'. PPPs involve contestable assumptions about market prices and the costs they reflect.

These problems were apparent in the paper by Feachem and colleagues published in the British Medical Journal in 2002 shortly after the NHS Plan announced the introduction of provider market (39). The paper's authors purported to show that Kaiser Permanente was more cost efficient than the NHS and that risk selection and other problems of comparison had been taken into account. However, within a week of publication the BMJ had 170 responses mostly critical of data, methods and assumptions (41).

Crucially, the populations served by Kaiser and the NHS are very different and so too are the range of benefits. Whereas the NHS provides universal, comprehensive cover to all citizens in the UK , around 60 million people largely free of charge Kaiser recruits healthier, wealthier and younger patients as members to plans with restricted benefits and numerous additional charges and does not provide comprehensive care. (41). No amount of risk adjustment can adjust for these differences; Kaiser's population can never be risk adjusted to become like the NHS as it was never designed to be comprehensive.

This case study shows a studied attempt to promote as more efficient a system in which competing insurers and providers can optimize their risks by selection. However, the more an insurer and provider can risk select the more cost efficient it is likely to appear. In fact, the paper rested on erroneous methodology and false claims.

5. How hospital league tables engender risk selection

The switch to providers and members as part of risk selection strategies of market oriented systems is played out in performance measures locally. Performance league tables, widely promoted as a means of privatizing provision (10), also reflect a shift from universality to risk individualization by substituting provider based performance for measures of access and equity at area level. They are products of economic theory that predicts markets will work imperfectly in circumstances where purchasers do not have full information. This problem, known among economists as "information asymmetry" (42), is particularly acute in health care where providers know far more than purchasers and are easily able to trade off cost against quality because the latter is so difficult to measure. League tables are intended to overcome this tendency by making comparisons of outcomes publicly available.

Hospital based mortality rates are often favoured as the measure of hospital quality; the reality is that area based mortality should be the focus. Jacobson and colleagues (20) and more recently Bottle and colleagues (21) have shown weaknesses in hospital mortality league tables. Among the problems identified are:

1. quality of data and coding and gaming
2. the numerator problem of deaths: patients may die on their way to hospital die because of delays in referral, or they may stay in hospital for different periods of time. Some may die out of hospital and others may be admitted but discharged and then readmitted to other hospitals before death and here the response is to apportion a death to all of the hospitals - the patient dies not once but several times over in several different hospitals!
3. denominator problems: the population is unstable and comprises those that can get access, but how are they counted as admissions, first admissions or FCEs and which population do you count?
4. case mix adjustment : different hospitals have different mixes of patients and services
5. institutional issues, small hospitals. poor quality and lack of data: coding incompleteness of data
6. inability to adjust for institutional differences

If they are to convey reliable information, league tables must at least adjust for differences in the risks present in different populations. However, risk adjustment methodologies are often spurious and involve unreliable data and complex modeling that conceals bias. In a landmark critique of hospital league tables in the Journal of the Royal Statistical Society, 1996, Goldstein and Spiegelhalter (43) conclude: 'No amount of fancy statistical footwork will overcome basic inadequacies in either the appropriateness or the integrity of the data collected'.

The journals are bursting with critiques of league tables but public authorities are impervious to them and use and publish them for marketing and recruitment purposes. A more profound problem arises when this type of data are used as the basis for pricing and cost comparisons and determination of whether an NHS hospital goes into deficit and whether it stays open or closes. More recently economists have tried to argue that hospital concentration and competition saves lives based on erroneous assumptions and data of this type (44). However such performance league tables can discourage clinicians and providers from treating patients with high morbidity and high costs.

And yet the geographic population focus of a public health frame is far simpler. For many decades public health has analysed variations in treatment, service use and access over time between and across populations, districts or PCTs and by social class. These data have been and used to conduct sensible detailed audits, confidential enquiries, surveys and investigations into the whole patient pathway including referrals from and access to primary care.

Conclusion

It has long been recognised that health care planning and equitable resource allocation cannot be left to the invisible hand of the market. As Abel-Smith put it in 1976, markets mean that there is "no single organization pledged to provide the best health service possible out of a limited budget (45, p. 154)." Indeed, the NHS was originally conceived as a non-market model in order to optimize resource use. However, our case studies show that a comprehensive service requires an administrative bureaucracy underpinned by information consistent with that function. Public bureaucracies are not destroyed overnight but rather through a succession of technical incremental changes to the information systems which inform the systems for resource allocation, capital allocation and coverage and provision. Where risk segmentation is the goal then there is an interplay between information and resource allocation systems which change the data requirements in fundamental ways so that the focus shifts from area-based populations to aggregates of individuals or enrollees for the purpose of risk management. This shift fundamentally affects the availability, production and analysis of area-based comprehensive data. Finally, once introduced risk-based data can be used to undermine universal systems by allowing providers and commissioners to be selective about coverage and care. This switch in data systems is therefore both a cause and a consequence of market fragmentation and enables the shift from national risk pooling to risk selection.

Central to all this is the unit of analysis. When the focus ceases to be comprehensive health care to the whole population living within an area and becomes instead risk allocation to individuals, members, enrollees or providers, then universality is no longer attainable because the necessary data underpinning it are no longer available and providers have the opportunity to risk select. As we show in our examination of the latest NHS legislative proposals, this change of focus is a way of managing the normative transition from universality to selection (2). That is why we have concluded that the information requirements which underpin risk selection contribute to the abolition of the NHS as a universal system of health care.

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Steinar Westin

The beginning of the NHS – and the impact on Norwegian health care

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The reason for us in Norway to keep an eye on what happens to the British National Health Service is related to the mutual influence of ideas and social policies between our countries, which has been particularly reinforced during and after the Second World War. The Norwegian government, as well as the King, several influential public servants and labour union leaders all took refuge in London during the war years. The ideas launched by the Beveridge Commission in 1942 set the pace for major reforms in post-war Britain, and inspired Norwegian welfare programmes as well, with gradual reforms leading to free – or almost free – access to health care and education for all.

While Britain started its National Health Service, with its motto "free for all at the point of use", in a major 1948 reform, Norwegian health care has moved more gradually towards the same goals, although since 1969 Norway has also had comprehensive publicly financed health care. As in Britain, general practitioners have a more independent status than hospitals. However, British general practice, with its admired achievements in research and education, was a major inspiration when a list-based system for general practitioners was introduced in Norway in 2001.

Since Margaret Thatcher's fund holding, the various British NHS reforms have been watched and viewed with interest and some anxiety among Norwegians, who believe in the virtues of an equitable health service provided according to need and not according to wealth. Nevertheless, the latest white paper by the Cameron coalition government, "Liberating the NHS", may undermine these ideas.

The purpose of this presentation is to examine our common ideals for health care, where these ideas came from and what impact the suggested British reforms may have on Norwegian health care.

> Each nation needs to develop its own memory of how solidarity systems were in fact developed through collective struggle.
>
> Julian Tudor Hart, 2007

This quotation by Julian Tudor Hart sets the stage: The Norwegian welfare state is not an evidence-based project, nor have the founding ideas for a comprehensive and publicly financed health care system come out of the blue – as pure ideas. Rather, these social institutions were the result of long-lasting political processes with conflicts and reconciliations.

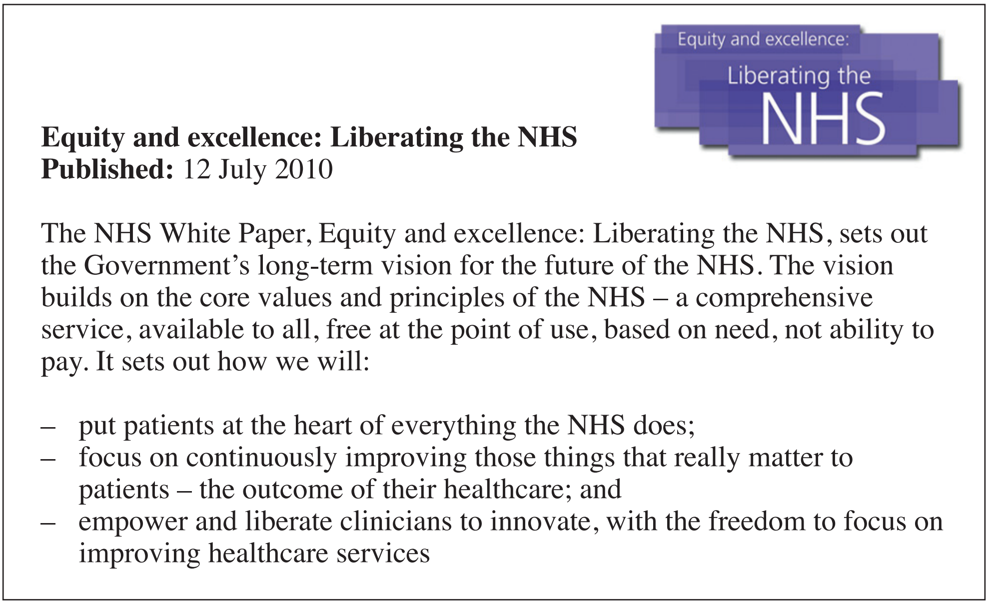
Over the years, I have come to be increasingly impressed by the wisdom, struggles, reconciliation, discipline and will not to resort to internal violence, which has become a hallmark of the Nordic countries over the last century. One great ideal coming out of these processes is *equity*, *equality, egalité*, maybe more so than in any other democratic country in the world. Particularly in the years after the Second World War, most policies and political parties have – more or less willingly – promoted ideas and practices aimed at the redistribution of wealth by means of taxation, by extensive social security and welfare legislation, by means of collective institutions and universal welfare, by means of free education and free health care for everyone and through strong labour inspection laws.

This is when I understand the famous British historian, Arnold J. Toynbee (1899-1975), who once stated: "Civilization is a movement and not a condition, a voyage and not a harbour". The rise and fall of civilizations was his preoccupation, which reminds us that any civilization is on the move, from somewhere – towards somewhere. And so are the Nordic welfare states and their health services. The questions are: So what is the direction? From where did the visions come? What is worth defending, and what needs to change?

Liberating the NHS?

The reason for us to take up the topic is the recent white paper by the David Cameron coalition government released in July of last year, named "Equity and excellence: Liberating the NHS" (1).

I have to admit that I had to look twice: "Liberating"? and "Equity and excellence"? Big words, and the following text no less in its grandeur: "… The vision builds on the core values and principles of the NHS – a comprehensive service available to all, free at the point of use, based on need, not ability to pay." This sounds like an echoing of the late Aneurin Bevan, announcing the original 1948 NHS reform:



Equity and excellence: Liberating the NHS
Published: 12 July 2010

The NHS White Paper, Equity and excellence: Liberating the NHS, sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. It sets out how we will:

- put patients at the heart of everything the NHS does;
- focus on continuously improving those things that really matter to patients – the outcome of their healthcare; and
- empower and liberate clinicians to innovate, with the freedom to focus on improving healthcare services

Figure 1 – From the Department of Health web pages, announcing its white paper in 2010.

> On July 5th there is no reason why the whole of the doctor-patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay fees – an aspect of practice already distasteful to many practitioners…

On further reading, however, an entirely different picture emerges, making the department's announcement sound like Orwellian New Speak. I realized that my anxieties were shared by others, as well as friends and colleagues in the UK, all of whom reported that they were no less than shocked. In their election campaign, the Conservative Party had presented themselves as defenders of the NHS, which I have learned is the ever discussed but most loved British public institution. "No more reforms" is what was said after a period in which the number of reforms allegedly matched the number of years since the conservatives introduced internal markets and the fund holding reform in 1991.

It took some time before the major medical journals really announced their stand on this. On January 29th of this year, I first read the *Lancet* editorial, "The end of the National Health Service", without questioning it (2). Next, a *BMJ* editorial on the same date directly addressed the UK

Secretary of State for Health, Andrew Lansley, the minister who presented the white paper: "Dr Lansley's monster: Too soon to let out of the lab" (3), which was illustrated by a not very nice-looking Mr. Hyde monster, and introduced the text like this:

> What do you call a government that embarks on the biggest upheaval of the NHS in its 63-year history, at a breakneck speed, while simultaneously trying to make unprecedented financial savings? The politically correct answer has got to be: mad.

Some years earlier I had quite accidentally come across an interesting but rather disquieting book in a London bookstore, warning about an impending privatization of the NHS, by someone named Allyson Pollock (4). I bought it and was no less alarmed at what seemed to be happening to the health services in the UK, with the public-private initiatives and all that. She has contributed considerably to the rising amount of critique, stating plainly in the *BMJ* that "the secretary of state for health proposes to abolish the NHS in England" (5). Allyson Pollock also appears in writing and movies on the Internet pages of what is now called KONP, a grass-roots movement to "Keep Our National Health Service Public" (6), which is a big resource for critical books, pamphlets and video presentations. And of course, for those who know where to look for the long story of the NHS, Julian Tudor Hart's book from 2006 was a revelation, and no less so with its updated version in 2010 (7). It is already clear that the British Medical Association is strongly against the reform, as are the Royal Colleges.

To a foreigner, it is hard to see how a government white paper can possibly survive such a massive resistance. Somehow though, the bill seems to have continued on through Parliament under the umbrella of Cameron's "Big Society", which, by the way, some Norwegian politicians have taken an open interest in since it also implies decentralization and possibly less public spending (8).

Bridges to Britain

So yes, there is indeed still a strong link to Britain in relation to science, culture and politics. When general practice was emerging as an academic discipline in the 1960s and 70s, the Norwegian founders were most of all looking to Britain and the Royal College of General Practitioners (9). I have learned that my colleagues in other medical disciplines have had similar experiences related to British hospitals and research institutions. To Norwegians, Germany was out after the war.

As a young assistant professor of general practice with a group of medical students in 1980, I shall never forget the inspiring meetings with the

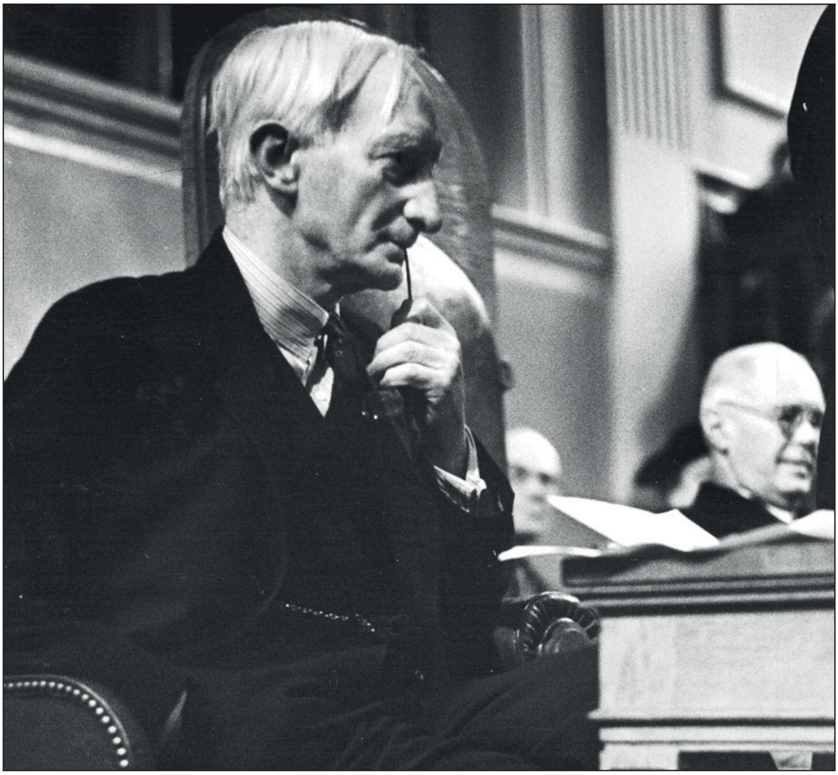


Figure 2. Lord Beveridge.

RCGP people when visiting the headquarters at Prince's Gate 14, which is a wonderful building south of Hyde Park. On a later occasion, I was asked by the *BMJ* editor to contribute to their special issue in 1998 to celebrate the NHS at 50 (10). I had to look deeper into the founding ideas of the NHS, and I guess this is when I started to learn about the Beveridge Commission and the brave moves by the post-war health minister, Aneurin Bevan (1897-1960), and Labour's NHS reform (11).

I have to admit that it feels overly ambitious to present my interpretations of British social history in front of British natives, although I shall try to make some remarks on how I think Britain's intellectual and political life have made an impact on post-war developments in Norwegian health care and social politics.

A brief history of health care for all

When Norwegian social history is told, reference is often made to the social consequences of late 1800s industrialization and urbanization, and to the political moves made by the German Chancellor Otto von Bismarck (1815-1898) in the 1880s. A common notion is that his groundbreaking reforms to implement the first state-based social security reforms were not generated from altruism or great humanitarian values, but rather strategic moves allowing him to curb the rising power of the revolutionary labour movement.

Any enthusiast for the computer game Civilization knows that when there is social unrest among poor peasants, or a revolution by hungry workers looms, "building a temple", means to either give the poor some social reforms or build a church. This helps to restore social stability. In other words, several objectives, but Germany and Norway as well, received the first state-based social security legislation and labour protection laws.

There may be similarities in different political processes during the Second World War. One key question could be: What motivated Winston Churchill and his war cabinet to set up a grand commission for social reforms in 1941 – under the leadership of a former colonial bureaucrat William Beveridge (1879-1963) – at a time when Hitler's bombs were still raining over London and no one knew for sure how or when the war would end?

The Second World War was not only about battles, bombs, tanks, invasions and brave collective resistance against the Nazis. It was also a war of ideas, a fight over visions for the future. This fight took place not only between nations, but also inside each country. One of Hitler's tempting visions was his social programmes with work for all and campaigns for education, good health and health services for all – all Aryans at least (12). The Dutch primary health care system, with a general practitioner – a huisarzt – for everyone, was implemented by the Germans during the war, which was actually the first list-based system for general practice in Europe, and they still have it.

The challenge was not only from the right – from the social order and hygienic visions of the Nazis. There was a challenge from the left as well. We must remember that social conditions for the working class in Europe under the economic recession of the 1930s were bad, very bad. Socialist and communist ideologies provided inspiring ideas for social justice and visions for a better life. The Spanish Civil War from 1936 was a formative event for an entire generation of youth in Europe.

During the initial phases of the subsequent Second World War, there were questions of war morale. It was by no means certain that the poor working classes of the allied countries would sacrifice their lives in defence of a society with immense class differences, unemployment and social injustice. Visions of a socialistic revolution were part of the political scene.

Figure 3 – The Beveridge Report: Facsimile from the Swedish translation in 1943, and one of many publications celebrating the Commission's 50th anniversary.

We can imagine that memories of the Russian Revolution in 1917, when poor Russian soldiers turned their guns towards their own ruling class and the Tsar, were causing unpleasant dreams among the British aristocracy, even into the initial years of the war. Why fight and die for the benefit of the upper classes? Rather, the revolution – or Hitler – would promise them a brighter future. Churchill and the British upper class must have had plenty to worry about. To Norwegians, these conflicts are vividly brought to life in the popular British TV series "Foyle's War", which features crime stories from southern England with an impressively detailed social background (such as Inspector Foyle's assistant driver, Sam, leaving a restaurant table, and her date, because she disliked his disapproval of the Beveridge ideas).

If the computer game Civilization had been there for Churchill and the Allies at the time, there would be one clear message for survival and success. Do something to boost morale: create a vision for a better future, a *common* future, something worth fighting or even dying for. Freedom was a great slogan, but hardly enough for the working class and the poor. Adding social justice to the vision would certainly help.

Figure 4 – Contemporary cartoon, showing Beveridge fighting the five evils.

This could be one answer to my previous question: Why did Churchill and his war cabinet bother to set up a commission for social reform during the battle of Britain? However, the answer is probably more complex. It seems as if Churchill was reluctant to accept the wider implications of the Commission's report, as social policy lecturer John Jacobs writes in 1992 (13):

> Beveridge had handed the wartime Coalition Government a Plan which could have revitalised the nation, boosted morale and enlisted the energies and commitments of the people in the war effort. Had they understood the effect it had on the public they would have embraced it with open arms and set about implementing the main proposals. But Churchill, far from welcoming the Report, set about trying to put the genie that Beveridge had released back into the bottle.

The Report was released in 1942 right after the battle of El Alamein, a time of emerging optimism for the Allies. "Legend has it", writes John Jacobs, "that a queue a mile long formed outside the Government Stationary Office in Kingsway; it sold over 635,000 copies, and the press and public were nothing short of ecstatic in its praise". A large number of copies were brought illegally behind the German lines as proof of the Allies' promises for a brighter future. A copy was even reported found in Hitler's Berlin-bunker after the fall of the Third Reich. In United States as well, it created a lot of optimism among workers and the poor. Why and how the Report was silenced in the US is another, and quite interesting, story (14).

The Report, which can be found on the Internet today as well, is rather technical, but presents strategies to fight the "five evils" of want, ignorance, disease, squalor and idleness. In Brian Abel-Smith's words (15):

> The report advocated family allowances, a free health service and full employment, and that all social insurance benefits should be at flat rate and at subsistence level with the aim of abolishing poverty. …

And, importantly to our context:

> … The report had a major influence in other countries by setting a much more ambitious agenda for social security than had generally been accepted before.

More generally, the Commission's report could be seen as a strategy for overcoming class conflicts. The aristocracy and the rich would have to give up some of their privileges to join in a social project aimed at providing more social justice for all. A stronger public sector financed by progressive taxation, thereby providing free education and free health services for all, even for children of the working classes, seemed necessary. A *grand social contract*, promising a brighter future for the poor once the war against Hitler was won, was something worth fighting for.

The outlines of the post-war welfare states had been created. In contrast to its position during the Spanish Civil War, churches and clergy in allied countries were now more sympathetic to the working-class movement, and to economic and social reforms. The reinvention of the word "welfare state", previously suggested in 1880s Germany, was possibly done by Archbishop of Canterbury William Temple (1881-1944), who in a famous speech endorsed the report by contrasting the visions of a "welfare state" with the German "warfare state".

Norwegian politicians and intellectuals in exile in London were certainly part of those political discussions. And the ideas had an impact on the political agenda in Denmark and Sweden as well. The Report was actually translated into Swedish during the war in 1943 (16). The charismatic Norwegian Surgeon General Karl Evang (1902-81) was among those influenced by the new ideas. As a medical student, I heard him lecture enthusiastically about the prospects of improved population health in the new kind of society: *The welfare state*, with free health care for all. And with state-based social security programmes to maintain purchasing power among the unemployed in case of recessions, to avoid the earlier crises of capitalism – welfare, stability and prosperity in one package! The post-war welfare programme of 1948 in Norway (Folketrygdmeldingen) was almost a blueprint of the ideas from the Beveridge Commission (17).

FINAL NIGHT EXTRA

Evening Standard

GODFREY DAVIS
SLOANE 0022

ONE PENNY

The National Health Bill is out. It will cost £152,000,000 a year

STATE TAKE OVER DOCTORS, HOSPITALS AND DENTISTS

'Free for all'—1948

PRIVATE PRACTICE STAYS, BUT NEW DOCTORS DIRECTED

From 1948 everybody's health will be looked after by the State without fee. That is Mr. Aneurin Bevan's new National Health Service, details of which are published to-day. It is estimated to cost £152,000,000 a year.

It comes under three main heads: the general practitioner service; the facilities to be provided by hospitals which are taken over; and the new Health Centres.

Publication of the plan will begin a great Parliamentary controversy which follows months of discussions outside Parliament. The big Parliamentary battles will be on the taking over of the voluntary hospitals, and the new conditions for the State doctors.

What you get—

Can they stay outside?

FIGURES

HAMBURG WITHOUT BREAD

Seventy per cent of the people of Hamburg have no bread.

PLANE DIVES ON SCHOOL

200 children at play: All safe

A blazing Mosquito airplane crashed between two buildings of Rusthall girls and infants' schools, near Tunbridge Wells, Kent, during the morning break to-day. Two hundred children in the playground escaped serious injury.

Mr. Claude de Bernales

'CIVIL PROCEEDINGS IMPENDING'

'Steep dive'

JOHN FROST COLLECTION

Figure 5 – The Evening Standard announcing the NHS reform, July 5, 1948.

The socialist revolution had been cancelled. The modern welfare state would make us all more equal, a peaceful social revolution without the hassles and dangers of a socialist revolution. Education and health care had to be a public responsibility, a human right for all that was sheltered from the injustices of the market. No longer should health care be a marketed commodity (18).

Most of us know the rest of that story. Britain got its National Health Service on July 5, 1948 (10-11), which was a dramatic and brave move by Secretary of State Aneurin Bevan in the post-war Labour government (11). "A new path entirely" for health care and welfare was his vision – and he could not conceal his disappointment with those medical doctors who opposed the reform out of pure business- and self interest he alleged. I later met some of those dissident doctors who fled to Australia, now regretting that they had failed Bevan. They were too late to see the braveness in the Beveridge visions of welfare state institutions.

By many measures, the NHS must have been a tremendous success. In the late 1980s, the NHS provided equitable health services to all British inhabitants at a cost per person slightly below the cost of just the administration of American health care (14). And then – as now – with millions of American people still uninsured. In my understanding, the problems of the NHS emerged when underfunding was obvious, in spite of it being very efficient. Tax-based financing is always challenged by the private market's "willingness to pay".

With their universal welfare-for-all policies, the Nordic welfare states have also proven to be a success, both economically and socially (19). And importantly, the frameworks of the welfare states had been created "before the oil". Otherwise, when foreigners look to Norway or the Nordic countries with some admiration for the welfare legislation and universal free health care, their usual response is "it must be the oil". It was not. It was about ideas.

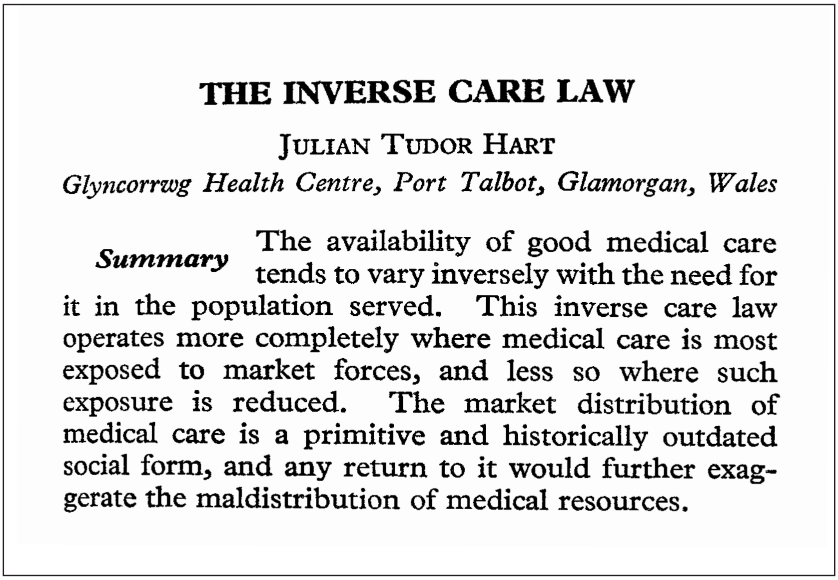
Implications for health care today

This story about why education and health care were removed from the market is largely forgotten in Norway – and I guess in the other Nordic countries as well. We assume that social structures are there to take care of us and our patients on equal terms, whenever it is needed. And for many years, we largely ceased to worry about social injustice or inequalities in health.

The common political consensus was that social classes had gradually disappeared – or merged – and that equity was achieved, and we were all becoming more equal. It is a nice vision, and to some extent it is true. There was indeed a trend towards more income equality during the post-war years, which is probably why the Nordic countries are still in the top rankings on many desired indices of health and health services (18, 20). However, since the 1980s socioeconomic differences in income and living conditions have gradually increased in all the Nordic countries, with Norway rising at the fastest rate, more precisely with a turning point in 1989 (Central Bureau of Statistics data, 2011). In many areas, the market has been striking back and challenging the health services (20), as well as the distribution of wealth. To quote Julian Tudor Hart again: "Greed is a powerful, but dangerous fuel to social machinery".

When epidemiologists started looking at health differentials in Norway in the 1990s, a worrying pattern emerged: The disparities in health and gradients in mortality were clearly increasing between the best-off and the worst-off, which was particularly easy to demonstrate among men (21).

The present Norwegian government has given this issue a high priority. Five years ago a white paper was presented to the Norwegian Parliament, the Storting, on "Strategies to reduce social inequalities in health" (22).



THE INVERSE CARE LAW

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Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Figure 6 – Facsimile of the 1971 Lancet paper, well-known to anyone concerned with equitable health services.

From a public health point of view, it is a rather great document, if documents can move the world. The white paper acknowledges the importance of looking at the "causes of the causes" for inequities, and announces initiatives in many sectors. It also challenges us in the health services to look more closely into whether the ideals of equity in health care are as real as we want to think.

The white paper makes special reference to the seminal paper by Julian Tudor Hart from the Lancet in 1971, presenting evidence for what he found to be an "Inverse care law" that was more or less visibly influencing the health services, (23). It is about the tendency for the health services to be worst for the people most in need of them. It has been a long time since this paper was published, although its message has gained increasing importance, as market mechanisms are being re-introduced into the health services in our part of the world without much concern about their side effect: increasing inequalities in the health services (20,24). The inverse care law is not a law of nature, as Julian Tudor Hart has emphasized. It is a description of what happens when health services are exposed to market mechanisms (25).

Why worry?

The impending reforms – or "the end of" – the NHS, if this is the prospect, will certainly be a major challenge to the Norwegian and Nordic health care systems. I think we have to raise a broader discussion about how neo-liberal politics and economic corporate interests can erode, or simply undermine, the principles of public funding, solidarity, comprehensiveness and equity. Under the pressure of economic globalization and market forces, health care is undergoing processes of "commodification" even in our countries, turning health services into commodities with price tags, patients into customers and doctors into commodity producers. In turn, this offers opportunities for big business to enter this huge, and up until now, largely uncommodified public sector. "Immature markets" have always been a challenge to big business.

Or we may look at it more ambitiously – as an editorial in the *Scandinavian Journal of Primary Health Care* did some years ago (26): "... an ambition to bring a message more forcefully to the world… that we have developed health care models worth looking at." We used to look to Britain, to the NHS. Soon, we may have to resort to a fresh version of Franklin Roosevelt's "look to Norway" – or rather, "look to the Nordic countries". In spite of the problems and challenges, and potential for improvements, our health services are basically there when needed – for all. We hope this will be the case for the NHS as well. But we will certainly, once again, keep our eyes on what happens to the NHS in Britain.

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Kaiser Permanente, information, and the integrated health care policy

Michael Quarterly 2011;8:490–8.

Kaiser Permanente, one of the largest health programmes in the United States, has 8.9 million members. As a prepaid system, it has many similarities to the Scandinavian health systems. The scope of the article is to look into how Kaiser Permanente brings information to their employees and their members. It focuses on the creation of a common electronic patient record, KP HealthConnect, for all Kaiser Permanente regions, and for their programmes directed towards members with heart failure. KP HealthConnect was created from 2003-2008 with the aim of contributing to a new way of working throughout the organization. The care should be integrated and given as early as possible, resulting in better patient outcomes and more cost effectiveness. The conclusion is that KP HealthConnect is a success. The second theme is a description and evaluation of a programme to Prevent Heart Attacks and Stroke Everyday (PHASE). This is a programme mobilizing patients to achieve a better outcome for their health, which Kaiser Permanente can document is successful. The Norwegian health service is working on how to reduce the unwanted differences in services given to patients, how to integrate specialist services with preventive medicine for large disease groups such as diabetes and heart failure, as well as the nationwide electronic patient record, which is still not in sight. Kaiser Permanente is working with the same problems, and claim they have come a long way on the road towards solving it.

Kaiser Permanente health programme

Being an organization quite similar to the Scandinavian health systems, it is meaningful to look into how Kaiser Permanente has taken on the problems common to our health services.

Kaiser Permanente is one of the largest health plans in the US, with a membership of 8.9 million. A total of 78% are connected through their employer, while 17% are also covered by Medicare. Different from most other health plans and insurance systems, it is both an insurance company and a service provider. Kaiser Permanente operates in nine states, though California is where it is most dominant. It owns and runs hospitals, medical offices (outpatient clinics) and pharmacies (1, 2). The staff is employed by the firm, as are the physicians, who are on fixed salaries with the possibility of getting bonuses. The total number of employees is 164,000, including 15,000 physicians.

Kaiser Permanente is financially organized as a prepaid system. The individual member, or the company where she or he works, pays a premium in advance, which then entitles them to the services covered by that premium. The members have to pay a smaller sum for each service given known as a co-payment, which has a ceiling for every fiscal year. The premium varies according to the overall health status of the group of employees who are covered by the different member firms, and is renegotiated at various intervals. Therefore, Kaiser Permanente and its member firms have a common interest in preventing illness and helping its individual members achieve a healthier lifestyle. They regard the physicians as their most important employees, thus underscoring that Kaiser Permanente is a physician-led health programme.

Communication and care

Kaiser Permanente presents itself as giving integrated care. They help their members live a healthier life, and use primary and secondary methods of prevention to achieve a better and less expensive service for their members. In order to achieve this, they are concerned about how to communicate information, both to their members and to their professional employees: How do they work on reducing the diversity among physicians on patient treatment? How do they educate their members to live a healthier life and enable them to help themselves? How do these actions result in a better health service for the patients and a sounder economic situation for Kaiser Permanente?

Data

The data for this article was gathered through an introductory course organized by the Global Health Leadership Forum, a section of the Department for Public Health of the University of California, Berkeley and Kaiser Permanente International, in April 2011. The course included lectures, discussions and visits to a Kaiser Permanente hospital, in addition to the Garfield Innovation Center, which is part of the organization. The topics included delivery of the best health services in a cost-effective manner, presenting different experiences from different countries, particularly from the US.

The course was followed by a two-week stay in Berkeley, which included interviews with academics and experts on health and social services, visits to relevant health institutions to verify and add information through health statistics for California, including additional statistics from Kaiser Permanente, as well as additional information from articles on the internet and the study of federal programmes such as Medicare and Medicaid, and agencies such as the National Committee for Quality Assurance (3), the Agency for Healthcare Research and Quality and the National Guideline Clearinghouse (4). The documentation used included books, articles, lectures and personal information.

How to achieve a better patient outcome and cost-effective service?

To achieve a cheaper and more cost-effective service that yields a better health service and outcome for the patients, Kaiser Permanente is working on the following seven areas:

- their data system "KP HealthConnect", which also is an electronic patient record (5);
- voluntary screening of the members to enable them to obtain advice and treatment in the early stages of their illness (6);
- developing their own treatment guidelines (7);
- the establishment of the Garfield Innovation Center (8);
- establishing a department to evaluate and develop the organization (9);
- an organization in which the different departments and clinics are led by physicians (7);
- setting up various programmes aimed at patient groups (10).

The creation and use of KP HealthConnect

The beginning of the 21st century was financially difficult for the health care industry in the US. Kaiser Permanente was no exception, and was losing market share (11, 12, 13). On top of that, there were published reports documenting that health care quality and safety were lagging behind other developed countries, even though the United States spends far more money on health care than other countries (14).

In 2002, Kaiser Permanente hired George C. Halvorson as its new CEO. His main vision for overcoming the crisis was to end the different regions' development of isolated data systems, creating one electronic medical record for the entire Kaiser Permanente organization. This work started in 2003, and the new KP HealthConnect was in use in all regions by 2008.

The vision was that KP HealthConnect should not only provide electronic help for the ongoing practice, but also contribute to a new way of working, helping the integration of care between different specialties and levels of services, bringing the patients closer to the service and raising the quality of care. Additionally, the system was designed to be consumer oriented, and had as its slogan to create the "Home as the Hub" (15, 16). The United States' health programmes are evaluated each year by The National Committee of Quality Assessment (NCQA) according to their Healthcare Effectiveness Data and Information Set (HEDIS).

Halvorson wanted the system to help Kaiser Permanente to achieve a score of better than 90% on all HEDIS parameters. It was, and still is, compulsory to use the system for all employees in Kaiser Permanente.

The system is an all-inclusive system incorporating scheduling, registration and billing alongside health and clinical information, while working together with ancillary systems for pharmacies, laboratories and radiology.

- With the information given, it is a fair conclusion that KP HealthConnect has achieved the following: Better quality, because it is possible to monitor what the various doctors do, and how they follow the treatment guidelines established by the organization, as well as the standards used by HEDIS, and Kaiser Permanente does use this opportunity.
- Having close to 9 million persons in the system is a great source for research activities, which makes it possible to:

  Register how various patient categories respond to treatment and develop better health programmes for population groups.

  Gather important information for specialty groups such as the hip register, which is the greatest private hip register in the United States.

  Creating smart systems for different specialties, helping them deliver higher quality care by learning about the effect they have.
- Patient safety will be better ensured, as the system can use different methods of "flagging" when suggested procedures and/or medication are outliers from what should be expected.
- The system is available for the members who can access part of their medical record, check their laboratory results, e-mail their doctor, schedule visits to a hospital or outpatient clinic and obtain information about illnesses, healthy living and how to help themselves. This part of the system is called, My Health Manager.

Kaiser Permanente claims that by using KP HealthConnect, it has been possible to reduce the variance among doctors in relation to how they treat patients, saving as many as 12,206 lives per decade and being able to follow up patients in a better way, while saving approximately USD 68.9 million in operational costs. Their total revenue in 2010 was USD 44 billion.

Prevent Heart Attacks and Stroke Everyday (PHASE)

PHASE was established in order to create a close link between the patient and the services, making prevention and specialist service part of a common treatment programme.

A total of 300,000 persons, or 11% of the members in Kaiser Permanente, are enrolled in PHASE (3, 4). It is open for all members to join, but it is those who have had a treatment related to heart disease that are asked to join. One of the theses put forth by Kaiser Permanente is that 80% of the treatment of a patient is done by the patient themselves. This coincides with findings in Norway, where 80% of the people who say they have some form of sickness on a particular day are not in contact with the health services (17). Sixty-eight percent of the PHASE population is registered with diabetes, and 43% have either had a stroke or are registered with cardiac disease. PHASE is a follow-up and addition to the ALL programme (Aspirin, Lisinopril and Lipid-Lowering Medication).

Using KP HealthConnect, Kaiser Permanente contacts members at risk of heart attack and stroke, and gives them the opportunity to register with the programme. Once this is done, the programme is mainly a close follow-up with tests at certain intervals, in addition to giving advice on taking medication, living a healthier lifestyle and being aware of other illnesses that can affect the risk of having a stroke or heart disease.

The programme has improved the treatment of patients by 30% over 2.5 years, and from 1996 to 2006 the mean low-density lipoprotein (LDL) has fallen from 145 LDL to approximately 95 LDL.[1] Another positive effect has been a lowering in the number of patients in need of a hospital bed. With programmes such as PHASE, Kaiser Permanente claims to have achieved their aim of giving better service with lower costs. A study from Kaiser Permanente in Northern California found a reduction of heart attacks by 24% since the year 2000 (18), whereas another study revealed that more than 40% of very high-risk patients were able to reach national cholesterol guidelines (19). Both studies claim that they were made possible because Kaiser Permanente is a large and integrated health programme that has a common electronic patient record and runs programmes such as PHASE.

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[1] 1 LDL is approximately 0.0259 SI units.

Discussion

From a situation in which they struggled to survive as an independent health care provider, Kaiser Permanente now has a healthy economic situation, with all of the organization's representatives demonstrating great enthusiasm about how they have attained this goal by delivering better health services.

With KP HealthConnect, they have created a tool to help in standardizing procedures, thereby bringing the patient closer to medical decisions and monitoring the physicians' practices in a better way.

Kaiser Permanente has succeeded in helping their organization understand that a good system means a good standardization of vocabulary and procedures. During this process, they developed their Convergent Medical Terminology based on the Systematized Nomenclature of Medicine. In the autumn of 2010, they donated this to the International Healthcare Terminology Standards Development Organization for distribution through the U.S. Department of Health and Human Services so that all health care providers can benefit from this translation-enabling technology.

With the vision of the "Home as the Hub", Kaiser Permanente focused very early on what could be done outside the hospital by the patients themselves, bringing the members of Kaiser Permanente on board as important users of KP HealthConnect connected through "My Health Manager". At present, Kaiser Permanente has half the number of hospital beds per capita in comparison to Norway, and they think they can reduce this number even more.

KP HealthConnect makes it possible to monitor the practice of their physicians who are striving for a better and more secure health care. When differences are discussed in Norway, it is between regions, and to some extent, between hospitals. How the information in KP HealthConnect is used in evaluating an individual physician's choices, and how this affects the working atmosphere, would be worthy of study.

A side effect of KP HealthConnect is that after some years it will yield a potent set of data for research. In Norway, the personal number (similar to a social security number in the US) of each inhabitant allows a variety of researchers to have the possibility to monitor people over a period of years, which is not the situation in the United States. With 8.9 million members and KP HealthConnect working across its various regions, Kaiser Permanente will have a unique opportunity as a United States company to come up with research results they could not have previously accomplished. In 2008, employees from Kaiser Permanente published 700 articles in peer review journals (20), while Norwegian specialist health services published 3,150 articles over the same year (21). It will be interesting to see whether the further development of KP HealthConnect will raise the number of published papers.

When it comes to PHASE and the other Kaiser Permanente programmes concerned with teaching their members to handle their illness better and live more healthy lives, they have achieved success when compared with other US health programmes. Kaiser Permanente has family physicians, but is first and foremost a programme that provides specialized services. Compared with the rest of the United States, they do that in a more integrated and coherent way.

In comparison to Norway, they do not cooperate with the municipalities, and do not have a programme for the people most at risk from diabetes, cardiac failures and stroke because these are mostly the people who are not insured (22). While they score high compared to other health programmes in the United States, reducing heart attacks by 24% over the last 10 years (18), figures from the Norwegian Institute of Public Health indicate that the fall in Norway has been approximately 40% over the same period (23).

Conclusions

KP HealthConnect has a success rate that few other health organizations of this size have attained. Kaiser Permanente has a foresight far beyond others by bringing the "Home as the Hub" as its main vision, and has succeeded in using its electronic medical records to change the way it works. It has managed to standardize nomenclature and procedures, while simultaneously involving professionals to contribute to the process of establishing a system that is accepted by the organization. They have dared to bring their members into direct electronic contact with their doctors, experiencing a result that this possibility makes the members more comfortable in handling some of their health problems by themselves, while freeing time for the physicians to attend to more demanding tasks.

KP HealthConnect has been working for just a few years. It will strengthen Kaiser Permanente's struggle for a more integrated care, and continue to be a powerful tool for implementing guidelines and narrowing unwanted variances.

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The grandmother approach: Teaching medical students medical history – some personal experiences[1]

Michael Quarterly 2011; 8: 499–513.

Experiences from a long-time commitment in teaching medical history have shown that teaching medical students needs some special considerations because it means conveying historical knowledge to a target group whose main motivation is to learn medicine *for their future professional life. The objective is to convey to them the ability to allow* time and space perspectives into their medical thinking. *Therefore, the teaching has to be tailored by means of: (1) an appropriate choice of topics covered by (2) the most suitable teacher. The (3) audience of students should be at an optimal point on their way through the curriculum. The (4) most effective teaching methods should be carefully selected, and one should see to that medical history fits into the general (5) teaching climate of the faculty in an integrated way.*

Some experiences gathered from an approximate 45-year engagement in teaching medical students medical history might be of interest to others in the field. During my years of service, some personal views on aims, methods and means in teaching medical history to a quite special audience have

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[1] Revised, abbreviated and updated version of a keynote lecture given at the XXII Nordic Conference on Medical History in Bergen 3.-6.6.2009 (Title of keynote: *Teaching medical students medical history; Necessities and challenges*). Some of the topics in the lecture dealt with medical teaching in general, particularly at the University of Oslo. These have been further elaborated on and are published in: Larsen Ø. The winds from Maastricht – some personal reflections on teaching medicine at the University of Oslo. *Michael Quarterly* 2011; 8: 329-43, and have therefore been omitted or tuned down here.

inevitably emerged, in which tailored messages are required – for the medical students.[2]

An example: Many years ago, I introduced my "grandmother trick"[3]. It works! Imagine that you are a university teacher standing in the lecture room in front of a new class of students. They are medical students at some stage of their six-year-curriculum, which is how we do it in Norway. The first challenge you will encounter appears immediately, and it is typically Norwegian: They are highly selected for their intellectual abilities. For example, at the University of Oslo less than one out of 10 applicants is accepted.[4] That means that these sparkling minds will instantly disclose any weak argument in your presentation, so be careful! But the upside to this is that they will also know to duly appreciate a well-balanced and meticulously prepared lecture.

But how to start? How to grasp their interest at the very beginning and make them your partners in setting a stage in which they see their position as future medical personnel with a perspective in both time and space?

When silence has settled over the room and the eyes of the expectant group are turned towards you, make a short but noticeable rhetorical pause, point at one of the students and simply say: I know something about your grandmother! The surprised student will look at you with a question mark, while the others are wondering what will happen next.

Beforehand, you have made some calculations: This 20-year-old student will probably have a grandmother who was born some 75 to 80 years ago. For the time being (2011), this means in the early 1930s. From your own command of medical and social history, you know fairly well how the life and health of a female from that cohort generally was and is. Therefore, you will not make any large mistakes if you start telling a story about prob-

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[2] As I have been occupied with teaching challenges for so long, I have written about it in various books and articles. In footnotes here, I therefore refer to writings in which the interested reader may find more extensive comments on topics taken up in this paper. (I started as a research fellow in medical history at the Institute of Hygiene of the University of Oslo in 1964 and am still teaching at the successor of this institute, the Institute of Health and Society.) From 1971 to 1977, I also taught medical history on a part-time basis at the University of Tromsø, and taught public health as a professor in preventive medicine in Tromsø 1976-77. Since 1998, I have given lectures in medical history at NTNU, the University for Technology and Natural Sciences at Trondheim, and for some time since 2008 at a public health course at UMB, the Norwegian University for Life Siences in Ås.)

[3] Magne Nylenna refers to it in his article, Formidlingens kunst. *Michael* 2008;5:175-9.

[4] In 2008, there were 1,139 applicants to Norwegian medical faculties who indicated the University of Oslo as their first choice. A total of 105 places were available. (*Universitas* 2009;63:#13, 4-5.)

able traits regarding her growing up in the 1930s, about her enduring rationing and nutrition problems during the war years, about her later embarking on an educational track, e.g. two or three years to become a school teacher or a nurse, before marrying in her early 20s in the 1950s.

You will be able to talk quite confidently about her health. You may for example suppose that she was regularly summoned by the health authorities to be checked to disclose any tuberculosis infection, that as a child she suffered from pneumonia, which scared the whole family because no effective drug was available at the time. From your demographic knowledge, you may assume that her summer vacations were spent on the family farm out in the countryside where her ancestors originally came from, and that these summers included weeks of diarrhoea and infected bruises on her knees etc., etc.

While listening, the student will sometimes nod affirmatively, sometimes shake his/her head and object that it was not exactly like that. But anyhow, the student has to admit that the description fits quite well at large.

Then your question to the audience is: How do I know all this? That is young friends, this is what you also will know when you are proficient in medical history!

You can see in their eyes that by now you have them in the palm of your hand.

You then proceed to the next questions: Have any of you been to a medical ward in a hospital? Even if they are young, many of them have invariably had a summer job in a health institution when thinking about applying to medical school. What sort of patients did you see there?

Their faces open up: They realize that the ward was dominated by grandmothers! Now the time has come for your conclusion: You point out to them that with a command of medical and social history, they will be well prepared to not only communicate with their grandmother's generation, but to also understand their patients' backgrounds, their attitudes – and their relationship to health personnel, to you, dear students!

The grandmother trick, or a similar setup, is hereby recommended!

Prerequisites for teaching

If a teaching situation is to be successful, the most important element of course is: (1) the topic. The next element is (2) the teacher. As a teacher, you just have launched a topic that has been accepted, found to be relevant and interesting by your (3) audience. In the example described above, the (4) teaching method chosen for communicating the topic from the teacher to the students is that of a lecture.

But in addition there is a fifth element, which we can call (5) the teaching climate. This includes the integration of the discipline, in this case medical history, into the curriculum, into the general objectives of the faculty, into the self-image maintained by the profession, and last but not least, into the knowledge and skills which are expected from the candidates by the public.

Successful teaching depends on control of and harmony between these five elements:

(1) Relevant topics

The context of the grandmothers in the hospital wards is only one example of the relevant topics; there of course is a series of others. When established, The Nordic Association for Medical History took up the discussion of relevant topics as one of its first tasks.[5] In the autumn of 1976, 29 scholars and students from the Nordic countries and Germany gathered at a symposium in Oslo in order to discuss, and agree upon, what a framework for medical historical teaching should look like.[6]

In the discussions, science history aspects were taken up, in addition to the history of medicine and so forth. The use of medical history in the teaching of medical nomenclature was also taken in. However, a special emphasis was put on the context-oriented medical history, in which a seamless connection to the general objectives of the medical curricula was described. Demography, the history of diseases and social history include highly relevant elements. Folk medicine in a wide sense, including changing

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[5] The idea of a Nordic Association was discussed at the *V. Nordic Congress for Medical History* in Helsinki in June 1975. The Finnish association *Amici Historiae Medicinae* under its chairman, professor Harald Teir, had taken the initiative. A preparatory meeting was held at the Medical Museum in Copenhagen in December 1975, and the Association was formally constituted in a meeting at the Medical Museum in Stockholm on March 27, 1976, with nine Nordic associations for medical history represented. On September 30. and October 1, 1976, a symposium on teaching medical history was held at the Lysebu Conference Centre in Oslo in connection with a meeting of the Nordic Federation for Medical Teaching. (See: S(trandberg) H. (Introduction) in: Larsen Ø. (red.) *Medisinhistoriske emner i medisinsk undervisning*. Tromsø: Institutt for samfunnsmedisin, 1976. 2. ed.)

[6] The participants were: Bente Alver, Anne Sofie Brønn, Lasse Efskind, Erik Falkum, Bente Gauslaa, Andreas Grimeland, Ejnar Hovesen, Arthur E. Imhof, Lorentz M. Irgens, Jørgen Koch, Wolfram Kock, Einar Kringlen, Ingegerd Frøyshov Larsen, Øivind Larsen, Laurits Lauridsen, Eddie Lidén, Bengt I. Lindskog, Kari Martinsen, Lauri O. Meurman, Arne Næss, Ingela Ohlin, Tomas Riesenfeld, Sam Schulman, Hindrik Strandberg, Harald Teir, Inger Wikström-Haugen, Odd Wormnæs, Lars Öberg and Bjørn Østberg.

attitudes toward health and disease, was also highlighted.[7],[8] A recommendation following these guidelines was presented to the Nordic medical faculties through the Nordic Federation for Medical Teaching.

In Norway, and especially in Oslo, these principles have been followed since 1971 in various forms, according to the shifting setup of the medical curriculum in general. The strongly context-linked topics have been shown to integrate quite well into the general curriculum.[9]

In the 1970s historical aspects from six fields were covered in Oslo and Tromsø: (1) What is health and disease? (2) Health and culture, (3) Medical thinking in history, (4) Measuring of health, (5) Environment with influence on health, and (6) Health conditions affecting the social environment.[10]

In the 1990s, the following subjects were taught in Oslo: (1) The development of the medical profession, (2) Primary health care history, (3) Diseases, demography and health services in Norway from the 18th century onwards, (4) The development of medical science – blood circulation as an example, (5) The history of psychiatry, and (6) Extinct and living Norwegian folk medicine.

A newer topic which has proven to be a good entry to medical historical thinking and to context orientation in general in Oslo is a series of lectures on *medicine and arts,*[11] including literature, music and architecture. This is comprised of a survey over medical motifs in Norwegian visual arts, with an additional lecture on the painter Edvard Munch (1863-1944) and his relationship to health and disease, which has been positively perceived by the students.

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7 See Larsen Ø. (red.) *Medisinhistoriske emner i medisinsk undervisning*. Tromsø: Institutt for samfunnsmedisin, 1976. 2. ed. The booklet includes surveys of medical historical teaching in the Nordic countries up to 1976.

8 In 1979, the Nordic congress for medical history in Oslo had attitudes against diseases as its main theme. See Larsen Ø. (red.) *Synet på sykdom*. Oslo: Universitetet i Oslo, 1979, 2. ed.

9 See Larsen Ø. Learning medical history in Oslo: Training for medical practice. *Croatian Medical Journal* 1999; 40(1):29-33.

10 In the 1970s, teaching in the new discipline of Behavioural science in medicine was gradually introduced in Oslo, with e.g. some sociological topics previously taught in medical history being taken over by teachers from behavioural medicine.

11 Larsen IF. Medisinens menneskelige ansikt – bildende kunst. *T. norske Lægeforen.* 2000; 120: 3762-4. See also Frich JC. Undervisning i medisin og kunst – hvilket utbytte har studentene? *Michael* 2008;5:245-54.

The relationship between *architecture and health in history* has considerable relevance when teaching housing hygiene during the public health term.[12]

(2) The teacher

Teachers in medical history are frequently academics with a medical background and an additional training in medical history. However, teachers are also often historians with a special command of medical history. What works best is an open question, though as a rule highly is dependent on the persons in charge. A combination of teachers with various backgrounds participating in the lecture series is an ideal situation. It may also be sensed that a language problem is lurking in the background. The professional language of, e.g. some social scientists, may sound like ringing bells to more grass-roots prone medical students. My key point is that the teachers should understand the professional traits of the disciplines involved. An historian who does not get under the skin of the doctors has the same handicap as a doctor who has not internalized the working methods and reasoning of the historians. Nonetheless, there is no sense here in stirring up the sometimes sleeping, sometimes open discussion as to whose field medical history belongs.

Medical history opens up for views on the relationship between health, science and society in a broader sense. Therefore, medical history may be perceived as provoking, and as such even has the potential to influence the development of, say, the role of the doctor and the setup of the health care system. Thus, the orientation and abilities of the teacher will be important.

One issue, however, is crucial: The ability to convey the topic in such a way that it is felt more or less as a necessity by the students to help fill a hole in their knowledge. The teacher should present the message as is done in anatomy or pathology, in which the use of high magnification lenses is supplemented by a low magnification survey. Medical history teaching is like switching in the low magnification on the microscope turret, and then subsequently putting the detailed information into its context.

The main objective of the teacher is to *teach,* not to *preach.*

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[12] While general medical historical topics are most easily taught relatively early in the six year curriculum, is the experience that housing history is felt most relevant by the students at the end of the curriculum – possibly also because they at this stage have been on the housing market themselves.

(3) The audience

This text deals with the teaching of *medical students.* Here, one should make an effort to place the teaching of medical history on the correct level in the curriculum. Where that is may be different in different medical schools, but the point is that the students on the one hand should be so socialized into medicine that they already have a professional identity. On the other hand, they should not be so high up in their study years that the scary prospect of the final medical examination is the only issue that fills their heads.

However, groups other than medical students also have a need for medical historical knowledge. Many a teacher in medical history will have had experiences with other categories of students. The common lesson learned will be that each group probably has its own attitudes and own expectations for the teaching, and that a quite deep concern about this fact is required to make the teaching successful.[13] For example, in nursing schools medical history being used as a tool to strengthen professional pride and professional ties is quite common. When I taught medical history in a high school for librarians, the knowledge to facilitate orientation in old literature was of course the special point of view held by the students. And to teach medical history at a so-called "university for the elderly" gives the lecturer a special, yet useful challenge, when confronted with the life experiences present in the lecture room!

Experience with teaching different groups is an asset because the need for *adjusting to the audience* clearly comes into view.

(4) Teaching methods

Personally, I think that the old-fashioned *lecture* still holds many virtues as an effective way to transfer medical history knowledge. I have no documentation behind this opinion other than my own experiences, listening to other teachers and giving lectures myself. Since *context* is the keyword, a well-composed lecture can give the audience a survey fit for further studies, as interest and curiosity may be awakened. Group work, etc. may be good

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[13] From 1971, and in some years onward, the University of Tromsø offered a one-year course called Basic Medicine ("Medisin grunnfag") to applicants from the social sciences, persons from the social security system, students who aimed at a position in health administration, etc. At least in the first years, medical history here had a strong position with a series of approximately 50 lectures. The reception by the audience was good, as many of the listeners were quite seasoned and had a considerable amount of life experience as background for reflexion. Science history should have its unquestioned place in postgraduate research training programmes, as well as the history of health and disease in programmes in international and global health.

for special topics, but it is more time consuming, may weigh heavily on the motivation in teachers and students over time, in addition to also blurring the perception of context.

What sort of audiovisual equipment is best for teaching medical history? I think there is a danger in making the teaching and the topic too exotic, in that you run the risk of setting up a distance between the *context in time and place* that you want to convey, as well as the *reality* in which the students are.

In the lecture situation, it may be wise to only use slides and other aides with caution, and only when a clear message is being conveyed. This way, the *means* are not allowed to distract from the *message.* Old photographs may well give documentation, but they may also constitute an unwanted distance. The grainy black-and-white mood in an old picture, showing people with strange clothing and haircuts, gives connotations that may be misleading and disturb what you want to say to people who are not used to penetrating such historical filters.

At least to me over the years, the oral presentation in front of a large blackboard, with an abundance of chalk at hand, has proven to be the audiovisual winner. Arguments evolving in white letters on the board, and being written down in the notebooks of the students, hold the pedagogic position. The students should learn that the past and its surroundings are not a foreign world that they make entertaining excursions into, the past is *part of this world.*

The students should learn that they live and work with ties to the realm of their grandmother's generation. To a large extent, the living conditions of the population today have been shaped by planners now resting in their graves. And the society of their own grandchildren will depend on attitudes held, and future decisions made, by the students themselves. These facts make medical history important to them.

The weight on context in time and place should also address the topic of *shifting attitudes* within the same time and place framework. From the very first day of a modern Norwegian medical curriculum, the students learn that medical practice should lean on *evidence-based knowledge,* which of course is correct. In contrast, they must also learn that there are other attitudes to life and other realities that may hold the same importance. Other forms of knowledge are around, and serve as background for decisions of many types.

In a clinical situation, it can be difficult to explain to one of the grandmothers that putting cat fur on her back will not necessarily work on her pain, even if she claims that her neighbour was totally cured in that way.

Popular and professional perceptions of evidence are different, and this fact must be taken into consideration.

In professional medicine, treatment based on the impressionistic "doctor's experience" still exists, and differences between outcomes of treatment in different hospital wards can probably also be interpreted that way, which is an interesting issue for discussion.

When the historical approach is used for public health topics,[14] it is important to stress by means of examples that medical knowledge comprises only one set of arguments and bases for decisions, e.g. with cultural traditions, political programmes or personal beliefs being important as well. *Meanings and opinions* not based on *knowledge,* and held by key persons and politicians, are often fully accepted as background when important decisions are settled. Here, the medical historian carries a special and important responsibility. In many parts of the Western world, the health services and welfare state institutions are under attack for reasons of cost saving, pursuit of liberalistic ideologies, etc. Most people involved in these discussions will be so young that they have no personal experience with the old society where this modern security net is lacking. Therefore, teaching about health, medicine and social conditions in earlier times may serve as an important eye-opener. Group studies, theses and so forth with materials from Norway in the period up to World War II may render results with practical bearings.

For curricula in which written theses of various sizes are required, topics from medical history can be well suited. In Norway, we have an abundant amount of archival material on the public health situation, e.g. reports written on an annual basis by the district's physicians. A well delimited topic for a student thesis may very well be set up based on this type material.

It is also necessary to find suitable examples to underscore the fact that for many people *health is only one valid value among other values,* and that the ranking of values change in time and place. As one example, a picture of some old psychiatric treatment procedure from the times before effective drug treatments were available, may be used as point of origin for a useful discussion of the necessity of looking upon history in context. A so-called long-bath[15] or a straitjacket from an old asylum should not immediately be regarded as inhumane or cruel. An understanding of the total situation of

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[14] In the current public health textbook used in public health in Norway, these factors are discussed more extensively. (Larsen Ø, Alvik A, Hagestad K, Nylenna M. (eds.) *Samfunnsmedisin.* Oslo: Gyldendal akademisk, 2008.)

[15] An example is the "long-bath" equipment from the medical historical museum in Stockholm. See Larsen Ø. Kulturelt akseptabel tvang. *Tidsskr Nor Lægeforen* 2002;122:1962.

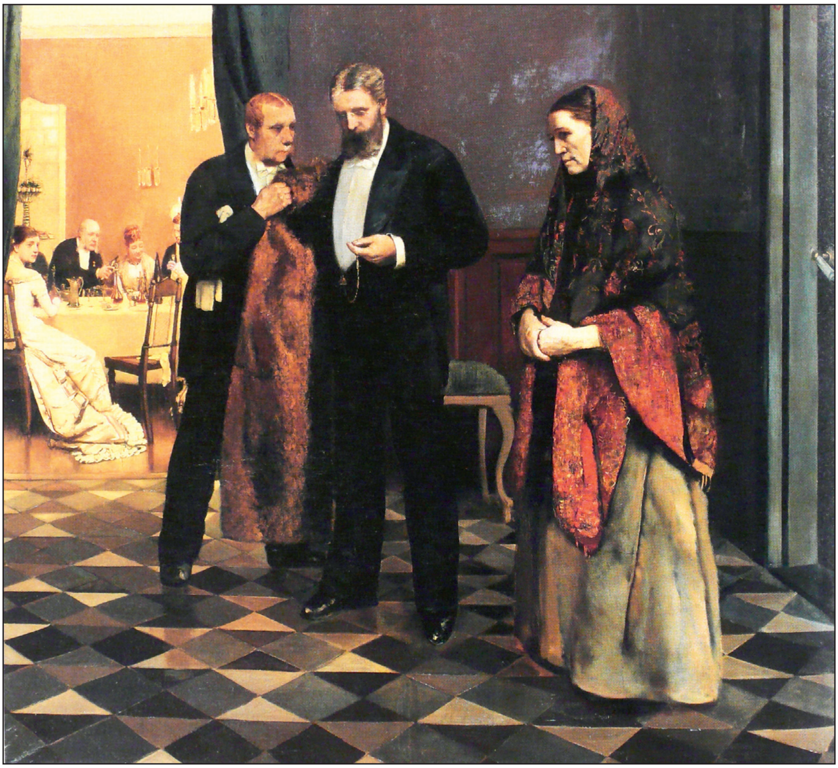

Figure 1: Bud efter Lægen *(1881-1882) by Christian Krohg (1852-1925). (Oil on canvas. Trondhjems Kunstforening) (Photo: Ø. Larsen)*

the time should be drawn up for the students, given other cultural standards ruling the use of restraint on the one hand, and the difficult task of controlling violent and dangerous patients in the pre-medication era on the other. A general discussion of the development of the perception of human rights could, if felt to be appropriate, follow in the wake. Examples such as this should also be used as a warning against cheap, populistic dives into medical history.

To use *pieces of art* as an entry point may be useful. A painting such as *Bud efter lægen (1881-1882)* (Calling for the doctor) by Christian Krohg (1852-1925) can illustrate several issues – from the class differences in a capitalist society to the humble respect for the doctor in the past.[16] (Figure 1.)

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[16] See Larsen Ø. *Legestudent i hovedstaden.* Oslo: Gyldendal Akademisk, 2002.

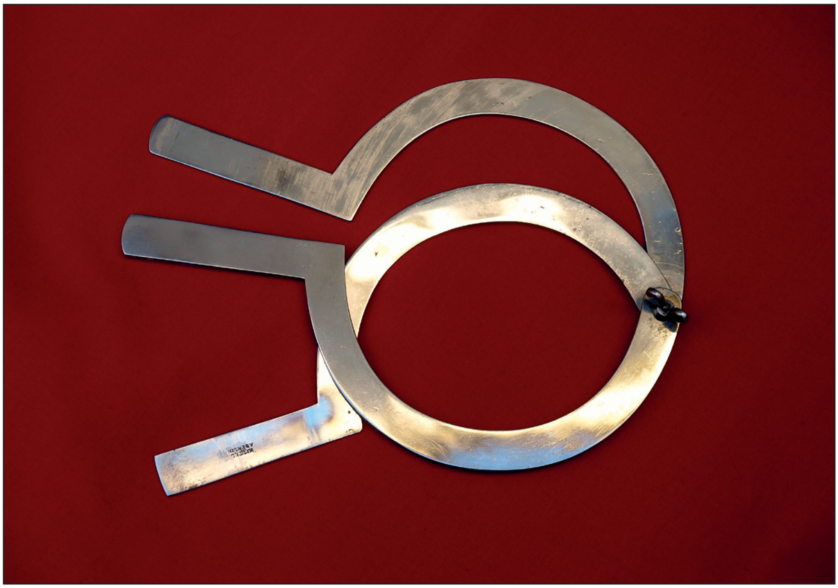

Figure 2: Amputator for female breasts, last decades of the 18th century. (Section for medical anthropology and medical history, University of Oslo) (Photo: Ø. Larsen)

I will probably surprise some of my readers by saying that I do not recommend museum visits as part of the teaching in medical history in the first place. Many museums present information taken out of context, or at least alienated from it. And nowadays, many museums primarily aim at reaching schoolchildren in their presentations, cleverly enough, although this approach may be disturbing to a mature student. What students learn in museum presentations has to come as *a supplement* when their command of the *context* is satisfactory.

However, the passing around in the classroom of an old surgical instrument may give the opportunity to stress the connection between the item and its context. An 18th century breast amputator (Figure 2) cannot be understood without looking into its clinical context, and may therefore serve well as a pedagogic tool.[17] This device effectively demonstrates the necessary techniques in the pre-anaesthetic era, when swift surgery was the most merciful to the patient. And a picture of a living leech can illustrate

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[17] Larsen Ø. Brystamputasjon – brutal eller skånsom? *Tidsskr Nor Lægeforen* 1987;107;V-VII.

that an obsolete method is not necessarily obsolete in another context, as leeches are still used today in hand surgery.[18]

Is it possible to make *excursions into history?* Yes, it is. Because societies develop at different paces, it is possible to learn about the past by visiting other societies. Excursions to exotic developing countries may be useful in this respect, even though in the years from 1995 to 2001 we had an annual four-week student training programme in not-so-exotic Latvia for groups of students from Oslo. At that time, Latvia was changing from a Soviet style of medicine, and had many traits in common with Norwegian medicine and Norwegian health conditions a generation earlier. In the hospitals, other caring principles could be observed, as well as other stages of diseases than what they were used to seeing, and even strange diseases such as diphtheria and leprosy.

From a 1996 parallel, collaborating student groups were deployed to La Crosse, Wisconsin in the US. On returning, they were supposed to write a report on a medical topic which they had studied and compare what they had learned in Latvia, the US and Norway. This outplacement proved to be very successful and resulted in 12 interesting comparative reports over the years. Concentrating on public health and contemporary medical history, the students really had been on an excursion in time and place.[19] Nonetheless, the situation changed rapidly, and Latvia had more or less approached Western European standards after 2001, and the pedagogic point of staying there became less visible.

The large medical museum in Riga was at least in the 1990's rather old-fashioned, but its wide-ranging exhibitions from pathological specimens to space medicine equipment could be thought provoking. Medical practice, not unlike earlier times in Norway, also is exhibited. The exhibition on Demikhov's transplantation experiments touch on problems of research ethics[20]. (Figure 3).

(5) The teaching climate

In 1996, a major change took place in the medical faculty at the University of Oslo, as a totally new curriculum[21] was introduced. The main principle

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[18] Larsen Ø. Blodiglen – en medarbeider i aksjon. *Tidsskr Nor Lægeforen* 1991;111:2231-3.

[19] See Larsen Ø, Kilkuts G. Health in Latvia 1991-2004; Years of conflicting values. *Michael* 2005; 2: Suppl 1. About the outplacement system in general, see Larsen Ø. Administrativ organisering og akademisk virke – Institutt for allmenn- og samfunnsmedisin ved Universitetet i Oslo. *Michael Quarterly* 2011; Suppl. 10.

[20] Larsen Ø. En forskningshund eller to. *Tidsskr Nor Lægeforen* 2000;120:3366.

[21] "Oslo -96". See: Larsen Ø. *Legestudent i hovedstaden.* Oslo: Gyldendal, 2002.

Figure 3: A case for discussing laboratory ethics: A two-headed dog from the transplantation experiments by the Russian researcher Vladimir Petrovich Demikhov (1916-98), stuffed and on exhibition in the medical museum of Riga. (Photo: Ø. Larsen)

from now on was the so-called Problem Based Learning (PBL), in which the number of lectures in all disciplines were reduced to a minimum and replaced by small student groups working under guidance with specific topics.[22]

While topics in medical history had previously been presented in a conventional series of 24-30 lectures, one had to concentrate in the new curriculum. Topics deserving to be highlighted were the development of public health, medical teaching and the role of the doctor, the medical profession and the development of infectious diseases. A PBL topic on tuberculosis was followed up by a keynote lecture on infections.[23] For a discipline such as medical history, more conventional approaches have been felt to be better because it then is easier to raise the eyes of the students

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[22] For further discussion of this topic, see: Larsen Ø. The winds from Maastricht. *Michael Quarterly* 2011; 8: 329-43.

[23] Since 2007 given by the specialist in Robert Koch (1843-1910) and history of infectious diseases, prof. Christoph Gradmann.

from singular problems to the general context, and make them slowly digest what they learn.

What about the doctor's role in the historical setting? An example: When the district physician, Marius Brostrup Müller (1841-1908), suddenly died from a heart attack during a strenuous travel to a house call, an enormous monument was erected by the municipality and his friends on the site where he expired. This was not only because of his work as a beloved doctor. But because he had also been an eager promoter of modernizing and developing the local society he was a part of.[24]

We have already touched on the ever ongoing discussions as to the role of the doctor in society. Should she or he be concentrated on the practical treatment of diseases and injuries? Or should the doctor have a wider perspective, including a responsibility for society as a whole in health matters? Should the doctor be a health worker or a health provider?[25] As waves are rolling in this discussion, headwinds and tailwinds may be experienced when teaching medical history – and also when teaching public health. The perspective affects the proneness to take in contextual knowledge. The health worker ideal is more likely to focus on the individual person, and on short-sighted perspectives, than is the health provider ideal of a doctor. At the universities in Norway, the perspective orientation probably shows some variations among the faculties, as does the teaching climate for medical history.[26]

When some students object that public health topics such as history, hygiene, public planning and other subjects dealing with health on an agglomerate level are not relevant to their future work, they are right to a certain degree because the general development in society and the medical profession has made it so. Even the re-emerging development of the discipline of social medicine, with its concentration on relief to the individuals of vulnerable groups, may be a problem for conveying a more overruling understanding of the group perspective, and for the command of context issues. To a health worker, the core system is the health care system. To the health provider, the core system may lie outside the health care system and the tools are to be found in politics, public planning, the public economy,

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[24] Larsen Ø. Endret rolle i samfunnet. *Tidsskr Nor Lægeforen* 1990;110:2733.

[25] The relationship between *the images* of the doctor (the life saver, the caring supporter, the gate-keeper) and the *objectives* of the doctor (serve the sick, serve the society, serve the science, serve yourself) is the main topic and have been discussed in depth in Larsen Ø. (ed.) *The shaping of a profession.* Canton MA: Science History Publications/USA, 1996.

[26] See: Larsen Ø. The winds from Maastricht. *Michael Quarterly* 2011; 8: 329-43 for the appalling differences between Trondheim and Oslo.

etc. Here, the health provider needs knowledge and skills. If well integrated into a faculty and curriculum, and in a suitable teaching climate, a teacher in medical history may contribute in an important way to encompassing the future doctor in society.

But anyhow dear students, do not expect that a large monument will be raised on your grave in the modern world.

Decades of development?

Experiences from my own life in the field of medical history over the past 45 years tell me that there exists an interesting paradox. The general interest for the history of medicine, health and the social context seems to be growing steadily. This applies within both medicine and other academic fields, as well as among the general public. This fact need not be documented or elaborated on further here. But in the modern medical curricula from which the coming doctors are trained, as a rule there is only rarely space for, say, a lecture series or an intensive course in topics from medical history. Teachers in medical history simply have to adjust to the fact that the curriculum can be felt to be like a straitjacket from old psychiatry.

However, according to my experience, the simple key to success when you have medical students in your lecture room is to have in mind that what they need in the first place is to achieve the ability to include the time and space perspective in their future professional work.

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Review. Ingvill Ellertsen, Marcelo H. Petri, Magnus Bäck

Atherosclerosis, inflammation and leukotrienes

Michael Quarterly 2011;8:514–22.

Atherosclerosis, which is a chronic inflammatory disease that leads to the formation of plaque on the inner lining of the arteries, is a global problem in terms of its consequences such as myocardial infarction and stroke. Although inflammation is an established factor driving the atherosclerosis process, understanding the vast complexity of the disease is crucial in designing anti-inflammatory treatments as part of the prevention of cardiovascular diseases. Proposing new ways to block inflammatory processes occurring in arteriosclerosis may be one way to operate in order to design new drugs which are adequate for the treatment and prevention of cardiovascular diseases. In asthma, a chronic inflammatory disorder that affects the airways, therapeutic agents that prevent the synthesis of leukotrienes have been shown to be an effective treatment and to also reduce inflammation in asthmatics. Therefore, inhibiting the leukotriene pathway may be a possible treatment of atherosclerosis. Leukotrienes are inflammatory mediators that are derived from the 5-lipoxygenase pathway of arachidonic acid metabolism. However, this pathway contains both pro- and anti-inflammatory mediators, and a complete understanding of these pathways in atherosclerosis still remains to be established. The present review will discuss some recent advances in the understanding of the role of inflammation in atherosclerosis, with a focus on studies on leukotreiens.

Background

On a global level, cardiovascular diseases (CVDs) are the number one annual cause of mortality (1). CVDs account for approximately 16.7 million deaths each year (2), and by 2030, the number of deaths is expected to increase to almost 23.6 million (1). In 2009, 3,380 people died only from acute myocardial infarction in Norway (3). The most common reason for myocardial infarction is an underlying atherosclerosis, which causes limitations of blood flow in the coronary arteries. In addition to coronary heart diseases, patients suffering from atherosclerotic lesions are also more prone to cerebrovascular diseases, thrombosis and embolisms.

Atherosclerosis is a chronic inflammatory disease in which the construction of a plaque in the inner lining of arteries may lead to fatal consequences for a normal functioning of the human body. The process of forming this plaque is referred to as atherogenesis. The disease occurs mainly in the aorta, the carotid arteries, the coronary arteries, the iliac- and femoral arteries and other large- to medium-sized arteries (4). Atherosclerosis may arise during exposure to elevated cholesterol levels, as well as other factors that can possibly harm the arterial walls. In addition, the body's immune system will be activated, which triggers the production of inflammatory mediators. Dysfunction of the endothelial monolayer at the inner lining of arteries may be one of the starting points in the atherosclerotic progression, as a fracture of the lining will promote the recruitment of immune cells (6). Elevated blood levels of cholesterol can also be a contributing factor to endothelial change and permeability (5).

Inflammation and atherosclerosis

Inflammation is a protective response against pathogens that protects the host from becoming invaded by intruding organisms, thus allowing the body to maintain its normal functioning. In the case of atherosclerosis, excess cholesterol taken up and presented by immune cells may be recognized as such "intruders" and lead to an activation of the immune system. In support of the latter, atherosclerotic lesions show features of chronic inflammation, such as the presence of excessive infiltration of leukocytes in arteries, as well as damage and loss of function of the arterial tissues (6). However, in contrast to an acute inflammation in response to for example infection, in which the immune response will reach a resolution phase once the intruders are defeated, the continued exposure to immune activators in atherosclerosis will induce a chronic inflammation. Hence, atherosclerosis may be viewed as a failed attempt at returning to homeostasis in the long run due to an inefficient resolution of inflammation (6).

Specific receptors on the vascular wall of arteries have been observed to cause the infiltration and migration of inflammatory cells in atherosclerosis (8). Monocytes, a form of leukocytes found in the blood, attach themselves through adhesion molecules on the endothelial lining of the arteries, and are transferred into the tunica intima, the inner arterial layer. Subsequently, stimulating factors make the monocytes differentiate into macrophages within the subendothelial environment (5). These macrophages will take

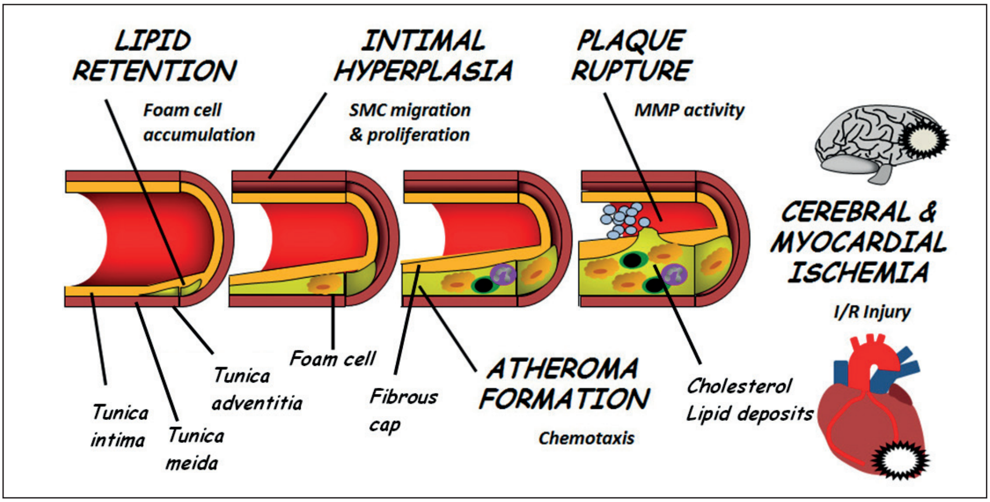

Fig 1: A cross section of an artery, showing the tunica intima (inner layer), tunica media (middle layer) and adventitia (outer layer). This figure also illustrates a developing atheroma formation, with foam cells inside the area containing cholesterol and lipid deposits under the fibrous cap. The final step is a rupture in the fibrous cap of the intima, which is caused by matrix metalloproteinases (MMP activity). Figure adopted from (9).

up oxygenated cholesterol and low density lipoproteins (LDL), and eventually become what is referred to as foam cells due to their structure and high lipid content (6). These cells form the core of the developing plaque, together with an extracellular matrix such as collagen, elastin and proteoglycans (8). The phagocytic foam cells also interfere in inflammation by assembling inflammatory mediators in the plaque that can promote inflammation, thereby contributing to the progression of lesions (8).

During the initiation of atherosclerosis, smooth muscle cells (SMC) from the tunica media, the middle layer of the arterial wall, migrate to the tunica intima (9). Some foam cells and SMC die in the plaque cavity leading to the formation of hardened plaque in the arterial wall, which may further lead to stenosis of the arterial lumen. The endothelial cells and the migrated SMC that lay outside the plaque cavity in tunica intima comprise what is referred to as the fibrous cap (Fig. 1). A rupture in this fibrous cap will expose the hard plaque content to the blood flow, leading to platelet activation that triggers the formation of a thrombus, which may occlude the entire vessel lumen and prevent blood flow. This will lead to ischemia of the tissue supplied by the vessel in question, and if this takes place in a coronary vessel, a myocardial infarction will occur. Hence, the rupture of the fibrous cap represents a transformation of the chronic atherogenesis into an acute coronary, cerebrovascular or peripheral extremity ischemic event. The exact cause of the plaque rupture remains to be established, although the instability of the plaque may be due the damaging of proteins in the fibrous cap caused by different proteases that break down the extracellular matrix such as the group of enzymes referred to as matrix metalloproteinases (MMP) (10).

In addition to elevated LDL cholesterol, C-reactive protein (CRP) levels are also increased in people who are at risk of CVDs (11). CRP is an acute phase protein synthesized in the liver in response to inflammation. When a patient has an acute inflammation, the CRP attains high levels, but under normal conditions it is expected to be between 0-5. The CRP level has been suggested to be one of the strongest predictors for identifying patients with a high risk of atherosclerosis. If a person has a constant CPR of 4, this may indicate a low-grade chronic inflammation, and may alert for the incidence of atherosclerosis (11). For this reason, CRP can therefore be seen as a major cardiovascular risk marker, and it has also been demonstrated that there is a strong correlation between CRP level and the risk of myocardial infarction, arterial disease, stroke and sudden cardiac death for both men and women (12).

Current treatments

It is well-known that an unhealthy lifestyle increases the risk of CVD. Factors such as smoking, hypertension, a high cholesterol diet, a low level of exercise and obesity increase the risk for disease. From an epidemiological point of view, a risk factor is a feature of a population or an individual that is recognized at an early stage in life as being associated with an increased risk of developing diseases in the future (12). If patients with established coronary heart disease quit smoking, they lower their death risk by 30-50% (4). Cessation of cigarette consumption is the most important intervention in preventative cardiology, as smoking has unfavourable effects on blood pressure, reduces myocardial oxygen supply and accelerates atherosclerotic progression (12). Long-term addiction may also increase the oxidation of LDL cholesterol (12). Blood pressure control is also important since it has been demonstrated that hypertension increases the risk of stroke, vascular mortality and general heart failure. The targeted blood pressure should be less than 140/90 mm Hg for the general population, and it has been shown that reductions as small as 4-5 mm Hg significantly reduce the risk of these incidences. Being overweight is also a factor that increases blood pressure, so by exercising, eating a healthy diet with low LDL cholesterol levels and

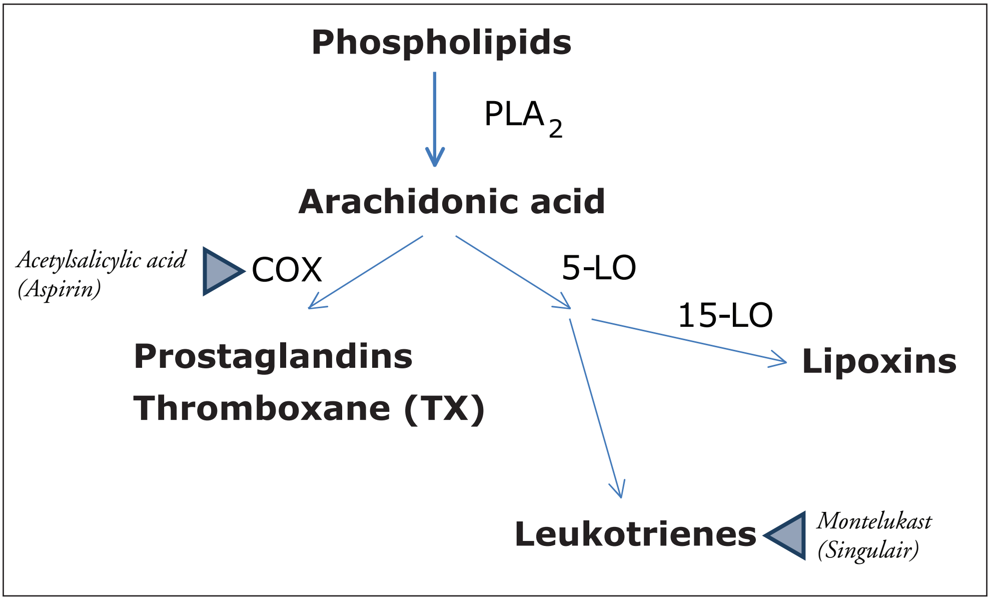

Fig. 2: Arachidonic acid is released from phospholipids by the enzyme phospholipase A_2 *(*PLA_2*). The formation of prostaglandins and thromboxanes is derived from the cycloxygenase pathway (COX) . Leukotrienes are derived from the 5-lipoxygease pathway (5-LO), while lipoxins are derived through the 5-LO and 15-LO pathways. The blue triangles indicate drugs targeting these pathways. Aspirin is a COX-inhibitor used to inhibit thromboxane-induced platelet aggregation, whereas montelukast is a leukotriene receptor antagonist currently used in the treatment of asthma.*

consuming no or low amounts of alcohol, the level of hypertension is expected to go down. High blood pressure is also treated with medication. Patients with high total cholesterol and/or high LDL-cholesterol levels should be treated with lipid lowering drugs (4).

Statins, a group of cholesterol-lowering drugs that are widely used in the treatment of CVDs, have been proven to be efficacious in the secondary prevention of cardiovascular events. In addition, statins have been reported to lower CRP levels (13), and experimental observations suggest that statins may also have an effect on immunological reactions and inflammatory processes (14). For example, statins stabilize carotid plaque, and delay the progression of atherosclerosis through anti-inflammatory effects in atherosclerotic rabbits (15). In 2008, it was revealed by a large randomized controlled study called JUPITER that for healthy subjects with elevated CRP levels, rosuvastatin significantly helped in reducing the incidence of major cardiovascular events (13).

The use of acetylsalicylic acid (Aspirin) in the prevention of CVDs has been well established and relies on the inhibition of thromboxane A_2 (TXA_2), which is a member of the prostaglandin cascade and a potent prothrombotic mediator through platelet activation. This lipid mediator is synthesized from arachidonic acid through the cyclooxygenase (COX) pathway (Fig. 2). Targeting TXA_2 through the common low-dose acetylsalicylic acid treatment for the prevention of thrombosis relies on the irreversible inhibition of the COX-1 subtype enzyme in platelets, which lacks the ability to resynthesize COX enzymes, thus leading to a selective inhibition of platelet TXA_2 formation, and the subsequent inhibition of platelet function and prevention of thrombosis formation on atherosclerotic plaque. In contrast, inhibitors of the COX-2 subtype enzyme have been shown to be associated with an increased cardiovascular risk. These findings illustrate the complexity of lipid mediators in atherosclerosis.

Leukotrienes as future treatment targets

In 1982, Bengt I. Samuelsson from the Karolinska Institute in Stockholm, Sweden was one of the three Nobel laureates who were awarded the Nobel Prize in Physiology or Medicine “for their discoveries concerning prostaglandin and related biologically active substances” (16). Prostaglandins (Fig. 2), which have been well-known for a long time, play a role in acute inflammatory response, including the regulation of local changes in blood flow and pain sensation (6). In addition, another discovery was leukotrienes and their role in the biological control system (16). These discoveries have been crucial for contemporary theories on how to tackle the problem of chronic inflammation in atherosclerosis.

Leukotrienes are inflammatory mediators which are derived from the 5-lipoxygenase pathway of arachidonic acid metabolism (Fig. 2) (17). Leukotrienes have specific cell surface receptors, and act as potent leukocyte chemoattractants. Some of these receptors have been recognized in human carotid artery atherosclerotic plaque (17). In other words, the activation of some leukotriene receptors may stimulate inflammatory events, e.g. monocyte recruitment, in the arterial wall (7). Macrophages represent a major source of a specific leukotriene production (LTB_4), and since macrophages are differentiated from monocytes through leukotriene receptor activation, this becomes a vicious cycle that accumulates inflammatory activity at atherosclerotic sites [8]. Recent studies have suggested that the inhibition of specific leukotrienes may be a possible therapeutic strategy for atherosclerosis, thereby suggesting leukotriene receptor antagonists as a complement to current treatments of atherosclerosis (17).

In fact, several of the above described reactions that characterize atherogenesis could potentially be induced by leukotriene signalling. In addition to activating immune cells and acting as chemoattractants, leukotrienes also activate structural cells within the vascular wall, and have been implicated in the early stages of atherosclerosis, *i.e.* endothelial dysfunction and intimal hyperplasia (cf. Fig 1). Finally, through the activation of matrix metalloproteinases, leukotrienes could also be involved in plaque rupture.

In support of a major role of leukotriene signalling in cardiovascular disease, inhibiting leukotriene signalling in different animal models has shown beneficial effects. Leukotriene receptor antagonists protect against atherosclerotic lesion development in hyperlipidemic mice, and reduce the intimal hyperplasia response after vascular injury (5). Nevertheless, negative animal studies have also been published in which leukotriene synthesis inhibitors had no effect on atherosclerosis development (5).

In humans, genetic association studies have identified several genes encoding various components of the leukotriene pathways as being associated with atherosclerosis and increased cardiovascular risk. For example, polymorphisms within the 5-lipoxygenase gene were linked to an increased thickness of the carotid artery in an initial study, which was followed by the demonstration of haplotypes within the gene encoding the 5-lipoxygenase activating protein that were associated with an increased risk of myocardial infarction and stroke. However, some contradictory findings exist in terms of the association of cardiovascular disease with genetic variations within the leukotriene pathway, as reviewed in (5).

In asthma, a chronic inflammatory disorder which affects the airways, therapeutic agents that prevent the synthesis of leukotrienes have shown indications of being an effective treatment (18). This could suggest a link between the inflammatory conditions of asthma and atherosclerosis, and inhibiting the 5-LO pathway might be a potential treatment option. Randomized controlled studies of montelukast (Singulair), a leukotriene receptor antagonist, have revealed that it has anti-inflammatory properties during the treatment of asthma (19). Both as monotherapy, or in combination with inhaled corticosteroids, studies indicate that montelukast led to an improvement in the symptoms of asthma, lung function, quality of life and the number of asthma exacerbations (19). Interestingly, montelukast also decreases CRP in asthmatics. As previously mentioned, CRP is an established risk factor in atherosclerosis, and experimental studies of animal models of atherosclerosis have in fact indicated beneficial effects when leukotriene signalling has been inhibited (5).

As mentioned above, not all studies point undisputedly to leukotrienes as potential targets in cardiovascular disease. In this context, it is important to stress that the pro-inflammatory leukotriene pathway may be balanced by anti-inflammatory mediators produced through the same biosynthetical pathway. These molecules are referred to as lipoxins (Fig 2), and have been suggested to promote the resolution of inflammation, allowing for inflamed tissue to return to homeostasis (19). For a complete resolution to occur, further leukocyte recruitment must be inhibited and leucocytes must be removed from inflammatory sites.

Conclusion

In summary, combating the problem of atherosclerosis is a vital task for lowering the rate of CVDs on a global level, and there are still areas of the disease that need to be explored before a fully designed medical treatment can be prescribed. Atherosclerosis has been proven to be more than what scientists used to think were only lipid deposits in the arterial wall. Although the importance of inflammation is now widely appreciated, understanding the vast complexity of the disease is crucial for designing anti-inflammatory treatments as a part of CVD prevention. The leukotriene pathway may be one such possible pro-inflammatory pathway, and drugs that target these mediators are already used in the treatment of asthma. However, in the absence of randomized controlled studies of anti-leukotrienes in patients with atherosclerosis, no recommendations can yet be made as to the use of these drugs in CVD prevention. In addition, lipid mediators may have both pro- and anti-inflammatory properties, and a complete understanding of these pathways in atherosclerosis still remains to be established.

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Kjell Asplund

Biafra – minnen och reflexioner kring 1960-talets stora svältkatastrof

Pliktetik, konsekvensetik och upprättandet av Läkare utan gränser (MSF)

Michael Quarterly 2011;8:523–31.

Under Biafrakriget 1967-1970 inträffade den första stora svältkatastrofen efter andra världskriget. I denna artikel ger jag några minnesbilder från min tid som Röda Korsmedarbetare i Biafra och reflekterar över plikt- respektive konsekvensetiska dilemman.

Ett starkt pliktetiskt patos finns bland många av oss hjälparbetare. Men ur ett strikt konsekvensetiskt perspektiv är det uppenbart att den humanitära hjälpen förlängde kriget och förmodligen bidrog till ökat lidande.

Bland hjälparbetarna fanns ett missnöje med hur det internationella Röda Korset drev de humanitära insatserna. Kritiken inriktade sig på den politiska undfallenheten, korruptionen, byråkratin, det dåliga samarbetet med andra hjälporganisationer, den bristande omsorgen om personalens säkerhet samt på det faktum att medarbetarna ålagts förbud mot att uttala kritik mot Röda Korset.

En grupp franska läkare bildade efter hemkomsten från Biafra en helt ny hjälporganisation, Médécins sans Frontiers (MSF; Läkare utan gränser) som, i motsats till internationella Röda Korset, skulle ha en liten, decentraliserad administration och öppet tala om övergrepp och maktmissbruk. Hjälparbetet skulle bedrivas enbart utifrån nödställda människors behov, dvs. vila på en strikt pliktetisk grund. På så vis kan man betrakta bildandet av MSF som ett resultat av de plikt- och konsekvensetiska dilemman som präglade hjälporganisationernas insatser och medarbetare under Biafrakriget.

Biafrakriget

Via TV och tidningar trängde åren 1968-1969 lidandet bland svältande, utmärglade barn i Biafra brutalt in i hemmen i de rika länderna på ett sätt man inte upplevt tidigare. För första gången kom lidandet tätt inpå oss i all sin upprörande nakenhet – barn där håret fallit av, där buken svällt groteskt, där blicken slocknat. De dog framför våra ögon. Detta var den första stora svältkatastrofen efter andra världskriget. Erfarenheterna från Biafra kom att under lång tid framåt prägla stora humanitära hjälpinsatser.

I denna artikel ger jag några utvalda minnen från mitt arbete som ung läkare för International Committee of Red Cross (ICRC)i Biafra och jag reflekterar över ett grundläggande medicinetiskt dilemma, där pliktetik och konsekvensetik står mot varandra.

Tabell 1. Korta fakta om Biafrakriget 1967-1970.

• Nigeria blev 1960 oberoende från det brittiska imperiet som en federal stat. I maj 1967 förklarade de sydöstra provinserna sig självständiga under namnet Biafra, något som ledde till inbördeskrig. Biafra erkändes som självständig nation av fem stater, fyra av dem afrikanska.
• Två huvudfaktorer till kriget brukar anges: (a) etniska motsättningar i de norra delarna av Nigeria, där ett stort antal igbos (inflyttade från sydöstra Nigeria) mördades i pogromer, (b) kampen om de nyupptäckta oljefyndigheterna i Nigerdeltat i sydöst.
• Efter ett års krig inringades Biafra sommaren 1968, så att inga sjö- eller landtransporter kunde nå enklaven. Följden blev en svältkatastrof. Ingen vet säkert hur många som dog – siffrorna varierar mellan några hundra tusen till tre miljoner, beroende på källan.
• En luftbro med mat och andra förnödenheter upprättades av en lång rad internationella hjälporganisationer. Av säkerhetsskäl fungerade luftbron endast periodvis.
• I januari 1970 kapitulerade Biafra.

Källorna

Artikeln bygger på mina personliga minnesbilder, över 40 år gamla och därför bräckliga, och med en längre intervju med Acke Hallén, då Chief Medical Officer för ICRC i Biafra, nu 88 år. Jag har också letat fram min dagbok och mina brev från Biafratiden och jag har haft tillgång till Acke Halléns nedtecknade (men opublicerade) minnen. En hel del annat skriftligt material har jag också sparat, och jag har på nytt läst många av de rapporter och debattskrifter som publicerades åren 1968-1969 (1-5). Under 1968-1969 förkom också i den internationella medicinska facklitteraturen en rad rapporter och debattinlägg (t ex 6-8). Bland det material som finns tillgängligt på internet är BBC-programmet *Nigeria War against Biafra 1967-1970* (9) med sin solida dokumentation överlägset – bl a intervjuas där många centrala aktörer i kriget.

Motiven

När jag 1964 kom till Uppsala som medicinarstudent kände jag mig tämligen välorienterad i internationella frågor. Men engagerad? Nej, knappast. Men resten av 60-talet blev de år då orättvisorna och förtrycket i tredje världen öppnade upp sig för många av oss i den rika världen. Mest handlade det om Vietnam och om södra Afrika. Jag engagerade mig i Afrikagrupperna som inriktade sig på Södra Afrika och i Verdandi, den klassiska uppsaliensiska studentföreningen, där diskussionerna dessa år kom att präglas av de stora tredje världenfrågorna.

Vi tog ställning mot apartheid och mot kolonialism, mot exploateringen av de fattiga länderna. Vi stödde befrielserörelserna. Men när Biafrakriget kom, stämde inget av de givna mönstren. Det handlade om makten över oljetillgångarna i Nigerdeltat, och den federala sidan stöddes av BP och Shell, Storbritannien och Sovjet. Så långt var ställningstagandena enkla. Mycket av vapnen på den biafranska sidan kom från Frankrike, en del från Kina – det hade vi inga större problem med. Men sedan blev det mer komplext. På Biafrasidan slöt också Sydafrika och inte minst Portugal upp, den apartheidregim och den kolonialstat som vi såg som de stora förtryckarregimerna i Afrika.

Avgörande för mitt beslut att arbeta för ICRC, det internationella Röda Korset, i Biafra blev ändå det uppfordrande humanitära åtagandet. TV-bilderna på de utmärglade barnen med svullna bukar och slocknade blickar överväldigade mig. Alla politiska analyser, all komplexitet sköts undan. Fortfarande när jag mer än 40 år senare återser bilderna och TV-reportagen drabbas jag av en så oändligt stark rörelse. Den gången kunde inget förnuftsmässigt resonemang i världen överflygla den känslan.

Många, många andra berördes lika starkt. Vi glömmer idag att proteströrelserna i Europa 1968 inte bara handlade om studentrevolt och demonstrationer mot Vietnamkriget. I London och Paris förekom väldiga demonstrationer där man krävde humanitärt bistånd till Biafra (att den biafranska ledningen kom att så cyniskt utnyttja den egna befolkningens väldiga lidande till stöd för sin sak blev, åtminstone för mig, inte uppenbart förrän långt senare). En artikel i Läkartidningen, «Läkarrapport från Biafra: Svält och åter svält» av Gävledoktorn Gustav Weissglas (10) övertygande mig att det var inte bara mattransporter som betydde något, utan att man också som läkare kunde göra en meningsfull insats. I den medicinska fackpressen kom även i Finland (11) och Norge (12) och många andra länder liknande rapporter från sjukvårdspersonal som arbetat i Biafra.

Det etiska dilemmat

Under Biafrakriget mobiliserades för första gången sedan andra världskriget de internationella hjälporganisationerna på det storskaliga sätt som kommit att bli mönstret vid de flesta större katastrofer som inträffat senare. Utmaningen var enorm – miljoner svältande, sjuka, döende i liten enklav utan möjlighet till land- eller sjötransporter och med ett enda mindre flygfält, ideligen bombat.

Den etiska fråga som så här i historiens ljus blivit så tydlig är: Minskade verkligen hjälpinsatserna lidandet? Eller var det möjligen så att hjälporganisationernas massiva insatser förlängde kriget och ökade det sammantagna lidandet?

Det hela kan ses som ett ovanligt tydligt exempel på hur plikt- och konsekvensetik ställs mot varandra. Många av oss som arbetade i hjälporganisationerna under Biafrakriget drevs av en i grunden stark pliktetisk mission – en handling ska bedömas utifrån sitt eget inneboende värde, inte utifrån de konsekvenser den får. Värdet i handlingen avgörs av vår bjudande plikt att bistå en lidande medmänniska (13).

Numera råder det knappast något tvivel om att den humanitära hjälpen förlängde Biafras dödskamp med månader, kanske med något år, och att hundratusentals barn och vuxna hann svälta ihjäl under denna tid. Som Sir David Hunt, brittisk High Commissioner (ambassadör) i Nigeria under kriget – och alltså representant för den nation som försåg den federala sidan med merparten av vapnen – uttryckte det i en BBC-intervju flera år senare (9):

– Kriget, och särskilt då den senare fasen av kriget, finansierades av de ideella organisationerna. Detta var det första krig i historien där detta skett.

Hunt exemplifierar med att den biafranska ledningen krävde att hjälporganisationerna skulle flyga in bränsle till armén och att Biafra tog ut höga landningsavgifter som Röda Korset och andra hjälporganisationer tvingades betala.

– Om de inte betalade, fick de inte ta in mat.

Hunts bild bekräftas i stort av den biafranske ledaren överste Ojukwu, sedermera framgångsrik politiker i det återförenade Nigeria:

– Det kom en tid när vi, för att kunna administrera hjälpen, tog betalt av hjälporganisationerna. De fick precis vad de ville [dvs. föra in mat], medan vi kunde använda hårdvalutan för att köpa vapen (9).

Många av detaljerna i relationerna mellan den biafranska ledningen och hjälporganisationerna var kända för oss hjälparbetare i Biafra, men jag tror att få av oss såg den samlade bilden, att kriget kunde hållas gående genom våra insatser. Jag kan inte erinra mig att vi någonsin på djupet diskuterade det grundläggande etiska dilemmat – vi förskansade oss i vårt pliktetiska försvarsverk och det fanns föga utrymme för konsekvensetiska överväganden.

I själva verket blundade vi för mycket. För att fungera i ett så påfrestande sammanhang som i Biafra solidariserade de flesta av oss så helt med den biafranska saken att vi kunde överse med den utpressningssituation som den biafranska ledningen utsatte hjälporganisationerna för. Vi kunde glädjas när de biafranska militära motstötarna lyckades och när den teatraliske svenske grev Carl-Gustaf von Rosen med sina MFI-plan attackerade den federala sidans stridsflyg.

I vår solidaritet med den biafranska sidan finner jag hur jag i min dagbok återgav rykten om de federala soldaternas brutalitet och använde samma terminologi som biafranerna – den federala sidan kallar jag genomgående «vandalerna». Acke Hallén berättar hur han vid hemkomsten till Sverige var så politiskt pro-Biafra att Röda Korsets presschef ställde in planerade massmediaframträdanden där han skulle berätta om nöden i Biafra.

Det är idag smärtsamt att inse att den insats som jag då upplevde vara så avgörande både för Biafrabarnen – vi räddade många liv med våra insatser – och för mig själv med all sannolikhet förlängde kriget och ökade lidandet. Men medan pliktetiska överväganden i regel är enkla, direkta och rättframma, kan de konsekvensetiska kalkylerna inte slutföras förrän långt i efterhand. De allra flesta biafraner var övertygade om att en massaker väntade om den federala sidan skulle vinna kriget. Omfattande pogromer mot igbos, den dominerande folkgruppen i Biafra, i andra delar av Nigeria hade bidragit till utbrytningen. I propagandan framställdes ibland igbos som Afrikas judar. Många, bl a BBC-journalisten Frederick Forsyth, sedermera uppburen thrillerförfattare, drog paralleller till Förintelsen (1).

Visst förekom det övergrepp efter Biafras kapitulation i januari 1970, men inte i den skala som igbos fruktade. Den sparsamma dokumentation som finns tyder på att svälten vek undan ganska snabbt. I juni och juli samma år hade näringstillståndet bland barnen förbättrats markant och skolorna kunde öppna på nytt, om än illa utrustade (14). Ett annat scenario, som t ex händelseutveckling som i folkmordens Rwanda ett kvartssekel senare, hade givetvis i grunden ändrat den konsekvensetiska balansräkningen.

Missnöjet med Röda Korset

Mycket i hjälporganisationernas arbete fungerade illa, och frustrationen bland personalen var stor. Givetvis bidrog det väldiga gapet mellan behoven och de faktiska möjligheterna att hjälpa till missnöjet bland de som arbetade inom hjälporganisationerna. Men det fanns också annat som bidrog.

För det första handlade det om ICRCs diplomati som många av hjälparbetarna upplevde som föråldrad. I neutralitetens namn manövrerade man ängsligt för att hålla sig väl med båda sidor i kriget. De politiska kompromisserna ledde till kraftlöshet – varför tog inte ICRC kompromisslöst ställning för kärnan i hjälparbetet, det humanitära åtagandet, frågade vi oss.

För det andra gällde det korruptionen. Mycket av ICRCs agerande kunde i nödfall försvaras som diplomati och pragmatism – dit hörde kanhända de höga landningsavgifterna för de flyg som transporterade mat in i enklaven. Men ofta kom den otydliga gränsen till korruption att överträdas, något som det finns återkommande notiser om i både Acke Halléns och mina egna anteckningar. Den första billasten med förnödenheter som kom in via den nattliga luftbron gick regelmässigt till överste Ojukwu och hans familj. Jag ser i min dagbok en upprörd notis från ett möte med ICRCs högste representant i Biafra, schweizare, där denne instruerar om alldeles speciella favörer för sin älskarinna, en pinsam konfrontation med den idealism som fört mig och många av de andra hjälparbetarna till Biafra.

Missnöjet gällde, för det tredje, hur de medicinska insatserna organiserades. Alla större beslut togs i Genève i en trög byråkratisk process, där formalismen spelade en central roll och där beslutsvägarna var långa men där ledarskapet ändå förblev otydligt. När Acke Hallén kom till Biafra som Chief Medical Officer fanns inga instruktioner om vad han förväntades göra. Vilka mandat han hade förblev oklara. Men han berättar om den uppskattning han rönte från ICRC-ledningen när han så småningom fick tillgång till en skrivmaskin och kunde börja leverera dagliga skriftliga rapporter: precis vad man längtade efter på ICRCs högkvarter i Umuahia och Genève.

En fjärde orsak till misshälligheter gällde samarbetet med andra hjälporganisationer. Det internationella Röda Korset, ICRC, var långt ifrån den enda hjälporganisationen i Biafra. Också flera av de nationella Röda Korsorganisationerna, mest storskaligt den franska, fanns på plats. Rädda Barnen var där. Kyrkorna, både det katolska Caritas och det protestantiska World Council of Churches (WCC) hade omfattande verksamheter. Men samordningen var nästan obefintlig. I stället var enklaven Biafra ofta strikt indelad i intresseområden som respektive hjälporganisation strängt bevakade som sina egna. Min dagbok innehåller en hel del utfall mot just kyrkorna.

Många av oss som arbetade med Röda Korset hade uppfattningen att de kyrkliga organisationerna drevs inte bara av humanitära utan också av rent missionerande motiv. Vad vi inte hade tillräckliga insikter om, men som jag förstått långt senare, var att kyrkorna hade en sådan stark lokal förankring. De flesta biafraner var kristna och de många kristna samfunden drev skolor och missionsstationer. Prästerna hade i regel starka lokala nätverk. Kyrkorna hade helt enkelt en infrastruktur väl förankrad i regionen, något som Röda Korset saknade. Röda Korsets team och sick-bays (små sjukhus för undernärda barn) var förlagda till just dessa skolar och missionsstationer.

Därtill kom missnöjet med ICRC som arbetsgivare. Som i de flesta stora organisationer tyckte de medarbetare som arbetade på fältet att de inte fick den uppskattning de förtjänade. Många kände sig utsatta och värnlösa i ett krig, där fronterna (som i den lilla enklaven aldrig var mer än ett par mil bort) ständigt förändrades och där man inte kunde förutse vad odisciplinerade soldater, ibland berusade, kunde ta sig till. Strax innan jag kom till Biafra dödades i ett av Röda Korsteamen en svensk Röda Korsarbetare och en jugoslavisk läkare tillsammans med personal som arbetade för Kyrkornas världsråd. En notis i min dagbok handlar om hur tre svenskar omkom i en olycka ute vid flygfältet. Många frågade sig: Var fanns ICRCs omsorg om den egna personalen? Kunde inte ICRC göra mer för vår säkerhet? De svenska Röda Korsarbetare som arbetade med mattransporterna krävde risktillägg, något som ICRC motsatte sig. Först efter en långdragen förhandling kunde de förmås ta upp arbetet igen.

Och som en sjätte anledning till frustrationen kom den munkavle ICRC satt på oss. Vi hade besök av många TV-team, andra journalister, parlamentariker från Västeuropa och Nordamerika. Men vår frustration med hjälporganisationernas arbete kunde vi inte förmedla – vi som arbetade för hade alla undertecknat ett kontrakt där vi förbundit oss att «… abstain from all communications and comments on its [ICRC's] mission …». Själva det faktum att ICRC förbjöd oss att ge uttryck för vår frustration bidrog säkert till att ytterligare förstärka den.

Läkare utan gränser bildas

Det blev uppenbart att Röda Korsets hjälparbete behövde reformeras. Men några av hjälparbetarna drog slutsatsen att ICRCs förstelning nått så långt att en genomgripande nyorientering av hjälparbetet knappast kunde ske inom ramen för denna organisation. Något nytt behövdes – en oberoende medicinsk hjälporganisation som talade öppet om övergrepp och maktmissbruk, en organisation där arbetet enbart styrdes av nödställda människors behov utan politiska hänsyn.

Under hela kriget var engagemanget för den biafranska sidan särskilt starkt i Frankrike. Och bland hjälparbetarna på plats inne i Biafra var det i första hand de franska Röda Korsmedarbetarna som reagerade mot det som de uppfattade vara politisk opportunism, undfallenhet, räddhågsenhet och inkompetens hos Röda Korset som organisation. Jag träffade flera av de franska läkarna under min Biafratid och slogs av deras chockerande rättframhet när de uttryckte sig om Röda Korset. Efter hemkomsten till Frankrike satte dessa läkare igång arbetet med utveckla den tanke som fötts i Biafra, nämligen att bilda en helt ny internationell hjälporganisation.

Ett år efter Biafrakrigets slut bildades i Paris Médécins sans Frontiers (MSF), Läkare utan gränser, av en grupp läkare som varit verksamma i Biafra. Den nya organisationen skulle tala öppet om övergrepp, maktmissbruk och korruption. Den skulle, till skillnad från Röda Korset, inte ha någon stor central administrativ apparat och den skulle kunna fatta beslut om insatser långt snabbare än ICRC. Hjälparbetet skulle, utan politiska hänsyn, styras enbart utifrån nödställda människors behov. Jag vill hävda att det nybildade MSF med en sådan programförklaring kom att ta ställning för en mycket profilerad pliktetik. Man skulle dialektiskt kunna se Röda Korsets hänsyn till möjliga realpolitiska konsekvenser av sina beslut och insatser som ett uttryck för en konsekvensetisk position. På detta vis kan man betrakta bildandet av MSF som ett arv från de plikt- och konsekvensetiska dilemman som präglade hjälporganisationernas insatser och medarbetare under Biafrakriget.

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«Askepotterne blant landets embetsmænd» – legenes vei til samfunnstoppen 1811–1960[1]

Michael Quarterly 2011;8:532–44.

Fram til slutten av 1800-tallet hadde medisinen ikke den samfunnsmessige status den senere fikk, og medisinerne kom i skyggen av jurister og teologer. Legene hadde en beskjeden plass i embetsstanden, deres dannelsesnivå var ansett som lavere enn hos andre universitetskandidater, evnen til å lege sykdommer var relativt beskjeden, og de deltok lite i offentligheten. I løpet av to-tre generasjoner snudde bildet: Vitenskapen gjorde store framskritt og fra teologene overtok legene rollen som herrer over liv og død. Det offentlige helsevesen ble sterkt utbygd med sykehusene som spydspiss, legene ble offentlige eksperter og intellektuelle og helsepolitiske entreprenører, de bygget landets sterkeste profesjonsforening og legestudiet tiltrakk seg de gløggeste hoder.

Fra ydmyk til selvbevisst

Da Universitetet i Oslo fylte 150 år, i 1961, brakte Aftenposten en reportasje fra studentmiljøet. Avisen skriver:

> «Allerede før de hadde satt foten innenfor på et sykehus, dukker de privilegerte opp i Aulakjelleren i hvite frakker med alle tegn på at de er seg sin særstilling bevisst. Mange av medstudentene er dumme nok til å la seg irritere, og ingen forundrer seg om dette gir en viss kildrende tilfredsstillelse og ekte medisinerfølelse slik den oppfattes i de tidligste stadier.»[2]

Med tanke på den status medisinerne hadde oppnådd rundt 1960, med utpreget faglig autonomi, sosial prestisje, god lønn og sykehusene med sine klinikker og laboratorier som en slags slott og borger for kongene og prinsene i faget – prinsessene var ennå nokså få – er det ikke lett å forestille seg at situasjonen bare noen få generasjoner tidligere hadde vært ganske annerledes.

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[1] Store deler av artikkelen bygger på Myhre JE. *Kunnskapsbærerne 1811-2011. Akademikere mellom universitet og samfunn*. Oslo: Unipub, 2011.

[2] *Aftenposten* 16.12.1961.

Bare for å ta studentene: Gjennom hele universitetets historie, helt fram til annen verdenskrig, var medisinerstudentene blant de minst begavede, målt i artiumskarakterer. Der konkurrerte de med jurister og teologer, og lå av og til litt over, av og til under.[3] Høyt over disse tre i karakterer finner vi realistene og aller øverst tronet filologene. Først ut i 1950-årene, etter mange år med lukket studium, var legestudentene i teten, altså etter artiumskarakterer.

Nå var det ikke først og fremst artiumskarakterene som fastla folks stilling i samfunnet. Filologer og realister hadde så avgjort ikke høyest status. Så når legene på 1800-tallet ikke nådde spesielt høyt i omdømme eller lønn, var det ikke på grunn av karakterene. Hvorfor var så legene fremdeles i 1887 «askepotterne blant […] embædsmænd», som Ole Malm (1854-1917) utrykte det i 1887?[4]

En beskjeden stand

Medisin var et av universitets eldste fakulteter, bare teologi og juss kom tidligere, og ett av de tre profesjonsstudier fra Universitetet i Oslos opprettelse i 1811. Medisin var lillebroren blant de tre også på andre måter. Medisinerne var fåtallige sammenlignet med jurister (særlig) og teologer. Først i annen halvdel av 1800-tallet begynte medisinerne å nærme seg teologene i antall, men lå alltid langt bak juristene. Dette viste seg blant annet i antall yrkesutøvere. Ved midten av 1800-tallet fantes færre enn 300 leger i landet, men over 700 offiserer, 500 prester og 6-700 jurister.[5]

Dette sier selvsagt langt fra alt. Hvor i samfunnet finner man dem, legene? Til å begynne med var mange av dem offiserer. Senere i århundret var det offentlige leger (distriktsleger og stadsfysici) som dominerte. Så sent som 1872 var bare ni prosent sykehusleger. Leger satt ikke særlig høyt i hierarkiene. Medisinen selv hadde lenge ikke noe spesielt utviklet forvaltningsmessig hierarki, slik som man fant det hos jurister og teologer. Generalkirurgen kom riktignok høyt på embetsrangen.[6] Også direktøren ved de få statlige sykehus fantes der. Men juristene regjerte i forvaltningen. Det har vært medisinernes styrke og svakhet sammenlignet med juristene at legene har drevet med medisin, og nesten bare det, mens juristene har gjort alt mulig.

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[3] Aubert V et al. *The Professions in Norwegian Social Structure*. Oslo: Institute for social research, 1961-1962: tables 79-124.

[4] Schiøtz A. *Folkets helse – landets styrke 1850-2003. Det offentlige helsevesenets historie i Norge 1603-2003.* Oslo: Universitetsforlaget 2003: 144.

[5] Myhre JE. *Kunnskapsbærerne 1811-2011*: tabell 2.2 etter Aubert V et al. *The Professions*: table 1.

[6] Se *Norges Statskalender*, diverse årganger. Embetsrangen varte til årsskiftet 1925/26.

Mange leger i de par første generasjonene var «preliminarister», dvs. at de fikk studere uten artium og dermed uten latin, fram mot en såkalt «norsk» medisinereksamen. Årsaken var at landet manglet leger. Det samme gjaldt for så vidt også for juristene, men ikke for teologene eller filologene som fikk et sosialt forsprang i den grad det å beherske latin var en yrkesmessig og sosial fordel. Og det hendte. Historikeren Ludvig Ludvigsen Daae (1834-1910) var en ihuga latiner, og har gjennom sine etterlatte notater delt ut mer og mindre fordomsfulle karakteristikker av mange samtidige. Medisinere stod ikke spesielt høyt i kurs hos ham, men landphysicus i Buskerud, Thomas Blich (1830-1879) i Drammen, kunne tilgis det meste på grunn av akademiske meritter og ikke minst fordi han førte sine journaler på latin.[7]

Heller ikke yrkesutøvelsen ga legene svært høy status. Dere evne til å helbrede var svært begrenset. De nøt som alle øvrighetspersoner en viss autoritet, og mange leger hadde godt ry. Det fantes likevel ikke sjelden gjensidig mistillit mellom folket og legen. Stortingsbøndene markerte en viss mistillit gjennom å være mot kvakksalverloven. De ville gjøre medisinsk praksis fri og fikk gjennom en liberal lov i 1871. En del leger kunne på sin side opptre nedlatende mot befolkningen, blant annet på grunn av det de så som skittenferdighet og uvitenhet. Doktor Carl August Knutsen (1826-1898) ved Bærums Værk forteller i anledning koppeepidemien i Bærum i 1866:

> «Enhver Forestilling om Sygdommers Smitsomhed møder … Almuen med sit eenstemmige urokkelige: 'Det trur jeg intet – En faaer døm i Lufta – vil Vorherre, En ska ha døm, saa faaer'n døm'» Ingen fornuftig forklaring virker; allmuen tror ikke på smitte. «Ligeoverfor en saa massiv Tro maa da Fornuft og Erfaring Forstumme»,

konkluderte distriktslegen.[8] Det faktum at legene spilte en viktig rolle når det gjaldt å forebygge sykdommer, var ikke umiddelbart merkbart for folk flest.

I det sosiale og det offentlige

Legene var sjelden sosialt ledende i det 19. århundret. I lokalsamfunnene, i bygder og småbyer, hørte de selvsagt til det gode selskap, men sjelden i framtredende posisjoner. De ble etter hvert ikke sjelden tillagt en spesiell sosial rolle. Distriktslege Johan Andreas Kraft (1808-1896) var «Byens eneste

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[7] Knudtzon N. *Professor, Dr. Ludvig Daaes erindringer og opptegnelser om sin samtid*. Oslo: Novus 2003: 272.

[8] Fra medisinalinnberetningene i Riksarkivet, etter Myhre JE. *Bærum 1840-1980*. Oslo: Universitetsforlaget 1982.: 148. Carl August Knutsen var verkslege ved Bærums Jernverk 1855-75 og ordfører i sunnhetskommisjonen for Asker og Bærum. Larsen Ø (red.). *Norges leger*. Oslo: Den norske lægeforening 1996: bd. III.

erklærede Fritenker», skrev Ludvig Daaes om sin barndoms Flekkefjord 1840-årene. Når Gregers Werle i Vildanden i siste scene ser for seg en moralsk heving, kommenterer doktor Relling, kynikeren, realisten, i stykkets siste setning: «Faen tro det.» Senere viste Øvre Richter Frichs dr. Jonas Fjeld seg som en handlekraftig mann uten nonsens. Dette bidro til økt status utover på 1900-tallet: «Jeg er lege», sa han (Dr. Fjeld), «og mengden vek til side».[9] Medisinerne var tidlig moderne i sin tro på vitenskap og fornuft og kanskje mindre på religion. Dette skulle med tiden vise seg å ikke være noen ulempe, men fram til det moderne gjennombrudd i 1870-80-årene var det knapt noen fordel.

Legene var på mesteparten av 1800-tallet var påfallende lite synlige i offentligheten, i alle fall i riksoffentligheten. De var sjelden i politikken, de var lite synlige i studentersamfunnet, de var sjelden forfattere, uten i egne tidsskrifter. Det fantes unntak, som professor Frederik Holst (1791-1871), en fremtredende samfunnsbygger, og Herman Wedel Major (1814-1854), en reformator av psykiatrien. Et annet unntak var professor Ernst Ferdinand Lochmann (1820-1891), men han var kulturelt meget konservativ, til forskjell fra mange kolleger. Medisinerne hadde sine egne faglige offentligheter og deltok i debatter om helse, men ellers lite. Medisinernes beskjedenhet gjaldt i noen grad også organisasjonslivet, som blomstret fra midten av århundret. Medisinerne organiserte seg selv i faglige foreninger, blant annet i Det norske medicinske Selskab, et faglig leseselskap fra 1826 som gikk over til å bli en formelt organisert forening i 1833. Men dette var ikke en fagforening eller profesjonsforening som skulle løfte standen i samfunnet. En slik organisasjon kom først i 1886 i form av det som ble legeforeningens mektige skikkelse.

Medisinerne kan også virke isolert i et universitetsmiljø der over halvparten av landets 161 professorer på 1800-tallet var i slekt eller inngiftet med en annen professor.[10] Nokså få medisinprofessorer hadde forbindelser med andre fags professorer, noe som var ganske vanlig ellers på universitetet. De medisinske slektskapsforhold hadde mer preg av familiedynastier, med navn som Boeck, Heiberg, Holst og Nicolaysen.

Legenes oppmarsj

Fra slutten av århundret fant det sted en markert vending i legenes status og stilling. Da Ole Malm i 1887 snakket om medisinen som Askepotten blant embetsmenn, lå i dette naturligvis en forhåpning. Askepott var den fattige piken som ble prinsesse.

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[9] Apokryft sitat fra Øvre Richter Frich.

[10] Myhre JE, *Det norske akademiske aristokrati*. Upublisert manus. Oslo 2010.

I 1912 ble distriktslegene formelt degradert fra embetsmenn til bestillingsmenn, altså funksjonærer. Det vakte sorg og harme hos legene. Embetsmannsstatusen var forbundet med en viss nimbus som nå var tapt. Saken var imidlertid den at embetsmennenes rolle og status i det norske samfunn i 1912 for lengst hadde begynt å synke. Økonomisk begynte nedgangen allerede i 1870-årene, ettersom en økonomisk oppgang gjerne medfører at offentlig ansatte blir hengende etter. Politisk var 1884 og innføringen av parlamentarismen et slag mot embetsstanden. Kulturelt og sosialt ser vi en langsom nedgang. Overleger og andre sykehusleger, sosialt framtredende, ble ansatt uten å bli embetsmenn.

Stadig flere leger ble derimot ikke offentlig ansatt i det hele tatt, men drev privat praksis. Det var gruppen av folk i frie, liberale yrker; leger, advokater, tannleger, ingeniører og arkitekter som stod fram som en ny akademisk og sosial elite innover i det 20. århundret. I hovedstaden Christiania hadde det fra 1841 eksistert en sosial eliteklubb, kalt *Balselskapet Foreningen*. Eliten i klubben bestod opprinnelig av folk embetsstanden og framtredende næringsdrivende, kort sagt byens kondisjonerte. Også kongefamilien var med så lenge Norge var i union. Etter 1905 kom i stedet det diplomatiske korps med. Foreningens manifeste hensikt var å avholde ball for medlemmene, dens latente funksjon var å holde eliten sammen gjennom at unge kvinner og menn fant hverandre. Henimot århundreskiftet begynte imidlertid den nasjonale eliten å splittes, politisk, økonomisk og sosialt. Embetsmenn og andre offentlige akademikere gled mer og mer ut av ballselskapet. Det ble mer og mer en sosietetsforening der næringslivet dominerte, og til dette næringslivet hørte ikke minst de omtalte advokater og leger.

Legene ble raskt langt mer tallrike enn før. Rundt 1890 passerte de teologene i antall, straks etter offiserene. De tok innpå juristene. Når vi kommer til 1950, var det sågar flere medisinere og tannleger enn universitetslærere og gymnaslærere til sammen. Blant legene ble det relativt sett langt færre legeoffiserer og offentlige leger. Medisinerne konsentrerte seg nå om to virksomheter. I 1953 var 38 prosent av dem i privat praksis og 41 prosent i sykehusene. Bare fem prosent av medisinerne drev da med forskning. Sykehusmedisinen ble gradvis mer prestisjefylt og helsevesenet ble mer sykehusorientert. Det gjaldt også utdannelsen, og det gikk så langt at man i medisinstudiet ble anklaget for å nedprioritere den medisinen som lå utenfor hospitalene.

Vitenskapens framgang og status

Medisinens, og legenes, økte status skyldtes langt på vei vitenskapenes – spesielt naturvitenskapenes – framgang og prestisje fra slutten av 1800-tallet av. Dette var selvsagt ikke et norsk fenomen alene. Aller fremst i medisinen lå Tyskland, og Tyskland var den fremste inspirator for norsk medisin. Norge var forholdsvis godt forberedt på utviklingen, og lå i enkelte tilfeller i fronten. Verden snakker således f. eks. om lepra som «Hansen's disease», etter Gerhard Armauer Hansen (1841-1912) . Toneangivende norske politikere var realistisk innstilt i en dobbelt forstand av ordet. Realartium ble innført i 1869, og Norge var antagelig det første land som fjernet latin som betingelse for høyere studier. Fordi den gamle latinskolen var en gutteskole, valgte interessant nok mange jenter realartium og senere medisinstudiet, da dette ble åpnet for dem i henholdsvis 1882 og 1884.

Vitenskap gir prestisje fordi den gir faktiske resultater. Da den norske sosialhjelpstaten, som Anne-Lise Seip kaller den, og dens etterfølger velferdsstaten, fra 1880-årene ble bygd ut på så vel helsesiden som andre sider av det sosiale hjelpesystemet, spilte legene en sentral rolle, og ikke bare på sykehus eller i frontlinjen i distriktene.[11] De ble f. eks. knyttet til vergerådene (barnevernet), til rettssystemet via fengslene og til helseorganisasjonene. Politikken ble gradvis knyttet til et ekspertsystem, et nett av høyt utdannede akademikere. Der fant man mange yrkesgrupper, økonomer, ingeniører og jurister, men også mange leger. Det er interessant å notere at ekspertene etter hvert kom sterkt inn i forvaltningen, særlig gjennom direktoratene, og der fortrengte juristene som forvaltere. Legene var imidlertid ganske sene i så måte. Helsevesenet ble lenge styrt av en jurist. Først i 1870 kom en medisiner som ekspedisjonssjef, og først i 1875 ble et direktorat opprettet.[12] Dette var en liten institusjon helt til 1938, da Karl Evang (1902-1981) ble sjef for Medisinaldirektoratet, senere kalt Helsedirektoratet. Resten er, som man sier, historie. Da hadde helsevesenet også fått det hierarkiet det manglet i det 19. århundret. Det har vært skrevet at legeyrkets storhetstid varte til 1970-årene.[13] Det er identisk med Evangs avgangsår, og sier mye om Evangs og Helsedirektoratets stilling.

Leger, men også andre akademikere, utkonkurrerte altså gradvis juristene i forvaltningen, spesielt på de feltene der fagkunnskap var viktig. Vel så viktig var kanskje legene på et annet felt. Medisinernes innflytelse steg samtidig med at teologenes sank. Da det rundt 1890 ble flere leger enn prester, symboliserte dette mer enn en akademikerprofesjons passering av

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[11] Seip A.-L. *Sosialhjelpstaten blir til: norsk sosialpolitikk 1740-1920.* Oslo: Gyldendal 1984. *Veier til velferdsstaten: norsk sosialpolitikk 1920-1975.* Oslo: Gyldendal 1994.

[12] Benum E. *Sentraladministrasjonens historie. Bind 2 1845-1884.* Oslo: Universitetsforlaget 1979.

[13] Larsen Ø i Larsen Ø, Berg O, Hodne F. *Legene og samfunnet.* Oslo: Seksjon for medisinsk historie og Den norske lægeforening,1986.

en annen i størrelse. Det symboliserte at legene var i ferd med å overta fra prestene rollen som herrer over liv og død.

Malms utsagn fra 1887 om legene som embetsstandens askepotter kan gi oss ytterligere en peker, nemlig mot det som var skjedd året før, dannelsen av Den norske Lægeforening, stavet med æ helt til 2008. Legenes storhetstid er ikke minst knyttet til Lægeforeningen.

Storhetstiden

Vi kan selvfølgelig knytte storhetstiden til *veksten* i tallet på leger og på sykehus, og i tallet på legenes medhjelpere, sykepleiere, laboratoriefolk og mange andre. Men den kan også, kanskje like gjerne, knyttes til *begrensningen* av antallet leger. Fra slutten av 1800-tallet steg søkningen til studiet merkbart, og det var bare ett sted i landet som hadde doktorskole, nemlig Det kongelige Frederiks universitet, fra 1939 kalt Universitetet i Oslo. Økningen i antall studenter ble særlig merkbar etter første verdenskrig. I 1946 og 1947 var medisin for første gang det største fakultetet i antall uteksaminerte kandidater. Det oppstod køer. Kandidatene fra 1930-kullet hadde i de fleste tilfeller studert i 7 til 7 ½ år, mens de fleste i 1939-kullet hadde holdt på i 9-10 år. Resultatet ble adgangsbegrensning fra 1940. Men fakultetet har også en historie med å holde leger fra utlandet på en armlengdes avstand. Resultatet var i alle fall en mangel på leger, altså et lite tilbud og en stor etterspørsel, et glimrende kort på hånden for enhver fagforening.

Legene var ikke bare synlige i sin yrkespraksis, i distriktene, på sykehusene eller i administrasjon av et stadig større helsevesen. I motsetning til på 1800-tallet ble medisinere på 1900-tallet stadig synligere i offentligheten. De var sågar synlige på Stortinget, der en man som Karl Wefring (1867-1938) gjorde seg gjeldende etter første verdenskrig. Han møtte på tinget i flere perioder 1916-1927 for Høyre og Frisinnede Venstre og var flere ganger forsvarsminister. I tillegg var han medisinaldirektør, direktør for Rikshospitalet, overlege for sinnsykevesenet og president i Legeforeningen, om enn ikke samtidig.[14]

Når helsespørsmål kom på den offentlige dagsorden, var leger raskt til stede. Høsten 1887 fant det sted en voldsom debatt i hovedstadspressen. Nyere statistiske oppgaver viste nemlig at dødeligheten, særlig spedbarnsdødeligheten, økte betydelig, blant annet på grunn av epidemier, især skar-

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[14] Haave P. Da legene skulle autoriseres. *Tidsskrift for den norske lægeforening* 2007;127: 3271.

lagensfeber og difteri.[15] Tallene vakte oppsikt av flere grunner. Man var vant til at dødeligheten sank, og man var vant til at Kristiania lå helt i teten blant europeiske hovedsteder, noe som hadde vært en kilde til kommunal stolthet. Nå i 1887 hadde mange utenlandske byer passert den norske hovedstaden og fått registrert lavere dødelighet. Men først og fremst vakte dødeligheten bekymring i et samfunn som i økende grad var opptatt av befolkningens velferd. I løpet av sju uker i november og desember brakte avisene 68 artikler og leserinnlegg om sunnhetstilstanden i byen, som utvetydelig ble oppfattet som et offentlig ansvar. Det ville langt på vei si at det var legenes anliggende. De deltok da også hyppig i debatten, ikke minst stadsfysikus Johan Lauritz Bidenkap (1828-1892). Noen år senere, i 1895, kom Axel Holsts (1860-1931)store undersøkelse om boligforholdene i hovedstaden til å avstedkomme en betydelig diskusjon.

Leger var også i høy grad til stede som helseentreprenører, det vil si sykehusbyggere, stiftere av foreninger til fremme av god helse og andre sosiale tiltak. Vi finner for eksempel, i randen av dette feltet, dr. Lauritz Stoltenberg (1892-1978), som i 1937 ga støtet til opprettelsen av husmødrenes barnehager, en milepel i barneomsorgen.[16]

Leger i offentligheten

Flere leger må karakteriseres som offentlige intellektuelle. Knapt noe tema var for brennbart for Johan Scharffenberg (1869-1965), snarere tvert imot. Ekteparet Kristian (1874-1957) og Alette Schreiner (1873-1951) var kjente fra pressen. Karl Evang var sterkt politisk engasjert, før, under og etter sin tid som helsedirektør. Oscar Nissen (1843-1911) var en kjent sosialreformator og arbeiderpartipolitiker. Da en journalist fra Dagbladet satte seg ned i 1930 for å lese kullboken til artianerne fra 1905, heftet de seg innledningsvis ved noen få navn. Et av dem var Otto Lous Mohr (1886-1967). Han var blant annet en kjent figur fra universitetets radioforedrag i landets eneste etermedium, en serie som hadde en kolossal tilhørerskare. Psykiateren Nic Waal (1905-1960) var en pionér i barneomsorgen. Hennes understreking av barnets rolle og rettigheter i familien, kombinert med engasjement og kontakter i arbeiderbevegelsen, gjorde at hun kom til å legge viktige premisser for boligbyggingen i Oslo. God mentalhygiene tilsa at barna skulle ha egne soverom. Dette betydde at kommunen satset på tre-

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[15] Myhre JE, *Hovedstaden Christiania 1814-1900. Oslo bys historie bind 3*. Oslo: Cappelen 1990: 388-389, som bl.a. annet bygger på et upublisert manus av Sivert Langholm og Turid Birkenes.

[16] Myhre JE. *Barndom i storbyen. Oppvekst i Oslo i velferdsstatens epoke*. Oslo: Cappelen 1994: 43ff.

romsleiligheter som standard for vanlige familier, en avansert målsetning. Carl Schiøtz 1877-1938) var skolehelsesjef i Oslo fra 1918 og satte i gang storstilte undersøkelser (hovedsakelig veiing og måling) av helsetilstanden på 1920-tallet. En sunn «Oslo-frokost» for alle folkeskolebarn og andre tiltak hadde betydelig virkning.[17] På tampen av sin karriere, fra 1932 til 1938, var Schiøtz professor i hygiene ved Universitetet. Han utga også en rekke populærvitenskapelige bøker i mellomkrigstiden, som *Lægevidenskap og Samfund*, og *Idrettsbok for norske gutter* (sammen med den olympiske tikampmester Helge Løvland).[18] I et voksende marked for populærvitenskapelig kunnskap, fant flere medisinere sin plass, ikke minst Evang gjennom sitt tidsskrift for seksuell opplysning.

Schiøtz var sentral, nesten en nasjonal strateg i mindre format gjennom vitenskap, helseforvaltning, skolepolitikk og vitenskapelige formidling. Ikke mindre sentral på mange felter var Axel Strøm (1901-85), kanskje det beste valg om man vil illustrere medisinernes innflytelse i samfunnet.[19] Strøm var høyt og lavt der medisinere vanket gjennom store deler av perioden fra 1930 til 1970. Han hadde vid yrkeserfaring fra distrikter og sykehus i inn- og utland, som bedriftslege i Freia, lege i forsvarets sanitet, overlege ved Rikshospitalet og professor i hygiene og senere sosialmedisin ved Universitetet i Oslo gjennom tretti år. Han var i perioder også sunnhetsinspektør i Oslo Helseråd og sakkyndig i trygderetten i Oslo. Axel Strøm var i mange år sentralt plassert i legeforeningen, som formann i Yngre Legers forening, og som visepresident og president i foreningen (1946-51). Ved universitetet var han formann i professorforeningen og argumenterte der for at denne skulle slutte seg til Fellesrådet for vitenskapelige tjenestemenn.[20] I tillegg var Strøm formann i Norsk akademikersamband. Han forfattet en rekke lærebøker. På 1960-tallet ledet Strøm to viktige komiteer som behandlet stillingsstrukturen ved Universitetet i Oslo. Han var dekanus ved det medisinske fakultet i Oslo 1956-63 og siden prorektor ved universitetet. Som dekanus ble Strøm intervjuet av Aftenposten om legestudiet. «Planen er svært presset», uttalte han, og beskrev et studium med sterkt skolepreg og stort arbeidspress.[21] Aftenpostens reportasje pekte på den særdeles viktige

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[17] Kjeldstadli K. *Den delte byen 1900-1948. Oslo bys historie bind* 4. Oslo: Cappelen 1990. Alsvik O. *«Friskere, sterkere, større, renere»: om Carl Schiøtz og helsearbeidet for norske skolebarn*. Hovedoppgave i historie, Universitetet i Oslo 1991.

[18] Schiøtz C. *Lægevidenskap og Samfund*. Oslo: Aschehoug 1933. Schiøtz C og Løvland H. *Idrettsbok for norske gutter*. Oslo: Aschehoug 1925.

[19] Larsen Ø (red.). *Norges leger.*

[20] Nilsen Y. *En sterk stilling? Norsk forskerforbunds historie 1955-2005*. Bergen: Vigmostad & Bjørke 2005.

[21] *Aftenposten* 16.12.1961.

samfunnsposisjonen de kommende legene ville få. Medisinerstudentene var sammen nesten hele tiden, også i de få sosiale sammenhenger, og utviklet en utpreget kullsamhørighet. Dette virket som en homogeniseringsprosess, som ble et godt utgangspunkt for etableringen av standsfølelse og profesjonsidentitet.[22]

Denne samhørighet og standsfølelse var både en årsak til, men kanskje enda mer en virkning av, arbeidet til Den norske lægeforening, stiftet i 1886, som den første av de store profesjonsorganisasjonene. Lektorer og lærere kom i 1890 og 1892, prestene i 1900, advokatene i 1908 og andre enda senere.[23] Lægeforeningen ble raskt en legendarisk sterk profesjonsorganisasjon, og profesjonsmakt var et godt utgangspunkt for fagforeningskrav. Legene nøyde seg ikke med belønning i himmelen og framsatte ikke beskjedne krav slik som prestene. Hva var legeforeningens styrke, sammenlignet med andre profesjoner og yrker?

Yrkets økende status var nok en selvstendig faktor. Derimot var det nok foreningens fortjeneste, og ikke minst de to sterke generalsekretærene gjennom et halvt århundre (1900-1948), Rasmus Hansson (1859-1934) og etterfølgeren Jørgen Berner (1883-1964), at foreningen holdt sammen, og hadde en gjennomgående meget høy medlemsprosent, i 1950-årene var den nådd 95 prosent. Yngre leger, kvinnelige leger, kristne leger, avholdende leger, privatpraktiserende leger, overordnede leger, underordnede leger, praktiserende spesialister og sosialistiske leger, for ikke å snakke om alle spesialitetene, kunne nok ha sine egne foreninger, men alltid under den store paraply. Det betydde imidlertid, som mange vet, på ingen måte at det ikke fantes stridigheter nok innenfor standen.

Modellprofesjonen

Medisinen er selve modellprofesjonen når profesjonssosiologen skal framstilles. De viktigste kjennetegn, bortsett fra en sterk organisasjon, er monopol på yrkesutøvelse, kontroll over egen kunnskap (utdannelsen) og generell autonomi overfor samfunnet omkring. Spørsmålet om autorisering stod sentralt.[24] Legene ville helst at standen helst skulle autorisere selv, og var redd for sin uavhengighet hvis det var Sosialdepartementet som skulle borge for legenes skikkethet. Slik ble det nå likevel i 1927, og legene kom til å mene at statlig autorisering var en fordel, spesielt når departementet gjerne rådførte seg med det medisinske fakultet. Autorisasjonen ga dessuten beskyt-

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[22] Larsen Ø. (red.) *The Shaping of a Profession. Physicians in Norway, Past and Present*. Canton, MA: Science History Publications/USA 1996: 538ff.

[23] Ingeniørene fikk en forening allerede i 1874, men den bygde ikke på artium.

[24] Det følgende bygger især på Haave P. *Da legene skulle autoriseres*.

telse mot kvakksalvere. En annen diskusjon stod om en spesialistgodkjennelsen. Der ble myndigheten i 1918 lagt til et utvalg i legeforeningen. En del leger var skeptisk til at noen utøvere på denne måten skulle framheves framfor andre. Et argument for spesialistautorisasjon var at dette kunne heve legestandens allmenne omdømme. Spesialister i den formelle betydningen finnes verken hos prester, advokater eller lektorer. I legeforeningen ble det faktisk lenge sett som et problem at det medisinske fakultet var så sterkt representert i styre og stell.

Legestanden stod antagelig atskillig nærmere universitetet i sin daglige gjerning enn de andre akademiske profesjonene gjorde. Den øverste autoritet for teologisk viten finnes ikke ved det teologiske fakultetet, men hos biskopene, eller enda høyere opp. Advokatenes og andre juristers siste instans er ikke fakultetet, men høyesterett, som har siste ord i å tolke loven, den egentlige siste instans. Lektorene kunne nok se hen til universitetet, men stod, og står, ofte i en underlig spagat mellom undervisningsfaget og pedagogikken. Legene står nærmere forsknings- og undervisningsinstitusjonen, selv om de henter mye fra sin praksis med pasientene. Sykehusavdelinger m.v. har f. eks. besøk av medisinerstudenter.

I lønnsspørsmål kom legene og deres forening raskt til å se på staten som motpart, spesielt i økonomiske spørsmål. Også privatpraktiserende leger hadde regulerte satser. Kanskje var det fordel at leger sjelden var embetsmenn (som stort sett gjaldt professorer og toppledere). Lønnskamp var nemlig vanskelig forenlig med embetsmennenes yrkesetos. Legeforeningens styrke og enhet (på tross av mange interne stridigheter), hjulpet av en økende legemangel, bidro på lengre sikt til et høyt lønnsnivå blant medlemmene. Blant akademikere kunne bare advokatene konkurrere når det gjaldt inntekter. Legeforeningen fikk en tydeligere fagforeningskarakter over tid. Mens slike saker utgjorde 33 prosent av emnene på Dnlfs legemøter 1887-95, var andelen økt til 76 prosent i perioden 1928-38. Generalsekretær Hanson brukte uttrykket «fagforening», men formante sine standsfeller ved sin avgang: *«Det gjaldt at lægene forstod, at bedre økonomiske kaar ikke var noget selvstændig maal, men et middel til at høine lægens virke utad. Det maatte ikke bare tales om krav, men ogsaa om pligter likeoverfor land og folk.»* Hans etterfølger, Jørgen Berner, minnet i 1938 om at legene ikke bare måtte tenke på seg selv, men også sitt klientell.[25]

Dr. Lauritz Stoltenberg, skoleoverlege i Oslo, redigerte i 1938 en bok som het *Våre hjem og våre barn*. Der skrev journalisten, forfatteren og sivil-

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[25] Berg O. Verdier og interesser – Den norske lægeforenings framvekst og utvikling. I: Larsen Ø, Berg O, Hodne F. *Legene og samfunnet*. Oslo: Den norske lægeforening, 1986, s. 217, 229, 236.

ingeniøren Georg Brochmann et kapittel om barnas utdannelse og fremtid. Han spanderte ekstra plass på medisinstudiet. Læger er *«høit betalte spesialarbeidere, og vil meget sjelden forlate lægeyrket. Det er ingen som i den grad holder sig til det arbeide utdannelsen kvalifiserer til som lægestanden.»* Studiet er også spesielt langvarig. Det gir høy studiegjeld, og *«det er ikke noe å undres over at lægene […] vil ta sitt monn igjen og sørge for standens økonomiske interesser.»*[26]

De kvinnelige medisinere

Enhver læge», het det i en av legeforeningens kollegiale regler fra 1930, *«må i all sin ferd iaktta hva der tjener standens ære, autoritet og anseelse.»*[27] Foreningen mente også at legenes moralske kall krevde at de fikk en relativt privilegert posisjon i samfunnet. De måtte derfor blant annet ikke sosialt deklasseres. Rekrutteringen til medisinerstudiet ble da også sosialt sett litt mer eksklusiv enn til andre studier utover på 1900-tallet[28], juss delvis unntatt. I 1940-årene hadde bare 42 prosent at de medisinske kandidater fedre som ikke var akademikere eller selvstendig næringsdrivende. Betydde dette noe for rekrutteringen av kvinner til studiet? Medisin var et favorittstudium hos første generasjons kvinnelige akademikere. De kom i det store og hele fra en sosial elite og utgjorde ikke minst en evnemessig elite (de hadde bedre karakterer hele veien) sammenlignet med sine jevnaldrende mannlige studenter. De hadde likevel store problemer med å gjøre karrière, kanskje enda større problemer enn i andre akademiske yrker. Alette Schreiner fikk aldri noen akademisk stilling, mens hennes klassevenninne fra skolen, Kristine Bonnevie, ble professor i biologi. En kjent historie var Louise Isachsens (1875-1932) forgjeves kamp for å få en reservelegestilling ved Rikshospitalets kvinneklinikk i 1911.

Jeg tror eksemplet med dr. Ingeborg Aas (1876-1958), født som gårdbrukerdatter på Hedemarken, kan illustrere rollen til en kvinnelige lege.[29] Hun tok artium ved Ragna Nielsens skole, en privat skole hovedsakelig for kvinner, omtrent samtidig med Bonnevie og Schreiner. Medisinsk embets-

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[26] Brochmann O. Barnas utdannelse og fremtid. I: Stoltenberg L (red.). *Våre hjem og våre barn*. Oslo: Cappelen 1938: 240.

[27] Berg O. Verdier og interesser: 240.

[28] Aubert V. m. fl. Akademikere i norsk samfunnsstruktur 1800-1950. I *Tidsskrift for samfunnsforskning 4/1960*: 185-204. Myhre JE. Academics as the Ruling Elite in 19th Century Norway. I *Historical Social Research/Historische Sozialforschung*, vol 33, 2/2008: 22-41. Myhre er bearbeidet etter Aubert V. The Professions in Norwegian Social Structure. I: *Transactions of the Fifth World Congress of Sociology*, vol III 1964: 243-258.

[29] Biografiske opplysninger: *Studentene fra 1896*. Oslo 1946 og Larsen Ø (red.). *Norges leger* I.

eksamen ble avlagt i 1903. Hun utførte kandidattjeneste ved Rikshospitalet og praktiserte fra 1905 i Trondheim, mesteparten av tiden som leder for poliklinikken for veneriske sykdommer, der hun fremdeles befant seg i 1946. Kvinner i medisin søkte typisk privat virksomhet, til forskjell fra kvinner i jus, fordi det lot seg lettest kombinere med familie.[30] De første kvinnelige medisinere nådde ikke langt i sin formelle medisinske karriere. Aas ble for eksempel aldri spesialist, til tross for at hun arbeidet med veneriske sykdommer i mer enn en mannsalder.

Men Ingeborg Aas tok sitt monn igjen på andre felter. Aas var sterkt engasjert i arbeid med folkehelsen gjennom hele karrièren, og var medlem av et utall av styrer, komiteer og utvalg. Hun skrev to bøker og en rekke artikler i pressen om helsemessige forhold som hygiene og seksualitet, veneriske sykdommer, abort og alkohol. Hun var politisk engasjert i Venstre, og var blant annet medlem av den norske straffelovkomité, reiste som delegert til Folkeforbundet og det internasjonale kvinnerådet. Aas var medlem av kommunestyret i Trondheim og satt i en rekke kommunale komiteer. Hun var gift med en lege som hun bestyrte klinikken sammen med, og de hadde sammen to barn. Omtrent halvparten av de kvinnelige medisinere før 1920 giftet seg.[31]

De kvinnelige leger holdt seg, eller ble holdt, lenge beskjedent i fagets bakgrunn. På dette området har samfunnet, og medisinen, forandret seg på 50 år. Men hvilken rolle kvinnene har spilt når det gjelder legenes samfunnsrolle, se det er en annen historie.

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[30] Aubert V. Kvinner i akademiske yrker. I *Tidsskrift for samfunnsforskning* 4/1961: 238-263.

[31] Frølich A. *Norges første kvinnelige leger*. Hovedoppgave i historie, Universitetet i Bergen 1984.

Torunn Arntsen Sajjad

En kritisk analyse av begrepet stigma knyttet til debatten om ekteskap mellom slektninger[1]

Michael Quarterly 2011;8:545–60.

Hvordan er stigmabegrepets anvendbarhet når det gjelder mediedebatten om søskenbarnekteskap og helseforhold hos barn og det jeg kaller reproduktive hendelser? Debatten, eller de stadig tilbakevendende debattene, handler i stor grad om ulike reaksjoner på Camilla Stoltenbergs (23) og hennes kollegers epidemiologiske forskningsresultater (17) og hvordan de brukes, og viser hvem som engasjerer seg, på hvilken måte dette gjøres og retorikken som brukes. I en analyse er det nødvendig ikke å ta for gitt at et fenomen er et stigma. *Klassifiseringen må undersøkes i praksis, det vil si hvordan fenomenet oppfattes av folk selv og hva de eventuelt gjør for å endre en praksis som kan oppleves som stigmatiserende. Et hovedspørsmål er derfor: Hva er det i debatten som bidrar til at det å gifte seg i slekten eller det å forsvare denne praksisen, kan forstås som et stigma for pakistansknorske par?*

Innledning

Følgende sitat er fra en far til et barn med en medfødt funksjonshemning, og er et eksempel på det som kan oppleves som en stigmatisering av pakistansknorske familier. Han og hans kone mener at personer fra majoritetsbefolkningen tenker følgende når de møtes:

> «Oi, her er et pakistansk par og de er gift fetter og kusine, ergo får de sjuke unger.»

På den ene siden er det viktig å stille spørsmål ved hvorvidt de som denne familien møter tenker slik, eller om dette er en reproduksjon av hva familien tror at andre mener, uten at de konkret har erfart at det forholder seg slik etter at debatten om søskenbarnekteskap og syke barn ble kjent. På

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[1] Prøveforelesning over oppgitt emne 3. oktober 2011 i anledning av forfatterens forsvar av sin PhD-avhandling (1) 4. oktober 2011 ved Universitetet i Oslo.

den andre siden har det seg slik at flere enn dette paret sier det samme. Disse personene får konkrete kommentarer av andre om ekteskapsformen og syke barn, enten de har syke barn eller ikke, som gjør at de oppfatter at majoritetspersoner tenker slik. De sier derfor at mange av de norske som de tilfeldig møter i det offentlige rom og de som de samhandler med i jobbsituasjoner og nærmiljø eller når de har time på helsestasjonen, tenker: Pakistaner = søskenbarnekteskap = syke barn. Ugifte forteller at spørsmålet kan være: «Du skal vel ikke gifte deg med en kusine/fetter?» og de svarer benektende for å stoppe tematikken, mens gifte av samme grunn svarer at de er gift med naboen uten å fortelle at naboen er en slektning. Men pakistansknorske par gifter seg også på annen måte enn i slekten, og bare et fåtall av de som gifter seg i slekten, får syke barn. Spørsmålet er imidlertid om det de forteller meg, og som de forstår som stigmatisering, kan forstås som dette fra et analytisk perspektiv, det vil si fra et forskerperspektiv.

Stigma og empirisk undersøkelse

Min bakgrunn for å drøfte stigma er først og fremst å finne i min avhandling om genetisk veiledning av pakistansknorske familier (1). Studien ble gjennomført i 2005-2008 ved bruk av flere kvalitative forskningsmetoder, som observasjon, intervjuer og deltakende observasjon. Den omfatter 19 medisinske genetikere og 35 pakistansknorske familier som fikk genetisk veiledning i 2005 og 2006. Ett av kapitlene handler om mediedebatten om søskenbarnekteskap i perioden 1997 til 2008, først og fremst i riskdekkende aviser og NRK, og om hvordan de som fikk genetisk veiledning, samt et utvalg på 17 pakistansknorske personer oppfatter debatten som knyttes til helseproblemer hos barn. Debatten handler om ulike reaksjoner på de nevnte forskningsresultatene og hvordan de brukes, og viser hvem som engasjerer seg, på hvilken måte dette gjøres og retorikken som brukes.

I analysen i avhandlingen (1) bringer jeg først og fremst inn maktteori, men også stigmatisering med hensyn til søskenbarnekteskap og også i noen grad når det gjelder funksjonshemmede barn, som i debatten blir beskrevet som «misdannede barn» og «misdannede innvandrere». I etterpåklokskapens refleksjon vil jeg si at så gjøres uten at stigmabegrepet eller anvendelsen av det drøftes tilstrekkelig. Det er derfor aktuelt med en problematisering av begrepet og anvendelsen av det. Dette er ikke nødvendigvis en kritikk av at stigmabegrepet benyttes. Men i enhver analyse skal man være reflektert og kritisk til valg av begreper. Kan *stigma*begrepet være konstruktivt som inntak til forståelse av debatten?

Stigmabegrepet

Begrepet stigma er opprinnelig gresk. Det ble brukt om et kroppslig påført tegn i den hensikt å vise at den som bar tegnet var annerledes i en negativ betydning og dertil umoralsk. I norsk språk kan denne betydningen oversettes med «brennemerking», fordi tegnet, det vil si stigmaet, ble brent eller risset inn i huden til den enkelte, og dermed vanskelig å unnslippe. I en tidlig kristen sammenheng kjenner vi begrepet stigmata som røde kroppsmerker som ble tolket som hellig nåde i betydningen Guds nådegave eller under.

I innledningen til boken Stigma (2), som alle som befatter seg med stigma på en eller annen måte forholder seg til, sier Erving Goffman at begrepet fortsatt brukes nært opp til den opprinnelige betydningen, men at stigma heller betegner vanæren som brennemerkingen innebærer enn selve de kroppslige kjennetegnene.

Goffmans klassiske definisjon er at et stigma betegner «en egenskap som er dypt diskrediterende» (2, s.15). Et stigma består av «en spesiell relasjon mellom en egenskap og en stereotyp klassifisering av mennesker» (2, s.16). Det er denne relasjonen som endrer egenskapen til et negativt stigma, som potensielt kan bidra til uønskede sosiale konsekvenser (3). Han gjør et skille mellom de kroppslige-, de karatermessige- og de gruppemessige stigma. Etnisk bakgrunn og nasjonalitet er eksempler på sistnevnte, og synlige funksjonshemninger er eksempler på kroppslige stigma.

Et poeng hos Goffman er at en «egenskap som stigmatiserer den ene type bærer av stigmaet, kan hos en annen være en bekreftelse på dennes normalitet, og er derfor i seg selv verken av positiv eller negativ verdi» (2, s.15). Han fremhever derfor det relasjonelle når det gjelder å definere noe som et stigma. Hvilke egenskaper som forstås som diskrediterende eller som vannære vil variere, og fordi det ved alt sosialt liv foreligger normer for hvordan noe skal defineres som normalt, vil det foreligge oppfatninger om det motsatte. Den som kategoriseres som bærer av et stigma, kategoriseres derfor i motsetning til den normale, som en som avviker fra de normales forventninger og er derfor uønsket. Goffman sier også at den som blir kategorisert slik ikke er fullt ut menneskelig, og en konsekvens av stigmaet er derfor at man blir utestengt fra sosiale sammenhenger ved at folk fokuserer på stigmaet og ikke de andre egenskapene ved personen. En nærliggende følelse, ifølge Goffman, er skam hos bærere av stigmaet.

Et annet poeng med Goffmans begrep er at vi fordomsfullt tillegger de stigmatiserte en hel rekke andre negative egenskaper og dermed gjør generaliseringer basert på stereotypier. Det er dette antropologen Robert Murphy beskriver i boken «The Body Silent» (4) når han som fysisk funksjonshemmet også blir behandlet som om han ikke hører eller ser.

Goffman viser hvordan ulike sykdommer eller slektsmessige tegn oppfattes forskjellig i samfunnet og at måten de oppfattes på, altså hvorvidt de kategoriseres som et stigma eller ikke, får konsekvenser for den enkeltes forståelse av seg selv. Samspillet mellom personen og omgivelsene påvirker personens selvforståelse og kan bidra til selvoppfyllende profetier som forsterker stigmatiseringen. Goffman gjør et skille mellom de som er diskrediterte, der stigmaet er synlig og kjent, og de potensielt diskrediterte, der stigmaet ennå ikke er kjent.

Som interaksjonist er han opptatt av det relasjonelle mellom mennesker som samhandler. Goffman bruker f. eks. teateret som en analogi for å forstå dagliglivets samhandling (5). Begrepet «frontstage» er metaforen for den rolleutøvelsen og samhandlingen som foregår på scenen, det vil si i samhandling der regien i stor grad er definert. Anvendt på forståelsen av stigma; der stigmaet er synlig eller potensielt synlig. «Backstage» er metaforen for samhandlingen bak sceneteppet, der hvor man i mye større grad kan slappe av og heller planlegge det som skal skje «frontstage» og i mindre grad utøve det han kaller inntrykkskontroll. Inntrykkskontroll handler om de ulike måtene man benytter for å kontrollere informasjonen om seg selv, beskytte sin egen rolle og det inntrykket andre får av en i samhandlingen. Derfor er inntrykkskontroll et vesentlig trekk ved all «frontstage»-samhandling, slik jeg viser i innledningssitatene.

I en norsk antropologisk kontekst har Harald Eidheims forskning fra tidlige 1960-tallet blant kystsamer vært viktig for å forstå stigmatisering. Han bruker begrepet slik Goffman gjør i artikkelen om etnisk identitet som et sosialt stigma, der han viser hvordan samene blir kulturelt stigmatisert av nordmenn, og hvordan de i samhandling «frontstage», forsøker å underkommunisere de sosiale karakteristikkene som norske tolker som tegn på samiskhet (6). Eksempler på dette er at de bare snakket norsk seg i mellom i sosiale sammenhenger hvor norske deltok for ikke å fremstå som samer, eller at de byttet navn av samme grunn, og at samisk var forbeholdt «backstage» der norske ikke deltok. Både de diskrediterte og de potensielt diskrediterte vil ifølge Goffman nettopp gjøre slik Eidheim viser, at de gjennom samhandling med andre «frontstage» vil benytte ulike strategier for å forsøke å redusere betydningen av det de opplever som et stigma gjennom en bevisst kontroll av informasjon om seg selv. Pakistansknorske kan på likende vis som disse kystsamene vise til når de blir spurt at de ikke gifter seg i slekten, men f.eks. med naboen, og underkommunisere at naboene nettopp kan være ens slektninger, fordi de vet at dette oppfattes negativt i en norsk kulturell kontekst.

I Eidheims analyse av samisk identitet som et etnisk stigma kan det stilles spørsmål ved hvorvidt dette fortsatt har gyldighet eller ikke. En gang stigmatisert innebærer ikke nødvendigvis evig stigmatisering. Det Eidheim har i sin analyse, og som fra et antropologisk perspektiv er viktig, er den kulturelle sammenhengen fenomenet må forstås på bakgrunn av. Et slikt manglende perspektiv utgjør noe av hovedkritikken mot Goffman og hans analyser av samhandling. Et viktig poeng er derfor ikke å ta for gitt at visse sykdommer og funksjonshemninger innebærer et stigma, ei heller pakistaneres kulturelle praksiser, og heller stille spørsmål ved hvorvidt det foreligger stigma eller ikke. Dessuten kritiseres Goffman for at maktforhold ikke har et klart fokus i analysene (7).

I boken *Funksjonshemmet er bare et ord* trekker Grue (7) frem et interessant poeng fra den britiske sosiologen og aktivisten Mike Oliver, som mener at stigmabegrepet egner seg som en metafor for annerledeshetens opplevelsesmessige og erfaringsmessige dimensjon, men at det gir liten mulighet til å forstå hvorfor stigmatisering finner sted. Link m.fl. (8) forsøker i sin definisjon av stigma å se stigmatisering prosessuelt og skapt av strukturelle maktforhold (9), noe antropologene Das m.fl. (10) også viser til når de sier: «The issue of power is often lodged in the apparatus of the State, whose agents and agencies can stigmatize entire groups « (9, s.1526). Dette er et viktig poeng mht. den norske debatten om slektskapsbaserte ekteskap og syke barn.

Ekteskap i slekten

Ekteskap mellom tremenninger eller nærmere beslektede personer kalles konsanguine. Et vanlig brukt begrep om slike ekteskap er *inngifte.* Selv har jeg valgt ikke å bruke inngiftebegrepet, nettopp etter refleksjon om at begrepsbruk kan bidra til stigmatisering, og heller si *slektskapsbaserte* om ekteskap mellom slektninger.

Assosiasjonene til inngifte er på mange måter negative. Et eksempel er fra avisen Morgenbladet som bruker begrepet *blodskam* i betydningen inngifte når tematikken igjen debatteres, f. eks. i januar 2011 (11). Blodskam er som kjent det begrepet som tidligere ble brukt for *incest.* Begrepsbruk sier mye om hvordan vi som lesere skal tolke tematikken. Hvorvidt endret begrepsbruk vil gi en endret betydning, kan ikke besvares her, men refleksjon er nødvendig.

På nettstedet www.consang.net (12) vises en oversikt over utbredelsen av konsanguine ekteskap. Denne viser blant annet at de utgjør mellom 20 og 50 prosent av alle ekteskap i deler av Nord-Afrika, fra Midtøsten til Pakistan, samt i Sør-India. I Pakistan er det å gifte seg i slekten, først og fremst konsanguint, tradisjonelt det foretrukne. Undersøkelser fra 1990-tallet viser at andelen varierer mellom 38 og 62 prosent i Pakistan (13).

Det anslås at mer enn halvparten av verdens befolkning lever i områder hvor konsanguine ekteskap er vanlig, men i det meste av Europa er utbredelsen under 1 prosent. Ingen europeiske land har forbud mot søskenbarnekteskap, men Kina og mange stater i USA har et slikt forbud. I USA er forbudet knyttet til bekymring rundt integrasjon av religiøse minoriteter og dateres tilbake til det 19- og tidlig tjuende århundre (14,15).

I perioder har det heller ikke vært tillatt med søskenbarnekteskap i Norge. Kong Christian Vs lov av 1687 forbød konsanguine ekteskap, men i praksis var det mulig å søke om bevilling. Siden 1800 har slike ekteskap vært tillatt, og for nøyaktig 120 år siden var hvert 14. ekteskap i Norge konsanguint (16). Reduksjonen av slike ekteskap har først og fremst hatt å gjøre med demografiske forhold, som migrasjon til urbane strøk og USA, veiforbindelser ut av trange dalfører og et økende fødselsoverskudd, og ikke helseforhold. Hva angår innvandrerbefolkningen har flere grupper tradisjon for konsanguine ekteskap, i tillegg til samer og romfolket. Det å finne en partner i slekten er derfor en kulturell praksis som omfatter mange befolkningsgrupper.

Risiko

Generelt har alle par som får barn 2,7 prosent risiko for at barnet vil ha få en medfødt genetisk tilstand, men hvis paret er søskenbarn, øker risikoen til 3,9 prosent, fordi søskenbarnpar i tillegg har økt risiko for å få barn med recessive tilstander (17) samt økt risiko for å få barn med multifaktorielle tilstander, som leppe-ganespalte, klumpfot og hjertefeil. Ved recessive tilstander arver barnet to kopier av den samme genmutasjonen, det vil si det samme sykdomsdisponerende genet; ett fra hver av foreldrene. Dette skyldes at det er økt sjanse for at begge i et søskenbarnpar har arvet en slik mutasjon fra felles besteforeldre, enn om paret ikke har slike besteforeldre. Hver og en av oss har tre til fem uheldige mutasjoner, men fordi den som vi får barn med vanligvis er bærer av andre slike recessive gener, går det stort sett bra. I en pakistansknorsk slekt vil imidlertid også par kunne være beslektet på annen måte i én eller flere generasjoner, noe som bidrar til ytterligere økt risiko.

Bakgrunnen for den økte risikoen for recessive sykdommer blant konsanguine par, er at denne formen for pardannelse bidrar til å redistribuere recessive mutasjoner for både sjeldne og mer vanlige sykdommer i befolkningen. Dette bidrar ikke til en økt risiko for noen bestemte sykdommer, unntatt der hvor det foreligger en kjent familiehistorie, og det bidrar til at enkelte sykdommer blir konsentrert i visse familier og ikke tilfeldig spredt i befolkningen (14,17,18,19), slik de er i den norske befolkningen.

Dette betyr det at de som er gift konsanguint vil ha ulik risiko for at hendelser skal inntreffe. Den ledende internasjonale kapasiteten på dette feltet, Alan H. Bittles (20) hevder at fordi man innen store deler av de befolkningsgruppene som praktiserer konsanguine ekteskap, også gjennom historien i mange hundre år har praktisert det å gifte seg innen avgrensede grupper, er det viktig å påpeke at det kan bli feil å knytte arvelige sykdommer til konsanguinitet. Han sier at «mange av de genetiske tilstandene som er beskrevet, er spesifikke for det enkelte samfunnet» (20, s.93). Dermed vil det ikke ha noen effekt å gifte seg med noen som en ikke regner som sin slektning, fordi de likevel genetisk er i slekt med hverandre (jf. 21, 22).

Debatten og tallene

Mediedebatten fører til at det dannes en offentlig diskurs om søskenbarnekteskap og helseproblemer hos barn. Den har utgangspunkt i resultatene i doktoravhandlingen til lege og epidemiolog Camilla Stoltenberg fra 1998 (23), og startet dagen etter at hennes første artikkel ble publisert i 1997. Hennes forskning på alle fødte i perioden 1967 til 1995 viser i tillegg til økt risiko for medfødte misdannelser og spedbarnsdød, en lett forhøyet risiko for dødfødsel hos barn av konsanguint gifte foreldre. Dessuten bekreftes betydningen av konsanguinitet ved at risikoen for gjentakelse av hendelsen øker mer blant par som er søskenbarn enn om foreldrene ikke er det.

Debatten nådde et nytt høydepunkt omlag ti år senere i tiden før og etter at Stoltenberg og kolleger ved Folkehelseinstituttet publiserte forskningsrapporten *Inngifte i Norge. Omfang og medisinske konsekvenser* (17), som først og fremst bekreftet Stoltenbergs tidligere funn.

Den største ikke-vestlige innvandringsgruppen er den pakistanske med drøyt 30 000 personer som er innvandrere og deres etterkommere, og som rapporten viser, er det blant denne minoritetsgruppen at den høyeste andelen av konsanguiene ekteskap finnes blant de som blir foreldre. Imidlertid viser rapporten at andelen søskenbarnpar som blir foreldre, tydelig er synkende i den pakistansknorske befolkningen fra 2001 til 2005, både i første generasjon (fra 43,9 prosent til 33,1 prosent) og blant etterkommerne (fra 43,5 prosent til 28,6 prosent). Det mediene presenterer, er imidlertid overskrifter som «Inngifte er farlig for barna» (24) og «Stor helsefare» (25).

Det disse to studiene viser, er at når foreldrene er søskenbarn, er den relative risikoen for dødfødsel 1,63 gang i forhold til den norske, ubeslektede befolkningen og tilsvarende er risikoen 2,43 gang høyere for spedbarnsdød og to ganger (dobbelt) så høy for medfødte misdannelser enn når foreldrene er ubeslektede.

De finner også en økt risiko ved andre typer slektskap, men den er lavere. De konkluderer med at de fleste barn av konsanguine foreldre er friske og overlever, at ekteskapsformen medfører økning i risiko, men at andelen som rammes likevel er lav, men at det er en sterk opphoping i enkelte familier på grunn av ekteskapsmønsteret. For barn av pakistanske foreldre er foreldrenes slektskap årsak til 30 prosent av dødfødslene, 42 prosent av spedbarnsdød og 32 prosent av de medfødte misdannelsene, ifølge rapporten. Dette viser at det også er mange andre årsaker til barnedød og medfødte tilstander enn at foreldre deler biologisk arvemateriale, og at hovedregelen er at de ikke er genetiske årsaker til dødsfallene.

De sier også at foreldres konsanguinitet, uansett norsk, pakistansk, samisk osv., samlet sett forårsaker mindre enn 10 ekstra tilfeller av dødfødsel og spedbarnsdød per år i Norge, og omkring 20 ekstra tilfeller av medfødte misdannelser. Om lag 1/3 av tilfellene forekommer i helnorske familier, 1/3 i pakistansknorske familier og 1/3 blant andre minoritetsgrupper (26). Tallene er dermed små, men Surén m.fl. (17) anslår at de kan være noe høyere. Mange medfødte tilstander oppdages ikke før etter noe tid og vil derfor ikke bli registrert i Medisinsk fødselsregister.

Diskusjon

Jeg skal gå nærmere inn i hvorvidt stigmabegrepet er dekkende for debatten. Spørsmålet er om begrepet, som nok kan forstås som klebende, er et alt for absolutt begrep. Imidlertid sier både Goffman (2) og andre, f.eks. Coleman (27,) at stigmatiserte tilstander kan være midlertidige. Kan det tenkes at man ved å ta begrepet frem i lyset, bidrar til at det blir mindre klebende og statisk, og derfor anvendbart eller rett og slett til å forkaste? Selv om begrepet kan knyttes til det å ha syke barn innad i pakistansknorske miljøer og utad i storsamfunnet til en etnisk gruppes ekteskapsform i en gitt tidsperiode, er det viktig nettopp å ha tidsdimensjonen med i en problematisering av begrepets egnethet.

Gitt at stigmabegrepet er egnet til å bidra til å forstå debatten, er det interessant å stille spørsmål ved hvem som i så fall blir stigmatisert. Slik jeg forstår debatten er det først og fremst de med pakistansknorsk bakgrunn som ikke åpenlyst tar avstand fra slektskapsbaserte og arrangerte ekteskap og de som ikke øyeblikkelig slutter å gifte seg i slekten. Dette fordi arrangerte ekteskap forstås som tvangsekteskap og søskenbarnekteskap forstås både som arrangerte og som resultat av tvangsekteskap.

Slektskapsbaserte ekteskap og syke barn kan neppe i debattens begynnelse forstås som et stigma blant pakistansknorske familier, men er begynnelsen på en debatt der forskningsresultater om helseforhold hos en etnisk minoritetsgruppe blir trukket ut av en større sammenheng og brukt slik at det skapes en sterkt polarisert debatt.

Familier med funksjonshemmede barn deltar ikke i selve debatten, men gjennom begrepsbruken fra enkelte der de nevnte begrepene «misdannede innvandrere» brukes, fanger jeg opp signaler om at de opplever retorikken som krenkende og menneskefiendtlig. Slik jeg forstår disse familienes opplevelse av begrepsbruken og debatten rundt det å forby søskenbarnekteskap, er at det oppleves som et stigma i Goffmans forståelse av dette. Det er nettopp slik et stigma virker ved at de det gjelder fratas muligheten til å definere seg selv. Familier med syke barn er allerede i en sårbar posisjon nettopp fordi de har syke barn når det gjelder en potensiell stigmatisering, og som Goffman påpeker kan også stigmaet ramme familien. I tillegg er de i en utsatt situasjon fordi de er pakistansknorske. Det er nettopp det som innledningssitatet viser; at etnisk identitet og funksjonshemning forsterker hverandre.

I debattens kontekst ser jeg to varianter av stigmatisering; en når det gjelder storsamfunnet, det vil si mediedebatten slik den utvikler seg, og en innad i pakistansknorske miljøer. Innad handler dette om at familier med barn med synlig annerledeshet i betydelig grad stiller seg spørsmålet hva galt har vi gjort som har fått ett eller flere slike barn, og at de tror at andre tenker at familien har gjort noe galt, samtidig som de kan bli konfrontert med dette. Kulturelt sett ligger det sterke føringer i de pakistansknorske miljøene om at funksjonshemning hos barn er knyttet til den religiøse prøvelsen, og at den enten er en straff for moralbrudd eller en gave (1, 28). De kan derfor oppleve å bli tillagt eller å tillegge seg skyld for hendelsen, samtidig som det kan medføre en betydelig opplevelse av skam fordi det blir tydelig for omverdenen at de har noe å stå til rette for overfor Gud.

Skyld kan rettes mot enkeltpersoner, mens skammen fordeles, det vil si den rammer flere. Dette innebærer at familier i stor grad underkommuniserer barns tilstander i møter «frontstage» med andre med pakistansknorsk bakgrunn, mens de erfarer at de som de møter i tjenesteapparatet, har en mer inkluderende holdning til dem og at de derfor kan slippe opp litt på inntrykkskontrollen i slike møter. Men også noen forteller at mediedebatten har endret de profesjonelles holdninger og at de også i møter med dem kan føle at de er ansvarlige for at barna ble syke, enten foreldre er i slekt med hverandre eller ikke, fordi hjelperne ikke til en hver tid vet hvorvidt de er slektninger og fordi denne forklaringsmodellen etter hvert er ganske utbredt blant de profesjonelle. På den måten kan ekteskapsformen forstås som et stigma utad og det å ha syke barn kan forstås slik innad i miljøene. Det å gifte seg i slekten er imidlertid en kulturell praksis som representerer det normale, mens det i debatten snus opp ned, og blir forstått som det unormale av majoritetsdebattantene. I debatten fremkommer det ikke at pakistanere kan føle skam, bare i samhandling «bakstage».

Manglende erfaringer fra levd liv preger debatten, det vil si stemmene til de som er gift i slekten og har syke barn, mens enkelte som har friske barn og er gift i slekten, står frem som sannhetsvitner på en vellykket reproduksjon. Når de med egenerfaring ikke har kommet på banen, kan dette i noen grad forstås på bakgrunn av at det også eksisterer makthierarkier innad i miljøene, der definisjonsmakten i størst grad er hos de som ikke er rammet. Det kan derfor godt hende at det ikke nødvendigvis er en stigmatisering av familiene som gjør at de ikke deltar, men helt andre mekanismer, eller det kan være at stigmatiseringen innad i miljøene er styrende for hvorvidt de med egenerfaring vil kommunisere at de har dette, eller om de vil fortsette underkommunisering. Slike makthierarkier kan være vanskelig å få innsikt i, mens definisjonsmakten i den offentlige debatten er mer iøynefallende. I debatten er det derfor viktig å stille spørsmålet om hvem som definerer felleskapsverdiene som minoritetsbefolkningen i debatten kreves at følger, samtidig som det er viktig å få innsikt i interne makthierarkier.

I en analyse er det som nevnt ovenfor nødvendig ikke å ta for gitt at et fenomen, i dette tilfellet slektskapsbaserte ekteskap, er et stigma. Klassifiseringen må undersøkes i praksis, det vil si hvordan fenomenet oppfattes av folk selv og hva de eventuelt gjør for å endre en praksis som kan oppleves som stigmatiserende. Antropologisk kunnskap er viktig og kan både vise at det er kan være slik man tror, eller motsatt.

Anvendt på mitt materiale vil jeg gi et eksempel på hvordan en familie med en diagnostisert recessiv tilstand som fikk genetisk veiledning anvender kunnskapen for å unngå å få flere syke barn i slekten. Familien ba om flere veiledninger og satte seg inn i den nye kunnskapen, spredde informasjon om arvegang til en hardt rammet slekt i flere land og å kartla slekten for å finne ut hvem som fortsatt kan være aktuelle ekteskapskandidater, og hvem som heller bør gifte seg ut av slekten. Ingen av slektens medlemmer har deltatt i diskusjoner utenfor slekten, men ungdommene kommer hjem fra skolen og forteller at de har hørt at søskenbarnekteskap ikke er bra, og mor sier da «hysj», og vet ikke helt når de skal ta det opp med barna. Men neste generasjon gjør kanskje andre valg med hensyn til ektefelle, ikke først og fremst fordi det er økt risiko for reproduktive hendelser, men fordi kulturelle praksiser stadig er i endring.

Denne familiens sykdom er en vel bevart hemmelighet mellom familien og spesialisthelsetjenesten, ikke fordi de opplever slektskapsbaserte ekteskap som stigmatisert, men fordi de oppfatter medfødte funksjonsnedsettelser og arvelige tilstander som et stigma innad i miljøene og derfor ikke vil tilkjennegi dette. Denne familien og slekten sier imidlertid som flere andre, at de ikke lenger gifter seg i slekten uten å tilkjennegi at de oppfatter seg som potensielt diskrediterte, og dermed også bærere av skam. De sier at når de ikke lenger kan gifte seg i slekten, vil opplysninger om at mange av slektens personer er bærere av en arvelig sykdom kunne ekskludere dem fra ekteskapsmarkedet om dette ble kjent. Derfor kan det å være arvebærer potensielt være diskrediterende.

Den nye kunnskapen gir familien mulighet til å påvirke slektens fremtid. Paret er også fornøyd med den nye kunnskapen fordi den, ifølge mor, avkrefter moralske teoriene som årsak til at man får syke barn. Som tidligere nevnt er det nettopp det moralske aspektet som er sentralt innad i pakistanske miljøer i betydningen hva galt har vi/de gjort, og som for familier med syke barn, kan forstås som et stigma knyttet til en betydelig følelse av skam.

Forstått i en norsk debattsammenheng er familiens strategi en måte å søke seg vekk fra ekteskapsformen som utelukkende forbindes med noe negativt, hvis reproduktivt resultat i form av syke barn forstås som unødvendig, fordi pardannelsen oppfattes basert på gale premisser. Slekten kan likevel ikke lenger beskyldes for å utøve tvang, at de ikke gifter seg av kjærlighet eller oppfordrer til seksuelle relasjoner som i majoritetsbefolkningen ikke er allment akseptert, og som dertil oppfattes å være årsaken til syke barn på en måte som kan sies å være tatt ut av sine proporsjoner.

Den risikoen som søskenbarnekteskap utgjør, er blitt den overordnede teorien. Andre forklaringer lukker man øynene for, eller de etterspørres ikke. Spørsmålet er derfor om det er *konstruksjonen av risiko* som blir stigmatiserende og dermed moralsk førende.

I en slik politisert debatt med sterk grad av polarisering blir overdrivelse og benektning viktige strategier for på den ene siden å fremme politiske interesser og på den andre siden å beskytte seg mot det som av pakistansk-norske kan forstås som krenkende kritikk og mangel på respekt for deres normative verdier, samtidig som andre viser at familier og miljøer lar seg påvirke. For noen forsterker stigmatiseringen grenser mot majoritetssamfunnet, mens den for andre går på selvfølelsen løs. Dette handler også om at de opplever seg vanæret, og mister både respekt og selvrespekt.

Respekt (ghaerat) og respektløshet (beghaerat) er et begrepspar som i en pakistansk sammenheng brukes for å definere ære (izzat). Motsetningen til ære er ikke nødvendigvis ikke å ha ære, men vanære, noe som innebærer skam. Ved at viktige aktører i debatten opptrer på en måte som oppfattes som en slik mangl på respekt, kan dette bidra til en strategi der folk forsøker å beskytte seg mot denne vanæren. Ifølge Yang m.fl. (9) er grunnen til at et stigma oppfattes truende nettopp fordi det innebærer tap eller ødeleggelse av verdier, i denne sammenhengen verdien av å gifte seg i slekten.

Kongefamilien skal tradisjonelt gifte seg med andre kongelige, og de to siste kongene er begge sønner av søskenbarnforeldre. Selv om det også har vært snakket om uheldige konsekvenser av slektskapsgifte blant kongelige, har det ikke bidratt til stigmatisering. Og det tok mange år før Regjeringen og Kong Olav V ga Harald tillatelse til å gifte seg med den ikke-kongelige Sonja nettopp fordi hun kom utenfra.

Denne prosessen har mange likhetstrekk med den som den pakistansk-norske «altmuligmannen» Abid Raja opplevde da han ønsket å gifte seg med en kvinne utenfor slekten. Men informasjon om at kongelige, samer og en betydelig andel av verdens befolkning praktiserer slike ekteskap, tar ikke fokus fra den pakistansknorske befolkningen og har neppe bidratt til å endre folks forståelse av pakistansknorske ekteskapsformer.

Både kongefamiliens og de pakistansknorskes ekteskapstradisjon handler også om å opprettholde identitet. Kongefamilien har på mange måter tilpasset seg storsamfunnet ved å endre praksis, men uten at de ble utsatt for press om å gjøre det; presset har heller gått den andre veien. Når de kongelige ikke kritiseres for ekteskap i slekten, mens de pakistanske opplever dette, kan det forstås i lys av statusforskjeller, samt at det å være etnisk minoritet ustanselig er en del av det å bli vurdert opp mot majoritetsbefolkningens verdier. Som ikke-kongelig kan imidlertid Mette-Marit raskt endre status og identitet gjennom giftermålet, noe etniske minoriteter med synlige tegn på annerledeshet ikke kan gjøre.

Hva er det så i debatten som bidrar til at det å gifte seg i slekten eller forsvare denne praksisen, kan forstås som et stigma for pakistansknorske par?

For det første fordi denne debatten bare er én av mange om innvandrere og pakistanere, som f.eks. debatter om muslimer, islamisering, hijab og tvangsekteskap, og som når de legger seg oppå hverandre, til sammen kan bidra til stigmatisering.

For det andre preges debatten av at den etter hvert sammenfaller i tid med arbeidet om ny utlendingslov og ekteskapslov, og en betydelig satsing fra myndighetenes side til å avdekke og forebygge tvangsekteskap. Dermed blandes dette sammen med debatten om helse.

For det tredje fordi den kulturelle praksisen med slektskapsbaserte ekteskap vurderes opp mot majoritetsbefolkningens normer når det gjelder kriterier for pardannelse; kjærlighet, altså følelser mellom to personer. Pakistanerne anses derfor for å inngå ekteskap på feil grunnlag. Stigma handler nettopp om at de reflekterer verdiene i den dominante gruppen (27).

For det fjerde fordi den kulturelle praksisen knyttes til seksuelle tabuer, det vil si noe umoralsk og nærmest incestiøst både med og uten konkret bruk av begrepet innavl, som kan tolkes som et tegn for en avhumanisering. Et annet eksempel er overskriften «Søskenbarn-sex» på lederplass i Norges største lokalavis, Romerikes Blad (29) og et utdrag fra teksten er følgende:

«Søskenbarnekteskap var sosialt akseptert blant vanlige folk inntil ganske nylig, men i dag er det i de aller fleste etnisk norske familier absurd og utenkelig å inngå ekteskap i så nære relasjoner.»

Dette viser en tydelig avstandstakende holdning til en blanding av kategorier som ikke skal blandes. Slikt skaper resonans i befolkningen, og over flere sider svarer et utvalg personer med ulik bakgrunn at slik vil vi ikke ha det, når journalistene spør dem.

På bakgrunn av refleksjon etter terrorangrepet i Oslo og på Utøya 22. juli 2011 har imidlertid statsråd Ola Borten Moe i VG (30) beklaget sin tidligere bruk (31) av begrepet innavl om søskenbarnekteskap. Men spørsmålet er om det har noen betydning å beklage hvis det ikke etterfølges av en mer nyansert forståelse av hva det innebærer å gifte seg i slekten, og en mer nyansert forståelse av hva forskningen om reproduktive hendelser handler om.

Avslutning

Jeg har gjort en analyse av en avgrenset tidsperiode. Men debatten vil fortsette, slik den også gjør i andre land (14, 32). Stoltenbergs forskning bidro utvilsomt, etter noe tid, indirekte til stigmatisering av slektskapsbaserte ekteskap, selv om Camilla Stoltenbergs stemme, når hun deltok, var en tydelig motvekt til den måten hennes forskning ble brukt på.

På samme måte vil min egen forskning kunne bidra til et enda sterkere fokus på en allerede utsatt gruppe, avhengig av hvordan forskningen blir forstått og brukt. Ingen kan se bort fra en slik effekt, og her har også mediene et etisk ansvar. Spørsmålet er om forskeres stemmer vil ha en dempende effekt eller bidra til økt stigmatisering. Som forsker og norsk har en uansett en betydelig grad av definisjonsmakt.

Spørsmålet for den videre debatten bør være: Hvordan kan det unngås at det å gifte seg i slekten blir et sosialt stigma i fremtiden på en måte som får en negativ betydning for pakistansknorske personer og familiers identitet og selvfølelse? Dette handler om hvordan de pakistansknorske på et mikronivå vil håndtere tematikken knyttet til slektskap og økt risiko for reproduktive hendelser. Handling på mikronivå er nemlig viktig med hensyn til hvorvidt et stigma blir opprettholdt (3). Dette kan de pakistansknorske familiene umulig håndtere uten bistand fra de som er eksperter i å gi genetisk veiledning; medisinske genetikere og genetiske veiledere.

Det handler også om hvordan helsemyndighetene, helsepolitikere, ansvarlige for utdanningene og helseinstitusjonsledere på et på makronivå kan bidra til å styre debatten over i et annet spor der ikke lenger ekteskapspraksisen er det sentrale, men det å yte best mulig kunnskapsmessig tilgjengelige helsetjenester til risikofamilier. Dette handler derfor også om å styre tematikken over i andre fora. Det er imidlertid nettopp med hensyn til helseforhold at jeg mener stigmabegrepet er anvendbart, og ikke generelt med hensyn til pakistanere.

Helsemyndighetene har tidligere vært stille i debatten, og dette har pakistanerne merket seg. Spørsmålet pakistansknorske miljøer derfor stiller seg, er hvorfor helsemyndighetene ikke viser at de engasjerer seg. Kan det være fordi problemet er mindre dramatisk enn det som gjenspeiles i debatten, eller har det seg slik at helseforhold hos minoritetsgrupper ikke er like viktige som for majoritetsbefolkningen?

Et interessant spørsmål er derfor hvordan debatten ville ha utviklet seg om helse og forhold for funksjonshemmede hadde vært hovedfokus i debatten, og med helsemyndigheter og funksjonshemmedes interesseorganisasjoner som pådrivere. Få med minoritetsbakgrunn er medlemmer av funksjonshemmedes interesseorganisasjoner, og dette kan forklare fraværet av foreningenes deltakelse.

Ved et perspektivskifte som her skissert, vil debatten ikke lenger få samme stigmatiserende kraft som når dens hovedaktører er de som er opptatt av innvandrings- og integreringspolitikk. I min studie har jeg nettopp funnet at genetisk veiledning er vanskelig tilgjengelig for de pakistansknorske familiene og at dette blant annet har sammenheng med at de som velvillig yter veiledning, opplever at de ikke har den kompetansen de burde for å veilede minoritetsfamilier på en mer hensiktsmessig måte.

Litteratur

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Takk

Følgende personer takkes for kommentarer til manuskriptet: Thomas Hylland Eriksen, Benedicte Ingstad, Arvid Heiberg, Camilla Hansen, Gry Sagli, Grace Romsland og Inger-Lise Lien.

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